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

WP4
Development of protocols among the actors involved in the assistance and protection of abused children in accordance with a transferable interdisciplinary intervention model

A.4.5 Development of a European interdisciplinary and multi-professional model for detecting abuse and mistreatment and protecting minors in need of assistance

D4.4 - Recommendations for a transferable, interdisciplinary model of intervention

Sommario

Abstract

This deliverable is the last output of research and survey activities carried out during the first year of project activities and is aimed at creating the basis for professional training, which will be delivered during the second year of the project.
The purpose of this deliverable is to collect recommendations and best practices stemmed during the research and survey activities led by partner organisations in WP3 and from open debates carried out in roundtables activities in WP4.
Indeed, despite national and local specificities as well as organisational procedures, some similar needs and interests emerged in all partner countries from professionals working in Child Protection Services and from families and children beneficiary of these services.
This deliverable is specifically addressed to professionals working in Child Protection Services (CPS), organisations (health, social, school services, police forces and judiciary authorities) and institutions/policy makers in order to help the former in their daily activities and the latter in the establishment of guidelines and procedures at the local and national level.

Background

PROCHILD is a European transnational project that aims at 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 to implement a joint approach on complementary competences and child's best interest. The project is co-funded by the European Commission under the Rights, Equality and Citizenship programme (REC). More information about the project and its partners can be found from the project website: www.prochildproject.org.

Introduction

This deliverable collects the major findings, conclusions and considerations emerged in WP3 and WP4, in the form of shared recommendations conceived to be transferable and adaptable to very different contexts. Recommendations will be on how to detect and report suspect and evident cases of mistreatment in order to reduce underreporting; what procedures and **collaboration to activate;** how to conduct treatment and protection of minors from a social, medical, psychological and legal point of view and the results of WP3 surveys and mapping of international and national practices and WP4 roundtable and focus group discussions organised by each partner organisation.

These recommendations will then be shared by partners at the regional and local levels, within their organisations and their networks, as an informative and support tool for professionals in their daily activities. They are not intended as binding protocols, but as general guidelines which could help operators in case of fully-blown or suspect case of violence, by improving their collaboration and interventions in the best interest of children.

Source

Recommendations from WP3 are based on five reports:

- D3.1 How to detect violence against children, support child victims and integrate services for their protection and support? Collection of good practices
- D3.2 Causes of violence against children in families with parental mental health problems
- D3.4 Training needs of professionals working with child victims of violence
- D3.5 Elements and criteria for early detection of abused minors
- D3.7 Report on protective and risk factors after child abuse for the development of psychosis

Recommendation from WP4 will include suggestions and major conclusions from roundtables and focus groups activities (A4.2-A4-3) carried out by partner organisations from November 2019 to January 2020. These multi-professional roundtable and focus group activities allowed operators, under the invitation by partners, to discuss and share best practices and to identify strengths and weaknesses in their intervention systems within their country, district or organisation to identify bottlenecks and solutions for improving their interventions and fostering integration of Child Protection Services (CPS). These discussions started from the results of the survey activities carried out in the previous months, notably the evaluation by minors and families/caregivers of the efficiency of CPS involved in cases of fully-blown or suspect case of violence.

Target of this Recommendations

These recommendations are aimed to be a useful tool for professionals working in Child Protection Services (CPS) and organisations (health, social, school services, police forces and judiciary authorities). Indeed, they're intended to be a flexible and dynamic tool to support them in their daily activities, in addition to the protocols and guidelines already in use in their organisations. Moreover, institutions and policymakers in partner countries can benefit from this report in the development of national and local policies and procedures.

Recommendations from WP3

Detection

Risk factors for child physical abuse are for example child's young age, child's disabilities, parent's personal history of violent childhood experiences, parental mental disorders, parental substance abuse, single-parenthood, parent's acceptance of violence and punishment as upbringing, domestic violence. (D3.5)

Possibility of child abuse should be considered if a child or adolescent has marked changes in behaviour or emotional state that differ from child's chronological and developmental age and are not explained by a medical cause, a known stressful situation other than child abuse. These signs are e.g. extreme distress, low self-esteem, nightmares with similar themes, excessive need to stick together, aggressiveness, excessive kindness with strangers, unexplained withdrawal, anger or frustration expressed by rage in school child, frequent anger due to minor frustrations, distress expressed by inconsolable crying. (D3.5)

Physical signs of child physical abuse are frequent access to the A&E, unjust delays in accessing care, repeated domestic accidents, bruising in pre-mobile children, contradictory or confused explanations of the cases of injury, injuries not associated with normal child accidents, bruising in unusual areas, multiple lesions of diverse period, repeated fractures at different stages. (D3.5)

Physical abuse may manifest in the mouth, so dental health professionals need to be aware of how to evaluate and address these concerns. Oral injuries that are not consistent with a child's developmental capabilities or parents' accounts as well as multiple injuries in different stages of healing should arouse suspicion for abuse (D3.5)

Emotional abuse should be considered if there is concern that interaction between children and parents may be harmful. Signs of harmful interactions include negativity or hostility towards a child or adolescent, rejection of the child or adolescent suffering, inappropriate expectations or interactions regarding the child's development (e.g. inappropriate threats or methods of discipline). (D3.5)

There are some high-risk circumstances where the possibility of intra-family sexual abuse might take place. For example, if the family is withdrawn and has little or no social relations with the outside world and the family refuses outside intervention. Also, if there are any

problems of filiation, absence of familial reference points or confusion of generations within the family (e.g. adult authority having a slight age difference with the minor, one of parents in a situation of great submission to the other, very young age of the mother). Another sign might be an ambiguous family climate with insufficient limits and prohibitions, eroticisation of parent/child relationships, lack of respect for privacy or parental roles and functions not fulfilled. Also, co-existence or a history of domestic violence may increase the risk of sexual abuse. (D3.5)

There are at least three distinct subtypes of children's sexual victimisation bearing different features, clinical profiles and epidemiological characteristics, namely (i) the sub-group of younger children-victims in which victimisation occurs typically in the family or by adults introduced to the child by their own caregivers and in which there is not a large difference in the victimisation of girls and boys, (ii) adolescent victims in which girls are more frequently victimised, some of which in the community with features bearing resemblance of the ones of sexual violence among adults and (iii) poly-victimised children living in households in extreme deprivation, social inclusion or severe family dysfunction in which sexual victimisation comes as a part of a series of victimisation incidents by different types of violence as a result of chronic lack of supervision and adequate care. (D3.5)

Signs of child sexual abuse can be infections, genital injury, abdominal pain, constipations, chronic or recurrent urinary tract infections, sleep disturbance or phobias. Professionals should exercise caution when considering sexual abuse, because the symptoms may indicate physical or emotional abuse or other stressors unrelated to sexual abuse. (D3.5)

Most cases of child sexual abuse are first detected when a child discloses abuse. At the same time, research has shown that the nature and dynamics of child sexual abuse make it exceedingly difficult for children to disclose their victimisation. There are certain barriers that reduce disclosure such as cognitive and developmental factors, strategies employed by perpetrators to gain and maintain compliance and silence, and internal and external factors that lead children to feel guilty or responsible for the abuse. (D3.5)

Even in confirmed cases of child sexual abuse, most children do not have physical findings diagnostic of sexual abuse. Therefore, the child's disclosure may often be the most important evidence in determining the likelihood of sexual abuse. When interviewing the child victim, the interviewee should be patient and friendly as children are often frightened by hurried or demanding examiner. Usually, the interview should be conducted with the child alone. Open-ended questions should be asked. In addition, when interviewing a child on alleged abuse,

proper interviewing techniques should be utilised to safeguard children's testimony from the effect of misinformation and suggestibility, as these could lead to false reports. (D3.5)

The physical examination of sexually abused child requires time and patience. As the child may be anxious, the examination should be explained to the child before it is performed. The examination should not result in additional physical or emotional trauma. (D3.5)

Signs of child neglect are the failure to provide for the child's physical (food, hygiene, shelter, clothing), emotional, medical (omission of care, refusal of treatment), educational or safety (inadequate supervision of activities, exposure to violent environment in home or neighborhood) needs. (D3.5)

Various studies have identified parental mental health problems as a strong risk factor in child maltreatment. However, it should be kept in mind that neither parental mental health problems nor other risk factors do inevitably lead to violence against children. Affected parents must not be reduced to their mental health problems. Stigmatisation and isolation inhibits them to seek the needed support. Nevertheless, impaired parental mental health prohibits adequate recognition and reaction to children's emotional and social needs. Professionals working with families are faced with the difficulty of building a trusting relationship with parents while protecting their children if necessary. These aims may at times contradict each other and it is therefore very important for professionals to cooperate in a transparent and effective way. (D3.2)

Training for professionals helps to detect child abuse and neglect. (D3.1)

Professionals need training in addressing suspected child abuse with the child. Especially the issue of child sexual abuse is difficult to address without proper knowledge. Future trainings should focus on distributing knowledge on interview techniques with children, especially the suggestibility of younger children or possibilities of re-traumatisation as well as the criminal investigation process. (D3.4)

Health care professionals, especially those working in Emergency Departments, are in a unique position to identify child maltreatment. There are several screening tools that are useful in health care settings to identify physical child abuse and neglect and child sexual abuse. In addition to screening child characteristics, there are tools such as the Hague Protocol that is used to identify child maltreatment based on parental characteristics. (D3.1)

Multiprofessional cooperation

Interagency between services can have a positive effect when a series of enablers occur. They are: a shared, agreed vision for working together as a way to drive collaboration toward like-minded goals; the formalisation of the model to set expectations and obligations of agencies, allowing all parties to work with transparent and agreed arrangements; an authorising environment, that is establishing a culture that encourages and enables working together; a clear leadership to guide interagency working and information sharing. (D3.1)
Studies show that child welfare professionals find 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. (D3.1)

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. (D3.1)

On a basic level, all professionals working with children or parents should ideally have knowledge about skills, jurisdictions and responsibilities as well as operational structures of other services working in child protection. This allows for the reduction of false expectations and creates understanding for actions or non-actions of professionals from other support services. Diverging tasks and assignments; different horizons of experience or patterns of thinking require exchange between institutions to avoid misunderstandings and to enable cooperation. (D3.2)

Multiprofessional cooperation should also focus on those children and families who may fall between gaps, those perhaps less easily recognised when strictly adhering to existing protocols. (D3.5)

Support and treatment

Families at risk of child maltreatment need sustained support in order to prevent acts of violence. (D3.5)

Studies show that Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is effective treatment for children exposed to maltreatment. TF-CBT can reduce post-traumatic stress disorder (PTSD) and anxiety symptoms in children who have been sexually abused as well as in children exposed to other forms of violence. (D3.1)

Types of interventions found effective in reducing child maltreatment in families are home visitation interventions, parent training interventions, family-based/multisystemic interventions, substance abuse interventions, and cognitive behavioural therapy. (D3.1)

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. (D3.1)

Cognitive behavioural therapy involves modifying parenting and children's behaviours through education and learning and encourages positive interactions between parents and children. (D3.1)

Studies have found that parent-child interaction therapy (PCIT) appears to be effective at reducing physical abuse recurrence and parenting stress for physically abusive families. PCIT is a parenting intervention, in which the family system is altered through modifying the behaviour of both the parent and child. It is grounded in social learning and attachment theories and it targets children aged 2-7 years. (D3.1)

Childhood abuse is associated with psychiatric disorders. It is estimated that 59% of mood disorders may be attributable to child abuse. By reducing child abuse, depression and anxiety disorders could be reduced as well. (D3.7)

Child abuse and its consequences such as mental disorders can be reduced in many levels:

Social and community

- Human rights implementation: implementation of human and childhood laws at national level
- Social and cultural promotion: policies for social cohesion, cultural differences
- Economic intervention to reduce poverty:
    - Economic support for vulnerable individuals
    - Reduce unemployment

- Promote gender equality and appraisal/promotion and knowledge about ethnic diversities
- Improving general population mental/physical heath
    - Tackle racisms and homophobia
    - Reducing the availability of alcohol and cannabis
    - Promotion of mental health and working on stigma about emotional/ mental distress and psychiatric disorder

Parents and caregivers

- Promotion of physical /mental health
- Training in parenting (especially in young parents) to support child – victims of abuse
- Empowerment of access to family counselling

Children and schools

- Promoting psychosocial support and psychological first aid for victims of abuse
- Training teachers and children to recognise early symptoms of mental disorders
- Promoting mental health particularly for vulnerable groups:
    - Peer violence, bullying and cyberbullying
    - Ethnic minorities
    - Gender
    - Children with disabilities

Heath care workers

- Awareness about child abuse and the different kind of abuse
- Training in child's abuse detecting
- Home visiting
- Consider and investigate (in appropriate setting) about childhood abuse when a psychological or a major psychiatric disorder is treated (potential benefits of trauma focused therapies) (D3.7)

Recommendation from WP4

During the roundtable and focus groups activities carried out by partner organisations, best practices and suggestions to improve the work and cooperation among CPS were raised by participants. Despite local specificities and needs, some of them emerged as fundamental measures that could significantly improve the activities of these services.

Procedures and protocols

Despite the existence in mostly all countries of protocols and procedures for CPS, professionals are not completely aware of them and sometimes, the presence and overlapping of several protocols confuse professionals. As a consequence, although there are laws and procedures, in practice the collaboration is not always smooth and professionals risk to do what he/she thinks best, often in parallel with other professionals but without communicating.

Making professionals aware of the existing protocols, by training them.

Standardising local services procedures in case of suspected mistreatment/abuse, using for example some risk assessment form (factsheet, check list), thus allowing consistency between the decisions of the various professional figures involved in a case.

Streamlining practices to maintain a unified policy for all children across regions

Assessing properly the role of professionals in the investigation process. Indeed, in case of a trial they present the judicial authority a “qualified report”, where the professional denounces the existence of a "Sufficiently well-founded suspect". It is obviously not up to the healthcare, social care, school and other professionals to verify the concrete existence of the crime prosecutable ex officio, as this assessment is the activity of the Judicial Authority

The adoption of a legislative or regulatory framework no longer dependent on voluntary acceptance but mandatory makes it possible to guarantee systematisation of measures

Access to information

Access to information is a persistent problem. On the one hand, in case of suspect or full-blown violence it is important not to conceal evidence and the need to collaborate with the police to assess the crime; on the other, children are usually exposed to an over-traumatisation risk since, as it emerged from CPS survey run by project partners (A4.1), they are usually heard by several professionals more than once and this is mainly due to the absence of communication sharing mechanisms among professionals.

> **Reporting and IT/databases at the national level** should be created for involved organisations to share data and develop good practices. Moreover, the establishment of a computerised system for recording relevant information on children to avoid the loss of information seems required.

> **Existing preventive services designed especially for children and adolescents such as help lines or other services must absolutely be maintained**, with their missions better identified by all professionals in contact with potential child victims, as well as reinforced, so that they can be perceived by professionals as sites where one can discuss problem cases, such as a suspicion of abuse is difficult to document objectively.

> **Effective and open information sharing mechanisms** and procedures which need to be simple and legally compliant.

Privacy and GDPR issue

Professionals can be hindered in their daily support activity because of privacy issues which don't enable them to access information about the child victim and the person who first denounced the crime.

> **Identifying "qualified access profiles" for accessing sensitive information** about minors within CPS. This requires a secure data management system where the circulation of data, is regulated and the circle of services within which each professional can share data are defined.

The name of the person who has made the initial referral cannot be kept secret. So, if the parents/carers of the child want to know who made the referral, the professional in charge of the case should suggest that they are informed by the prosecutor's office.

Contacting responsible Institutions such as the Guarantor for children and adolescents to assess this issue, thus enabling professionals to intervene properly.

Training of professionals

Usually the various professionals working in CPS services don't receive adequate and peer training on how to detect and report cases of abuse and violence. Moreover, they don't receive multi-professional training or information on how to cooperate with other professionals.

Including the treatment of mistreatment / abuse of minors in training courses, first of all within the University with its High Degree Courses and Specialisation Schools, to increase professionals' awareness and skills from the beginning, since these issues can involve all professionals in their daily activities.

Providing professionals which work in first response services with specific recommendations, to deepen their knowledge on child abuse in order to act as "sentinel" in some doubtful situations.

Training in listening to children's words should concern all those involved in judicial procedures, **including judges, lawyers as well as police officers.**

Interoperability and multi-professional interventions

Professional's working in CPS have to deal with internal procedures and priorities which can hinder prompt intervention and undermine cooperation with other services i.e. from the point of view of social services, the protracted nature of judicial procedures, especially at the stage of investigation, is generally perceived as having a negative effect. Moreover, some professionals are not used to working together in multi-professional networks.

Developing interdisciplinarity among professionals by 1) developing esteem among professionals and acknowledging the work of volunteers; 2) finding the best compromise, in the interest of the child.

Constitution of structured interprofessional networks and systematisation of interprofessional meetings at the local level

Engaging parents

Intervening preventively on parents and family dynamics, by supporting parental responsibility and need, can help in reducing the risk of maltreatment and abuse of children during childhood and adolescence.

Working on parenting needs to begin with pregnancy. Professionals should be able to listen and empathise towards parents,

Access to social assistance for families in economic difficulties.

Managing properly M/A cases when the emergency regards both **mother and the mino**r and both need support and ready placement in structures responsible for their reception

Supporting and at the same time keeping families together, by avoiding the institutionalisation of children

Conclusion

The present report stems from research activities, surveys and discussions carried out by partner organisations with professionals working in CPS and families and children, including also victims of M/A and beneficiary of these services. These enquiries allowed to identify shared problems and needs that professionals face in their daily activities of support and protection to children in all partner countries, as well as best practices and suggestions and feedback from families and children beneficiary of these measures. The breakthrough of this report, however, is the direct engagement of professionals from different CPS to identify common solutions to these problems. Consequently, this report is a collection of recommendations, stemming directly from the involved services, in a bottom-up approach, whose ultimate purpose is the best interest of children.