PROCHILD
PROTECTION AND SUPPORT OF ABUSED CHILDREN THROUGH MULTIDISCIPLINARY INTERVENTION

Co-funded by the Rights, Equality and Citizenship Programme (REC) Programme of the European Union

WP3
Mapping of operators' needs and good practices for an early and integrated detection and treatment of abused minors

D3.1 - How to detect violence against children, support child victims and integrate services for their protection and support? Collection of good practices

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1. Background

Violence against children, in all of its forms, is still an underground phenomenon that is not fully captured in statistics. It is also a multifaceted phenomenon affecting all social classes and ethnicities. It is often difficult to notice because of cultural mechanisms of minimization and denial and because it mainly occurs within the family (WHO 2002). Besides the immediate threats to the short-term well-being of children, the long-term effects of violence are severe and often affect broad aspects of life (Widom 2013). Long-term consequences of experienced violence may be an increased risk of (re-)victimization, physical or mental health problems, such as depressions, anxiety disorders or post-traumatic stress disorder (Lenz, 2014; National Center for Injury Prevention and Control, Division of Violence Prevention, 2016). Experienced child maltreatment is also associated with failing to achieve secondary school qualifications (Boden, Horwood & Fergusson, 2007) or risky sexual behavior (Norman, Byambaa, De, Butchart, Scott & Vos, 2012).

Professionals working with children and families play a crucial role in both detecting violence against children as well as supporting child victims and their families. This report maps good practices of integration of services for the protection and support of abused minors by conducting a literature review and collecting national good practices. It is targeted to policy makers, social and health care professionals, the police, educational agencies, judicial authority and lawyers, and other professionals working with children and families. The report is produced under project PROCHILD - Protection and support of abused children through multidisciplinary intervention.

1.1 Project PROCHILD

Co-funded by the Rights, Equality and Citizenship Programme (REC) Programme of the European Union

PROCHILD project is a European transnational project co-financed by the European Commission under the Rights, Equality and Citizenship programme (REC). PROCHILD is creating a multi-professional, integrated model of cooperation among stakeholders involved in providing response to violence against children, in order to tackle underreporting and fragmentation of services and implement a joint approach based on complementary competences and child's best interest.

Notably, it is intended to:

- raise awareness on child violence and how to give/receive support;
- improve the integration and interdisciplinary of protection and support services;
- increase professionals' skills in detecting, reporting and supporting child victims;
- complete protocols tackling existing gaps in the integrated intervention;
- improve protection and care systems through children's active involvement;

The project's purposes will be reached through the following activities:

- mapping good practices of integrated protection and support;
- definition of the causes of child violence and parental mental health;
- mapping of professionals' training needs;
- identification of criteria for early detection of violence;
- quality assessment of protection and support services and of awareness-raising material;
- definition of shared protocols through round-tables and focus groups of stakeholders;
- development of EU interdisciplinary, multi-professional model;
- development/testing of training modules for operators and e-learning platform and lectures for university students.

The project is expected to reach at least 360 trained child protection professionals (social/healthcare, police, Judicial Authority) and educational staff; 300 university students; 144 stakeholders in round-tables; 460 stakeholders reached by dissemination events; as

well as 6000 citizens reached by dissemination/communication tools in all the partners' countries.

As a transnational project, PROCHILD involves six organisations from six countries having a profound and varied experience and competences in child care services:

- Alma Mater Studiorum Università di Bologna (Italy), Department of Medical and Surgical Sciences, works closely with experts from the University Sant'Orsola Hospital - avantgarde pole in Italy, social and health services as well as Police, Judicial Authority law enforcement services to tackle the phenomenon of violence against child.
- Terveyden ja Hyvinvoinnin Laitos (Finland) promotes population's wellbeing and health. Coordinates the National Action Plan for Injury Prevention among Children & Youth, including reduction and prevention of disciplinary violence.
- La Voix De L'enfant (France) is a Federation of 80 charitable organizations whose activities include: legal assistance to child victims and parents; Paediatric Medical-Judicial Hosting Units for child victims; protected hearing room in District Court and confrontation rooms to improve conditions of child victims' hearing.
- The IARS International Institute (United Kingdom) provides educational, research, policy services in 3 areas: user and civic participation; restorative justice and dialogue; individual empowerment and responsibility.
- Katholische Fachhochschule Nordrhein-Westfalen (Germany) is a German Institute on addiction and prevention research exploring substance abuse in relation with parental violence, notably violence by parents with mental disorders.
- Institouton Ygeias Tou Paidiou (Greece) is a semi-public agency funded by Ministry of Health & Social Solidarity. ICH Dept. of Family Relations operates as Centre for Prevention of Child Abuse & Neglect and carries out research as well as training and services on violence against children and prevention of victimization

1.2 International conventions

All children have a right for protection. This is stated e.g. in the United Nations Convention on the Rights of the Child (UNCRC) in article 3 (chapter 2). Also, many other agreements on human rights – such as the European Convention on Human Rights – apply equally to all individuals, children included. The protection of children from violence, maltreatment and sexual abuse is an essential part of many international treaties that bind most nations.

The United Nations Convention on the Rights of the Child was adopted by the UN General Assembly in 1989. It has been ratified by all members of the UN except the United States. Three optional protocols have been adopted later. They include (1) The Optional Protocol on the involvement of children in armed conflict, (2) The Optional Protocol to the Convention on the sale of children, child prostitution and child pornography, and (3) The Optional Protocol on communications procedure. United Nations Committee on the Rights of the Child monitors the implementation of the Convention on the Rights of the Child.

Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (also known as “Lanzarote Convention”) requires criminalisation of all kinds of sexual offences against children. It outlines that states in Europe shall adopt specific legislation and take measures to prevent sexual violence, to protect child victims and to prosecute perpetrators. All 47 Council of Europe member states have signed and 44 states have ratified the convention.

The Council of Europe Convention on preventing and combating violence against women and domestic violence (also known as “Istanbul Convention”) acknowledges that children do not need to be directly affected by violence to be considered victims as witnessing domestic violence is just as traumatising. Therefore the convention has several provisions

that deal explicitly with children. For example the states are required to provide support services and shelters for women victims of violence and their children and to ensure that significant incidents of violence against women and domestic violence are taken into account when determining custody and visitation rights.

1.3 Definition of child maltreatment

The World Health Organization defines **child maltreatment** as “the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment”. Since especially younger children depend on their caregivers for their every need, it is not surprising that in general the greatest risk for children is within home (Miller-Perrin & Perrin, 2013). The definition of child maltreatment in general and the different forms of it in particular always depend on the cultural context.

Besides emotional abuse, **physical abuse** is the second most frequently reported form of child abuse (Stoltenborgh et al., 2015). Physical child abuse is defined as one or more physical injuries inflicted upon the child intentionally. Physical abuse can be the result of punching, beating, kicking, biting, burning, shaking, or other actions likely causing injuries, trauma or other physical suffering. A child who is physically abused may have repeated physical injuries and a number of emergency room or other doctor's visits. There often is no adequate explanation as to the origin of the injuries (Herrmann et al., 2016). Parents or caregivers may claim them to be accidental or provide other implausible explanations about how the child got hurt. There is a substantial debate going on about corporal punishments

and their relationship to other forms of physical abuse. Abusive parents or caregivers may not have intended to hurt the child, the child's injury may have resulted from overly harsh discipline or corporal punishment instead.

Although physical child abuse with its often noticeable injuries or bruises is more apparent, **child neglect** might do at least as much damage to young children. There are different ways a child can be physically neglected, which is why definitions may vary depending on the professional standpoint taken (e.g. legal, medical, psychological or social service perspective) (Farrell Erickson & Egeland, 2002). So in a very broad way, physical neglect is defined as the failure to provide for a child's basic physical needs, including adequate shelter, food or clothing as well as the failure to protect it from harm or danger (Farrell Erickson & Egeland, 2002). Mennen et al. (2010) found that the most common type of neglect was supervisory neglect followed by environmental neglect. With the exception of medical neglect, all types of neglect were significantly correlated with each other. Neglected children had more reports of maltreatment and experienced more different types of maltreatment than those who were maltreated, but not neglected.

Emotional abuse and neglect is a very common, but under-recognized form of child maltreatment. Stoltenborgh et al. (2015) even found it to be the most frequent form of child maltreatment. Their review determined a worldwide prevalence of 363/1000 for self-reported measurements. Professionals still find it difficult to recognize and operationally define it. Additionally there is a significant uncertainty about proving it legally because of the absence of clear physical evidence and the fact that it often starts when children are too young to speak out. In general, emotional abuse and neglect are defined as pattern of harmful interactions in a carer-child relationship. Neither a physical contact with the child nor motivation to harm is required (Glaser, 2002). The child's development is impaired in a broad variety of domains of functioning. Since these are not specific to emotional abuse and neglect, they cannot be regarded as diagnostic (Blesken et al., 2019). Emotional abuse or

neglect of a child often occurs together and/or simultaneously with other forms of abuse (Häuser et al., 2011).

Emotional neglect is also distinct from emotional abuse. Emotional abuse on the one hand are acts of commission (for example name-calling, badgering, or constant complaining); whereas emotional neglect on the other hand are acts of neglectful omissions. **Emotional or psychological abuse** is the ongoing emotional maltreatment of a child and shows itself in a variety of behaviors. The caregiver may devalue a child by inadequate punishments or insulting language. Children may be exploited in parental conflicts or made feel guilty. Emotionally abused children are prevented from an adequate and healthy development (Blesken et al., 2019). **Emotional neglect** involves failing to provide emotional support that parents or caregivers should provide. This lack of support may affect different aspects of child's needs. First, children have a need for security and for living in a save and loving family environment. The younger a child is the more it needs the presence of an emotional available and sensitive caregiver. Second, children have the need for acceptance and a feeling of self-worth.

"Child **sexual abuse** is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society" (WHO Consultation on Child Abuse Prevention, 1999). This includes not only sexual contact but exposure to sexual acts or material as well, as long as the activity is intended to gratify or satisfy the needs of the other person. Child sexual abuse includes any activity between a child and (whether adult or child) who regarding age or development is in a relationship of responsibility, trust or power.

This may include but is not limited to

- the inducement or coercion of a child to engage in a sexual activity;

- the exploitative use of a child in prostitution or other unlawful sexual practices;
- the exploitative use of children in pornographic performance and materials

1.4 Research questions

Child abuse is often repeated and victims receive protection and rehabilitative, social and psycho-emotional treatment at a later stage. Clinical evidence and research have shown short, medium and long-term consequences of violence on health highlighting how physical and psychological damages require early, integrated and specialised treatment. In services dealing with child and adolescent protection, the need has emerged for an improved integration of health care services, social services, schools and early childhood education, judicial authority and the police. Project PROCHILD aims at creating a multi-professional and integrated model of cooperation. This report is a part of this work by collecting existing knowledge and good practices for creating a research based foundation for the development of project PROCHILD's activities.

This report seeks to answer the following questions: (1) What kind of good practices there are to detect physical/emotional child abuse/neglect and sexual abuse? (2) What kind of good practices there are to provide support for abused minors? (3) What kind of good practices of integration there are among services for the protection and support to abused children?

2. Methodology

The aim of this report is to map practices/interventions that help professionals to detect child maltreatment, to offer support to victims and to cooperate, and that are evaluated as effective. We cover existing scientific research and reports of national practices.

2.1 Database search

Several scientific databases were searched for systematic reviews and other relevant studies. While the definition of a child in the literature review is a person aged 0 to 17 years, we divided them into following age groups: young children (aged 0 to 12 years) and adolescents (aged 13 to 17 years). The literature search took studies and literature reviews from 2008 to present into account. Since the keywords for the database searches were in English, the results consequently cover research and reports written in English. The mapped practices were created for health and social care settings, since these professionals have the principle responsibility for detection of any form of child maltreatment. For this reason, practices created only for educational settings were excluded.

A search of Medline, CINAHL, PsycINFO, ASSIA, Sociological Abstracts, SocINDEX and Web of Science was undertaken using search strings created together with THL's information specialist Pia Pörtfors. Detailed search stings are available on request from the authors. Studies identified through this search were examined as to their relevance to the research questions. This involved first a read of the title and abstract and then a read of the full text if the research was considered relevant. Studies were retained if they evaluated interventions or practices relating to detection of maltreatment, support for victims, or service integration. The results are presented in chapter 3.

2.2 Gray literature

All partners searched for national good practices from national reports and studies, internet and correspondence with relevant stakeholders. The results of these search is presented in chapter 4.

3. International good practices

This chapter presents the results from scientific database searches. The results are outlined according to our three research questions.

3.1 Detection of maltreatment

What kind of good practices are there to detect physical/emotional child abuse or neglect and sexual abuse?

The detection of any form of child maltreatment is a crucial point in the child protection process. Early identification of abused or neglected children allows a timely involvement of children in support services and treatment. This may help to decrease mortality and morbidity in abused children (Bailhache et al., 2013), reduce long-term consequences of child maltreatment and increase the installation of successful support for the families (Chen et al., 2010; Hoft et al., 2017).

The recognition of child abuse and neglect is inconsistent and often triggered by other events or concerns about vulnerable children (Daniel et al., 2010). One manifestation of child maltreatment is that a lot of affected children do seldom gain access to child protection services. Parents or caregivers are unwilling or afraid of seeking help in public support systems. Therefore, health as well as education professionals play a crucial role in recognizing signs of child abuse or neglect. For example, parents of neglected children are often known to various professionals, such as the law enforcement, health care staff in

substance misuse agencies, psychotherapists or learning disability advocates and it is crucial for them to be alert to signals that could impact adversely upon their children (Daniel et al., 2010).

The literature search regarding this research question analyzed good practices for detection of child maltreatment. In the end, twenty studies met all criteria and where therefore included. Seven of them were (systematic) reviews, while the others were surveys, evaluations or prospective diagnostic accuracy studies.

A vast amount of theoretical and empirical information is available on the signs and symptoms of child abuse and neglect (Hoft et al., 2017). Since there seldom was a distinction between different forms of child maltreatment, the results are sorted according to the professional setting they were created for.

Health care setting

The main proportion of all practices used for the detection of child maltreatment were in some sort of health care setting.

Bailhache et al. (2013) conducted a systematic review including thirteen studies. They analyzed practices for all kinds of abuse in different age groups. They found that physical examinations, CT scans or prediction rules that combine different variables/symptoms to detect physical child abuse and neglect were mainly used for younger children up to 4 years. Additionally comparisons between injuries and parents or caregivers explanations for them were drawn. They found that questionnaires for detection of emotional abuse were used for children aged 13-15 years old. For example the adolescents were asked how often they experienced a given parental behavior. The researchers found that for the identification of child sexual abuse a variety of practices were used: anal and genital examination, the frequency of a variety of sexual behaviors or a questionnaire consisting of a list of 12

symptoms (e.g. change to poor school performance, unusual interest in sex matters) answered by caregiver. Unfortunately there was a low quality of studies and the instruments in 11 studies only identified abused children if they had clinical syndromes.

Hoft et al. (2017) reviewed the literature in regard to screening instruments for child abuse and neglect. The included nine studies used different screening instruments such as questionnaires (for example "Escape" by Louwers et al.), screening checklists, behavioral observations or physical abuse screening flow charts. The practices were used for various forms of abuse and different age groups. A total of 5 tools were used for the detection of physical abuse. These instruments as well as the ones created for the identification of sexual abuse proved themselves useful in health care settings such as the Emergency Room or Intensive Care Units, while psychological abuse could not be detected. But a lot of instruments, such as screening tools empirically developed to detect child abuse, mainly physical abuse in the context of the emergency department, have been found to be minimally effective and lacking rigor (Hoft et al., 2017).

Crichton et al. (2016) analyzed screening instruments as well. Their study highlights the need for the development of a brief and uniform screening tool for child physical abuse which can potentially increase abuse detection and thereby decrease the bias in evaluating at-risk children.

Dinpanah et al. (2017) evaluated the screening tool "Escape" (Louwers et al.) for children and adolescents up to 16 years. The screening instrument is used for physical child abuse risk assessment by professionals in the Emergency Department. Using this instrument, screening rates increased from 20% in February 2008 to 67% in December 2009. The detection rate in the screened children was 5 times higher than those not screened. Therefore, it seems that “Escape“ is effective in increasing detection of potential child abuse.

Ezpeleta et al. (2016) developed a screening tool enabling identification of infants and toddlers at risk of family abuse and neglect. It was created for professionals in the health care system who come in contact with children aged 3 or younger. The instrument is a nine-item screening tool, consisting of items assessing relational emotional abuse, physical abuse and other risk factors. It was applied to more than 200 families with 0 to 3-year-old children attending public health centres. Clinicians reported that they agreed on the inclusion of the questions (86.4–100%) and that they found the questions to be useful for the clinical evaluation of the family (63.2–100%). The instrument has good face validity and was reported feasible by an international set of clinicians.

Horrevorts et al. (2017) evaluated a screening tool 'Instrument for Identification of Parents at Risk for child Abuse and Neglect (IPARAN)'. The results of this study support the concurrent validity, discriminatory power and feasibility of the IPARAN among a population of Dutch parents with a newborn child. These three domains are considered: child and family characteristics, parental developmental history and personality (including parental awareness) and characteristics of the social context. It is a self-report form, containing 37 items in total. The IPARAN has a general part (filled in by both parents), a part for the mother and a part for the father/other parent. The general part consists of five items relating to risk factors in the first domain: birth weight of the child, duration of pregnancy, age of mother at delivery, age of father at delivery and family structure. The section filled in by the mother and the section filled in by the father/other parent each consists of 16 items. These items relate to risk factors in all three domains.

Woodman et al. (2010) conducted a systematic review on the screening of injured children for physical abuse or neglect in emergency departments. They assessed screening markers used in emergency departments to identify children who should be further examined for possible physical abuse and neglect. The used markers were: age, repeat attendance in ER and type of injury. There was no evidence that any of the markers were sufficiently accurate

to screen injured children in the ER to identify those requiring paediatric assessment for possible physical abuse or neglect. Clinicians should be aware a high proportion of abused children in the ER will present without these characteristics and a high proportion of non-abused children will present with them. Information about age, injury type and repeat attendances should always be interpreted with this in mind.

Schouten et al. (2016) developed a screening instrument called SPUTOVAMO-R2 for child abuse at out-of-hours primary care (OOH-PC) services. Positively screened cases were discussed by a multidisciplinary team. The checklist that followed by a reporting code guaranteed consistent actions and care for children in cases of suspected child abuse. The percentage of positive checklists was in the current study lower than expected. The validity of the checklist should be further assessed in a diagnostic study.

Erfurt et al. (2011) systematically reviewed radiological diagnostic procedures in cases of clinically diagnosed injuries to the head, thorax, abdomen or extremities of a child, especially if there was no case history or if the reporting of an inadequate trauma suggested physical child abuse. Radiological diagnostic can be used to identify physical child abuse through a full skeletal survey up to three years of age and old fractures which are unaccounted for in children older than that.

Daniel et al. (2010) give a systematic overview of the literature regarding recognition of neglect and early responses to it. Health care as well as educational professionals were asked to rate the importance of 45 signs and symptoms of neglect (created by Lewin & Herron, 2007). There is evidence that professionals can identify signs of neglect but are not always clear about the best response. There remain gaps in evidence about how best to respond to neglected needs, especially within educational staff in schools. Daniel et al. conclude that professionals need to develop networks built on trust and mutual aims in order

to ensure that children get easy access to required support. Another conclusion by the authors is that law enforcement is an overlooked group in research on detection of neglect.

Johnson et al. (2018) conducted a systematic review regarding how training programs may improve paramedics' ability to identify and report child abuse and neglect. Since paramedics have access, often at short notice, into the home of a child in a context that is generally not accessible to other health professionals, they are in a unique position for detection of child maltreatment. The limited evidence published so far suggests that training improves the confidence and ability levels of paramedics in recognising and reporting child abuse. The authors call for further research into the topic before drawing robust conclusions.

Ezzo & Young (2012) developed and evaluated the Cleveland Child Abuse Potential Scale (C-CAPS). C-CAPS is an actuarial risk assessment tool for child maltreatment and is comprised of eight Historical Factors, five Personality/Mental Health Characteristics, eleven Family Characteristics, three Substance Abuse Characteristics, four Parent–child Relationship Characteristics, four Ecological and Other Factors, and five Protective Factors. The major contribution of C-CAPS is to identify risk and protective factors in child maltreatment and develop treatment plans to reduce the risk factors and support and strengthen the protective factors. Study results provide compelling support for overall classification accuracy, with 100% specificity and 95% sensitivity and an overall hit rate of 98%, when only the maltreatment and non-maltreatment groups were compared. The instrument was able to correctly classify 85% of Non-Maltreatment cases and 76% of Maltreatment cases.

Sittig et al. (2015) analyzed the value of systematic detection of physical child abuse at emergency rooms. Therefore all children aged 0–7 years attending the ER because of physical injury were systematically tested with an easy-to-use child abuse checklist. They found that although cases of inflicted injury of this children presenting at ERs for injury are

very likely captured by easy-to-use checklists, there are high false-positive rates. Additional assessment by child abuse experts can therefore be restricted to children with positive screens at very low risk of missing cases of physical child abuse.

Van Looveren et al. (2017) assessed the risk of physical child abuse in parents of children referred to the child and adolescent psychiatry. They used the Dutch version of a self-report screening questionnaire consisting of 160 statements that have to be scored with a forced-choice format. The statements measure attitudes and beliefs to assess the risk to physically abuse children. They found that one out of four families (25%) in the child and adolescent psychiatry department of the Ziekenhuis Netwerk Antwerpen (ZNA) Erasmus hospital is at risk for child abuse.

Wills et al. (2007) analyzed whether a comprehensive organisational change approach may lead to improved identification of child and partner abuse. For example a formal organisational change approach included receiving senior management support, community collaboration, developing resources to support practice, research, evaluation and training.

Cambell et al. (2014) leaded to say that Medical professionals could identify younger children who could be at risk of emotional maltreatment because of their unique positions. Medical professionals can identify this risk by observing the interaction between the caregiver and his or her child, by noting difficult or inappropriate interactions between them and by detecting risk factors for emotional maltreatment in the family's social history.

Van der Put et al. (2016) analyzed the California Family Risk Assessment (CFRA) used in the Netherlands for the detection of unsafety in families with parental and/or child developmental. CFRA can be used by professionals in social and health care services. Results show that more than a half of CFRA items were most strongly related to future reports of child maltreatment were the number of prior neglect or abuse interventions, reports and/or investigations, and domestic violence.

Lusk et al. (2015) asked school psychologists if they could identify child maltreatment. School psychologists have an important position by identifying child abuse because they are part of education and health care services and they are uniquely equipped to identify and report child maltreatment. The study shows that 43 percent of participants received just the initial two-hour training required to work in a school. The trainings improve the ability of school psychologists to identify and report child maltreatment, but the study suggest that many school psychologists could benefit from supplemental training to improve the recognition and reporting of child maltreatment.

Peak et al. (2018) developed a screening tool for child maltreatment called Finding Instrument for Non-accidental Deeds (FIND) by using a modified Delphi study. This screening was used by healthcare providers in Emergency Departments for children under the age of fourteen years and included eight questions. One of the items (suspected signs in physical examination) had 100 percent agreement; three items (inconsistency with development, inconsistent history by caregivers, and incompatible injury mechanism) had 86.7 percent and the last four items (delayed visit, inappropriate relationship, poor hygiene, and head or long bone injury in young infants) had 80 percent agreement. Peak et al. developed an ED-based screening tool for child abuse for injured children. The use of such screening tool in the ED with low reporting rate of child abuse is expected in increase the reporting rate. However, Peak et al. suggest the need of further study to investigate the accuracy of the screening tool using national child registry.

Diederich et al. (2014) analyzed the Hague Protocol used in a new region. The Hague Protocol is used to identify child maltreatment based on parental characteristics instead of child characteristics. The following three parental categories are included on the fact that these could be serious conditions that often require medical care at an ED and are conditions that may severely and adversely impact any children of the patients: domestic violence, intoxication with alcohol or drugs and suicide attempt or self-harm. The results of

the Hague Protocol used in Friesland demonstrated that this Protocol can be successfully implemented in a new region. One of the most notable outcomes is the increase in the number of referrals from the ED to the Reporting Centers for child abuse and neglect (RCCAN), from 3 to an average of 62 per 100.000 ED patients.

3.2 Support for victims

What kind of good practices there are to provide support for abused minors?

Support can play a crucial role in the later well-being of a victim of child maltreatment. After detection of maltreatment and immediate treatment of potential injuries, it is important that the victim receives support with both the criminal investigation process as well as coping with the consequences of abuse. Sometimes supporting child victims requires supporting also the parents/caregivers.

The search provided all together twenty-one literature reviews and meta-analysis that met the criteria of inclusion under this research question. Most of the research covered different kinds of treatments provided for abused children and their parents/families. There was a lack of research on support provided to child victims during criminal investigation process. The results are sorted according to type of practice/intervention.

Child advocacy center model

Herbert & Bromfield (2016) conducted a systematic review on child advocacy center model (CAC) including 27 studies. The Child Advocacy Center (CAC) was initially developed to reduce systemic trauma (caused by multiple and redundant interviews). While the CAC model employs elements that themselves have a strong evidence base, there is a limited

research and limited evidence of the model's efficacy in terms of child and family outcomes. The study found it problematic that much of the evidence for CACs relies on the measurement of outcomes that simply suggest that approach is operating as intended.

Most studies measured CAC's criminal justice –related outcomes, but there were also studies concerning service user satisfaction, child physical and psychological well-being and family functioning. There was limited evidence that CACs were associated with better criminal justice outcomes, mostly in terms of increased number of arrests and cases proceeding prosecution. There were conflicting results in studies examining the effect of CACs in the rate of abuse in the community. CACs were found to result in increased medical services, multidisciplinary collaboration and mental health referrals. There were no difference in number of interviews between CACs and other services. Fairly high levels of satisfaction from children, parents and workers with the CAC approach were found. When compared with other communities, caregivers were considerably more satisfied with CAC service delivery, while children reported no significant difference in their satisfaction. No difference was found between satisfaction with medical examinations in CAC and standard service (Herbert & Bromfield 2016).

Secondary intervention programs for violently injured youth

Snider & Lee (2009) and Mikhail & Nemeth (2016) studied youth violence prevention programs targeted for violently injured youth who visit trauma centers of emergency departments (ED).Their reviews covered interventions targeted to youth aged between 10 to 24 years. All interventions were based in North America. Snider & Lee found 7 studies describing four interventions:

- Case management program in the ED in Chicago, where intervention patients were assigned to a case manager who assessed and then referred the patient to suitable resources (education, job readiness, mental health support, health care, legal assistance etc.).
- Case management program for youth attending pediatric ED in Baltimore, where patients were contacted in the weeks after the ED visit, intensive case management consisted of counselling by telephone or in person for 4 months.
- Case management intervention in Milwaukee, where a social worker and project representative offered the program services (home visitation, mental health services, youth activities) to the youths and their families during the initial ED visit.
- Intervention program in Oakland, where the intervention specialist provides case management and mentorship, working with the patient and family up to 1 year identifying short- and long-time needs and connecting the patient and family with local resources (education, job training, counselling, legal assistance etc.).

Most interventions showed positive results, but few were statistically significant because of small sample size and limited power. Case management interventions reported in the articles suggest that these programs can reduce future criminal involvement.

Mikhail & Nemeth found 10 studies presenting 9 programs in 10 cities. These trauma center based programs incorporated brief interventions or comprehensive case management programs. Brief interventions were defined as time-limited patient intervention contacts (1 or 2 contacts) following screening for hazardous and harmful behaviors while case management referred to coordination of health services by a case manager who guides the patient through recovery often extending into the community. Mikhail & Nemeth conclude that extensive variation in individual level influences suggests that no single prevention

program applied across trauma centers will produce uniform effects. Case management was found to be positively associated with a reduction of violence outcome measures. 90% of studies showed some improvement in one or more outcome measures. The intervention dose, quality, intensity and duration appeared to correlate with improved outcomes. Aspects that correlate with higher success include high-intensity follow-up, early after injury, and availability of mental health services and vocational training and/or employment opportunities. Mikhail & Nemeth state that the success of the trauma center case management programs makes clear that an integrated hospital-community approach is superior to a hospital stand-alone intervention like brief intervention.

Commercial sexual exploitation

Felner & DuBois (2017) conducted a systematic review on commercial sexual exploitation of children and youth in developed countries. They found 13 studies that evaluated programs or policies that 1) aimed to prevent sexual exploitation or commercial sex among children or youth; or 2) aimed to intervene with children or youth who have engaged in commercial sex; or 3) identified children or youth who had been sexually exploited in some capacity. Their conclusion was that given the limitations of the study designs and sample sizes in the reviewed documents, it is premature to reach any conclusions about the effectiveness of the programs or policies involved.

Treatments for children

Leenarts & Diehle et al. (2013) reviewed studies that included various types of maltreatment (physical, sexual) concerning children aged 6-18 years. The studies also included various typed of psychotherapeutic treatments. Best-supported treatment for children exposed to

maltreatment was found to be Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT). In addition studies provided support for cognitive-behavioral intervention for trauma in schools (CBITS) as the best treatment option for children who can be treated in school setting.

Macdonald et al. (2012) conducted a systematic review of the efficacy of cognitive-behavioural approaches (CBT) in addressing the immediate and long-term sequelae of sexual abuse on children and young people up to 18 years of age. CBT interventions for children who have been sexually abused are typically short-term structured interventions around 12 sessions, though they can extend upwards to 40 sessions depending on the case. Their data suggested that CBT may have a positive impact on the sequelae of child sexual abuse, but most results were not statistically significant. Strongest evidence for positive effect of CBT appeared to be in reducing post-traumatic stress disorder (PTSD) and anxiety symptoms, but even in these areas effect tended to be moderate at best.

Miller-Graff & Campion (2016) found in their review on interventions for post-traumatic stress with children exposed to violence that individual CBT treatments showed the strongest effects in child trauma treatment. They also found that the inclusion of an exposure component was relatively critical. Older children seemed to respond to treatment better than younger children. The effects of treatment did not seem to be influenced by the origin of participants' trauma.

Harvey & Taylor (2010) conducted a meta-analysis of the effects of psychotherapy with sexually abused children and adolescents. They examined different kinds of interventions defined as therapy. Their overall results suggested that psychotherapy for the effects of child sexual abuse typically provides beneficial outcomes, which was assessed in terms of symptom reduction as well as improved self-esteem and overall functioning for the child or

young person and non-offending caregiver. They also found evidence that a number of factors might moderate treatment outcome (especially for trauma-related outcomes), and that therapy approaches may be more effective when tailored to the individual needs of the child or young person, taking into account their specific symptom constellation, development, context, and background. They concluded that in determining what is effective in treatment for children and young people, a “no one size fits all” approach is necessary.

Miffitt (2014) conducted a review of 8 articles on the use of group therapy formats with sexually abused children and adolescents under age 18 years. They found that group therapy modalities appeared to hold promise as effective interventions for the myriad of symptoms children may demonstrate following child sexual abuse, although the current state of empirical evidence is unable to support any particular modality over another. A variety of group therapy interventions showed potential for decreasing PTSD symptoms.

Trask et al (2011) studied the overall effectiveness of treatments for the negative consequences of child sexual abuse as well as the specific conditions under which treatments might be more or less effective in their meta-analysis. They found that overall, treatment was effective in reducing many negative outcomes of child sexual abuse. Therapeutic interventions also significantly decreased specific emotional problems in sexually abused children. Individual and group treatments were found to be equally effective.

Parenting/family interventions and parent involved treatments

Van der Put et al. (2018) conducted a meta-analysis on effective components of child maltreatment interventions in 130 studies which examined the effect of home visitation

interventions, parent training interventions, family-based/multisystemic interventions, substance abuse interventions, crisis interventions, cognitive behavioral therapy, and combined interventions. They included both preventing and curative interventions. They found larger effect sizes for curative interventions targeting maltreating parents than for preventive interventions targeting at risk families/the general population, but this difference did not reach significance. Types of curative interventions that were effective in reducing child maltreatment were home visitation interventions, parent training interventions, family-based/multisystemic interventions, substance abuse interventions, and cognitive behavioral therapy. Crisis interventions did not have a significant effect on reducing child maltreatment. Specific individual interventions with a significant effect on preventing or reducing child maltreatment were: MST-CAN/BSF (intensive family therapy), Triple P (a parent training), ACT-Parent's Raising Safe Kids Program(a short-term parent training), and Healthy Start (a home visitation intervention). For curative interventions, larger effect sizes were found for improving parenting skills, improving personal skills of parents, addressing parents' mental health problems, providing social and/or emotional support, and improving child well-being.

O'Reilly et al. (2010) conducted a literature review on the efficacy of family support and family preservation services on reducing child abuse and neglect. They included family-centred interventions that fall under both family support and family preservation services such as home visiting, cognitive behavioural therapy (CBT), group therapies and intensive family preservation services (IFPS). Home-visiting interventions consist of visitation of parents and children in their home by child welfare workers who convey information, offer training and support, or perform a combination of activities with the family. Cognitive behavioural therapy involves modifying parenting and children's behaviours through education and learning and encourages positive interactions between parents and children. Group therapy provides the parents of abused and neglected children with education on

parenting and opportunities for social skills enhancement and the development of social support networks. Intensive family preservation services are brief, intensive services for high-risk families in crisis with the goal of preventing removal of a child from the family home and include case management, home-based counselling, anger management and provision of concrete services. O'Reilly et al. found that IFPS and CBT are the most effective intervention evaluated for preventing and reducing child abuse and neglect amongst high-risk families. This implied that the use of CBT and IFPS would be favourable for child protective services and their clientele. Conversely, home visiting, while largely evaluated, had inconsistent results.

Schweitzer et al. (2015) studied intensive family preservation services (IFPS) that combine case management with intensive therapy and other services. They included four US based programs in their study and found that the research on IFPS does not meet the standards for well supported efficacious practice in child welfare according to the criteria established by The California Evidence-Based Clearinghouse for Child Welfare. However, IFPS does meet the standard of a promising practice as it is based on cognitive behavioral, social learning, and crisis intervention theory, it is replicable (books and training are available), it is supported by three published studies with comparison groups and there is no evidence of greater risk than usual care.

Johnson et al. (2018) found promising results of trauma-informed parenting interventions on parenting practices and child psychosocial outcomes in their meta-analysis of effects of trauma informed parental interventions. They found moderate to large effect sizes for both positive parenting practices and children's internalizing and externalizing behaviors and trauma symptoms However, they stated that their findings should be interpreted cautiously as the number of studies evaluating these outcomes was small.

Corcoran & Pillai (2008) studied in their meta-analysis, how parent-involved treatment of child sexual abuse victims affected child adjustment in terms of different symptom areas (internalizing and externalizing symptoms, sexualized behaviours, and/or PTSD) when compared to another type of treatment or a control group. Their results suggested that, at post-test, parent-involved treatment of child sexual abuse victims had small effects on child adjustment over various types of comparison treatment. Internalizing outcomes showed the strongest effects, followed by PTSD, sexual behaviors, and externalizing behaviors. At follow-up, treatment effects on the four categories of outcomes were smaller (except for sexualized behaviors). It appeared, therefore, that the effects seen at post-test tended to diminish by the follow-up period.

Kennedy et al. (2016) conducted a meta-analysis on the effectiveness of parent–child interaction therapy (PCIT) at reducing future physical abuse among physically abusive families. They defined parent–child interaction therapy (PCIT) as a dyadic parenting intervention, in which the family system is altered through modifying the behavior of both the parent and child. The intervention is grounded in social learning and attachment theories, it employs a family systems approach, and targets children aged 2–7. They found that parents receiving PCIT had significantly fewer physical abuse recurrences and significantly greater reductions on the Parenting Stress Index than parents in comparison groups. They concluded that PCIT appears to be effective at reducing physical abuse recurrence and parenting stress for physically abusive families, with the largest treatment effects seen on long-term physical abuse recurrence.

Batzer et al. (2018) reviewed parent-child interaction therapy (PCIT) in maltreating population. The intervention assumes that the parent–child relationship is built upon a

multitude of interactions that serve as a powerful force in shaping the feelings, thoughts, and behaviors of both parent and child. By intervening and changing the parent's response to their child, relationships are enhanced and a child's behavior often improves. Additionally, the therapy focuses on the concrete activities that occur between parent and child that helps a parent learn to reinforce adaptive behaviors and extinguish maladaptive behaviors in their child. Batzer et al. found that PCIT holds promise as an effective intervention in the child welfare setting for physically abusing parents. Of the 11 studies included in their literature review, all demonstrated strengths of the model with this population.

Dijkstra et al. (2016) studied the effectiveness of family group conferencing (FGC) in youth care in their meta-analysis. FGC is a decision-making model that focuses on the family and its social network, and which aims to gather all parties with an interest in the wellbeing of a child and their family to make a family group plan that teaches and supports active responsibility. It focuses on the strengths and resources of families that can be addressed to solve their problems and to take care of their children. The assumption is that a plan developed and supported by the family and social network of the family is more likely to be carried out than a plan developed by professionals. An additional assumption is that families, by giving them the opportunity to make their own family group plan, feel that they have a voice in matters that concern them and are more motivated to solve their problems. This is expected to result in improved collaboration with youth care agencies.

The findings of Dijkstra et al. indicated that, overall, FGC did not outperform regular care in terms of less child maltreatment, reduction of out-of-home placements and less involvement of youth care. However, moderator-analyses indicated that in studies using a retrospective design, FGC led to less reports of child maltreatment and reduction of out-of-home

placements when compared to regular care, whereas this effect was not present in studies using prospective research designs.

Kinship care

Winokur et al. (2018) conducted a systematic review that evaluated the effect of kindship care placement compared to foster care placement on the safety, permanency and well-being of children removed from home for maltreatment. They found that based on the available data, children in kinship care experience better outcomes in regard to behavior problems, adaptive behaviors, psychiatric disorders, well-being, placement stability (placement settings, number of placements, and placement disruption), guardianship, and institutional abuse than do children in foster care. There were no detectable differences between the groups on reunification, length of stay, educational attainment, family relations, developmental service utilization, and physician service utilization. However, children placed with kin were less likely to achieve adoption and to utilize mental health services, while being more likely to still be in placement than were children in foster care.

3.3 Integration of services

What kind of good practices of integration there are among services for the protection and support to abused children?

Multidisciplinary strategic collaborations are becoming increasingly commonplace particularly in relation to safeguarding children (Horwhat, Morrison, 2011). A number of different services working for child safeguarding are usually involved in case of violence

against a child. These services include health and social services, educational services, law enforcement, judiciary courts.

No single service is responsible for child protection and there are numerous injunctions to collaborate across the service system. However, organisations may see child protection through their own lens and may frame the problem accordingly (Macvean, Humphreys & Healey 2018). This diversity brings benefits and challenges to multiagency working (Laing, Humphreys, & Cavanagh, 2013). Risks can arise when services are unable to work together, including fragmentation of services (Ross, Frere, Healey, & Humphreys, 2011); gaps and overlapping of services (Australian Law Reform Commission, 2010); and a failure to consider relevant risks (Potito, Day, Carson, & O'Leary, 2009). Such issues can create inadequacies in service provision and negatively impact service responses (Humphreys, 2007).

The literature search regarding this research question analysed good practices in the integration of services working for protecting and supporting children victims of violence. In the end, 25 studies met all criteria and where therefore included.

We categorised the results according to the type of violence (sexual abuse, neglect, physical and emotional abuse) and the age of children (younger children 0-12; adolescents 13-17).

Physical and emotional abuse – neglect in younger children and adolescents

Macvean, Humphreys & Healey (2018) found that an interagency between child protection services (including services for child maltreatment and out-of-home care) and domestic family violence (DFV) services (including services for both women and perpetrators), or

family law services, or the courts can have positive effects only when a series of *enablers* (factors) occur, they are: a *shared, agreed vision* for working together as a way to drive collaboration toward like-minded goals; the *formalization of the model* to set expectations and obligations of agencies, allowing all parties to work with transparent and agreed arrangements; an *authorizing environment*, that is establishing a culture that encourages and enables working together; a *clear leadership* to guide interagency working and *information sharing.*

O'Leary P, Young A, Wilde T, Tsantefski (2018) added other factors which affect positively interagency intervention, these are: common training and understanding of domestic violence, common frameworks used by agencies, leadership, managers' understandings of domestic violence and their values (*practice and leadership*).

Also Horwath J, Morrison (2011) recognised strategy (as shared recognition of the need for collaboration) and governance (governance structures should not only be consistent with the vision but also facilitate efficient and effective decision-making) as key enablers of interagency for the success of interventions. Moreover, they identified other three factors, which are: systems and capacity, that is systems and structures – a working plan - as vehicle for ensuring desirable behavior of actors; an output-oriented approach, that is the idea that services for end-users are the primary output of partnerships; an outcome-oriented approach intended as a shift from a focus on outputs to outcomes: that is establishing what difference joint working makes to service-users.

Some authors stressed the importance of collaboration among social and health services and child welfare agencies and decision makers. Lalayants M, Epstein I, Adamy D (2011) research findings indicated that child welfare practitioners found the multidisciplinary clinical

consultations to be extremely helpful for the assessment of child abuse and neglect cases, making referrals, making decisions about case outcomes and developing caseworkers' clinical skills and knowledge.

Also, an informed decision-making at the initial assessment; promoting safe, timely, and stable permanency options for children; ensuring the well-being of children by integrating a trauma informed care approach to child welfare practice and promoting a culture of learning whereby staff persons at all levels can improve practices and policies, proved successful to ensure children safety (Casanueva C, Harris S, Carr, 2018).

Eventually, the establishment of common guidelines providing a roadmap for collaboration among child welfare systems, dependency courts and domestic violence service providers proved successful (Banks D, Landsverk J, Wang, 2008), but some elements can hinder a successful collaboration such as the lack of information sharing; diverse organisations' mandates, due to diverse organisations' priorities and approaches (philosophy of intervention) (O'Leary P et al, 2018).

Every type of abuse – younger children and adolescents

Chinitz et al. (2017) stated that the integration of child mental health services and competences in the practice of child well-being seems to have direct benefits for infants, toddlers and their parents. This can be done with the support of medical and health personnel to improve the practice, and through training for judges, lawyers and professionals in child care.

Dávid B. et al (2014) analyzed the work relationship structure of the members of the safeguarding system: pediatricians, social worker in the Child Welfare Centre, health visitor, other professionals (probation officers, etc.), head of organization (nursery, preschool, school), child and youth care office. The research revealed that there are no isolated individuals, everybody has at least one link to someone else. In the social sector, reducing the gap between research and practice has high priority, and thanks to the improved cooperation, relations of the safeguarding partners have also strengthened.

Collaboration should also include universities, as research involving true partnership between agencies and universities offers the best opportunity to focus on questions that are directly related to real world practice, to engage researcher and practitioner expertise, to improve rigorous design, and to build evaluation capacity and an appreciation for evidence-based and outcomes-focused practice (Collins-Camargo et al, 2011).

In a study conducted by C. J. Kistin et al. (2010), it was highlighted that variables associated to Child Protection Teams (CPTs) effectiveness are: hospital variables (hospital provides adequate support staff, space, and equipment; protected time for team members; hospital demonstrates that it supports the activities of the CPT); variables that will lead to CPT members' working together again (good communication among team members, strong CPT leadership, team members feel a sense of collegiality); how participation in CPT provides opportunity for professional growth (Active interdisciplinary collaboration, opportunity for child abuse or neglect education); how CPT contributes to members' well-being (feeling that working as a team leads to better outcomes, mutual support from members); characteristics of high-quality CPTs (members feel mutual trust and respect, participants are professionals from multiple disciplines, CPTs review their own program on a regular basis).

Good practice examples of Child Health Partnership programs based on service integration model will shape the future initiatives. Considering the difficulties in mapping outcome success, a commonly agreed framework in designing and evaluating child health partnership models is emphasized (Jayaratne K et al.,2010).

Some authors focused on dealing with child abuse in parental mental or drug and alcohol problems. They underlined that the barriers to cooperation in these cases are: challenges with information sharing and confidentiality, low level and quality of collaboration, tensions between the different theoretical paradigms and insufficient clarity around processes and expectations (D.Coates,2017). This collaboration in substance abuse situations has positive outcomes on a child's well-being (Ogbonnaya (2018).

Other authors as Selvaraj K. (2018) focused their attention on the development of child toxic stress. In these cases the development of physician–teacher partnerships to promote positive teaching can be very helpful, as toxic stress symptoms are often first noticed by teachers.

L. A. Weinberg et al (2009) tried to identify problems in the education of foster children in their counties, and a case study showed that understanding the local context of each county is essential for establishing a workable process for developing cross-agency policies and procedures.

In a study by Watkin A. et al (2009), a facilitated interprofessional learning (IPL) programme was implemented to assess if such an intervention could overcome some of the barriers to effective interprofessional and inter-agency team working. Findings from this study demonstrate statistically that the programme offered an overall positive learning experience.

Instead, Montoya et al (2010) suggest that medically oriented child maltreatment teams and mental health services for maltreated children would improve gaps in services by: (1) recruiting and training bilingual professionals, (2) ensuring that children or family members who are deaf receive professional ASL services and (3) ensuring that training is provided related to the needs of children with special health care needs.

Sexual Abuse - younger children and adolescents

Also in case of sexual abuse, scholars confirmed the above-mentioned practices as necessary to guarantee the safeguarding of children. Notably, they highlighted the following elements as enabler for successful protection and support interventions: child welfare decision-makers must be informed of infant brain development and knowledgeable about the particular needs and circumstances of each child; collaboration between clinicians and foster agency caseworkers and others responsible for intervention planning and forensic interviews ensuring appropriate child protection plans (Farah W et al, 2015).

Physical and emotional abuse – neglect younger children

When working with younger children, collaborative partnerships between schools and community entities is fundamental (Hardin 2015) and some practices may lead to success in developing and sustaining such partnerships. While a majority of these practices are applicable for school-community partnerships in all contexts, specific issues should also be considered for stakeholders in rural settings. Creating collaborative educator training opportunities; encouraging dialogue between stakeholders when/if a child's case enters the juvenile court system, CASA/GAL works closely with both the CAC and Children Services

(Hartman et al, 2017). However, studies revealed that these efforts vanish when intervention had brief duration or when it was universal (i.e. students in entire classrooms participated rather than high-risk individuals). Furthermore, the impact of the intervention on a high-risk population might lead to more significant and meaningful results (Shuval, 2010).

3.4 Conclusion

The conducted literature search revealed that there are different contexts in which child maltreatment might be identified. A large proportion of studies relied on health care professionals, mostly in Emergency Departments. These often find themselves in a unique position among all professionals working with children. Health care professionals are able to do a full examination on children who they suspect to be victims of child maltreatment. The literature search therefore showed that there are numerous different screening tools for child abuse and neglect. Although several of these screening instruments proved themselves useful in health care settings this was limited to physical child abuse and neglect as well as child sexual abuse. Psychological abuse or neglect could not be detected through these instruments. Some of the described tools did not focus on children but on their parents. For example the Hague Protocol (Dederich et al., 2014) is used to identify child maltreatment based on parental characteristics instead of child characteristics. It has proven to be very effective but there are different requirements on behalf of professionals in adult health care settings. Detection of child maltreatment is often seen as the responsibility of paediatric care and therefore neglected by adult medicine. The Hague protocol offers a chance to increase the number of identified maltreated children. The results highlight the need for the development of a uniform and effective screening instrument that is able to detect all forms of child maltreatment in children's hospitals. Additionally it is necessary to raise awareness

in adult health care settings in regard to increase the number of detected cases of child maltreatment.

There are multiple types of interventions and treatments offered to parents and families with a history of child maltreatment. Research showed mixed results with some interventions, but all in all therapeutic interventions aiming at modifying the family system and behaviour of parents and children seem to be effective. Several literature reviews and meta-analysis indicated that cognitive-behavioural treatments are effective for maltreated children, sexually abused children and children exposed to violence. In the case of adolescents facing street violence, intervention programs for violently injured youth offer an interesting intervention for young people who are victims of violence and at risk of engaging in violent and harmful lifestyle. Especially intensive early after injury provided case management programs with mental health services and employment opportunities seem to have positive impact. As for the criminal procedure, the Child advocacy center model was the only practice found in this literature review that offered support to victims during a criminal investigation process. The CAC model employs elements that have a strong evidence base, but there seems to be limited research and limited evidence of the models efficacy in terms of child and family outcomes.

Collaboration between different professionals is not self-evident. Research showed that it requires active working together and creating a common understanding. Also leadership plays a crucial role. Co-operation and service integration can be created and maintained by common training and knowledge building, good communication and information sharing, shared guidelines and frameworks and active dialogue.

4. National good practices

In this chapter we present the findings of national good practices. Each partner collected national practices that aim at identifying child maltreatment and supporting victims in multi-professional environments. Some of the practices have been evaluated and some have not. In any case, the list should be viewed as indicative and not comprehensive, as all national good practices could not be included. More information can be requested from partner organisations (listed in chapter 1.1).

4.1 Finland

National guidelines

In Finland, health care professionals (and other professionals working with children) are obliged to report suspected child maltreatment cases to the police and social services. The police are responsible for the criminal investigations. The forensic child psychiatry units are responsible for child interviews and somatic examinations in suspected child abuse cases if the police, prosecutor or the court asks for assistance. Otherwise, the police perform the interviews. While doing the child interviews, the forensic child psychiatry units also evaluate the child's need for further treatment. After the police have asked for assistance from the forensic psychiatry unit, the investigating policeman, professionals form the unit and social worker meet to discuss, change information and plan future actions. When the interviews and somatic examinations have been done, the professionals may meet again to discuss the case.

In Finland, there are several national guidelines for professionals working with child maltreatment. For example the Finnish Current Care Guidelines gives suggestions to health care professionals, how to detect sexual abuse (information in Finnish, includes English summary: http://www.terveysportti.fi/dtk/ltk/shp01243). Nursing Research Foundation (Hotus) has also issued guidelines for effective methods for identifying child maltreatment in social and health care (see English abstract: http://www.hotus.fi/system/files/SUOSITUS_lasten_kaltoinkohtelu_ENGLANTI.pdf). The guidelines list risk factors and signs of child maltreatment. It also lists principles and methods of identifying and intervening in cases of maltreatment. Both of these guidelines are based on scientific research.

The ministry of justice has evaluated the current criminal procedure from the victim's perspective (in Finnish, includes English abstract: https://api.hankeikkuna.fi/asiakirjat/70a1ccb8-a41b-48e8-a241-21455266c2cb/201d71b4-57ea-47e5-81b0-27d95da9acf6/KIRJE_20181031111104.pdf). The report stated that the criminal procedure in cases of child victims takes too long and it needs to be shortened by providing enough recourse for every step of criminal procedure. Also, the report suggested that the child interview training should become a permanent training for police officers.

The Finnish national institute for health and welfare (THL) has issued handbooks for professionals working with children and families, one of which is "Luo luottamusta - Suojele lasta" ("Build trust - Protect the child")(in Finnish: https://thl.fi/fi/web/lapset-nuoret-ja-perheet/ajankohtaista/luo-luottamusta-suojele-lasta-opas-ja-verkkokoulutus-yhteistyosta). The handbook consists of multi-professional working methods and legislation relative to cooperation. The handbook is accompanied by online training material.

There are several models and practices developed at the national and local level concerning combating violence against children. Two of them are introduced here.

LASTA model

Pilot project LASTA developed a child-friendly and integrated model based on CAC/Barnahus working through networking, without creating new physical units or centers. A structured risk assessment form for the collection of information in cases of child maltreatment was created and tested in the project. It was used to support the police in choosing children with higher risk to be discussed in a structured multi-professional meeting. The form functioned as a screening instrument. The information gathered with the form aimed at supporting the police and prosecutor in making better-informed decisions on the extent of the investigation. With more complicated cases, the multiprofessional meeting supported a more nuanced assessment of the needs of the child for child friendly judiciary investigations as well as for protection and support. The project was located at the Turku University Hospital.

In the LASTA-model, the police send a request for background information for all children suspected of having been physically assaulted or sexually abused. The LASTA-coordinator collects the information by accessing health records and by phoning a social worker for child protection/social welfare records. The police decide based on the information on the cases to be discussed in the multiprofessional meeting. In the weekly meeting, the police officer, prosecutor, somatic specialist, forensic psychologist, specialist social worker, child psychiatrist and crisis work specialist go through every case for 30 minutes each. They assess the facts, risk factors and protective factors to create a common action plan on how the police, the social services and health services proceed.

More information on the model (in Finnish, English abstract is included): http://www.julkari.fi/bitstream/handle/10024/134582/URN_ISBN_978-952-302-850-0.pdf?sequence=1

Ankkuri (Anchor) model

Ankkuri –model aims at tackling youth violent and criminal behavior as well domestic violence at an early stage. The model has a process for handling domestic violence by breaking the cycle of violence and offering help and treatment for both the victim and the perpetrator. When an adolescent is caught in violent or criminal act, the whole family is treated to detect the causes for the behavior.

Ankkuri –model is based on integrated services located in police stations. Ankkuri –team consists of police officer, social worker, psychiatric nurse and youth worker. All team members (excl. police officer) are employed by local municipality. The team performs first assessment and meets the adolescent and the family. After that they assess the need for services.

More information on the model (in Finnish): http://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/79022/Ankkuri-malli%20moniviranomaisyhteisty%C3%B6ss%C3%A4.pdf

4.2 France

Unité d'accueil médico-judiciaire pédiatrique - The Pediatric Medico-legal Units model (PMLU) - Orléans

Since the first example in 1999, 82 structured Pediatric Medico-Legal Units has been implemented or are currently being implemented (in France 78, in Romania 3 and in Russia 1) and the recently appointed **Secretary of State for children and youth** has declared he wanted to generalise this measure in France.

PMLU in Orléans: Upon the issue of a disclosure or a complaint of violence or other criminal issues against minors, the PLMU takes in charge, by a multidisciplinary team, the children victims and their families or the family/legal guardians. The PMLU ensures that the minors receive quality services:

- greeting of the child by the medical team (pediatrician, nurses, psychologist, social assistant, secretary), presentation of the site and of the key team members
- recorded interviews of the child by a police/gendarmerie officer, in presence of a **c**hild and youth psychiatric or a psychologist
- medical-forensic examination, if necessary, after the interview, except in case of an emergency.

Operating protocols of the hearing room and of the protected confrontation room located in the PMLU, has been signed, between law enforcement authorities and PMLU team, and a specialised and appropriate training of police and legal officers, ensure:

- the quality of the interviews in a soundproof, comfortable and child-friendly room with a return video, in a technical adjoining room
- the safety of the child who will not be physically confronted by the perpetrator/accused person of the abuse, but only through a videoconference

installed between the Brigade de protection de l'Enfance de l'Hôtel de police and the PMLU (Central Police Station – special Child Protection Brigade)

The multi professional team is composed of pediatrician, psychologist, nurse, social worker, medical secretary, police officer specially trained to interview children, investigating judge specialised for minors and all relevant legal staff from disclosure to trial.
This model has been evaluated by ONPE:
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwiZ07XK-uffAhVDKBoKHWpBDnEQFjAAegQIBRAC&url=https%3A%2F%2Fwww.fondation-enfance.org%2Fwp-content%2Fuploads%2F2016%2F10%2Fonpe_considerer_parole_enfant_victime_etude_UAMJ.pdf&usg=AOvVaw2E01_n2suTRlQQmo0bqvuf (in French)

Creche "Enfant present" – Paris

The Crèche implemented since 1989 in Paris, for children aged from two months to three years, drives a device specialized for the detection of children at risk of abuse or neglect. The aim is to identify situations of abuse, neglect and to provide a safe place for children whose parents are encountering difficulties in different registers (family, social, educational, medical, and psychological.)

First, the parents are met by the head of the service, the psychologist and a social worker. After this meeting, children undergo a medical examination and decision to integrate the child into the Crèche or to more investigate this case in taken by the head of the service and her colleagues. This assessment of the familial situation of the child is objectified by the use of alert criteria of danger for the children crossed with the pediatric examination results.

If the risk “children in danger” in validated, then the admission of the child is refused and then a synthesis meeting is organised with all the relevant professionals for choosing the most appropriate disclosure measure.

If the child is admitted into the Crèche, a multi professionals and multi registers monitoring programme is implemented; a particular attention is drawn to the positive, responsible way in which parents are acting, in order to meet fundamental needs of the child. The ethics and technical positioning of the professionals is based on first the safeguarding of the needs of the children and on the developing, if possible, of a qualitative link between parent and child and not a link “at any cost”. The team is composed with paediatrician, psychologist, social worker, educational professional for young children, home caregivers and other guardians. This model has been evaluated by ONPE:
https://www.onpe.gouv.fr/sites/default/files/dispositifs/Dpt75_EP_0.pdf (In French)

Cellule de recueil d’informations préoccupantes (CRIP) - Units in charge of gathering and evaluating alarming information

CRIP is a national system set up at the departmental level for the purpose of processing and evaluating alarming information concerning minors. The evaluation of the situations is carried out by a multidisciplinary team (doctors, assistants of social services, educators,) Treatment of information follows the following procedure:

- A first meeting with the child and at least one parent or a legal guardian, explaining the reasons of the intervention and how to apply it.
- In-depth examination of the situation of the child or adolescent. It is a moment of expression of the points of view of each member of the family/legal guardians and of the child himself.
- Through observation in familiar places to him or through the direct collection of his statements, all difficulties encountered by the child must be taken into account. The collection

of the statements must be made with a particular precaution. When the child is met alone, the professional warns him that some of his remarks cannot be kept secret if it is necessary to protect him. In this case, the child's comments must be reported in extent as well as the circumstances of their collection.

- Parents must be listened and heard, it can't be a questioning to obtain confessions, the observation of their educational attitude toward the child must be taken into account.
- Interviews with anyone who has contact with the child, on an ad hoc or regular basis, may provide useful insights.
- Interviews with any child-related professional (school, high school, nursery, etc.)

The evaluation report includes all the information necessary to understand the situation in order to making a decision. It is submitted to the technical reflection of multi-professionals and multi-institutional decision-making persons within the framework of a meeting of synthesis.

- If it turns out that the information of concern is not applicable, it is decided on its ranking.
- The evaluation can detect a certain fragility of the family, and therefore some risks for the child, which can justify the proposal of the establishment or the maintenance of a support within the framework of the socio-educational, medico-social or health prevention.
- In case of danger for the child, the President of the General Council immediately informs the public prosecutor.

More information:
https://cvm-mineurs.org/page/la-cellule-departementale-de-recueil-des-informations-preoccupantes-crip - in French
No external evaluation.

Jean BRU shelter in Agen (France)

Jean BRU shelter in located in Agen and hosting **young minors girls' victims of family sexual violence.** The minors have been declared victims of sexual abuse before admission in the "Maison Jean Bru" by the departmental units in charge of gathering and evaluating disturbing information, or a complaint to the police/gendarmerie. These reports or complaints are forwarded to the public prosecutor who makes the decision to refer the child to the "House Jean BRU".

25 minor victims of similar trauma are accommodated in the same building (response to the founding principle of the project: to gather the similar to make the singularity to come out). This "grouping" promotes the emergence of a word freed from a part of shame linked to this type of trauma, avoids the mechanisms of denial and repetition identified in traditional shelters. Following admission, an observation period of two months is determined to assess the relevance of the orientation and the minor's adherence to the project. During this period a visit to the family environment is organised to know the positioning of the mother, her ability to mobilize herself for her daughter, her links with the perpetrator, her attitude at the time of the revelation of incest, what support can be expected from her, the availability of resources coming from the extended family and especially from the siblings. At the end of this period of observation is a signature of a contract of objectives including:

- Individualized educational support in a secure collective concept: "boarding frame"
- Provision of a private space whose privacy is respected (particularly important for this type of trauma)
- Therapeutic environment, access to psychic and somatic care
- Taking into account the judicial context and support in the penal process
- Maintaining links with the holders of parental authority, the extended family.

Evaluation has been done by National Observatory for child protection: https://www.onpe.gouv.fr/dispositifs

Dispositif d'accueil parental (DAP) La Forestière - Parental reception arrangements
This practice is implemented in the Pas de Calais

It is a place where parents who have been deprived of parental care, are allowed to meet their child, from birth to six years, under control of social educational workers/mediators in the context of visits authorized by the judge. These children have been victims of neglect and/or abuse before their placement.

The "visit arrangements", in the presence of a professional third party for the support of children in danger, are carried out in a place that allows bathing, nursing, meals, etc. The place of reception is arranged like a large flat giving directly access to a terrace equipped with exterior games. This device promotes a thorough observation of child-parent interactions going beyond a time of encounter and play, an overview of parents in everyday gestures and care practices to the child, an assessment of parental mobilisation and parental skills, an assessment of the evolution of parental skills and the quality of the child-parent interaction. A pre-draft contract is drawn up by the professionals after receiving the PPO application (provisional placement order) which is a basis for the "parental support contract" signed by the professionals and the parents, which determines the implementation of identifiable and reasonably simple operational objectives.

At the first visit, there is a presentation of the center to the child and to the person in charge of him/her to whom are explained the reasons justifying this kind of visit under the control of a mediator/social/educational worker and a visit of the premises is organised. This first approach allows the child to become familiar with the premises and the people. The first time parent and child meet, in the context of the DAP, time is spent on a phase of play or

awakening taking place in the large visit room of the DAP. The "contract of accompaniment to the "parenting function" is reassessed every 3 months and cannot exceed 18 months of support except as part of a request for exceptional derogation that can extend the contract by 3 to 6 additional months.

Validation by National observatory for child protection (ONPE) (in French): https://www.onpe.gouv.fr/dispositifs

4.3 Germany

"Netzwerk für Familien" (Network for Families)

This model aims at prevention and early detection of need for support or child maltreatment of any kind. It combines prevention, support and protection for children and adolescents. The Child Protection Services ("Jugendamt" in Germany) in the City of Dormagen routinely visit all families with a newborn soon after the birth of the baby. Each family receives a "welcome-package" including vouchers, toys, books or information material on day care. During the visit, the social workers get to know the family, build trust and can give access to support of different kinds. If families in need of support are detected, they receive regular visits from social workers, free lunches for the children, free after school programs or free learning material. Another offer for families at high risk for child maltreatment is the "school for parents" where parenting skills are taught.

The "Network for Families" integrates social services (Child protection services) with education professionals in schools and kindergarten as well as professionals in health care (for example midwifes or pediatricians).

This practice has been evaluated by Spieckermann & Schubert (2009). There is a high acceptance of this practice among involved parents and families. The access to support is uncomplicated. Early detection and intervention is cost effective in the long term.

4.4 Greece

In Greece, Child Protection (CP) has always been focused either on particular issues (like abuse and neglect) or on specific vulnerable groups of children (like disabled children, Roma children). For the time being child care is provided by many different services and organizations, while often child protection is referred to as including exclusively welfare services. This does not diminish the role of existing services operating in the context of other sectors of public administration, such as prosecution and police authorities, health or education services. Still, the biggest challenges arise from (a) the fragmentation of welfare child protection services and (b) the lack of coordination and clarification of roles and responsibilities among the agents and services that comprise the “whole” of the child protection system.

In Greece the lack of a structured child protection system and the lack of specific services for children who have been abused represent a significant obstacle in the recognition and the confrontation of the phenomenon. The need for permanent and stable procedures to the detection and support of children who have been abused is obvious from our collaboration with the professionals. All the following practices were not evaluated by typical procedures. This report is based on our professional knowledge and also on our collaboration with professionals in the field.

“Integrated Approach for the Investigation, Diagnosis and Management of Child Abuse and Neglect” Program

This program aims at promotion of a uniform interdisciplinary approach based on realistic guidelines for professionals working with children. Main goal is the institution of a procedure ensuring the protection and well-being of children. Necessary for the efficient management of similar cases is the education and training of the professionals involved, as well as cooperation among them. The protocol may serve as a guide to the management of abuse and neglect cases, as it:

- accustoms professionals to the basic international legal terminology on abuse and neglect issues, as well as to the main forms and expression of the phenomenon
- lists the indicators that may reveal a possible case of abuse or neglect
- provides information about the reporting of a possible child abuse or neglect case
- provides an overview of the respective laws and highlights the obligation of citizen and professionals to report cases of child abuse or neglect
- clarifies the roles, duties and responsibilities of professionals and services
- ensures an effective network of protection and response by the authorities, services and professionals in a possible or proven case of child abuse and neglect, according to the children's best interests and needs.

The protocol is addressed to professionals working in the sectors of health, welfare, public policy, justice and, education providing information on the investigation, diagnosis and management of child abuse and neglect cases.

The responsible operator is Department of Mental Health and Social Welfare, **Institute Child of Health**, Athens

"Training of professionals at a national level", Methodology of diagnostic assessment of children's living conditions: Building capacities of social workers

The aim is to cover the needs of social workers who handle cases following a public prosecutor's order. Main goal is the institution of a procedure ensuring the protection and well-being of children. This consists of a uniform methodology for managing suspected cases of abuse and neglect and one common report for all the social workers who have to investigate child abuse and neglect. Trained professionals will disseminate the methodology to all the social workers of the municipalities who handle cases of child abuse and neglect. The responsible operator is Department of Mental Health and Social Welfare, **Institute Child of Health**, Athens.

European Helpline for Children and Adolescents 116111

The aim is to provide counseling support for free to children and adolescents. The Helpline 116111 plays a crucial role in preventing phenomena of violence that children may encounter (Physical, Sexual and Psychological Abuse, Neglect, Bullying, Smuggling & Trafficking), as well as cases of missing children. The Helpline 116111 is staffed exclusively by specialized psychologists and is available nationwide, 24 hours a day, 365 days a year. Furthermore, the Helpline 116111 is interconnected with the 112 European Emergency Number and belongs to the Network of Child Helpline International Foundation (CHI). The call centers of the European Helpline 116111 are located in Athens (Marousi and Kareas), Thessaloniki and Patras. The responsible operator is NGO, **"The Smile of the Child"**, Athens.

More information: https://www.hamogelo.gr/gr/en/paidia-thimata-vias:116111/

National Helpline for Children SOS 1056

The recognized National Helpline for children SOS 1056 is operated by «The Smile of the Child» and it is available for every child and adult for the provision of support on issues of their concern. The 1056 Helpline plays a key role in addressing situations of violence that children are faced with (Physical, Sexual & Psychological Abuse, Neglect, Bullying and Trafficking). The 1056 Helpline is staffed exclusively by specialized Social Workers and Psychologists and is available throughout Greece on a 24-hour basis, 7 days a week, 365 days a year. Through the Helpline SOS 1056, the following services are provided:

- Registration of anonymous and named reports about children victims of abuse;
- Immediate intervention for children who are at risk (direct intervention);
- Activation of care procedures for children who have been abused and are in hospitals (transitional stage);
- Handling of requests for abused children in the 10 Homes of the Organization;
- Provision of guidance on every issue and interconnection with other services;
- Mobilization of blood and blood platelet donors.

For the provision of the above-mentioned services, vehicles of Direct Intervention and Mobile Medical Units of Intensive Care for newborns and children are at the disposal of the Helpline 24 hours a day.

Emphasizing communication with children and adolescents, apart from the communication via a telephone call, children also have the possibility to “talk” to trained professionals via email, chat and social media. Furthermore, the Helpline 1056 is interconnected with the 112 European Emergency Number and belongs to the Network of Child Helpline International (CHI). The Calling centers of the National Helpline for Children SOS 1056 are located in Athens (Marousi and Kareas), Thessaloniki and Patras.

It is worth mentioning that «The Smile of the Child» has established a Disaster Recovery Area at the El .Venizelos International Airport of Athens in an effort to ensure the smooth operation of the Helpline 1056 under any circumstances. The responsible operator is NGO, **"The Smile of the Child**", Athens.

More information: https://www.hamogelo.gr/gr/en/paidia-thimata-vias:sos-1056/

Training of professionals at a national level

Since there is a shortage of physicians specialized in the area of child abuse in Greece, ELIZA **formed a multilevel partnership with the 2nd Department of Pediatrics (N.K.U.A) to address this significant deficiency.** The partnership is based on the following strategic pillars:

- Creation of the first nationwide network of physicians dedicated to protecting children from physical abuse and training of first line health professionals. Having sought guidance and advice from experts in child abuse and neglect from the US Universities of Yale and Iowa, we developed an educational curriculum on Child Physical Abuse for a group of physicians from all the pediatric departments of all the medical schools in Greece. The educational curriculum was adapted to provide a 6-hour workshop on Child Physical Abuse. Eight workshops were conducted in seven cities of Greece with 1.220 participants, mostly physicians.
- Retrospective research on child physical abuse. A key element of this initiative was a retrospective study focusing on children hospitalized at the "P. & A. Kyriakou" Children's Hospital during a 2-year period (2014 & 2015). Among 35.273 admissions, the medical records of 161 children with social problems and/or an acute serious injury were selected and analysed.

- Protocol for the recognition and support of suspected child physical abuse. In the context of the program, a Protocol i.e. a user-friendly standardized procedure was developed for the assessment of suspected physical abuse, which can be applied at all Greek hospitals.

The responsible operator is **ELIZA Society for the Prevention of Cruelty to Children,** a charitable organization, Athens.

More information:**https://eliza.org.gr/en/drasis/ekpedefsi-nosokomiakon-iatron/**

Child Safety Care Unit

The first hospital-based child protection unit in Greece. The needs of children at risk of abuse and/or neglect are best addressed by hospital-based protection teams. Thus, the Child Safety Care Unit's ultimate goal is to identify infants and children at risk of abuse and neglect, at the youngest possible age, and to safeguard vulnerable families. The responsible operator is **ELIZA Society for the Prevention of Cruelty to Children,** a highly specialized charitable organization.

SOS Babies Home Maroussi

A pioneering program that is focused on the care and protection of abused babies and infants. This program refers to the sheltering, education and social reintegration of babies and infants, up to 5 years old, as well as to the psychological and social support of their biological parents. The responsible operator is SOS Children's village - Athens.

4.5 Italy

"Il 1° quaderno del professionista" (the 1st professional's manual)

This training manual is part of a collection of training manuals, established by the Emilia-Romagna Region, providing medical and non-medical staff with specific guidelines for the detection of the diverse forms of abuse/violence and with information on the procedures to be carried out when the abuse or violence is strongly suspected and eventually confirmed. This manual helps professionals identify a suspicion of violence which can rise in different situations, for instance when a child attends frequently the A&E. Then, the manual accompanies the professional in the different phases of the clinical and forensic analysis which will confirm or exclude the suspicion. In case of confirm, this examination will be used in the judicial proceeding.

The forensic and clinical examination is formed by four phases: reception, operative intervention, drafting of a sheet for detecting the violence/abuse suspicion, activation of a supporting and accompanying path. During the reception phase, the medical and non-medical staff cooperates: the nurse at the A&E front desk assigns a priority code to the minor and places them in a safe place, then they inform in a confidential way the doctor on call which will evaluate the case and activate the forensic doctor as well as a multi-professional medical team and social services when necessary.

The operational intervention includes collecting all data related to the child and their family as well as the clinical examination describing the physical and psychic objectivity. Then professionals draft a specific sheet reporting the clinical and anamnestic frame. This phase is followed by the activation of a supporting and "outgoing" accompanying procedure.

In so doing, professionals act in the best interest of the child ensuring:

- Psychological and physical protection of the minor, thus it becomes necessary to take the minor away from blaming, mistreating and stigmatizing behaviours;
- Evaluation of the necessity of a hospitalization, notably in case of health emergency or to protect the minor, even when there's no clinical urgency;

- Evaluation by social and health services over the necessity of protective measures outside the hospital.

This practice has been evaluated by the hospitals' working groups and commissions.
For further information: http://salute.regione.emilia-romagna.it/news/regione/maltrattamento-e-abuso-sui-minori-le-raccomandazioni-per-lassistenza-e-il-video-del-convegno-dell1-ottobre

Integration of services at the local level, where there's a teamwork methodology at two levels:

- 1st level: the Municipality, where the minor resides and which is responsible for their protection (officially, the Major is responsible for unaccompanied children), acts through the Social services and the Health services according to a principle of technical-sharing and cost-sharing between Social and Health Services. Social services envisage a social worker of reference who will monitor the child's progress with continuity, and they involve the educational, social and health professions specific for that case (social worker, educator, psychologist, neuro-psychiatrist). The complexity of the case is evaluated by the Multi-dimensional Evaluation Unit (MEU) and the Integrated Territorial Team (ETI - *Equipe* Territoriale Integrata) which define the individual childcare project. In case of intra-family sexual abuse/violence there's the involvement of the Juvenile Court and the minor can undergo a criminal law proceeding.
- 2nd level: The Social and Health territorial Conference fosters the activation of second level specialised teams (*equipe*) in the area of provincial and upper-district protection. These teams perform functions on the field of protection, foster care, community home and adoption on the basis of local procedures (*protocolli locali*). Organisations, like Il Faro Specialised Multi-professional Centre, can access the second level team only by mandate of the territorial services. These organisations work closely with the health and social services, notably the

Integrated Territorial Team (ETI - *Equipe* Territoriale Integrata), including judicial services as the Juvenile Court or Criminal Court.

Professionals of local Social Services, Health Hospital Services and the family paediatrician, family doctors; Educational Agencies, Public Prosecutor's Office and Minor Court systematise existing good practice in the integrated management of child maltreatment or abuse through the elaboration of Protocols and Procedures and multi-professional dialogue, thus forming an integrated network of services against the mistreatment/abuse on children and adolescents.

Evaluated by the Regional Units dealing with family, children and adolescent assistance and operatively, by Hospitals.

The CISMAI - the italian network of services against child maltreatment and abuse

Since 1993 the CISMAI (*coordinamento italiano dei servizi contro il maltrattamento e l'abuso all'infanzia* - the italian network of services against child maltreatment and abuse) has been active. CISMAI is a unique association because of its multidisciplinarity and theoretical reflection and it forms a cultural and training permanent home regarding prevention activities and treatment of violence against children, with particular attention to intra-family abuse.

The CISMAI:

- promotes coordination and exchanges among public and private services and centres, working for prevention and treatment of child abuse;
- identifies guidelines for the taking charge of cases and it defines intervention protocols for the different services;

- promotes contacts and exchanges with political and institutional authorities, with the aim of communicating priorities to fight violence against minors;
- promotes workshops, seminars, lectures, debates, researches, publications and training courses;
- cooperates with national and international associations, working for children's rights defence

The CISMAI takes part in some important organisations to shape national child policy: starting with the first National Observatory on children established in 1995, to the national Commission against Child Abuse, to the Committee ex art. 17 1998/269 established in 1999-2000 to coordinate actions against sexual exploitation and abuse against minors.
Through its experts the CISMAI took part to the Childhood National Observatory's works and to consultations and projects coordinated by the National Centre on Childhood and Adolescence Documentation (Centro Nazionale di Documentazione sull'Infanzia e l'Adolescenza) and the Innocents' Institute in Florence(l'Istituto degli Innocenti di Firenze).

For further information: www.cismai.it

Terre des Hommes Association

The Terre des Hommes Association, in Italy since 1989, aims at protecting children from every type of violence/abuse, from economic and sexual exploitation and to get children off the street. It envisages specific centres as "Le case del Sole" and programmes to help working children, child victims of underage sex trafficking, children domestic slavery or children in jail or in conflict with law.

Terre des Hommes works also to raise awareness on public opinion with campaigns such as "Giù le mani dai bambini", "Please Disturb", Stop Child Trafficking". Since 2015 it supports

hospital anti-violence centres, by acknowledging the prevention and early detection of maltreatment against children and it started to cooperate with these centres:

- Milan: SVSeD – Soccorso Violenza Sessuale e Domestica (Clinica Mangiagalli) - Domestic and Sexual Violence Recovery (Mangiagalli Clinic)
- Turin: Ambulatorio BAMBI (Ospedale Regina Margherita) - Bambi clinic (Regina Margherita hospital)
- Padua: Centro Regionale per la Diagnostica del Bambino Maltrattato (Azienda Ospedaliera) - Regional Centre for the Diagnosis of the Abused Child - (Hospital)
- Florence: Progetto "GAIA" – Gruppo Abuso Infanzia e Adolescenza (Ospedale Meyer)- "GAIA project: Childhood and Adolescence Abuse Group (Meyer Hospital)
- Bari: Progetto GIADA – Gruppo Interdisciplinare Assistenza Donne bambini Abusati (Ospedale Pediatrico Giovanni XXIII**) -** GIADA Project - Interdisciplinary Group to Assist abused women and children (Giovanni Paolo XXIII Child Hospital)

For further information: www.terredeshommes.it

4.6 United Kingdom

Four UK models have been developed, identified and analysed as positively detecting violence against children and adolescents, including but not limited to general maltreatment, neglect, physical and emotional abuse and sexual abuse, offering support for young victims and integrating a variety of services from professionals and institutions that might be directly influential and effective in each situation.

First, NICE's child abuse and neglect guideline has been developed by a multi-professional and lay working group (the Guideline Development Group or GDG) convened by the National Collaborating Centre for Women's and Children's Health (NCC-WCH). This model covers the signs of possible child maltreatment in children and young people aged under 18

years. Its objective is to help health professionals who are not child protection specialists to identify the features of physical, sexual and emotional abuse, neglect and fabricated or induced illness. A multi-part procedure was created to detect violence against children. These steps are 1.1: Physical features of abuse, 1.2: Clinical presentations, 1.3: neglect – failure of provision and failure of supervision, 1.4: emotional, behavioural, interpersonal and social functioning symptoms and 1.5: child-parents' interactions.

In offering support for the victims, NICE's guidelines say that if alerting feature or considering child maltreatment prompts a healthcare professional to suspect child maltreatment, they should refer the child or young person to children's social care, following Local Safeguarding Children Board procedures. This may trigger a child protection investigation. Additionally, supportive services may be integrated, being offered to the family following an assessment or identifying alternative explanations. While this guideline targets mainly professionals and users of the National Health Service (NHS) in England and Wales and in the independent health sector, it also includes professionals working in social services and education / childcare settings who have extended interaction and influence among possible child and adolescent victims.

More information on the model can be found at:

https://www.nice.org.uk/guidance/cg89/evidence/full-guideline-pdf-243694625

Additionally, a model in Safeguarding Children: Referral and Management of an Abused or At-risk Child provides guidelines on how health professionals in particular can aid in the detection and support of violence against youth, specifically younger children but also adolescents. The model recommends that healthcare professionals who come across injuries, other concerns or an outright disclosure of abuse to think of suitable explanations for the alerting features and either consider, suspect, or exclude maltreatment. Each

scenario has a different course of action to be taken, but thorough records should be kept and professionals are asked to remember that the child's welfare is paramount and, thus, his or her best wishes should override other considerations such as confidentiality, consent and the guardian or carer's interests.

If a child is suspected to be at risk, the model lists these three services to which the professional should refer as an initial course of action: the local child social services, the police, and the NSPCC. As each hospital has its own protocol for such situations, the model also urges healthcare professionals to be fully acquainted with these regulations as well as the designated lead professional in such cases. However, while each hospital may operate under different regulations, the guidelines stress that police must get involved if the child is at risk of immediate serious harm. The model also specifies guidelines for supporting the victim, including practical steps as obtaining consent, respecting the child's views, and remaining calm.

More information on the model can be found at:

https://patient.info/doctor/safeguarding-children-referral-and-management-of-an-abused-or-at-risk-child#nav-4

Next, the UK presented a National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault in 2011. The guidelines are primarily written for health care clinics, including health professionals and all other staff. The main objective of this guideline is to provide information on the initial assessment and aftercare (including psychosocial support) of those who disclose a history of sexual assault to healthcare professionals in the setting of Genitourinary Medicine (GUM) / Sexual Health clinics in the United Kingdom. This guideline is aimed at managing sexually assaulted adults of both sexes but the forensic aspects can also be applied to adolescents. In providing support for the victims, healthcare

professionals should respect the client's wishes, provide a non-judgemental, supportive and safe environment and thoroughly record all interactions and actions. Additionally, the National Guidelines request that all staff dealing with potential sexual abuse victims be trained in communication skills and knowledge of forensic timeframes and aftercare aspects of sexual assault, child protection, domestic violence, and self-harm risk identification issues. Staff should also have contact information for local Sexual Assault Referral centres (SACRs), police stations, and child services, child protection agencies, local mental health departments, general practitioners, and voluntary organisations such as Victim Support, Rape Crisis Centres, Survivors UK, Respond and others.

More information on the model can be found at:

https://www.bashh.org/documents/4450.pdf

Finally, the Royal college of General Practitioners produced the RCGP/NSPCC Safeguarding Children Toolkit for General Practice. The toolkit aims to provide Practices in the UK with a framework for integrating safeguarding children and young people into existing practice systems and processes for delivering primary care. The Toolkit is devised to support GPs to improve outcomes for children and families by bringing together relevant guidance and information, focusing on good medical practice and signposting to existing safeguarding statutes, policies and tools. Every effort of the practice is said to work toward keeping the patient at the centre of their organisational focus in order to create a safe, timely, appropriate and reliable response to rapidly changing patient needs at the same time as meeting statutory and professional obligations, contractual demands and regulators' requirements. Thus, the need to integrate patient-centred safeguards into already existing processes.

This is echoed in the toolkit's urge for practice policies and procedures to include staff training, readily accessible contacts for child protective services, the police, and other

agencies and professionals involved with children. Effective records should be kept, including coding, correspondence, siling, and summarising. Additional procedures to safeguard children are suggested, including procedures to identify and follow up children with more than expected unscheduled appointments at the Practice, OOHs, A & E Departments, Walk-in Centres, procedures for safe information sharing, and pre-planned procedures to communicate concerns and implement actions in a number of possible situations.

More information on the model can be found at:

https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx

Similarities can be seen among these four UK models for detecting violence against children and adolescents offering support for young victims and integrating a variety of services from professionals and institutions that might be directly influential and effective in each situation. For example, it appears to be a broadly agreed practice to keep thorough and effective records particularly when suspicion of sexual abuse is found. Also, each of the four models refers to many of the same agencies as helpful services to utilize in the suspected case of child maltreatment. Additionally, two of the four suggest a three-step line of thinking when alarms arise: Consider Suspect, or Exclude Maltreatment. Another two aimed more specifically at healthcare clinics as a whole rather than individual professionals urge the powers that be to train all staff who could come into contact with physical, emotional, or sexual abuse victims in appropriate composure, practices, communications, and courses of action, both in alerting a designated professional or an outside agency.

4.7 Conclusion

As different countries have different kinds of historically developed health care, child protection and judicial systems, the responses to violence against children will vary between and even within countries. There are many practices that have been developed to national or local needs to support abused children. What is common to these practices is the need to create and develop collaboration between professionals from different fields.

The national practices listed in this report provide a wide range of practices on detection of violence, support to victims and integration of services. There are practices that aim at fluent criminal investigation processes, such as LASTA model in Finland or PMLU in France. Others are targeted to early detection of violence, for example Netzwerk für Familien in Germany. Some practices provide easy access services such as European Helpline for Children and Adolescents 116111 in Greece. There are also practices that offer information, guidelines and training for professionals from different fields, like I quaderni del professionista in Italy or Safeguarding Children: Referral and Management of an Abused or At-risk Child in the UK.

5. Discussion

There are many screening tools developed for the detection of physical and sexual abuse. Some of them have been found effective while others still lack rigor. There is still need for development of detection tools. Studies show implications that training will improve the ability of professionals to identify child maltreatment. The conducted literature search showed that currently, affected children are identified late. It is therefore necessary to improve the identification of problems earlier and to better connect interventions between child agencies and the health care system. Cooperation has to be integrated into a fixed

framework to create material and time resources in institutions and thereby establish an exchange of activities, decisions and developments that is independent of individual professionals. According to research therapeutic interventions show the strongest effects in child and family treatment. This shows that there should be effective treatments available for children and families affected with violence. Professionals should be aware of the benefits of treatments and they should work together to refer children and families to appropriate treatment.

The purpose of this report was to collect good practices of detection of violence against children, support for child victims and integration of services among professionals working with children. We searched for international as well as national and local practices. This report covers a vast variety of good practices and it is designed to work as a basis for upcoming actions in project PROCHILD. At the same time it is targeted to professionals working in health and social care, the police, education and court to give an overview of good practices in this field. It may work as a basis for local and national development.

6. References

The APSAC handbook on child maltreatment. 2nd ed. ed. Thousand Oaks: Sage Pub; 2002:582.
Bailhache M, Leroy V, Pillet P, Salmi L. Is early detection of abused children possible?: A systematic review of the diagnostic accuracy of the identification of abused children. *BMC pediatrics*. 2013;13:202.

Australian Law Reform Commission. (2010). Family violence: A national legal response. Chapter 19, The intersection of child protection and family laws.

Banks D, Landsverk J, Wang K. Changing Policy and Practice in the Child Welfare System Through Collaborative Efforts to Identify and Respond Effectively to Family Violence. Journal of Interpersonal Violence 2008 Jul;23(7):903-932.

Batzer S, Berg T, Godinet MT, Stotzer RL. (2018) Efficacy or chaos? Parent–Child interaction therapy in maltreating populations: A review of research. *TRAUMA VIOLENCE ABUSE REV J*.; 19(1):3-19.

Blesken M, Franke I, Freiberg J, et al. *AWMF S3+ leitlinie kindesmisshandlung, -missbrauch, -vernachlässigung unter einbindung der jugendhilfe und pädagogik.* 1st ed. ; 2019.

Boden, Joseph M.; Horwood, L. John; Fergusson, David M. (2007): Exposure to childhood sexual and physical abuse and subsequent educational achievement outcomes. In: Child Abuse & Neglect 31 (10), S. 1101–1114

Brink, Farah W.|Thackeray, Jonathan D.|Bridge, Jeffrey A.|Letson, Megan M.|Scribano, Philip V. Child advocacy center multidisciplinary team decision and its association to child protective services outcomes. Child Abuse & Neglect 2015;46:174-181.

Campbell AM, Hibbard R. More than words: The emotional maltreatment of children. *Pediatr Clin North Am*. 2014;61(5):959-970.

Casanueva C, Harris S, Carr C. Helping Young Maltreated Children and Their Families: Outcomes among Families at Safe Babies Court Team Sites. Outcomes among families at safe babies court team sites. 2018;38(6):29-37.

Chinitz, Susan|Guzman, Hazel|Amstutz, Ellen|Kohchi, Joaniko|Alkon, Miriam. Improving outcomes for babies and toddlers in child welfare: A model for infant mental health intervention and collaboration. Child

Coates D. Working with families with parental mental health and/or drug and alcohol issues where there are child protection concerns: inter-agency collaboration. Child & Family Social Work 2017 Mar;22(S4):1-10.

Collins-Camargo C, Shackelford K, Kelly M, Martin-Galijatovic R. Collaborative research in child welfare: a rationale for rigorous participatory evaluation designs to promote sustained systems change. National Library of Medicine ;90(Child welfare):68-85.

Corcoran J, Pillai V.(2008) A meta-analysis of parent-involved treatment for child sexual abuse. *RES SOC WORK PRACT*.;18(5):453-464.

Crichton KG, Cooper JN, Minneci PC, Groner JI, Thackeray JD, Deans KJ. A national survey on the use of screening tools to detect physical child abuse. *Pediatr Surg Int*. 2016;32(8):815-818.

Daniel B, Taylor J, Scott J. Recognition of neglect and early response: Overview of a systematic review of the literature. *Child & Family Social Work*. 2010;15(2):248-257.

Dávid B. Social Network Analysis: Applied Tool to Enhance Effective Collaboration between Child Protection Organisations by Revealing and Strengthening Work Relationships. European Journal of Mental Health 2013 Jun 30,;8(1):3-28.

Diderich HM, Dechesne M, Fekkes M, et al. Facilitators and barriers to the successful implementation of a protocol to detect child abuse based on parental characteristics. *Child Abuse Negl*. 2014;38(11):1822-1831.

Dinpanah H, Akbarzadeh Pasha A, Mojtaba Sanji. Potential Child Abuse Screening in Emergency Department; a Diagnostic Accuracy Study. *Emergency*. 2017;5(1): e8.

Erfurt C, Hahn G, Roesner D, Schmidt U. Pediatric radiological diagnostic procedures in cases of suspected child abuse. *Forensic science, medicine, and pathology*. 2011;7(1):65-74.

Ezpeleta L, Pérez-Robles R, Fanti KA, et al. Development of a screening tool enabling identification of infants and toddlers at risk of family abuse and neglect: A feasibility study from three south european countries. *Child: care, health and development*. 2017;43(1):75-80.

Ezzo F, Young K. Child maltreatment risk inventory: Pilot data for the cleveland child abuse potential scale. *J Fam Viol*. 2012;27(2):145-155.

Dijkstra S, Creemers HE, Asscher JJ, Deković M, Stams, Geert Jan J. M. (2016) The effectiveness of family group conferencing in youth care: A meta-analysis. *Child Abuse Negl*.; 62:100-110.

Farrell Erickson M, Egeland B. Child neglect. In: Myers JEB, ed. *The APSAC handbook on child maltreatment.* 2nd ed. ed. Thousand Oaks: Sage Pub; 2002.

Felner JK, DuBois DL. (2017) Addressing the commercial sexual exploitation of children and youth: A systematic review of program and policy evaluations. *J Child Adolesc Trauma*;10(2):187-201

Glaser D. Emotional abuse and neglect (psychological maltreatment): A conceptual framework. *Child Abuse Negl*. 2002;26(6-7):697-714.

Hartman S, Stotts J, Ottley J, Miller R. School-Community Partnerships in Rural Settings: Facilitating Positive Outcomes for Young Children Who Experience Maltreatment. Early Childhood Educ J 2017 May;45(3):403-410.

Harvey ST, Taylor JE. (2010) A meta-analysis of the effects of psychotherapy with sexually abused children and adolescents. *Clin Psychol Rev*.; 30(5):517-535.

Herbert JL, Bromfield L. (2016) Evidence for the efficacy of the child advocacy center model: A systematic review. *Trauma, Violence & Abuse*; 17(3):341

Herrmann B, Dettmeyer R, Banaschak S, Thyen U. *Kindesmisshandlung.* Berlin, Heidelberg: Springer; 2016.

Hoft M, Haddad L. Screening children for abuse and neglect: A review of the literature. *Journal of forensic nursing*. 2017;13(1):26-34.

Horrevorts EMB, van Grieken A, Mieloo CL, et al. Concurrent validity, discriminatory power and feasibility of the instrument for identification of parents at risk for child abuse and neglect (IPARAN). *BMJ open*. 2017;7(8):e016140.

Horwath J, Morrison T. Effective inter-agency collaboration to safeguard children: Rising to the challenge through collective development. Children and Youth Services Review. 2011: 33(2): 368-375.

Humphreys, C. (2007). Domestic violence and child protection: Challenging directions for practice. Australian domestic and family violence clearinghouse. Issue Paper 13.

Häuser W, Schmutzer G, Brähler E, Glaesmer H. Maltreatment in childhood and adolescence: Results from a survey of a representative sample of the german population. *Deutsches Arzteblatt international*. 2011;108(17):287-294.

Jayaratne K, Kelaher M, Dunt D. Child Health Partnerships: a review of program characteristics, outcomes and their relationship. BMC health services research 2010 Jun 17,;10(1):172.

Johnson SL, Elam K, Rogers AA, Hilley C. (2018) A meta-analysis of parenting practices and child psychosocial outcomes in trauma-informed parenting interventions after violence exposure. *Prevention Science*; 19(7):927-938.

Johnson KB, Doecke E, Damarell RA, Grantham H. Do training programs improve a paramedic's ability to identify and report child abuse and neglect? A systematic review. *Australian Journal of Paramedicine*. 2018;15(3).

Kennedy SC, Kim JS, Tripodi SJ, Brown SM, Gowdy G. (2016) Does Parent–Child interaction therapy reduce future physical abuse? A meta-analysis. *RES SOC WORK PRACT*.; 26(2):147-156.

Kenny MC, Lopez-Griman A, Donohue B. Development and initial evaluation of a cost-effective, internet-based program to assist professionals in reporting suspected child maltreatment. *Journ Child Adol Trauma*. 2017;10(4):385-393.

Kistin, Caroline J, Irene Tien, Howard Bauchner, Victoria Parker, John M Leventhal. Factors That Influence the Effectiveness of Child Protection Teams. Pediatrics 2010 Jul 1,;126(1):94-100.

Laing, L., Humphreys, C., & Cavanagh, K. (2013). Social work and domestic violence: Critical and
reflective practice. London: Sage Publications.

Lalayants M, Epstein I, Adamy D. Multidisciplinary consultation in child protection: a clinical data-mining evaluation. International Journal of Social Welfare 2011 Apr;20(2):156-166.

Leenarts LE, W., Diehle J, et al. (2013) Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *Eur Child Adolesc Psychiatry*; 22(5):269-83.

Lenz, Albert (2014): Kinder psychisch kranker Eltern. 2., vollst. überarb. und erw. Aufl. Göttingen, Bern, Wien, Paris, Oxford, Prag, Toronto, Boston, Amsterdam, Kopenhagen, Stockholm, Florenz, Helsinki: Hogrefe.

Louwers, Eveline C. F. M., Korfage IJ, Affourtit MJ, et al. Accuracy of a screening instrument to identify potential child abuse in emergency departments. *Child Abuse Negl*. 2014;38(7):1275-1281.

Macdonald G et al.(2012) Cognitive-behavioural interventions for children who have been sexually abused. *Cochrane Database of Systematic Reviews*. 2012(5)

Macvean ML, Humphreys C, Healey L. Facilitating the Collaborative Interface between Child Protection and Specialist Domestic Violence Services: A Scoping Review. Australian Social Work 2018 Apr 3,;71(2):148-161.

Mennen FE, Kim K, Sang J, Trickett PK. Child neglect: Definition and identification of youth's experiences in official reports of maltreatment. *Child Abuse Negl*. 2010;34(9):647-658.

Miffitt LA. (2014) State of the science: Group therapy interventions for sexually abused children. *Arch Psychiatr Nurs*.; 28(3):174-179.

Mikhail JN, Nemeth LS.(2016) Trauma center based youth violence prevention programs: An integrative review. *Trauma Violence & Abuse*;17(5):500-519

Miller-Graff LE, Campion K. (2016) Interventions for posttraumatic stress with children exposed to violence: Factors associated with treatment success. *J Clin Psychol*.; 72(3):226-248.
National Center for Injury Prevention and Control, Division of Violence Prevention (2015): Child maltreatment: risk and protective factors. Hg. v. Centers for Disease Control and Prevention (CDC). Online verfügbar unter http://www. cdc. gov/violenceprevention/childmaltreatment/riskprotectivefactor. html.

Miller-Perrin C, Perrin RD. *Child maltreatment.* 3. ed. ed. ; 2013:451

Montoya, Louise A.|Giardino, Angelo P.|Leventhal, John M. Mental health referral and services for maltreated children and child protection evaluations of children with special needs: A national survey of hospital- and community-based medically oriented teams. Child Abuse & Neglect 2010;34(8):593-601.

Norman, Rosana E.; Byambaa, Munkhtsetseg; De, Rumna; Butchart, Alexander; Scott, James; Vos, Theo (2012): The long-term health consequences of child physical abuse,

emotional abuse, and neglect: a systematic review and meta-analysis. In: PLoS medicine 9 (11), e1001349

Ogbonnaya IN, Keeney AJ. A systematic review of the effectiveness of interagency and cross-system collaborations in the United States to improve child welfare outcomes. Children and Youth Services Review 2018 Nov;94:225-245.

O'Leary P, Young A, Wilde T, Tsantefski M. Interagency Working in Child Protection and Domestic Violence. Australian Social Work 2018 Apr 3,;71(2):175-188.

O'Reilly R, Wilkes L, Luck L, Jackson D. (2010) The efficacy of family support and family preservation services on reducing child abuse and neglect: What the literature reveals. *J Child Health Care*.; 14(1):82-94.

Paek SH, Jung JH, Kwak YH, et al. Development of screening tool for child abuse in the korean emergency department: Using modified delphi study. *Medicine*. 2018;97(51):e13724.

Potito, C., Day, A., Carson, E., & O'Leary, P. (2009). Domestic violence and child protection: Partnerships and collaboration. Australian Social Work, 62(3), 369–387

Ross, S., Frere, M., Healey, L., & Humphreys, C. (2011). A whole of government strategy for family violence reform. Australian Journal of Public Administration, 70(2), 131–142.

Schouten MCM, van Stel HF, Verheij TJM, Nieuwenhuis EES, van dP. A screening protocol for child abuse at out-of-hours primary care locations: A descriptive study. *BMC family practice*. 2016;17(1):155.

Schweitzer DD, Pecora PJ, Nelson K, Walters B, Blythe BJ. (2015) Building the evidence base for intensive family preservation services. *J PUBLIC CHILD WELF*.; 9(5):423-443.

Selvaraj K. What's the Punchline?: Promoting Child and Teacher Resilience Through Pediatrician-Teacher Partnerships. Pediatrics 2018 Jan;141(1).

Shuval K, Pillsbury CA, Cavanaugh B, McGruder L, McKinney CM, Massey Z, et al. Evaluating the impact of conflict resolution on urban childrens violence-related attitudes and behaviors in New Haven, Connecticut, through a community-academic partnership. Health education research 2010 Oct;25(5):757-768.

Sittig JS, Uiterwaal, Cuno S. P. M., Moons KGM, et al. Value of systematic detection of physical child abuse at emergency rooms: A cross-sectional diagnostic accuracy study. *BMJ open*. 2016;6(3):e010788.

Snider C, Lee J. (2009) Youth violence secondary prevention initiatives in emergency departments: A systematic review. *Canadian Journal of Emergency Medicine*;11(2):161-168

Stoltenborgh M, Bakermans-Kranenburg M, Alink LRA, van IJzendoorn MH. The prevalence of child maltreatment across the globe: Review of a series of meta-analyses. *Child Abuse Rev*.

Trask EV, Walsh K, DiLillo D. (2011) Treatment effects for common outcomes of child sexual abuse: A current meta-analysis. *AGGRESSION VIOLENT BEHAV*.; 16(1):6-19.

van dP, Hermanns J, van Rijn-van Gelderen L, Sondeijker F. Detection of unsafety in families with parental and/or child developmental problems at the start of family support. *BMC Psychiatry*. 2016;16:15.

van Looveren N, Glazemakers I, van Grootel L, Fransen E, van West D. Assessment of physical child abuse risk in parents with children referred to child and adolescent psychiatry. *Child Abuse Rev*. 2017;26(6):411-424.

van der Put, Claudia E., Assink M, Gubbels J, van Solinge, Noelle F. Boekhout. (2018) Identifying effective components of child maltreatment interventions: A meta-analysis. *Clin Child Fam Psychol Rev*.; 21(2):171-202.

Watkin A, Lindqvist S, Black J, Watts F. Report of the Implementation and Evaluation of an Interprofessional Learning Programme for Inter-agency Child Protection Teams. Child Abuse Review 2009 May;18(3):151-167.

Weinberg, Lois A, Andrea Zetlin, Nancy M Shea. Removing Barriers to Educating Children in Foster Care Through Interagency Collaboration: A Seven County Multiple-Case Study. Child Welfare 2009 Jul 1,;88(4):77-111.

Widom, Cathy Spatz (2014): Longterm Consequences of Child Maltreatment. In: Jill E. Korbin und Richard D. Krugman (Hg.): Handbook of Child Maltreatment, Bd. 2. Dordrecht: Springer Netherlands (Child Maltreatment), S. 225–247.

Wills R, Ritchie M, Wilson M. Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. *J Paediatr Child Health*. 2008;44(3):92-98.

Winokur MA, Holtan A, Batchelder KE. (2018) Systematic review of kinship care effects on safety, permanency, and well-being outcomes. *Research on Social Work Practice*; 28(1):19-32.

Woodman J, Lecky F, Hodes D, Pitt M, Taylor B, Gilbert R. Screening injured children for physical abuse or neglect in emergency departments: A systematic review. *Child: care, health and development*. 2010;36(2):153-164.

World Health Organization (WHO). Report of the Consultation on Child Abuse Prevention. Geneva 1999

World Health Organization (WHO) 2002. World report on violence and health. Genev.