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Guidelines for the INTOVIAN Screening Tool

To identify families at risk of, or with already established, infant/toddler abuse and neglect problems

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Introduction

Child abuse and neglect remains a complex and major public health problem (WHO, 1999). In particular, the population of infants and toddlers seems to be disproportionately at risk of maltreatment compared to older children (USDHHS, 2008). Global estimates of child homicide (World Health Organization, 2002) suggest that infants and very young children are at the greatest risk, with rates for the 0 to 4-year-old age group being more than double compared to the age group of 5 to 14-year-olds. Children at these ages are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves (Child Welfare Information Gateway, 2014). However, not all cases of abuse and neglect result in a violent death. On the contrary, most children who have been victims of abuse and neglect will grow up dealing with their childhood traumas. According to the World Health Organization (WHO, 2013) consequences of child maltreatment include impaired lifelong physical and mental health for the victim, but also at a societal level, the social and occupational outcomes of child maltreatment could ultimately slow a country's economic and social development.

In general, evidence shows that early identification of, and intervention for, child abuse and neglect, can prevent or reduce long-term adverse effects for the child-victim (Ethier, Lemelin & Lacharite, 2004; Chartier, Walker & Naimark, 2007; Felitti et al., 1998; Louwers et al., 2014). However, domestic violence against this population is rarely detected or prevented before hospitalization, probably because this population has limited contact with others outside family social groups and because violent incidents often occur within or around family, in what is called “a circle of trust” (Finkelhor, 1994; Nikolaidis, 2009). Even at the emergency departments of hospitals, early screening for child abuse and neglect has been reported as inadequate (Louwers et al., 2012).

The INTOVIAN Project

The aim of the INTOVIAN project was to increase the effectiveness of European child health services regarding the prevention of, and early screening of, infant and toddler abuse and neglect. For this purpose, a screening tool for identifying families at risk of or with already established abuse and neglect problems, including measures specifically concerning the age-group of infants and toddlers (0-3 years old), has been developed. This tool has been constructed in such a way that it is applicable to any EU country (six EU countries participated in the INTOVIAN project: Cyprus, Greece, Italy, Spain, Portugal and the UK). Further, one of the project's objectives was for this tool to be implemented by first line health professionals during routine health examinations of infants and toddlers. Most families with infants and/or toddlers in EU countries usually follow nationally specific health exam programs during the first years of the child's life and thus infants and toddlers become more easily accessible for assessment by health professionals as opposed to professionals from other fields.

The development of this screening instrument has been informed by: (i) previously published screening instruments, such as the "Escape" screening instrument (Louwers et al., 2014) (ii) the diagnostic descriptive features of parent-infant relationship qualities suggested by Axis II, DC: 0-3R (Relationship Classification) (Zero to Three, 2005), that were piloted in a sample of 115 caregiver-infant/toddler dyads from the general and clinical population in six EU countries (Cyprus, Greece, Italy, Spain, Portugal and the UK) and (iii) health professionals' feedback after piloting two drafts of the tool at pediatric hospitals, community child health services and social welfare family services; professionals evaluated the instrument's **functional feasibility**.

Chapter I. The INTOVIAN Tool

The "Tool for identifying families at risk of or with already established infant and toddler abuse and neglect problems", called INTOVIAN Tool, is a five-item checklist addressing risk indicators for physical and/or psychological violence, neglect, and disordered/abusive relationship patterns between the infant/toddler and his/her caregiver (see Annex I).

1. What is the INTOVIAN Tool for?

The main aim of the INTOVIAN Tool is to initially identify families either at risk of/or with already established infant and toddler abuse and neglect problems, by looking for risk indicators of infant/toddler abuse and neglect, or of abusive relationship patterns in **any** caregiver-infant/toddler dyad. The Tool is specific to children ranging from 0 to 3 years old, who are brought to a (primary or tertiary) health care setting with his/her caregiver. The INTOVIAN screening tool is intended to be used as the first step of an assessment process of current child maltreatment pertaining to any infant or toddler (0-3 years old) within the general population, especially among those who have risk of abuse and neglect from family violence.

The INTOVIAN Tool is to be used as a supplementary instrument during the first examination of the infant/toddler by a health professional during the (first) visit to health services by the family. The INTOVIAN Tool **does not substitute for any other tool or examination** a professional may use in his/her daily work, but it is recommended that it is used as a supplementary tool for the risk assessment of abuse and neglect in caregiving relationships. Any families with an infant/toddler will be screened to identify abuse and neglect and abusive relationship problems through a simple "triage" system discriminating between two broad categories: (1) suspicion of abuse and neglect or abusive relationship patterns indicating the necessity of an intervention or further assessment/evidence, and (2) exclusion of maltreatment.

2. Who can use the INTOVIAN Tool?

The INTOVIAN Tool is designed for use by health and social care professionals who are working either in primary (i.e. community child health centers) or in tertiary care (i.e. child hospitals, pediatric clinics) with children aged 0-3 years old and their families. In particular, this is a checklist that may be completed by the following specialties of professionals: health visitors, nurses, pediatricians, social workers, psychologists and child psychiatrists.

3. What is the Target Population of the INTOVIAN Tool?

The target population of the INTOVIAN Tool is infants and toddlers aged from 0 to 3 years who are accompanied by their caregiver to health or social care services. The accompanying person can be any person to whom the infant/toddler is dependent on. Due to its screening use as a means to detect families at risk of infant/toddler abuse or neglect, this tool can be applied to any toddler/infant that the professional is examining in his/her practice.

4. When and Where should the INTOVIAN Tool be Completed?

Preferably, the tool should be completed during the first intake or the first examination of any infant/toddler; although its application is possible in follow-up visits, as well as with families examined by you (or a particular individual) on a regular basis. For example, the tool can be completed after observing caregiver-child interactions in your office and/or in the waiting room of your institution/organization.

Chapter II. Instructions for Completion

This is a short checklist that will take 5 minutes to complete. You score ALL the questions of this tool based on your observations and/or your personal clinical opinion. On the basis of the guidelines for description by Zero to Three (2005, p. 46) regarding the quality of the caregiver-child interaction, it is suggested that you focus your observation on:

- the behavioral quality of the caregiver-child interaction,
- the affective tone of the caregiver-child interaction,
- the psychological involvement of both partners of the interaction, and
- the information you are provided with by the family and/or other professionals.

If the family you are working with has more than one infant/toddler please complete **one tool for each child**. In case the child is accompanied by more than one caregiver, complete the tool for the caregiver who is responsible for the child for the most number of hours during the day. However, if you observe any risk indicators related to the other caregiver who also accompanies the child, please report this in the open space of "question 5". Should the child be accompanied by several caregivers, it is suggested that the completion of the INTOVIAN Tool is prioritized regarding the mother, followed by the father.

Note: The symbol ❍ indicates that only one answer is right. However, the symbol ☐ indicates that more than one answer might apply.

The Items of the INTOVIAN Tool

The first four (4) items are aimed at collecting information related to the demographic characteristics of the infant/toddler, such as age, sex, and the identity of the person(s) accompanying the child. The INTOVIAN Tool was developed and tested within a research context, thus, it was important to keep the anonymity of the child, his/her caregiver and of the professional. However, this Tool is strongly recommended for use in clinical settings too, and, for inclusion in the personal health record of the child.

Below you will find a more comprehensive analysis for each item of the Tool.

Question a: **Date of family's evaluation (dd/mm/yyyy)**

Here you write the date of completion of the Tool. It is noteworthy that the INTOVIAN Tool should not be completed at a different date from the date of the child's examination, but during or at the end of the meeting with the family.

Question b: **Child's age (in months)**

It is suggested that the age of the child is written in completed months.

Question c: **Child's sex**

Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics (National Health Data Dictionary, version 12, p. 365). In other words, this item aims to collect information regarding the biological sex and not the gender, which refers to social constructs. However, if the most proper answer is "intersex or indeterminate", which refers to a person born with reproductive organs or sex chromosomes that are not exclusively male or female because of a genetic condition, or whose sex has not yet been determined for whatever reason, you could write this information on the tool.

Question d: **Who accompanies the child**

In this question, you tick all answers that apply. This item was suggested by health professionals who have pilot-tested the INTOVIAN Tool based on the fact that the person who accompanies the child is also a person who is responsible for him/her. However, taking into consideration that the person(s) who accompanies/(-y) the child might be or might not be his/her main caregiver, you should ask a question such as: *"Who is the adult who looks after <index child's name> on a frequent basis?".* Based on the response you obtain, you will fill in the next five items.

Who accompanies the child (in relation to the child)? [please, check all that apply]

If female:	*If male:*
☐ Mother/Stepmother	☐ Father/Stepfather
☐ Foster mother	☐ Foster father
☐ Sister	☐ Brother
☐ Grandmother	☐ Grandfather
☐ Other female relative (e.g. aunt): _____ _____	☐ Other male relative (e.g. uncle):
☐ Other female person (pls. specify): _____ _____	☐ Other male person (pls. specify):

Question 1a: **In case of noticing a physical trauma/mark or being informed about an accident, is the caregiver's story consistent?**

This question is aimed at detecting the risk of possible physical abuse or neglect of the infant/toddler. If the answer to Question 1a is *"No"* (see the dark boxes above), the risk of possible maltreatment is increased and further assessment is recommended. In any case, the presence of this risk indicator is not evidence of abuse or neglect of the child. Further, it is likely that the parent informs you of an accident that has happened to the infant or toddler, but no physical mark is observed on his/her body. In that case, it is recommended that you ask for more information about the circumstances of the accident in order to decide whether the caregiver's story is consistent. You may pose an open question such as *"how did this accident happen?"*, making sure that your stance towards him/her is NOT judgmental. Moreover, it is important to detect if there are other signs of physical trauma on the child's body that denote chronicity, like older trauma of the same type (e.g. bruises changing color: blue/green/yellow).

In order to evaluate the story's consistency, you may consider the following two aspects:

(a) Narrator's Story Telling

You should evaluate if the story is always told in the same way by the caregiver, who continuously describes the same place, time and circumstances (e.g., where the incident took place, who was there, what they were doing and what happened).You should pay attention to whether the information makes sense and if it includes rich details (e.g., specific descriptions of the place, time, people, objects and events). In reality, such details allow for contextualizing of the event. Additionally, the investigation of whether the place and time of the incident are associated with a regular/daily routine of the infant/toddler or of the dyad (caregiver-infant/toddler) may be helpful to further evaluate the consistency of the story.

A caregiver's report on the thoughts and feelings experienced during the event should also be considered. This is because the story's accuracy may be further confirmed if the caregiver is capable of reporting specific verbalizations made at the time of the event (e.g., "I told him: «Be quiet!»"), specific thoughts (e.g., "when that happened I immediately thought «why did I leave him alone!?»"), or feelings (e.g., "I was worried").

Example: *Initially, the caregiver said that the child's sister was present, but later she said that she was alone with the baby.*

(b) The Explanation of the Physical Trauma/Mark

You should evaluate whether the caregiver's explanation about the occurrence of the physical trauma is consistent and explains sufficiently well the child's trauma, or if there are other possible explanations. For instance, you should assess if there are any signs suggesting physical violence towards the child that are not consistent with the story or that are clearly a sign of abuse such as marks of pulling or shaking the child (e.g., pulling hair and ears), hitting the child with a hand or an object, burning (e.g., with a cigarette, boiling water or electrical appliance), or of suffocating, etc.

Moreover, the professional should evaluate whether the reported trauma is compatible with the motor development of the child and/or his/her siblings. For example, bruises that could be compatible with falling down while walking or running, or falling from a height, should be further investigated if the caregiver refers to an infant who cannot yet walk.

Examples of inconsistent stories: *The caregiver suggests that the physical trauma/mark is due to an accidental fall, but the physical mark is found on a part of the child's body that is not consistent with a fall of this nature; the caregiver said that the child fell but she/he has a mark on the inside part of the arm, or on both sides of the neck.*

Question 1b:	**In case of noticing a physical trauma/mark or being informed about an accident, could the accident/physical trauma have been avoided or prevented with age-appropriate supervision?**

This item aims to assess a risk indicator for neglect of an infant or a toddler. If the answer is "Yes", further assessment is recommended. It is suggested that assessment could be made whether or not the incident could have been avoided by exploring if:

- the caregiver or another adult was present, supervising the child,
- whether the supervision provided by the adult was age-appropriate (e.g. was somebody close enough to a 12-month-old who has just started walking? Was the child playing with age-appropriate toys or objects?), and
- the place was secure enough for an infant or a toddler (e.g. were toxic and harmful objects such as batteries and cell phones, out of reach).

Furthermore, here, whether the supervision was appropriate not only for the infant or toddler's age, but also for his/her developmental stage, may be evaluated. For example, a 3-year-old toddler may be expected to have sufficient motor control to walk steadily and independently; however, this particular toddler may present delayed motor development and for this reason has not yet reached motor milestones expected by toddlers of his/her age. In that case, the caregiver is expected to provide supervision adjusted to the infant's/toddler's very specific needs.

When assessing the lack of supervision it is essential to take into consideration the dimensions of time and context. Different contexts demand different supervision. Also, a lack of supervision for a short time while the infant/toddler lays down on his/her bed, or plays in his/her room, is qualitatively different from a lack of supervision for a short time while the infant explores the neighbourhood's park.
Example: *The child fell into the bathtub and the caregiver was not present. Or the child has a cut on his/her hand because a knife was within the child's reach. Or, the child had an accident because the caregiver was reading a book sitting at a park bench and the child was hanging around alone without supervision.*

Question 2a:	**Is the caregiver-infant's/toddler's interaction characterised by anger and/or hostility?**

This question aims to assess risk indicators for emotionally abusive caregiver-infant/toddler relationship patterns. You score this item as positive when the emotions of anger and/or hostility are expressed **either** by both partners of the interaction, by the caregiver, or by the

child. Anger and/or hostility should be the predominant emotions of the caregiver-child's interaction.

In general, when anger and hostility are the predominant emotions of the caregiver-infant/toddler's relationship, the interactions are "harsh and abrupt, often lacking in emotional reciprocity" (Zero to Three, 2005, p.49). In order to decide whether anger and hostility are the predominant emotions of the caregiver-infant/toddler's relationship, you may observe the behavioral quality of the interaction (e.g. the behaviors of both the caregiver and the infant/toddler), the affective tone of the interaction (e.g. the emotions more commonly and more often shared between partners), and the quality and degree of psychological involvement between caregiver and infant/toddler (Zero to Three, 2005).

Below you will find descriptive features for each of the three components of the caregiver-infant's/toddler's interaction based on the descriptive criteria suggested by Zero to Three (2005).

Behavioral Quality of the Interaction

- The caregiver and/or the infant may express anger through their facial expressions of emotions. The infant may accompany the facial expressions of anger with movements which communicate his/her will to avoid and/or to block away the caregiver.
- The caregiver may express anger and hostility through verbal statements, characterize the infant/toddler as demanding and "difficult to care for", and/or taunt or tease the infant/toddler.
- The caregiver may handle the infant/toddler abruptly, and in an insensitive way (see Question 3 below).
- The caregiver may be insensitive to the toddler's/infant's cues, not perceiving the infant's/toddler's needs and intentions.
- The infant/toddler may appear frightened, anxious, inhibited, or diffusely aggressive.
- The infant/toddler may exhibit defiant or resistant behavior with the caregiver.
- The infant/toddler may exhibit fearful, vigilant and avoidant behaviors.

Affective Tone

- Anger and hostility are the predominant emotions of the caregiver-infant's/toddler's interaction.
- An observer is likely to note moderate to considerable tension between the parent and infant/toddler and a noticeable lack of enjoyment or enthusiasm.
- The infant/toddler may express a limited range of emotions, compared to what is expected for his/her age.

Psychological Involvement

- The caregiver may view the toddler's/infant's dependence as demanding and overwhelming, and resent the toddler's/infant's neediness (Zero to Three, 2005). The

dyad may seem to be either lacking psychological involvement, or being engaged in a tense and angry/hostile manner.

Question 2b:	**Is the caregiver-infant/toddler interaction characterized by coldness and/or detachment?**

This question aims to assess risk indicators for emotionally abusive caregiver-infant/toddler relationship patterns. You score this item as positive when the emotions of coldness and/or detachment are expressed either by both partners of the interaction, by the caregiver, or by the child. Coldness and/or detachment should be the predominant emotions of the caregiver-child's interaction.

In general, the caregiver and the infant/toddler may show only sporadic, infrequent involvement or connectedness with each other. Lack of connectedness is often reflected in the low quality of care offered by the parent directly or purchased as child care. In order to decide whether coldness and/or detachment are the predominant emotions of the caregiver-infant's/toddler's relationship, you may observe the behavioural quality of the interaction (e.g., the behaviors of both caregiver and infant/toddler), the affective tone of the interaction (e.g., the emotions more commonly and more often shared between partners), and the quality and degree of psychological involvement between caregiver and infant/toddler (Zero to Three, 2005).

Below you will find the descriptive features for such interactions and relationship based on the descriptive criteria suggested by Zero to Three (2005).

Behavioral Quality of the Interaction

- The caregiver is insensitive and/or unresponsive to the cues of the infant/toddler, maintaining a distant and disengaged attitude towards him/her.
- The caregiver may make engaging verbal statements about the infant/toddler, provide detailed information and describe everyday experiences of the dyad; however, the quality of observed interaction between the caregiver and the infant/toddler may lack warmth, predictability and reciprocity.
- The caregiver ignores, rejects, or fails to comfort the infant/toddler.
- The caregiver seems unable to adequately mirror the infant's/toddler's behaviour through appropriate reflection of the child's internal feeling states.
- The caregiver does not perceive when it is necessary to protect the infant/toddler from sources of physical or emotional harm, or abuse by others, because of her/his detachment and cold stance towards the infant/toddler.
- The caregiver and the child often appear to be disengaged, with little eye contact or physical proximity.

- The infant/toddler may appear delayed in motor and language skills, due to the lack of appropriate stimulation. Some infants/toddlers, however, may be precocious in motor and language skills, using these capacities as part of an inhibited character style with adults.

Affective Tone

- Sadness may often be the predominant emotion of the interaction.
- Flatness, withdrawal, or a limited range of expressed emotions may characterize the affective tone of this type of caregiver-infant/toddler interaction.

Psychological Involvement

- The caregiver may not demonstrate awareness of the infant's/toddler's cues or needs in discussions with others or in interactions with the infant.
- To the observer the caregiver-infant/toddler interaction suggests lifelessness and a lack of pleasure.

Question 2c:	**Is the caregiver-infant/toddler interaction characterized by tension and/or excessive anxiety?**

This question aims to assess risk indicators for emotionally abusive caregiver-infant/toddler relationship patterns. You score this item as positive when interactions between the caregiver and the infant/toddler are tense and constricted, with little sense of relaxed enjoyment or mutuality. Tension and/or excessive anxiety should be the predominant emotions of the caregiver-child's interaction.

In order to decide whether tension and/or excessive anxiety are the predominant emotions of the caregiver-infant's/toddler's relationship, you may observe the behavioral quality of the interaction (e.g. the behaviors of both caregiver and infant/toddler), the affective tone of the interaction (e.g. the emotions more commonly and more often shared between partners), and the quality and degree of psychological involvement between caregiver and infant/toddler (Zero to Three, 2005).

Below you will find the descriptive features for such interactions and relationships based on the descriptive criteria suggested by Zero to Three (2005).

Behavioural Quality of the Interaction

- The caregiver may have a heightened sensitivity to the infant's/toddler's cues and may appear to offer the infant/toddler what is needed before it is asked for.
- The caregiver expresses frequent concern, and may seem particularly anxious about the child's wellbeing, behaviour or development. To an observer the caregiver may appear "overprotective".

- The caregiver's physical handling of the infant may be awkward or tense, lacking fluency and sensitivity.
- The caregiver may have unrealistic expectations of the infant/toddler, or her/his expectations may be incongruent with the infant's/toddler's temperament or developmental capacities.
- The infant/toddler may be unusually compliant or anxious around the caregiver.

Affective Tone

- Anxiety is the predominant emotion of the interaction. It may be expressed through motor tension, apprehension, agitation, facial expressions of emotion communicating anxiety and tension, and a high-pitched tone of voice and quick-paced speech.
- The interaction is characterized by overreacting behaviours by both the caregiver and the child.
- Emotional and behavioral dysregulation also characterise the interaction and often coexist with underlying regulatory difficulties in the child.

Psychological Involvement

The caregiver who is anxious or tense often "does not really see the infant/toddler". Consequently, she/he misinterprets the child's behavior and/or affect and consequently responds inappropriately.

Question 3: **Does the caregiver handle the infant/toddler in a physically rough and/or harming way?**

This question aims to assess a risk indicator for physical abuse of an infant/toddler. You score this item as positive when you have noticed **ANY** of the following behaviours not only during medical consultation at the (medical) office but also at the medical center (including the waiting room or after the completion of the medical consultation). If another health professional, such as a nurse, a social worker, etc., mentions any such situation that you have not observed by yourself, you should CONSIDER such information when filling in this question.

The clinician (doctor, nurse, other health professional) observes or detects that the adult caregiver:

Holds the child abruptly

- Systematically grabs the child's wrist and pulls him abruptly rather than holding his/her hand
- Grabs the infant/toddler abruptly from his/her clothing or other body part

- Grabs the infant/toddler abruptly without care when dressing or undressing him/her during the consultation
- Forces or imposes the infant/toddler to stand in a position that is painful for the child while talking to the doctor
- Ignores and/or underestimates the urgent state of physical pain or psychological suffering of the child (and continues his/her normal activity)

Holds the child in a way that harms him/her

- Holds the child in such a way that hurts him/her (strongly squeezes his/her arm, hand, neck, shoulder, etc.; it may be observed that the child's skin changes colour because of the clamping pressure of the adult).
- Grabs the child by the hair, holds his/her ear while twisting it, pinches the child, stabs the elbow, or stepping on his/her foot.
- The adult's abrupt or brusque movements make the child fall on furniture, walls or other objects and cause harm or pain to the child.
- The clinician detects injuries caused by the adult's abrupt movements, such as contusions, bruises, lacerations, fractures, deformity of the region, or trauma.

  These lesions, which are usually multiple, should be differentiated from injuries explained by an accident, as they are often observed in unusual body locations. Also, it is likely that the professional observes more than one lesion of this type which seems to have been provoked at different points of time. The caregiver may appear unable to provide sufficient explanations about how such lesions occurred, or the caregiver's explanations do not correspond to the professional's clinical evaluation. Some examples of such lesions are marks around the wrists, pinch bruises on the arms or thighs, multiple bruises from blows to various parts of the body, broken teeth, etc.

Such restraining strategies described above should not be justified by the professional as being necessary containment measures for when the child is out of control (e.g. s/he has an exaggerated and excessive tantrum). Professionals should remember that caregivers should contain and impose limits on children without harming them.

Moves the child forcibly or abruptly

- Makes the infant/toddler sit using exaggerated force or throws him/her into the chair/sofa.
- Obliges the child to move by pushing him abruptly and with exaggerated force.
- Lifts the child forcibly by their underarm and carries him/her in way that hurts the child.
- Shakes the child (e.g., the adult holds the child by the shoulders or the chest and shakes him/her causing the head to move forcibly forward and backward. The child is unable to control his/her head movements).

 ATTENTION in babies! Be aware of the "*Shaken baby syndrome*".

Shaken Baby Syndrome (SBS) is a form of child physical abuse. It is a condition occurring in infants less than one year old, caused by violent shaking by the arms and shoulders that makes the brain whip back and forth in the skull, causing subdural hematomas and bleeding in the eyes (Random House Kernerman Webster's College Dictionary, 2010). It results in intracranial swelling and bleeding and subsequent symptoms such as lethargy, seizures, loss of consciousness and often permanent brain damage or death (American Heritage® Dictionary of the English Language, 2011). This set of clinical and pathological changes have made it a distinct and recognizable syndrome (American Academy of Pediatrics, 2001).The signs and symptoms of SBS may range from mild to severe and from nonspecific to obvious.

The doctor should suspect child abuse in the presence of the following signs associated with the inability to explain them through accidental injuries or other medical conditions (Campos, 2006; Generalitat de Catalunya, 2008): retinal hemorrhages (the most characteristic associated injury); subarachnoid hemorrhages; outbreaks of concussion; ischemic stroke; subdural hematomas; progressive cerebral atrophy with cystic degeneration and secondary dilatation of the ventricular system; oxygen deprivation and brain edema, which lead to significant neurological impairment in the developing infant due to damage to brain tissue.

For a child under two years who had a seizure, a seemingly lethal episode or whooping cough bouts, investigation of the presence of retinal hemorrhages in order to rule out physical abuse is required (Pou, 2009). If retinal hemorrhages are present it may be necessary to continue the investigation to rule out child abuse.

Additional reading:

National Institute of Neurological Disorders and Stroke (2015, January 8). *Shaken Baby Syndrome Information Page*[Web page]. Retrieved from http://www.ninds.nih.gov/disorders/shakenbaby/shakenbaby.htm

Zuccoli, G., Panigrahy, A., Haldipur, A., Willaman, D., Squires, J., Wolford, J., Berger, R.P. (2013). Susceptibility weighted imaging depicts retinal hemorrhages in abusive head trauma. *Neuroradiology, 55*(7),889-893. doi: 10.1007/s00234-013-1180-7.

Question 4a: **Are there any other signals that make you doubt the physical safety of the infant/toddler?**

Remember:

Recognizing child abuse and neglect can be difficult, and should involve careful listening and observing. In order to get the whole picture of the child, and his/her nurturing environment, you will need to put together information from many sources, including: (1) developmental and medical history, (2) previous or current reports of abuse and neglect from a third party, (3) child's appearance and behaviour, (4) physical signs or symptoms, and (5) interaction between the caregiver and the infant or toddler.

As part of the normal rough-and-tumble of everyday life children will have cuts and bruises on their bodies which happen whilst they are moving about or playing. These are injuries that have an acceptable and reasonable explanation. Therefore, injuries need to be interpreted in the context of the child's medical and developmental stage, and the explanation given by the child's parent/caregiver.

Thus, be aware of injuries with an unsuitable or implausible explanation which seem inadequate or inconsistent with the child's presentation, normal activities, existing medical condition, and developmental stage. Also, be aware of explanations that differ between parents or caregivers, and between accounts over time. Please note that explaining an injury based on cultural customs and practices is also unsuitable because cultural peculiarities should not justify hurting a child.

In the context of this question, the professional should also evaluate whether the caregiver deliberately delayed seeking medical treatment for the child when this was necessary.

Possible indicators of physical abuse, which may be considered in the context of this Question 4a:

Bruises

- Bruising in a child who is not independently mobile, or at a pre-crawling or pre-walking stage
- Bruises on any non-bony part of the body or face (e.g., eyes, ears, buttocks, cheeks, palms, arms, feet, back, buttocks, stomach, hips, backs of legs)
- Bruises on the neck, which is usually an indication of attempted strangulation
- Bruising in or around the mouth, which is a good indication of force feeding
- Bruised eyes, without bruising to the forehead
- Multiple bruises on the head or on sites that are unlikely to be injured accidentally
- Multiple bruises in clusters that can be seen on the upper arms or outer thighs

- Bruises that show the outline of an object used e.g. belt marks, hand prints
- Bruising around, behind, or on the earlobe(s) is indicative of injury by pulling or twisting
- Bruising on the arms, buttocks and thighs may be an indicator of sexual abuse

Thermal injuries (i.e., Burns or scalds)
- Burns with the clear shape of an object, e.g. cigarette (characterised by small round burns), a hot iron, metal rods or electrical fire elements (characterised by linear burns)
- Burns in an area which is not expected to come into contact with a hot object in an accident (e.g., the backs of hands, soles of feet, legs, genitals, or buttocks)
- Scalds to buttocks, perineum and lower limbs
- Scalds to limbs in a glove or stocking distribution, or with symmetrical distribution
- Scalds with delineated borders
- Old scars which suggest that the child did not receive medical treatment

Fractures
- One or more fractures without any medical condition that predisposes the child to fragile bones (e.g., osteogenesis imperfecta)
- Swelling and lack of use of limbs
- Allegedly unnoticed fractures: As fractures cause lots of pain during injury, it is difficult for a caregiver not to be aware of the child's pain. However, fractures heal quickly in children which enable them to use a fractured limb without pain within a few days, thus masking a healing fracture

Spinal injuries
- Signs of spinal injury such as injury to vertebrae without confirmed accidental trauma
- Cervical injury that is associated with an inflicted head injury
- Thoracolumbar injury that is associated with focal neurology or unexplained kyphosis

Cold injury
- Injuries without obvious medical explanation such as swollen hands or feet
- Hypothermia that has unsuitable explanation

Bites
- A human bite mark that is not caused by another young child.
- An animal bite, which suggests that the child has not been adequately supervised

Lacerations (cuts) and abrasions
- Lacerations or scratches on a child who is not independently mobile
- Multiple lacerations or abrasions that are symmetrically distributed on areas usually covered by clothing such as at the back, chest, or abdomen
- Lacerations or abrasions that are seen on the eyes, ears and sides of face
- Lacerations or abrasions that are seen on the neck, ankles and wrists and which appear like ligature marks

Eye trauma

- Retinal hemorrhages
- Injury to the eye without confirmed accidental trauma or a known medical explanation

Ano-genital signs and symptoms

- A child is suspected to have been sexually abused if the following symptoms are present for which the explanation is either absent or unsuitable:
- Genital, anal or perianal injury (as evidenced by bruising, laceration, swelling)
- Persistent or recurrent genital or anal symptoms (e.g., bleeding or discharge)
- Dysuria (i.e., discomfort on passing urine) or ano-genital discomfort
- Presence of one or more foreign bodies in the vagina or anus

Question 4b: Are there any other signals that make you doubt the emotional safety of the infant/toddler?

Emotional abuse is usually difficult to measure due to absence of clear outward physical signs. Below are **possible indicators of emotional abuse and neglect**, which may be considered in the context of this question (and are not considered under questions 2a, 2b, and 2c).

1. Caregiver - child interactions

Harmful parent/carer–child interactions as seen through negative relationship patterns or rejection, or the scapegoating of a child. *Scapegoating: The caregiver constantly blames the infant/toddler for what goes wrong in life and for any difficulty in the caregiver's life.*

- Developmentally inappropriate expectations of a child such as inappropriate requests and punishments for not meeting the expectations, including inappropriate methods of disciplining the child.

- Failure to promote the child's appropriate socialisation such as isolation.
- Parental emotional unavailability and unresponsiveness towards a child.

Other possible indicators of emotional abuse related to caregiver-child interaction include:

- Abnormal attachment (as characterised by anxious, indiscriminate or no attachment) between a child and parent/caregiver. Because to this lack of attachment, the children do not respond to the parent's presence or absence because they have learnt that their parent will not respond to their distress.
- Indiscriminate attachment or failure to attach.

- Delay in reaching developmental milestones (e.g., emotional development or learning to speak).

2. Emotional Neglect

Emotional neglect is the persistent failure to meet the child's basic psychological needs which is likely to result in the serious impairment of their health or development.

Some possible indicators of emotional neglect include:

- Child is left with adults who are intoxicated or violent
- Child is left alone for excessive periods of time.
- Child is not taken to see a doctor when he/she is ill or has been injured.
- Child displays a marked change in behaviour or emotional state which deviates from what would be expected for his/her age and developmental stage or cannot be explained by medical causes. Examples of such behaviour or emotional states are: being fearful, being withdrawn, habitual body rocking, indiscriminate contact or affection seeking, over-friendliness to strangers, excessive clinginess.

Question 5:	**Is there any other risk factor that makes you doubt the safety and/or the appropriateness of care for this infant/toddler?**

You score this item positively when you have noticed further physical, behavioral or emotional cues by the child or any other risk indicator in the context of the caregiver-child relationship/interactions that make you doubt the safety and/or the appropriateness of care for this infant/toddler. To answer «Yes» in this question, the information noted must not be included in the previous questions. As for the abovementioned questions, these cues may be observed during a visit to family's home, or during a medical consultation or medical exam, or in the waiting room of the organisation you work at.

In order to decide **whether the infant or toddler "is safe or is not safe",** you could and should use your clinical judgment and experience as a professional. Safety is defined as the maintenance of the infant's/toddler's physical and mental integrity, and the absence of any danger which could hurt the child physically and/or mentally.

In order to decide **whether there is any reason to "doubt the appropriateness of care for this infant/ toddler"**, you could and should use your clinical judgment and experience as a professional to evaluate whether the care provided to this child is appropriate for this specific infant/toddler and whether the infant/toddler lives in an appropriate environment. Appropriate can be defined as an environment that is safe for the infant/ toddler, both physically and mentally, and provides the infant/toddler all the factors necessary for healthy developmnet.

Question 5: ***If yes, please specify*:**

More specifically, in this question you are asked to write down any other signs you have observed which might place the child at risk of abuse or neglect; these signs are different to the ones you have already evaluated in the previous questions.

For example:
Information from observation, either in the waiting room or during a medical consultation: Observe the interaction of the child with the caregiver, the interaction between the parents or caregivers and the interaction of the parent/caregiver with another child. If you detect any signs that make you doubt the safety and/or the appropriateness of care for this infant/toddler, it is important to report them in this question.

1. Interaction between parent/caregiver and the child:

The interaction assessed in Question 2 refers to anger and/or hostility, coldness and/or detachment and tension and/or excessive anxiety. During your consultation with the family, or whilst in the waiting room, you might be able to observe matters which fall or do not fall within these categories. If the indications you observed do not fall under these categories, however, this is something to make you worry about the infant/toddler, it is important to assess this family further. For example, if you observe an excessive intimacy between the caregiver and the child, e.g., the caregiver is kissing the child on the mouth or vice versa, or there is some inappropriate touching, this might be something that makes you suspicious regarding the appropriateness of the parenting behaviour towards the child and that you consider important to note.
! BE CAREFUL: Intimacy might be subject to cultural differences.

More examples:

- Parent/Caregiver acting on developmentally inappropriate expectations. For example, a parent/caregiver may expect the infant/ toddler to do, say or think things that are not developmentally appropriate. For instance, a parent who expects his/her 12-month-old infant to speak fluently should be considered as having developmentally inappropriate expectations from the child, since at this age children are only able to use a limited number of words, or small two or three-word phrases.

- Distorted parental understanding of the child. For example, a parent/caregiver may have a distorted understanding of the child's needs, intentions, behavior, or thoughts. For instance, the infant may be crying because s/he is in pain and the parent explains the child's crying as hunger, or due to angry feelings towards the caregiver.

- Inappropriate parental response to the infant's/toddler's needs, intentions, wills or behaviour. For example, the child may be crying because he/she feels insecure in an unknown environment, and the caregiver mocks or laughs at the child, or becomes angry with the child.

- The caregiver seems suspicious when the child makes contact with other people; or, the caregiver speaks for the child, although the child would be able to speak for himself/herself.

- There is an apparent lack of involvement (emotional or in general) between the caregiver and the infant/toddler.

- The child does not follow the limits or the rules set by his/her caregiver/parent.

- The caregiver refuses to allow a toddler to speak to a healthcare professional on his/her own, even when it is necessary for the assessment of the child (if applicable, based on the child's age).

- Neglect of child's physical needs: A common form of neglect is the lack of provision for basic needs, such as inadequate food, clothes, warmth, hygiene and medical care.

  Other possible indicators of physical neglect may include:
    - Presence of severe and persistent infestations (e.g. head lice).
    - Use of consistently inappropriate clothing or footwear (e.g. child's size, for the wrong season).
    - The child is persistently smelly and dirty.
    - Presence of frequent and untreated nappy rash.
    - The child presents failure to grow within normal expected pattern and/or has weight loss due to an adequate or appropriate diet.

2. Observing the interaction between infant/toddler's parents/caregivers:

In this case, you might report signs that make you doubt the safety and/or appropriateness of care for this infant/toddler by observing the interaction between parents or caregivers. Anger and/or hostility, coldness and/or detachment and tension and/or excessive anxiety might characterize the interaction between partners (e.g., the infant's/toddler's caregivers or parents). For example, you should note whether the caregivers/parents seem to have a conflictual relationship, i.e. shouting or swearing at each other, or blaming each other for difficulties related to the child. Personal or environmental factors may be responsible for such a conflictual relationship, which may result in frequent or chronic discord. Also, caregivers may be involved in custody-related conflict, or there may be previous

involvement with law enforcement and/or child protection service. Note that **exposing a child to intimate partner violence is considered a form of maltreatment**.

3. Observing the interaction between infant's/toddler's parents/caregivers with another child:

The careful observation of the interaction between the infant's/toddler's parents/caregivers with another child may further inform your clinical evaluation and decision-making. In such a case, you may also be interested in noting any indicator which has already been described as alarming in the previous sections of these Guidelines. It is also worth noting any differences or similarities in caregivers'/parents' interaction with the infant/toddler, and with this other child.

Further risk indicators which may increase the likelihood of an abusive caregiver-child relationship (the list is indicative and by no means exhaustive) include:

3a) Child's Disability, Mental Health or Developmental Disorders, or Medical Syndromes:

Some children are more vulnerable than others. Children and infants with disabilities, mental health disorders, developmental disorders, and/or medical syndromes may be less able to protect themselves and are particularly dependent on adults for their safety and well-being. In addition, bringing up an infant or toddler with special needs in terms of care provision is a very demanding task, which often pushes the caregivers to their limits of tiredness, anxiety, disappointment, etc. As a health professional, you should be especially vigilant of suspected abuse or neglect involving such children.

3b) Maternal or paternal depression during the perinatal period is a risk factor for neglect:

Infanticide is rare, however it presents higher rates in the context of postpartum illness (Spinelli, 2004). Caring for a young infant is a requiring task even for healthy adults. Consequently, when the caregiver suffers from mental health problems, caring for an infant may become extremely difficult and demanding. Be aware of families which seem to face mental health problems and evaluate whether and to what degree caregivers' mental health problems affect the provision of care to the child.

Chapter III. Scoring

Scoring of the INTOVIAN Tool **does not lead to any diagnosis of child abuse and neglect (CAN)**. On the contrary, **one single positive answer** reflects that the professional has **one risk indicator to suspect either child maltreatment or an abusive caregiver-infant/toddler relationship pattern** that needs to be assessed further in order to be confirmed or to be excluded. The more positive scores, the more risk indicators the professional has to start the assessment process including any intervention that is provisioned by the national protocol for suspected CAN cases and/or by the protocol of the organization you work for (i.e. further examinations, referral to the social services of the hospital etc.) without delay. It is important to remember that the "INTOVIAN" is a supplementary tool that does not substitute any other screening process you may already follow. Additionally, the aim of the tool is NOT to evaluate the risk (i.e. high, low or medium) of child abuse and neglect but rather to identify the presence or absence of it at the time of the family's visitation. However, the number of positive answers to the following items should lead to a more solid decision to take action immediately.

In particular:

Nb of Question	Answer (Yes/No)	Action
Q1a.	No	Needs further assessment/intervention
Q1b.	Yes	Needs further assessment/intervention
Q2a.	Yes	Needs further assessment/intervention
Q2b.	Yes	Needs further assessment/intervention
Q2c.	Yes	Needs further assessment/intervention
Q3.	Yes	Needs further assessment/intervention
Q4a.	Yes	Needs further assessment/intervention
Q4b.	Yes	Needs further assessment/intervention
Q5	Yes	Needs further assessment/intervention

Chapter IV. What are the Next Steps of the Assessment process?

Section 11 of the Children Act 2004 places a duty on key persons and bodies to make arrangements in any local area to safeguard and promote the welfare of children and improve the outcomes for children. Thus, all professionals in agencies with contact with children and members of their families must make a referral to local authority (LA) children's social care if there are signs that a child:

- Has suffered significant harm through abuse or neglect, or
- Is likely to suffer significant harm in the future.

The timing of such referrals should reflect the level of perceived risk of harm.
If you think a child is in immediate danger, call straight away:

- The police on 999
- The NSPCC on 0808 800 5000
- The LA children's social care emergency duty team or out-of-hours team

Seeking urgent medical attention

If you notice that the child is suffering from a serious injury, immediate medical attention from accident and emergency services must be sought. You must also inform the duty consultant paediatrician at the hospital and inform the local authority children's social care. In the case that abuse is alleged, suspected or confirmed regarding a child, the child must remain in the hospital until the local authority children's social care local to the hospital and the child's home address (in the case of different LA children's social care) are notified that there are child protection concerns.

Where there is a risk to the life of a child or a likelihood of serious immediate harm, local authority social workers, the police or the NSPCC are obliged to use their statutory child protection powers to act immediately to secure the safety of the child.

Initiating the referral

If you have concerns about a child's welfare (e.g., based on the scores on the INTOVIAN Tool), you can make a referral to a local authority (LA) children's social care/children services which is responsible for clarifying the nature of the concerns. In normal circumstances, permission should be sought to discuss concerns with the family before making the referral. However, this should not be done where such discussion and agreement-seeking could place a child at increased risk of suffering significant harm.

When referring your concern to the LA children's social care, report the result of your assessment using the INTOVIAN Tool and whether the child needs immediate protection. Other relevant information about the child that you may be requested to share with the local authority (LA) children's social care includes:

- Child's developmental needs
- The capacity of his/her parents or carers to meet these needs
- Full name, date of birth and gender of the child
- Family address (and where relevant the name of the nursery attended)
- Identity of his/her parent(s) or carer(s)
- The child's NHS number
- Ethnicity, first language and religion of children and parents
- Any significant incidents/events (recent or past) in the child's or family's life
- Referrer's relationship and their knowledge of the child and parents
- Involvement of other agencies or professionals (if known)

This information will help to determine the type of services that the child needs.

Within one working day of a referral being received by a local authority children's social care, you will be informed by a local authority social worker about a decision regarding the type of response that is required. This will include determining whether:

- the child requires immediate protection and urgent action is required;
- the child is in need, and should be assessed under section 17 of the Children Act 1989;
- there is reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm, and whether enquires must be made and the child assessed under section 47 of the Children Act 1989;
- any services are required by the child/family and what type of services; and
- further specialist assessments are required to help the local authority to decide on further action.

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ANNEX I. The INTOVIAN Screening Tool

Tool for identifying families at risk of or with already established infant and toddler abuse and neglect problems

The tool that follows was developed to be applied to families from the general population with infants and toddlers from 0 to 3 years of age by health and social services professionals. Please answer all questions based on your observations and/or personal opinion. Tick one circle for each line✓.

Date (dd/mm/yyyy):__ /__ /____ Child's age (in months): ___

Child's sex: Boy ❍ Girl ❍

Who accompanies the child (in relation to the child)? [please check all that apply]

If female:

☐ Mother/Stepmother
☐ Foster mother
☐ Sister
☐ Grandmother
☐ Other female relative (e.g. aunt): _____
☐ Other female person (pls. specify): _____

If male:

☐ Father/Stepfather
☐ Foster father
☐ Brother
☐ Grandfather
☐ Other male relative (e.g. uncle): _____
☐ Other male person (pls. specify):_____

	Question	Yes	No	Not Applicable
1	In the case of noticing a physical trauma/mark or being informed about an accident: (a) is the caregiver's story consistent?	❍	❍	❍
	(b) could the accident/physical trauma have been avoided or prevented with age-appropriate supervision?	❍	❍	❍
2	Is the caregiver-infant/toddler <u>interaction</u> characterized by *(a, b and c are NOT mutually exclusive)*: a. anger and/or hostility?	❍	❍	

	b. coldness and/or detachment?	❍	❍	
	c. tension and/or excessive anxiety?	❍	❍	
3	Does the caregiver handle the infant/toddler in a physically rough and/or harming way?	❍	❍	
4	Are there any <u>other</u> signals that make you doubt: a. the physical safety of the infant/toddler?	❍	❍	
	b. the emotional safety of the infant/toddler?	❍	❍	
5	Is there <u>any other risk factor</u> that makes you doubt the safety and/or the appropriateness of care for this infant/toddler?	❍	❍	
	If yes, please specify: _____ _____ _____ _____ _____ _____			

ANNEX II. List of Risk and Protective Indicators for Infant/Toddler Abuse and Neglect

Enhanced knowledge about the risk and protective factors give professionals who work with families a general understanding of factors which may place the child at risk of being abused or neglected, or factors that may protect them from such harm, as well as the extent to which these factors may interact with each other. It should however be noted that although these risk factors exist in families where child abuse and neglect takes place, their presence does not necessarily result in child abuse and neglect. Similarly, the presence of protective factors may not necessarily protect the children from being abused or neglected.

Common risk and protective factors for child abuse and neglect

	Risk Factors	**Protective Factors**
Child factors	Premature birth Birth anomalies Low birth weight Disability (physical/cognitive/emotional) Serious illness (physical or mental) Difficult temperament Behaviour problems (e.g., aggression) Attention deficits Developmental delays	Good health Adequate physical development Easy temperament
Parental/family factors	Parent's characteristics: Poor impulse control Low tolerance for frustration Feelings of insecurity Lack of trust Physical health problems History of child abuse and neglect Parental disability Teenage parent(s) Non-biological parent(s) Low parental education High parental stress Low self-esteem Social isolation Lack of support	Parent's characteristics: High parental education Parental resilience Good coping skills Parenting styles: Secure attachment Warm parent-child relationship Supportive family environment

	Parenting styles: Poor parent-child interaction Negative attitudes and attributions about the child's behaviuor Family structure: Single parent with a lack of support High number of children in household Separation/divorce High parental conflict Domestic violence Parental psychopathology: Substance abuse Depression Anxiety	
Social/environmental factors	Low socioeconomic status Lack of access to medical care Lack of social services Lack of housing Parental unemployment Social isolation/lack of social support Exposure to racism/discrimination Dangerous/violent neighborhood Community violence	Mid to high socioeconomic status Access to health care and social services Consistent parental employment Adequate housing Strong and positive social networks

Annex III. Relevant National laws and Guidelines

Children's rights are provided for by a large number of laws – some that were specifically enacted to safeguard and promote the welfare of children, and others that contain a few sections that pertain to children and provide them with essential rights. Given the volume and complexity of these laws, this report provides a broad overview of the legislation relevant to safeguarding and promoting the welfare of children.

In England the law states that people who work with children have to keep them safe. This safeguarding legislation is set out in The Children Act (1989) and (2004).

The Children Act 1989

The aim of the Children Act 1989 is to ensure that children's welfare and developmental needs are met, including the need to be protected from harm. This piece of legislation identifies the Local Authority (LA) requirement to provide services for children in need for the purposes of safeguarding and promoting their welfare. Local Authorities also undertake assessments of the needs of individual children to determine what services to provide and action to take.

The criteria for when a child should be referred to the LA children's social care for assessment and for statutory services are listed under:

- Section 17 of the Children Act 1989 (children in need)
- Section 47 of the Children Act 1989 (safeguarding)
- Section 31 of the Children Act 1989 (care proceedings)
- Section 20 of the Children Act 1989 (duty to accommodate a child).

The LAS and their statutory partners (i.e. NSPCC and the police) also have power to take emergency action to safeguard children. **Emergency protection orders** state that the court may make the order under s44 of the Children Act 1989 , but only if, it is satisfied that there is reasonable cause to believe that a child is likely to suffer significant harm if:

- he is not removed to accommodation; or
- he does not remain in the place in which he is then being accommodated.

Children Act 2004

The Children Act 2004 made amendments to the Children Act 1989 in response to the Victoria Climbie inquiry. The Act aims to improve effective local working together to safeguard and promote children's wellbeing. It also takes a child-centred approach and includes universal, targeted and specialist services. The Act emphasizes the importance of inter-agency work and co-operation in meeting the needs of children and ensuring that children's views are ascertained and represented, and in improving outcomes for all children. In order to achieve this aim, local authorities are given a lead role in securing the co-operation of partners in setting up children's trust arrangements.

The main provisions of the Act are summarised below:

- The establishment of a Children's Commissioner whose role is to promote awareness of the views and interests of children.
- The establishment of statutory Local Safeguarding Children Boards to replace the non-statutory Area Child Protection Committees.

Working Together to Safeguard Children

In addition to the above legislation, the government also provides guidance to inter-agency working to safeguard and promote the welfare of children in their document "Working Together to Safeguard Children".

The document also provides a framework for **Local Safeguarding Children Boards** (LSCBs) in challenging safeguarding practice and in monitoring the effectiveness of local services. The LSCBs are the inter-agency statutory boards that bring together the local authority, police, health organisations and other local agencies to co-ordinate and ensure effective local arrangements to safeguard children. It is important that you familiarize yourself with local LSCB procedures and protocols.

Multi Agency Safeguarding Hubs (MASH)

In order to ensure high quality and swift safeguarding responses of vulnerable children, MASH operates on three principles: information sharing, joint decision making and coordinated intervention. Various agencies represented within multi-agency safeguarding approaches include local authorities (children and adult services), police, health and probation.

The core functions of a MASH include:

- Acting as a single point of entry where notifications related to safeguarding are gathered in one place.
- Thorough examination of each case in order to identify potential risk.
- Sharing information between agencies through a joint information sharing protocol

- Triaging referrals by using the agreed risk ratings.
- Facilitating early intervention.
- Managing cases through co-ordinated interventions.

Sources of information and guidance

National laws

Children Act 1989 (1989) HMSO, London.
www.legislation.gov.uk/ukpga/1989/41/contents

Children Act 2004 (2004) HMSO, London.
www.legislation.gov.uk/ukpga/2004/31/contents

Guidance

General Medical Council: Protecting children and young people - The responsibilities of all doctors
www.gmc-uk.org/static/documents/content/Child_protection_-_English_0712.pdf

London Child Protection Procedures and Practice Guidance
http://www.londoncp.co.uk/index.html

Multi Agency Safeguarding Hubs (MASH)
https://www.gov.uk/government/publications/multi-agency-working-and-information-sharing-project

NICE: Guidance on when to suspect child maltreatment
http://www.nice.org.uk/guidance/CG89

NPIA / ACPO: Guidance on Investigating Child Abuse and Safeguarding Children
www.ceop.police.uk/Documents/ACPOGuidance2009.pdf

Royal College of General Practitioners: Safeguarding Children and Young People: The RCGP/NSPCC Safeguarding Children Toolkit for General Practice
http://www.rcgp.org.uk/clinical-and-research/clinical-resources/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx

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What to do if you're worried a child is being abused: Advice for practitioners.
https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2

Working Together to Safeguard Children
https://www.gov.uk/government/publications/working-together-to-safeguard-children

ANNEX IV. Psychosocial and Environmental Stressor Checklist

Complete information for all stressors that apply

	Age of Onset (in months)	**Comments** (including duration and severity)
Challenges to Child's Primary Support Group		
Birth of a sibling		
Change in primary caregiver		
Child adopted		
Child in foster care		
Child in institutional care		
Death of a parent		
Death of other family member		
Death of non-family significant other		
Marital discord		
New adult in household (e.g. boyfriend)		
New child (not by birth) in home (e.g. adoption, step sibling, cousin)		
Parental separation or divorce		
Parental remarriage		
Parental separation, other (e.g., parental hospitalization)		
Educational/Child–Care Challenges		
More than 9 hours/day in out-of-home care		
Multiple changes in child care provider		
Poor-quality early learning environment (e.g., health and safety concerns; high child: staff ratios and large groups; inadequately trained staff; lack of attention to social and emotional development)		
Housing Challenges		
Dislocation from home		
Homelessness		

Multiple moves		
Problems maintaining heat, electricity, water, and telephone		
Unsafe neighborhood		
Unsafe or overcrowded housing		
Health-CareAccess Challenges		
Inadequate health services in area		
Lack of or inadequate health insurance		
Health of Child		
Hospitalization of child		
Medical illness in child (acute or chronic); child accident/injury (e.g., animal bite, passenger in vehicular accident)		
Medical procedure(s) performed on child (e.g., spinal tap)		
Legal/Criminal Justice Challenges		
Child Protective Services involvement		
Custody dispute in the context of parental divorce		
Immigration status		
Parental arrest		
Parental incarceration		
Child victim of crime		
Other		
Natural disaster (e.g., fire, hurricane)		
War/terrorism		
Other (please specify):		

ANNEX V. List of Organizations Working with Child Abuse and Neglect

Numerous organizations and institutions are available that work with child abuse and neglect. Some of these institutions are listed below:

1. National Society for the Prevention of Cruelty to Children (NSPCC)

Address: Weston House, 42 Curtain Road, London EC2A 3NH
Telephone: 0808 800 5000
E-mail: help@nspcc.org.uk

The NSPCC is the major national charity fighting to protect children from abuse and neglect in the UK and Channel Island. It also helps children who have been abused to rebuild their lives, protect those at risk and find the best ways of preventing abuse from ever happening.

The NSPCC operates a national 24 hour Child Protection Helpline (Telephone: 0808 800 5000), offering advice to adults and children worried about a child's safety or welfare. The Helpline accepts referrals and passes the information to the relevant LA children's social care services.

The service can usually provide an interpreter, if one is requested at the beginning of a call. There is a free textphone service (0800 056 0566) for adults or children who are deaf or hard of hearing.

The NSPCC's Asian child protection helpline provides advice in
- Bengali (0800 096 7714)
- Gujurati (0800 096 7715)
- Hindi (0800 096 7716)
- Punjabi (0800 096 7717)
- Urdu (0800 096 7718)
- Asian/English (0800 096 7719)

2. Child Abuse Prevention, Child Abuse and Neglect (BASPCAN)

Address: 17 Priory Street, York YO1 6ET
Telephone: +44 (0) 1904 613605
E-mail: baspcan@baspcan.org.uk

The BASPCAN is a registered charity which aims to prevent physical, emotional and sexual abuse and neglect of children by promoting the physical, emotional, and social well-being of children.

3. Action for Children

Address: 3 The Boulevard, Ascot Road, Watford WD18 8AG
Telephone: 0300 123 2112
E-mail: ask.us@actionforchildren.org.uk

Action for Children has been supporting the most vulnerable and neglected children and young people throughout the UK since the last 145 years.

Following calls from Action for Children (http://www.actionforchildren.org.uk/campaigns), the Government has launched a new national web portal for reporting child abuse. This web portal (https://www.gov.uk/report-child-abuse) explains what abuse and neglect might look like and enables the public to report concerns to their local children's services or police.

4. The Children's Society

Address: The Children's Society
Edward Rudolf House, Margery Street, London WC1X 0JL
Telephone: 020 7841 4400
http://www.childrenssociety.org.uk/

The Children's Society work directly with the most disadvantaged children (including child poverty and neglect head on) through their extensive network of frontline services. Their actions include: uncovering desperate situations, exposing injustice and addressing hard truths to improve children's lives.

5. Barnado's

Address: Barnardo's, Tanners Lane, Barkingside, Ilford, Essex IG6 1QG
Telephone: 0208 550 8822

The purpose of Barnardo's is to transform the lives of the UK's most vulnerable children, that is, those in the abused, the forgotten and the neglected. Barnardo's believe that every

child deserves the best start in life and the chance to fulfil their potential. The knowledge they gained from their direct work with children help them to effectively campaign for better childcare policy and to champion the rights of every child.

6. Africans Unite Against Child Abuse (AFRUCA)

Address: Unit 3D/F Leroy House 436 Essex Road London N1 3QP
Telephone: 0207 704 2261
http://www.afruca.org/

AFRUCA was established in May 2001 as a platform for advocating for the rights and welfare of African children. Their vision is to see a world in which African Children can live free of cruelty and abuse at the hands of others.

7. WAVE Trust

Address: Cameron House, 61 Friends Road, Croydon, Surrey CR0 1ED
Telephone: +44 (0)20 8688 3773
E-mail: office@wavetrust.org
http://www.wavetrust.org

Through research, advocacy and implementation of a primary prevention approach WAVE works to break damaging cycles of family dysfunction and child maltreatment.
Their work involves:

- Consolidating the best of scientific understanding of both causes and solutions
- Using this knowledge gained to create both practical and effective action plans to break cycles of violence, childhood abuse and neglect
- Assisting the practical adoption and implementation of these aforementioned action plans by working with policy-makers.

As part of their "70/30" campaign, which is to reduce child maltreatment by 70% by 2030, WAVE Trust is launching 6 Pioneer Communities across the UK to significantly reduce child maltreatment by taking a primary preventive approach.

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