Screening & Referral Protocol

Enhancing the Capacity to combat chiLd abuse through an Integral training and Protocol for childcare professionalS

This project has received funding from the Rights, Equality and Citizenship (REC) Programme of the European Union under grant agreement No 101005642.

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ECLIPS

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INTRODUCTION TO THE PROTOCOL

This protocol was developed as part of the research project "Enhancing the Capacity to combat child abuse through an Integral training and Protocol for childcare professionalS" (ECLIPS), REC-RDAP-GBV-AG-2020-101005642. The project aimed to raise awareness and build capacity amongst childcare professionals for the detection and referral in cases of domestic violence and dealing with trauma symptoms among children in the 0-3 age group.[1]

POSITIONING OF THE PROTOCOL

The project team carried out a study on practices and tools available to childcare professionals in 4 project partner countries and concluded that there is a lack of screening instruments designed for childcare professionals. This protocol is developed for childcare professionals to help identify signs of child abuse among children aged 0-3 and refer in case of possible abuse.[2]

Children of this age group are particularly vulnerable to abuse. Young children often slip through the care system because they are unable to comprehend and/or communicate their suffering verbally to such caregivers as childcare professionals. These childcare professionals often miss the nonverbal signals of children at risk, feel incompetent to react, or have no tools or procedures to indicate or sign their concerns. As such, childcare professionals are essential actors for multi-agency cooperation against domestic violence directed at this age group.

Children show us more often than tell us that something bad is happening to them, so it is extremely important to recognise the signs. Even if a child tries to tell you something, the information may be vague, and they may not have the words to describe or explain what happened. Children may also not acknowledge they are victims and/or may deny that anything happened to them. This is caused by fear, guilt, shame, embarrassment, or pressure from others to deny what has happened. Many signs of abuse are easily masked, so it takes a "trained eye" to detect them. This protocol will help to detect these signs and refer the family for support.

1 More about the project: https://eclipsproject.eu/

2 Adverse Childhood Experiences (ACE) can shape child's future and cause multiple problems. Please see protocol on Trauma-sensitive care for more detailed information.

Please note that this tool is not designed for diagnosing trauma and abuse (for example, as in the case of psychodiagnostics) but rather as supporting guidance for childcare professionals to screen and detect worrying signs, discuss these signs with primary caregivers[3], and colleagues and refer to the appropriate specialists. Training on using this protocol provided by a direct supervisor could be highly beneficial.

AIM OF THE PROTOCOL

This protocol is designed to provide childcare facility staff[4] with clear and objective information:

1. How to communicate with primary caregivers about what is observed in their child's behaviour, emotional state, development, and needs.
2. How to refer suspected or known child abuse to the authorities.

EXPECTED OUTCOMES OF THE PROTOCOL

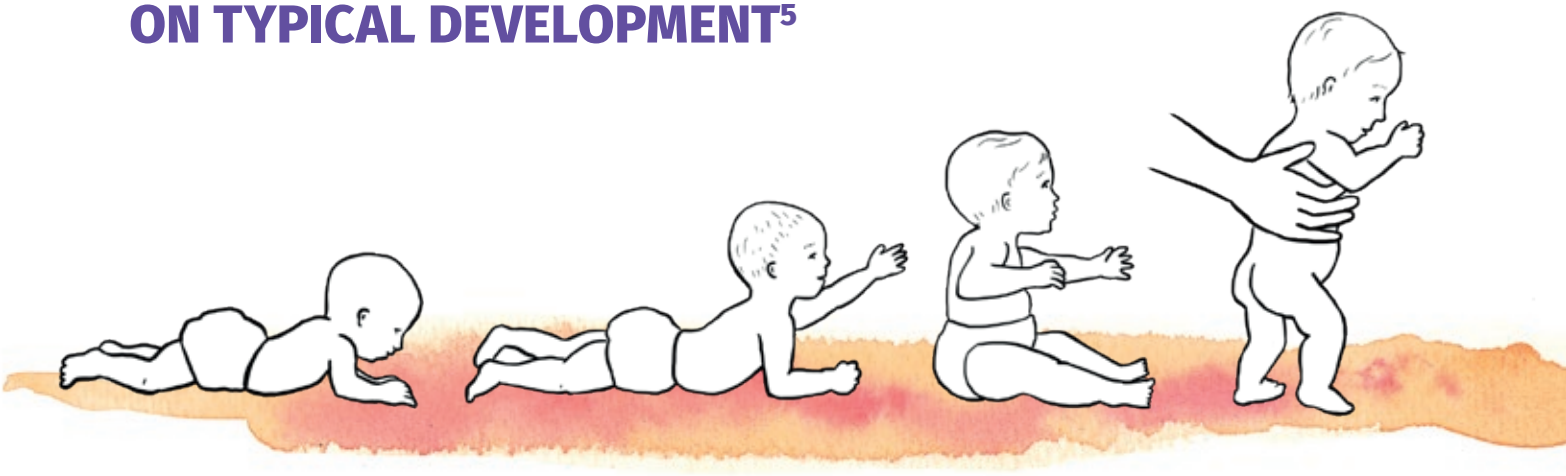
- Increase knowledge, awareness, skills, and changed attitudes in childcare professionals about child abuse, signs of child abuse, and the consequences
- Increase capacity of childcare professionals to deal with child abuse
- Development of clear referral guidance in case of suspicion of child abuse
- Improve communication skills with primary caregivers
- Improve awareness of staff's wellbeing and awareness of unintentional harmful behaviour among pre-school staff.

3 Within the protocol we use general term "primary caregivers" that includes the child's parents and other caregivers involved in caring for and raising the child (e.g., grandparents). In specific occasions we have used "parent" as the more appropriate term (for example, when the childcare facility is initiating a meeting about identified problems with a child. In this case, parents should be invited first-hand. Parents themselves can decide if they want to invite other relevant primary caregivers (e.g., grandparents) involved in the child's life to participate in the meeting).

4 There are many terms that describe different forms of organised/professional childcare services and organisations (e.g., preschool, day-care, childcare, nursery, nursery school, kindergarten, nanny services). Throughout the protocol we have used a general term "childcare facility" as an umbrella term of many childcare forms.

AN OUTLOOK ON TYPICAL DEVELOPMENT AND CHILD ABUSE

ON TYPICAL DEVELOPMENT[5]



Below is a summary Table of the typical development of children in the 0-3-year age range and guides childcare professionals in their observation of what is going on with a child aligned with their development. This Table helps to better understand and distinguish between typical and atypical behaviours and emotional expressions among children in different age groups. Untypical behaviours and expressions can be related to the experience of abuse or any other problem or discomfort a child may experience. The Table summarizes developmental milestones concerning four developmental areas, as well as a general area of concerns:

Emotional-Relational (includes the development of emotional expression, regulation, comprehension, as well as social development and attachment patterns).

Linguistic (includes the development of linguistic expression, comprehension and production, and adaption to the environment).

Cognitive (includes the development of general intelligence, the ability of problem-solving, and interaction with the environment).

Physical-Motor (includes the development of gross and fine motor skills).

Concerns (includes examples of atypical and potentially worrying behaviours and signs for each area of development).

5 Adapted from CDC's Developmental Milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html

	DEVELOPMENTAL AREA				
	 **Emotional-Relational**	 **Linguistic**	 **Cognitive**	 **Physical-Motor**	 **Concerns**
6 MONTHS	Distinguishes familiar faces from those of strangers Likes to play, especially with primary caregivers Responds to other people's emotions	Responds to sounds by making sounds Make vowel sounds ("ah", "eh", "oh") Responds to own name Makes sounds to show joy and displeasure	Brings things to the mouth Shows curiosity about things and tries to get objects that are out of reach Begins to pass objects from one hand to the other	Rolls over in both directions Begins to sit without support	Is missing developmental milestones[6] as compared to their age group Doesn't try to get things that are in reach Shows no affection for caregivers Doesn't respond to surrounding sounds them Seems very stiff or floppy
1 YEAR	Is shy or nervous with strangers Cries when the parent leaves Has favourite things and people Repeats sounds or actions to get attention Plays games like "peek-a-boo"	Responds to simple spoken requests Uses simple gestures, like shaking head "no" or waving "bye-bye" Tries to say words you say	Explores things by shaking, banging, throwing Looks at the right picture or thing when it's named Copies gestures Starts to use things correctly; for example, drinks from a cup Follows simple directions like "pick up the toy"	Gets to a sitting position without help Pulls up to stand, walks holding on to furniture Can stand alone	Is missing developmental milestones[7] for their age group Doesn't crawl Can't stand when supported Doesn't say single words like "mama" or "dada" Doesn't learn gestures like waving Doesn't point to things Loses skills acquired before

6 Developmental milestones are defined in previous columns.

7 Developmental milestones are defined in previous columns.

	DEVELOPMENTAL AREA				
	 **Emotional-Relational**	 **Linguistic**	 **Cognitive**	 **Physical-Motor**	 **Concerns**
1,5 YEARS	Likes to hand things to others in play May have temper tantrums May be afraid of strangers Shows affection to familiar people May cling to caregivers in new situations Explores alone but with a primary caregiver close by	Says several single words Says and shakes head "no" Points to show someone what he/she wants	Knows what ordinary things are Points to get the attention of others Shows interest in a doll or stuffed animal by pretending to feed Can follow 1-step verbal commands without any gestures; for example, sits when you say "sit down"	Walks alone May walk up steps and run Drinks from a cup Eats with a spoon	Is missing developmental milestones[8] for their age group Doesn't point to showing things to others Can't walk Doesn't know what familiar things are for Doesn't copy others Doesn't gain new words Loses skills acquired before
2 YEARS	Copies others, especially adults and older children Shows more and more independence Shows defiant behaviour (doing what they has been told not to) Plays mainly beside other children, but is beginning to include other children	Knows names of familiar people and body parts Says sentences with 2 to 4 words Follows simple instructions Repeats words overheard in conversation	Begins to sort shapes and colours Completes sentences and rhymes in familiar books Plays simple make-believe games Follows two-step instructions such as "Pick up the toy and put it in the box."	Stands on tiptoe Kicks a ball Begins to run Climbs onto and down from furniture without help	Is missing developmental milestones[9] for their age group Doesn't use 2-word phrases (e.g., "drink juice") Doesn't know what to do with common things (e.g., spoon) Doesn't copy actions and words Doesn't walk steadily Loses skills acquired before

8 Developmental milestones are defined in previous columns.

9 Developmental milestones are defined in previous columns.

	DEVELOPMENTAL AREA				
	 **Emotional-Relational**	 **Linguistic**	 **Cognitive**	 **Physical-Motor**	 **Concerns**
3 YEARS	Distinguishes familiar faces from those of strangers Likes to play, especially with primary caregivers Responds to other people's emotions	Responds to sounds by making sounds Make vowel sounds ("ah", "eh", "oh") Responds to own name Makes sounds to show joy and displeasure	Brings things to the mouth Shows curiosity about things and tries to get objects that are out of reach Begins to pass objects from one hand to the other	Rolls over in both directions Begins to sit without support	Is missing developmental milestones[10] as compared to their age group Doesn't try to get things that are in reach Shows no affection for caregivers Doesn't respond to surrounding sounds them Seems very stiff or floppy

10 Developmental milestones are defined in previous columns.

11 References:

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SIGNS AND SYMPTOMS OF CHILD ABUSE

This Table covers indicators (signs and symptoms) of child abuse. Based on multiple academic and clinical references[11] it combines the most relevant indicators of abuse for the 0 to 3 age group. The Table is intended as guidance for childcare professionals and not as diagnostic tool.

PHYSICAL ABUSE AND NEGLECT

 CHILD-RELATED INDICATORS	 FAMILY-RELATED INDICATORS
Physical indicators: • malnutrition; • persistent poor hygiene of the child that creates difficulties also in the relationship with peers; • absence of health checks and vaccinations; • lack of medical care; • damaged soft tissues and the presence of lesions; • constantly inadequate clothing for the season and neglected hygiene; • injuries occurred in a child who is unable to move; • the child is frequently injured, and injuries cannot be justified; • primary caregiver frequently seeks medical attention with unusual symptoms; • poor physical development and nutrition; • the child's appearance or behaviour is suspicious. **Behavioural indicators:** • permanent fatigue and inattention; • difficulties in daycare; • child complaining of hunger; • unjustified long hours at daycare; • seeking affection from strangers; • child who appears detached and does not seek contact with family members; • mental disability and language retardation due to lack of stimuli; • passivity and apathy.	• psychiatric problems; • alcoholism and drug use; • separated primary caregivers forming a new cohabitation; • cohabitating or marital conflict; • lack of control over children's conduct; • primary caregivers with a history of abuse; • excessive physical intimacy between primary caregivers and children also expressed in the form of play; • primary caregivers who leave their infants unattended for an excessive amount of time considering the age of the child; • primary caregivers who use alcohol or drugs; • primary caregivers who are intellectually disabled or mentally ill; • confused and depressed mothers; • very young mothers; • poor perception of the child's needs; • inability to care for the child; • absence of the partner in the family management in the presence of a fragile primary caregiver; • social isolation and lack of support from the extended family; • economic difficulties; • inadequate or improper housing; • frequent moving; change of habitation • welfare assistance as the only source of income; • disorganised family life; • poor problem-solving skills; • numerous unplanned pregnancies; • passivity and apathy.

SEXUAL ABUSE

 CHILD-RELATED INDICATORS	 FAMILY-RELATED INDICATORS
Physical signs: • difficulty walking or sitting; • abdominal pain or itching in the genital area; • bruising, bleeding, or other injuries to the genital area; • STDs; • painful urination; • unexplained health problems. **Behavioural indicators:** • age-inappropriate knowledge of sexual issues; • child asks age-inappropriate questions about sexuality; • child plays, draws scenes of a sexual nature; • intense masturbation; • panic attacks; • extremely afraid of a person, place, or area; • child does not want to undress.	• child not desired by one or both primary caregivers; • conflictual situation in the relationship; • overprotective primary caregivers; • primary caregivers who are too demanding; • primary caregivers who are too liberal, who do not know how to set rules; • manipulation of the child in situations of conflictual separation; • inability to assess the child's needs and to see/ understand their problems; • inability of the primary caregiver to ask and receive help; • difficulty or refusal of primary caregivers to recognise the consequences of their actions; • a family environment that is not very supportive; • primary caregiver does not show positive emotions towards the child, especially the infant, or small child; • does not react to the child, does not pay attention to his signals, and needs; • dismissive, critical, hostile, humiliating towards the child; • increased stress level; • has increased expectations about the child's age/development/abilities; • excessive threats, intimidation, painful methods of discipline; • the use of the child in the interests of the primary caregiver (e.g., family conflicts); • inadequate socialization of the child (e.g., involvement in illegal actions or isolation); • foster care placement, humiliation in front of other people; • humiliating the child in front of other people.

EMOTIONAL ABUSE

 CHILD-RELATED INDICATORS	 FAMILY-RELATED INDICATORS
• developmental delay; • emotional, behavioural, and social symptoms applicable to infants and toddlers; • regression to behaviour pertaining to a younger age; • blank expressionless face, lack of eye contact; • shyness, alarm, hypersensitivity to environmental stimuli; • hypervigilance, overly alertness; • distrust of adults (intense fear reaction from people of certain gender or appearance); • distrust of close relatives, mostly primary caregivers, fear of them; • unexpected, sudden behavioural changes. • poor sociability or attachment/stickiness; • regressive behaviours; • improper or stereotyped habits (sucking, biting, rocking); • problems eating; • altered sleep habits; • nocturnal terrors and nightmares; • impulsiveness and defiant behaviour.	• child not desired by one or both primary caregivers; • conflict situation in the relationship; • overprotective primary caregivers; • primary caregivers who are too demanding; • primary caregivers who are too liberal, who do not know how to set rules; • instrumentalisation of the child in situations of conflictual separation; • inability to assess the child's needs and to see/ understand their problems; • inability of the primary caregiver to ask and receive help; • difficulty or refusal of primary caregivers to recognise the consequences of their actions; • a family environment that is not very supportive; • primary caregiver does not show positive emotions towards the child, especially the infant, or small child; • does not react to the child, does not pay attention to their signals and needs; • dismissive, critical, hostile, humiliating towards the child; • increased stress level; • has increased expectations in relation to the child's age/development/abilities; • excessive threats, intimidation, painful methods of discipline; • the use of the child in the interests of the primary caregiver (e.g., family conflicts); • inadequate socialisation of the child (e.g., involvement in illegal actions or isolation); • foster care placement, humiliation in front of other people; • humiliating the child in front of other people.

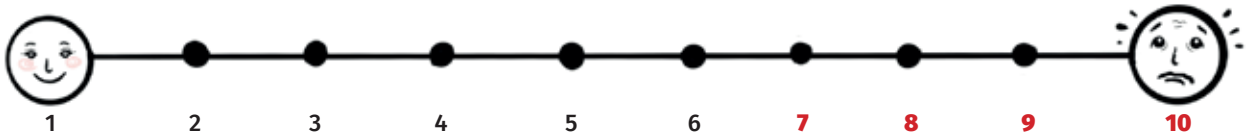
THE SCREENING TOOL

SELF-ASSESSMENT SCREENING TOOL FOR CHILDCARE PROFESSIONALS

The self-assessment tool is intended to be a voluntary, once-a-week, quick self-assessment for childcare professionals. The results of the self-assessment need not be submitted to the childcare professional's direct supervisor unless the professionals themselves seek support based on the assessment results and willingly decide to submit them.

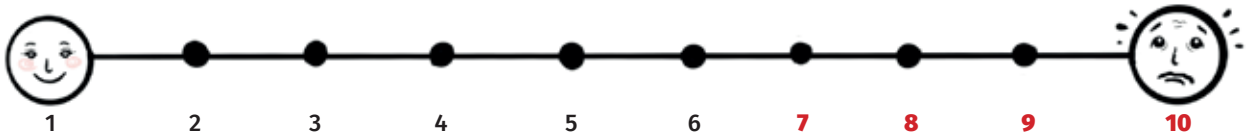
1. **Please rate the level of difficulty you have experienced in handling your childcare duties this week.**

(1 – no difficulties to declare; 10 – extreme difficulties in handling my childcare duties)



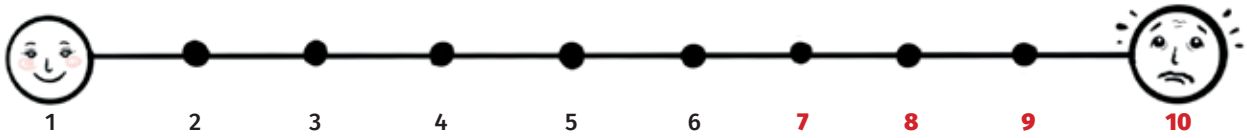
2. **Please rate the level of stress you have experienced in your workplace during the past week.**

(1 – no stress at all; 10 – extreme distress)



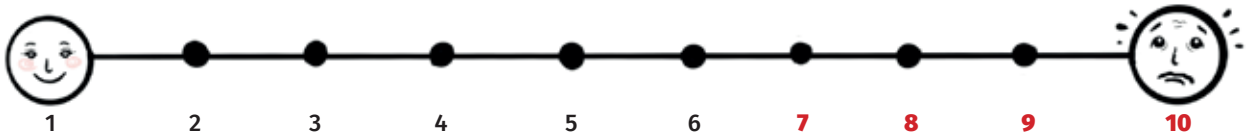
3. **Please rate the level of difficulty you have experienced in working with your colleagues this week.**

(1 – no difficulties to declare; 10 – extreme difficulties in working with my colleagues)



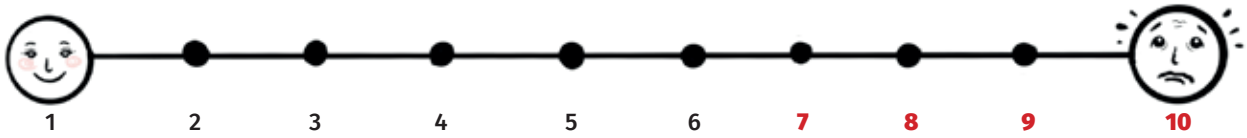
4. **Have you felt depressed or hopeless lately?**

(1 – no feelings of depression; 10 – extreme level of feeling depressed)



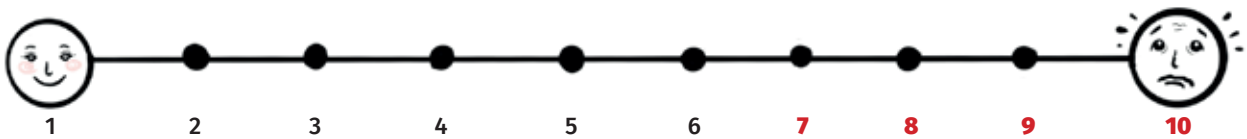
5. **Have you lately felt little interest or pleasure in the things you used to like?**

(1 – very high interest or pleasure in things I like;
10 – extremely low interest or pleasure in things I like)



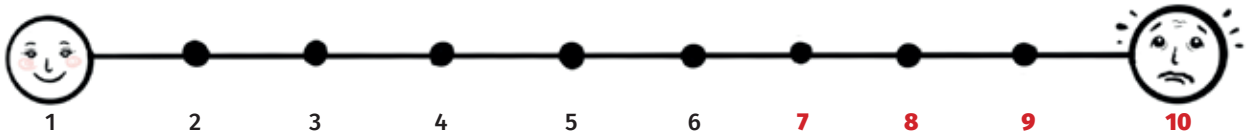
6. **Have you felt anxious lately?**

(1 – no feelings of being anxious; 10 – extreme level of feeling anxious)



7. Have you felt extreme fatigue and as though you did not want to go to work (burn-out[12])?

(1–no feeling of fatigue and/or burn-out; 10–extreme level of feeling fatigued and/or burn-out)



8. Have you felt you needed support or help with your childcare duties? ☐ Yes ☐ No

9. During the last week, did you come close to shaking, spanking, slapping, or hitting the child(ren)? ☐ Yes ☐ No

During last week...

10. Did you yell[13] at the child(ren)? Never 1-2 times 3-4 times 5+ times

11. Did you use negative words towards the child(ren) (e.g., stupid, lazy)? Never 1-2 times 3-4 times 5+ times

12. Did you ignore one or more children and their needs? Never 1-2 times 3-4 times 5+ times

13. Did you neglect to report worrying behaviours of the child (e.g., odd behaviours, for example sexualised behaviour, signs of distress, etc.)? Never 1-2 times 3-4 times 5+ times

12 World Health Organisation (WHO) defines burnout as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: (1) feelings of energy depletion or exhaustion; (2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and (3) reduced professional efficacy. Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life." WHO also emphasize that burn-out is not classified as a medical condition. Source: https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases

13 A need to talk louder so that everybody can hear you or a need to shout out loudly when a child is in danger are not considered as problematic. Rather, instead of using other approaches, you yell at a child for behaving improperly or doing something that seems annoying.

SCORING

In case of:

1. Answer values **equal to or higher than 7** to **questions 1 to 7** for **3 or more weeks** in a row

and/or

2. A **positive** answer to **question 8** for **3 or more weeks** in a row

and/or

3. Answers **other** than "Never" to **questions 10, 11, 12** and/or **13** for **2 or more weeks** in a row.

↓

It is advisable to present your situation and ask your direct supervisor for help.

In case of:

A **positive** answer to **question 9** ↓

Contact the head of the childcare facility immediately and/or ask for a leave of absence. It is highly advisable to consider psychological consultation. Please ask your colleagues and direct supervisor where to seek professional help (e.g., helpline). Remember that hitting a child constitutes physical abuse and it is a crime: there are appropriate educational practices for disciplining a child which does not involve violence and it is your job as a childcare professional to be informed about them and use them properly.

THE THREE-LAYERED SCREENING TOOL

This screening tool is designed for children aged 0 to 3 years old specifically. The signs included in the screening tool are based mainly on staff observations of the child's appearance and behaviour, as well as on observed interactions between the child and their caregivers.

The screening tool has three parts:

1. Red flags

These are five signs of particular concern that require an immediate response.

2. Quick screener

12 signs regarding four areas, namely

(a) NEGLECT OF BASIC NEEDS,
(b) DELAYS IN DEVELOPMENT,
(c) UNUSUAL BEHAVIOURS, and
(d) INTERACTION WITH THE CAREGIVERS.

These signs allow for very quick identification of children who need a more structured and in-depth assessment. If at least three of these 12 signs are identified by the childcare professional, then these children are subjected to further in-depth screening.

3. In-depth questionnaire

These are 25 detailed signs, divided into the same four areas as the quick screener

(a) NEGLECT OF BASIC NEEDS,
(b) DELAYS IN DEVELOPMENT,
(c) UNUSUAL BEHAVIOURS, and
(d) INTERACTION WITH THE CAREGIVERS.

In this part of the screening tool, the professional assesses the manifestation of the signs on a frequency scale "never/rarely/sometimes/frequently" and obtains a certain score. The instrument then grades the score according to the traffic light principle:

GREEN when the score is not alarming;

AMBER when a possible risk of violence is identified and advice should be sought from specific agencies (e.g., Social Services);

RED when an immediate referral is needed. Each of these colour guides a further action scheme that corresponds to each colour.

This screening tool is not recommended for use during a child's adaptation period, as some of the signs mentioned in this screening may not be related to possible abuse, but the child's reaction to the adaptation process. The exception to this is the red flags in the screening, which should always be given special attention.

A description of each sign is included in the Annex to the protocol. These sign descriptions are intended to be educational. Please note that the description of the signs does not cover all possible manifestations of the signs and we encourage you to add examples of these signs from your own experience.

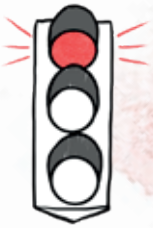
Screening of children is recommended once a month, with the possible exception of the red flags, which require an immediate response and follow-up as soon as at least one red flag is identified and without waiting for the next scheduled screening date.

If the child has attended the pre-school irregularly (for example, due to illness) within a 1 month-period, skip the screening process for the child. If you are not able to carry out screening more than 3 times, talk to caregivers about the possible issues related to irregular attendance (if the reasons are not known to you).

Screening can be carried out by one or more childcare professionals at the same time, allowing results to be compared. When there is a difference of results, please discuss with colleagues and when necessary, involve the direct supervisor in these discussions. You can also carry out another screening a week later and compare results again.

The screening tool is intended to be available in different formats (Excel/printable). Specifically, for the in-depth questionnaire, one could use the printable version of the tool for the monthly assessment, and then insert the results of the screening in the Excel file, which will allow automatic scoring of the results and, therefore, suggest the most appropriate referral path.

RED FLAGS



- These are signs that require **immediate further assessment and response**.
- If ONE of the red flags is identified:
  - → Proceed to the IN-DEPTH QUESTIONNAIRE
  - → Follow the **RED ACTION MODE**, regardless of the result of the in-depth screening.

1. The caregiver is verbally and/or physically aggressive towards the child in the presence of the childcare specialist and/or another primary caregiver.	☐ Yes ☐ No
2. The child displays suspicious injuries, bruises, puncture marks, burns, welts, fractures.	☐ Yes ☐ No
3. The child displays signs of sexual abuse.	☐ Yes ☐ No
4. The caregiver visits the childcare facility under the influence of intoxicating substances (e.g., alcohol or drugs).	☐ Yes ☐ No
5. A member of staff is informed directly by the child's primary caregiver that the child is not being looked after or is being left alone at home.	☐ Yes ☐ No
Notes and comments:	

Note: For an in-depth description of each screening item please see **Appendix 1: Description of screening signs**

QUICK SCREENER

- Please fill in the in-depth screening referring to the last month during which you observed the child. Answer as truthfully as possible using a "yes/no" assessment.
- Proceed to the IN-DEPTH QUESTIONNAIRE if the answer is "**yes**" to at least **THREE items**.

NEGLECT OF BASIC NEEDS	1. The child is often dressed in dirty clothes and/or is unclean/unhygienic for a month.	☐ Yes ☐ No
	2. The child appears undernourished and/or is not growing.	☐ Yes ☐ No
	3. The child does not receive basic health care (e.g., not treated for fever, does not have glasses if needed).	☐ Yes ☐ No
DEVELOP-MENTAL DELAYS	4. The child does not reach the expected developmental milestones.	☐ Yes ☐ No
	5. The child suddenly regresses from previously achieved developmental milestones (e.g., suddenly stops talking).	☐ Yes ☐ No
UNUSUAL BEHAVIOUR	6. The child hurts themself.	☐ Yes ☐ No
	7. The child appears physically fearful (e.g., they defends themself when frightened, as if they fear being hit).	☐ Yes ☐ No
	8. The child has suddenly experienced stuttering and/or manifests physical tics.	☐ Yes ☐ No
INTERACTION WITH THE CAREGIVERS	9. The child "freezes" at the sight of a caregiver or other adult.	☐ Yes ☐ No
	10. The child reacts with fear and/or anguish in the presence of the caregiver.	☐ Yes ☐ No
	11. The caregiver interacts with the child with coldness or indifference.	☐ Yes ☐ No
	12. The caregiver often has visible bruises and/or scratches.	☐ Yes ☐ No
Notes and comments:		

Note: For an in-depth description of each screening item please see **Appendix 2: Description of screening signs**.

IN-DEPTH QUESTIONNAIRE

Please complete in the in-depth screening referring to the last month during which you observed the child. Answer as truthfully as possible using the following scale:

0	1	2	3	4
NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS

NEGLECT OF BASIC NEEDS	1. The caregiver forgets to pick up the child, arrives very late or the child is absent from the childcare facility for no justified reasons.	0	1	2	3	4
	2. The child's health problems and symptoms are not treated appropriately or not treated at all.	0	1	2	3	4
	3. The child is very hungry.	0	1	2	3	4
	4. The child is dressed in very dirty and/ or threadbare or ripped clothes.	0	1	2	3	4
	5. The child appears dressed inappropriately for the season.	0	1	2	3	4
DEVELOP-MENTAL DELAYS*	6. The child tends NOT to move, crawl or walk. 	0	1	2	3	4
	7. The child does NOT explore the surrounding environment (e.g, displays no interest in new objects, sounds, people). 	0	1	2	3	4
	8. The child refuses or does not want to speak (including, babbling). 	0	1	2	3	4
	9. The child appears too scared, anxious without apparent reason. 	0	1	2	3	4
	10. The child cannot sustain attention to the objects, toys, people, although appears to be trying to focus. 	0	1	2	3	4

***Legend:**

 physical-motor delay

 cognitive-linguistic delay

 emotional-relational delay

UNUSUAL BEHAVIOUR	11. The child rapidly alternates between emotions and moods without apparent reason.	0	1	2	3	4
	12. The child is apathetic, emotionally detached, and/or lacks motivation.	0	1	2	3	4
	13. The child refuses to or does not engage in play.	0	1	2	3	4
	14. The child gets very frightened when hearing loud noises or seeing sudden movements (e.g.sudden hand gestures).	0	1	2	3	4
	15. The child is aggressive and/or violent towards objects (e.g., breaks, bites, throws toys, uses violent, swear words).	0	1	2	3	4
	16. The child becomes rigid, "freezes" or has an empty gaze when interacting with known adults and/or peers.	0	1	2	3	4
	17. The child does not show a need for comfort when frightened or injured.	0	1	2	3	4
	18. This child is crying intensely, almost violently, and is inconsolable.	0	1	2	3	4
	19. The child hurts themself (e.g., banging the head, scratching themself).	0	1	2	3	4
INTERACTION WITH THE CAREGIVERS	20. The child actively avoids contact with the primary caregiver by moving away, crying, appearing frightened, or stiffening in the presence of the caregiver.	0	1	2	3	4
	21. The child acts conflicted or confused towards the caregiver (e.g., moving towards the primary caregiver, then withdraws).	0	1	2	3	4
	22. The caregiver ignores the child (e.g., does NOT smile, talk to, show affection, and/or cuddle the child).	0	1	2	3	4
	23. The caregiver talks about the child in a negative sense (e.g., child as "burden", "problem", critical comparison with other children).	0	1	2	3	4
Notes and comments:						

Note: For an in-depth description of each screening item please see **Appendix 2: Description of screening signs**.

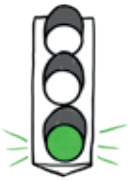
SCORING AND INTERPRETATION

The present screening tool is meant for childcare professionals as guidelines to monitor and detect potential signs and symptoms of abuse in children aged 0 to 3 years old. It is not a standardized measure meant for diagnostic and/or clinical use and it should not be used for that purpose. The following scoring cut-offs are based on a mathematical calculation based on the means (e.g., the green light is suggested with a maximum of half-ones and half-twos in all items). However, further opportunities for testing the screening tool within educational contexts will help refine the scoring cut-offs.

FROM 0 TO 31

There are no indications of a risk of violence.

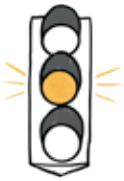
Please follow the green steps below.



FROM 32 TO 49

Possible risk identified.

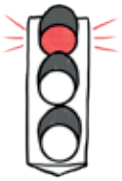
Please follow the amber steps below.



50 AND MORE

Immediate intervention is required.

Please inform the responsible staff member and follow the red steps below.



HOW TO SCORE AND INTERPRET DATA

To facilitate the scoring procedure of the ECLIPS screening tool, we designed the ECLIPS Excel scoring sheet, which will allow to score and store each child's annual screening. Click the following link (ECLIPS Excel scoring sheet) and you will be directed to an Excel file that you'll be able to download. The Excel file is named "ECLIPS scoring_NAME SURNAME": you should substitute "NAME SURNAME" with the child's actual given name and surname. You can duplicate the file as many times as you need so that you will have a file for each child in your childcare facility.

The Excel file has 13 sheets; 12 of these are to be completed during the screening every month: for each item, you'll need to report the number you crossed on the printable in-depth questionnaire for each item – but you can also file the questionnaire directly on the Excel sheet.

What do you need to do? You just have to insert the number corresponding to your answer to each item in column C, "Answer". As you will see, while you are filling in the questionnaire, the score will automatically be calculated, and a traffic light will be coloured according to the referral action mode (green, amber, or red) suggested.

The 13th sheet is a summary graph, useful for the longitudinal interpretation of the annual data. It will automatically update every time you complete a (monthly) scoring sheet.

LONGITUDINAL INTERPRETATION

It is important to keep the monthly screening results to better understand the child's situation using a dynamic approach and to monitor the safety and well-being of each child over the long term. If, thanks to the summary graph, you notice that the child's situation is getting worse over time, you can use this information to express your concern to the primary caregivers, even if the child has not reached the specific threshold for the referral yet.

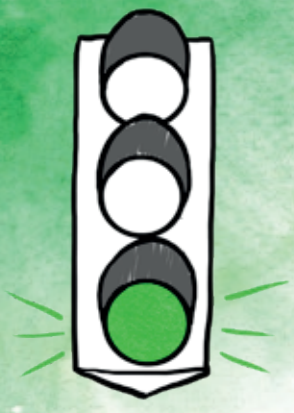
REFERRAL GUIDELINES

THE REFERRAL FLOWCHART

- The further action instruction consists of a flowchart of the traffic light type (green-amber-red) according to the results of the screening. In addition, several recommendations are included to help reduce concerns and fears about the need to refer.
- The traffic light type referral flowchart provided on the next page is only a suggestion but is easily adoptable to specific national/regional/local contexts and will hopefully serve as clear guidance for childcare professionals as to how and to whom to refer possible abuse.
- Staff must refer suspected or known child abuse.
  Some key principles:
  - → You do not have to prove that child abuse has taken place. Remember that it is up to the responsible authorities, who are specially trained to investigate allegations of abuse, to investigate in depth.
  - → Suspicion of abuse is a reasonable belief that any other person in the same situation would have had, e.g., observed behaviour, appearance, development. Screening gives an objective view of these signs.
  - → The duty to refer overrides any professional codes of practice that otherwise require confidentiality. Similarly, a referral made in good faith does not constitute unprofessional conduct or a breach of professional ethics.

LEGAL ASPECTS ON A NATIONAL BASIS

The flowchart included below is meant to be a general referral guideline applicable to all European Countries. Of course, given that each country (and even region or territory) has a different judiciary system and a different agency system, it is not possible to detail which service childcare professionals must refer to in each specific case of abuse. For this reason, red flags and a high score in the in-depth questionnaire convey the indication of an immediate referral, unlike the amber action mode, which instead suggests a consultation with the competent territorial agencies. **Appendix 2** lists the country-specific referral procedures that are available for project partner countries: Belgium, Hungary, Italy, and Latvia.



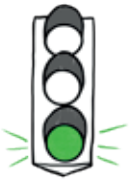
FURTHER ACTION IN GREEN MODE

1. Screening score between 0 and 31

2. Inform parents about the screening results if they wish.

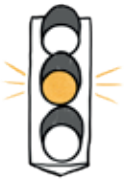
3. Have a routine screening after a month

New screening result unchanged in green mode



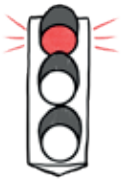
Continue routine screening every month in green mode. Inform parents of the results if they wish.

New screening result worsens and reaches amber mode

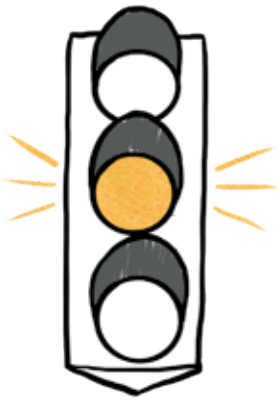


Switch to amber mode for further action

New screening result deteriorates rapidly and reaches red mode



Follow the red action mode

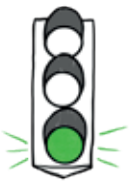


FURTHER ACTION IN AMBER MODE

1. Screening score between 32 and 49

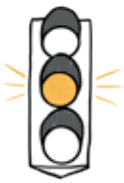
2. Inform supervisor about the next appropriate/context-specific steps. For example, consult with appropriate authorities (Social Services); organise a meeting with parents about the identified risk. Schedule another screening after a month.

New screening result improves and reaches green mode



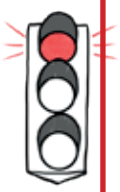
Continue routine screening after one month. Inform parents of results.

New screening result unchanged and remains in amber mode

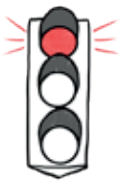


Repeat steps 2 of this flowchart.

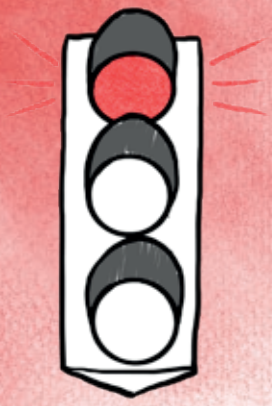
If the result of the next screening remains in amber mode and there is no improvement, switch to red mode for further action.



New screening result worsens and reaches red mode



Follow the red action mode.



FURTHER ACTION IN RED MODE

1. Screening score 50 and more

and/or

Red flag(s)

2. Report to supervisor about the next appropriate/context-specific steps. The head or other designated responsible staff member drafts a report:

Parent visits a childcare facility under the influence of intoxicating substances

[add appropriate action here]

Suspected or known emotional violence

[add appropriate action here]

Child not being looked after or left alone at home

[add appropriate action here]

Suspected or known physical or sexual violence

[add appropriate action here]

Child has a health problem

[add appropriate action here]

Suspected or known neglect; parenting difficulties; parents with mental disorders; emotional difficulties in the family (e.g., mourning, divorce). Screening results that cannot be linked to a specific form of violence, but are equally worrying

[add appropriate action here]

RECOMMENDATION 1:

WHAT KIND OF INFORMATION SHOULD I PROVIDE WHEN REFERRING TO APPROPRIATE AUTHORITIES?

1. **Information about the child and his/her family**

   - Names of the child and his/her parents/caregivers;
   - Child's age, sex, date of birth;
   - Address of residence;
   - Age, sex of other children living in the child's home;
   - If known, information on the family's current cooperation with any of the responsible services; involvement in violence prevention services.

2. **Details of suspected or known abuse**

   - Description of the signs of abuse and of the behaviour observed raising the suspicion of violence. Direct and specific descriptions are very important, i.e. be specific when identifying the observation.
   - As regards the inclusion of photographic evidence, this is optional. Instead, if possible, include the nurse's description of the physical injuries.
   - The impact of the alleged abuse on the child (observed behaviour).
   - Identity of the possible perpetrator(s).
   - Other useful information that may assist in the assessment of the case of child abuse.
   - Include detailed descriptions by the educator(s) observations of the child's problems (also over a longer period) - in this case, a description of all screening results.
   - Description of the steps the childcare facility has already undertaken (whether there have been meetings with parents, what methods have been used, etc.) and of the parents' attitudes (focus on specific facts, be concise, and do not interpret).

3. **Information about the person making the referral**

   - Official form and information of the childcare facility.

It is important to collect enough information to report but be careful: collecting as much detail as possible could unwittingly undermine the assessment of the case by one of the authorities responsible. It is better to leave the assessment, investigation, information gathering, detailed questioning of the child/family in the hands of professionals who are specially trained to carry out these steps. You do not need irrefutable proof of the abuse to report it to the authorities. If you have a reasonable suspicion (signs observed, child's behaviour observed), this is enough to report to the services responsible.

RECOMMENDATION 2:

WHAT WILL HAPPEN AFTER I HAVE REFERRED?

Worry and uncertainty about what will happen after referring are one of the greatest barriers to referral. Explanations and suggestions on how to engage further with the services responsible will help to reduce this barrier.

What will be the involvement of the childcare facility in case of confirmed child abuse?

Please follow the guidelines for trauma-sensitive care, which will allow you to offer better support to the child who has suffered abuse.

What should I say to other parents and children when I get questions about what happened?

What to say to parents of other children: if other parents are familiar with the case or have concerns and insist on sharing information about it, remind them that other children are not at risk if their parents do not know the details of the situation, which is, in any case, private information of the family-in-need which cannot be shared with others. Alternatively, you can mitigate the concerns of other parents by emphasising that their concerns are understandable and that the privacy of the information makes it impossible to share anything more about the situation. You can also remind them of the legal obligation of staff in educational institutions to refer child abuse.

What should you say to other children: if the child leaves the childcare facility, you can tell the other children that the child has left and will be missed. If the child is receiving extra attention from staff, you can explain to the other children that we are taking care of the child for the time being to make him/her feel better again and that it takes a little more time and attention. It can be stressed that we would help another child just as much if they needed help.

What should I do if the authorities do not find child abuse after my referral, but the signs and concerns about abuse persist or the situation worsens?

If you are not satisfied with the response of the authorities and you still see the situation unchanged or worsen, refer again with a new description of your observations.

Similarly, if the situation improves for a while but after a time, you again identify suspected abuse, refer again.

How will I feel if the referral I make leads to the end of my relationship with the parent?

It is important not to be guided by personal feelings and to put the relationships aside. We act as professionals, guided by certain principles. Our focus, our duty, and responsibility are the safety of the child and protecting him/her from possible abuse.

If available, supervision or coaching support can help. Feelings can be managed by sharing them with someone else, especially when thinking about the teacher-parent relationship in the future.

Sometimes professionals have the misperception that referring is punishment to the family. It is much more useful to see referring as necessary to protect the child (and in the long term the parents) by providing the necessary help and support.

GUIDELINES FOR COMMUNICATING WITH PARENTS

KEY POINTS FOR COMMUNICATING WITH PARENTS

Keep parents informed about screening results unless you are restricted by legal requirements.

See section 1 of the ECLIPS "Guidelines for communication with parents" for more details.

Provide a safe and welcoming space, prepare for the meeting by talking with colleagues and your supervisor, and document the meeting.

See section 2 of the ECLIPS "Guidelines for communication with parents" for more details.

Build a safe and trusted environment in which all stakeholders can express their concerns.

See section 5 of the ECLIPS "Guidelines for communication with parents" for more details.

Engage an external specialist when needed.

See section 3 of the ECLIPS "Guidelines for communication with parents" for more details.

Emphasize that childcare professionals and primary caregivers form a team working together on behalf of the child's best interest.

See section 6 of the ECLIPS "Guidelines for communication with parents" for more details.

Remember that effective communication is a skill that everybody can develop and strengthen.

See section 6.2 of the ECLIPS "Guidelines for communication with parents" and the ECLIPS "Trauma-sensitive care" protocol for more details.

Remember that effective communication is built on both listening and talking.

See section 6.1 of the ECLIPS "Guidelines for communication with parents" and the ECLIPS "Trauma-sensitive care" protocol for more details.

1. WHEN TO INFORM / EXPLAIN / PRESENT THE RESULTS OF THE SCREENING TO PARENTS?

- It is important to talk about concerns as and when they arise. Problems usually do not go away on their own. If you allow problems to accumulate, they may become increasingly difficult to resolve.
- It is also important to talk about positive results/progress/change.
- Please see further action diagrams for informing parents.

2. INSTRUCTIONS ON HOW TO PREPARE FOR A CONVERSATION WITH A PARENT

- Make an appointment to discuss the issue. Set a clear agenda of that you want to discuss.
- Provide a safe and private space for the meeting.
- The presence of an employee who has already developed a positive relationship with the parents would be best

- If possible, invite at least two caregivers to the meeting (who are most involved in raising the child).
- Prepare to talk about complex issues. Quite simply, parents can find conversations like these upsetting and frightening. If you think about what you have to say in advance and find the most sensitive and respectful way to say it, it can help the conversation. You can try what you have to say with another colleague.
- Prepare a document that allows you to record the course of the meeting and the next steps (please see Appendix 3 for a sample form). Take a few minutes at meetings to inform the head of the institution about the planned conversation. Send meeting minutes to all participants of the meeting, including parents/caregivers.

3. GUIDANCE ON WHEN TO INVOLVE OTHER PROFESSIONALS IN SOLVING A PROBLEM

Consider engaging another, external specialist (for example, a psychologist, a social worker) if

- An additional assessment of the situation is needed;
- Meetings have become unproductive and deliver no progress;
- The situation is too complicated to end on its own.

4. HOW PARENTS ARE INFORMED ABOUT THE SCREENING AND FOLLOW-UP POLICY AT THE CHILDCARE FACILITY

- By signing a cooperation agreement with the childcare facility;
- By learning about the internal rules of the childcare facility.

5. HOW CAN PARENTS REFER OBSERVED VIOLENCE AGAINST A CHILD BY AN EMPLOYEE OR ANOTHER PARENT?

- Offer several options for the parent to choose from:
  - Refer to the head of the childcare facility;
  - Refer to a specific specialist;
  - Anonymous drop-box.

  To encourage building a safe environment, we suggest choosing the first two options. If there is a lack of trust, then the third option could be recommended.
- It is important to stress that referring an employee will not pose a risk to the child.
- It is important to provide feedback on what to do next.
- Emphasise that this would help pay proper attention to the child in need and carry out screening. It does not mean that this situation will be referred immediately. We all have the responsibility of preventing and stopping child abuse.
- If the situation does not change, refer to the external responsible authority.

6. TIPS FOR EFFECTIVE COMMUNICATION[14]

6.1. GENERAL TIPS

Listening

Let parents know that they can always turn to you and that you appreciate their views or concerns. Listening is one way to show that you genuinely believe this.

- Stop what you are doing and look at the parents while they talk to you.
- Show that you are listening and interested in what they are saying, by nodding from time to time or saying something to show that you agree with them.
- Let the other person finish what they are saying, then summarize what they have said and check that you understand everything.
- Make sure that you know how this makes the parents feel. For example, "This worries you, doesn't it?"
- Use open-ended questions to ask for more information if you need it. Open-ended questions give a person the opportunity to expand on what is being said, rather than simply saying 'yes' or 'no'. For example: "What did you mean when you said that John / Ana was being naughty?"
- Try to understand the other person's perspective, even if you do not agree. Try to put yourself in the other person's situation.

14 Adapted from VANCO Education training materials and Australian parenting website https://raisingchildren.net.au/

Talking

Our communication with parents will either foster partnerships or make it difficult to work together. A partnership works best when the messages are clear, specific, and consider the other person's feelings. Always talk to the parents, keeping in mind your goal of strengthening relationships.

- When we are in a hurry or caught off guard, we can say things we later regret. It is best to stop for a moment. If you are unsure about a sensitive topic, agree on a time when you can continue the conversation in a relaxed atmosphere.
- Talk from your position, that is, how the situation makes you feel, rather than focusing on what you want the parents to do in this situation (i.e., don't blame the parents).
- Be specific about what you see. Be honest, even if you didn't notice the problem yourself.
- Talk only about the situation at hand, do not touch on the problems of the past. If the problem persists, move on to the solution.

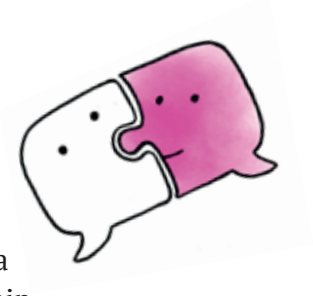
Expressing concerns to parents

- Be open and honest with the parents and talk about problems when they arise. Problems usually do not go away on their own; if left unresolved, they may be more difficult to solve later.
- Make an appointment to discuss issues. Prepare for the conversation and create a clear agenda of items you want to discuss.
- Give parents accurate information about what you are observing.
- Explain exactly what the problem is and why it might be a concern.
- Check what parents think about the problem and whether it worries them. Ask if they have the same problem at home.
- If possible, provide information on the nature of the problem. For example, “Many children starting to attend a childcare facility are tired at this time of day. It is a tiring time”. Parents will be better able to come up with a solution if they understand the problem.
- Do not beat around the bush and instead stress that you want to act in the best interests of the child. If the child's behaviour is a concern while he/she is in your care, it is your responsibility to come up with a solution. Reassure parents that you will work on the problem but ask them to help you find a solution. For example, you could suggest, “Children at this age often bite each other. This does not mean that they are bad or aggressive. We can teach a child how to achieve what they wants without biting, but our experience shows that it is better to work with the child's parents to find the best approach for each child.
- If you are talking about complex issues, offer various solutions. Offering solutions is a consultative process. Ask the parents for their inputs. Consider as many solutions as possible, then evaluate the pros and cons of each solution.

Dealing with parental concerns

- Listen to parents' concerns.
- Do not provide immediate explanations or justifications; the most important thing is for parents to feel that their concerns have been heard.
- Show interest in the well-being of parents and children.
- Show enthusiasm for any attempt by parents to help solve a problem.
- Offering solutions is a consultative process. Ask the parents for their opinions. Consider as many solutions as possible, then evaluate the pros and cons of each solution together.
- Sometimes it can be difficult to find a solution, so you don't always have to solve the problem. If the situation cannot be resolved, you can help by simply listening to the parents.
- Even if you use all these skills, sometimes problems will persist. In that case, tell the parents about your institution's complaint procedure and make sure they know how to use it.

6.2. HOW TO COMMUNICATE WITH PARENTS IN DIFFICULT SITUATIONS



Don't forget about your feelings

- If you are facing a confrontational attitude from a parent, it may be difficult to understand what you are saying if you do not know how it makes you feel. As a result, you will not be able to respond properly and develop a positive relationship.
- If you listen to yourself and your feelings during the workday, you will be better able to respond to the parents' worries without stress and anxiety during the meeting. If you have a peaceful internal dialogue, you will be able to talk with the parents without succumbing to your own stress and dissatisfaction.

Listen and try not to take a defensive stance

- If you manage not to lose your temper, you will be better able to understand what the parents are saying. Even if you disagree, try not to take a defensive stance when it comes to hearing parental concerns or criticism. Parents just want to be heard.
- Do not interrupt the parents, wait until they have finished speaking and try to understand why they feel this way. Whatever the circumstances, you all want the best for the child. Sharing this common ground, you may be able to take on a challenging conversation more productively.

Talk from your own perspective

- Sometimes people forget that childcare facility staff are also humans, not robots. Talking from your own perspective in a difficult conversation with the parents will help you understand the problem and find a compromise. Say something along these lines:

  "I don't think this conversation is productive. And what do you think about looking at this question from a different angle. For example…".

- Never say: "You are making this conversation unproductive".
- A simple change in sentence structure can make a big difference so that parents don't feel the need to be defensive.

Stress that you are on the same team

- Speak not only from your own position but also from that of the parent, emphasising the shared concern for the child: “I know we both care about John/Anna and we are worried about his/her anger issues. I try to calm him/her in these ways. What do you think about that?"
- Such statements will unite you for a shared purpose. You are on the same team, even if one of the team members forgets it.

Ask questions

- Like the statement above, asking a question after making your point will help you involve the parents in the conversation. Asking a question indicates that you care about their opinions and thoughts. It also makes it clear that you need their help to solve the problem. It makes parents feel needed and involved in your team.

Try to imagine how the parents might feel

- Everyone involved in childcare knows that parents have close emotional ties with their children. Although it may be harder to see, they also have emotional ties to you. Even if they don't show it, most parents want to please you and feel hurt if they don't. Any “negative” comment about their child is heard as a critique of their parenting skills.
- Try to imagine yourself on the other side of the table and express loving care for the child. Praise how parents deal with problems and acknowledge their efforts before expressing any concern.

Be specific

- Recognize that this is not an easy task. Tell parents you don't want to criticize anyone, but you want them to know what you see. If the parents deny the truth of what you’re saying and argue that no one else has seen it, keep focusing on your experience. Talk about specific behaviours that illustrate your concerns about the child. If you have questions, be specific and avoid vague general statements that could be misinterpreted.

Focus on the problem at hand

- A sense of tact is very important in understanding how to talk to parents about their child's development. No matter how calm you are, be prepared for parents to be angry. Try to maintain an empathetic attitude and remind yourself that you care about the child. Show appreciation and concern for the child.
- When parents are upset, it may be difficult for them to "hear" you. This can happen even if the parents themselves have drawn your attention to the problem! Focus on what you see and hear.

Respect the choice of parents

- Always respect the parents' choices. If they decide otherwise despite all your efforts, it is their right. In any case, they will remember that you showed concern by approaching them with a difficult recommendation.

Seek common grounds

- Even if parents deny it, they have usually heard about any serious problems from various sources. You may even notice that one parent seems more responsive and conscientious than the other.
- It may be helpful for one parent to talk about the observed behaviour using their own words so that the other parent understands that you are not criticising them or the child. You just want to help. The more you can emphasise how much you value the efforts of the child and parents to do their best for the child, the more likely it is that your views will be heard.

Looking for a compromise

- First, ask the parents if they have any ideas on what to do next. Do you share a consensus on all issues? Are there things where your thoughts differ? It will be easier for you to compromise with the parents if you first ask them to do it themselves. In such cases, compromise is often the best way. The results are usually good for the child, and that is our goal here.

Further contact after a difficult conversation

- Contact the parents soon after a difficult conversation or incident. Further contact shows that you care, and it is not your intention to forget about anybody. This will show that you want to work with parents and children, improve the relationship and create a solid foundation for further work.
- Those involved in educating and caring for children know that communication is not always an easy matter. However, it is an essential skill that facilitates the management of a childcare program. Whether you are in contact with employees, children, or families, following the advice given can help you avoid unproductive conversations that turn into disputes.
- More importantly, communication allows you to actively find solutions to issues, and this contributes to the well-being and safety of the children in your care. And that is the most important goal!

APPENDIX 1: DESCRIPTIONS OF SCREENING SIGNS

RED FLAGS

Sign:	Description:
1. The caregiver is verbally and/or physically aggressive towards the child in the presence of the childcare specialist and/or another parent	The caregiver is harsh, physically aggressive towards the child (e.g., shaking, dragging the child). The caregiver is verbally aggressive towards the child, e.g., screams, threatens, criticises, mocks, belittles, berates, makes derogatory comments about the child. Corporal punishment. The caregiver demands unrealistic expectations of the child that are not appropriate to the child's age or stage of development. Inappropriate control over the child (lack of control, too much control, or inconsistent control). The caregiver loses their temper when disciplining the child (e.g., poor anger management or self-regulation of emotions).
2. The child displays suspicious injuries, bruises, puncture marks, burns, welts, fractures	**What is referrable physical violence:** • Deliberately injuring a child or deliberately endangering the child's health or life; • Unlawful disciplining of a child or injury caused by such action; • Physical injury resulting from anything other than an accidental cause. **Physical violence does not include situations where:** • Injuries sustained during fighting or playing between children and their peers; • Injuries resulting from the use of force that was reasonable and necessary to prevent the child from being in a riskier situation (e.g., saving a child from drowning, from running into traffic). **There are two key steps in the determination of whether an injury is suspicious and could indicate possible physical violence:** 1. The injury itself must be seen on the child's body. 2. Obtain an explanation from the child's parent/caregiver about the injury and assess its reliability.

Sign:	Description:
2. The child displays suspicious injuries, bruises, puncture marks, burns, welts, fractures (continued)	**1. Different types of injuries that may initially be considered suspicious:** **1.1. Suspicious bruises:** • On face, lips, mouth, torso, back, buttocks, thighs; • Bruises and injuries in various stages of healing; • Injuries resembling imprints of objects (belt, hair comb); • Injuries that appear after the child's absence, after the weekend, after holidays; • Human bite marks; • Injuries resembling palm prints. **1.2 Suspicious burns:** • Cigarette burns (especially on feet, hands, back, buttocks); • Burns resembling marks left by hot objects (e.g., iron, electric heater, hair styler); • Burns from hot liquids (unintentional burns are usually asymmetrical in shape and cover the side of the child's leading hand, e.g., when reaching for a hot cup of tea), intentional burns are symmetrical and look like the result of 'immersion' of a part of the child's body. **1.3. Suspicious wounds, injuries:** • Mouth, lips, gums, eyes, around ears; • Difficulty walking or sitting; • Pain or itching in the genital area; • Wounds and injuries of the external genitalia; • Frequent urinary tract infections; • Looping wounds left by belts, straps, wires; • Straight-line wounds on the back, buttocks left by sticks, rods; • Skin abrasions around ankles or wrists which may indicate that the child has been tied. **1.4 Any fracture**

Sign:	Description:
3. Child displays signs of sexual abuse	To establish suspected or clear knowledge of child sexual abuse, it is important to compare and distinguish between normal behaviour, troubling behaviour, and behaviour that requires immediate intervention. Children's behaviour 0-5 years[15]: **1. Normal sexual behaviour (age-appropriate curiosity about one's body)** • Not ashamed to be naked/enjoys nudity; • Masturbation as a self-soothing behaviour; • Attempts to touch or is curious about the genitals of other children or adults; • Touches and plays with own genitals without shyness; • Interested in body parts and their functions; • Interested in the differences between boys and girls; • Intense interest in bathroom activities. **2. Troubling sexual behaviour (indicates possible risk and should be carefully monitored, especially the length and frequency of observed behaviour)** • Frequently masturbates instead of other daily activities; • Intensive observation of other people during toilet activities; • Insistently touches other children's genitals/intimate parts; • Touches intimate body parts of adults, disregarding reprimand; • Takes a keen interest in adult sexual behaviour; • Speaks about sex using adult slang; • Talks about sexual acts seen on TV or the internet. **3. Behaviour that requires immediate intervention:** • Curiosity about sexual behaviour becomes an obsessive pursuit • Excessive and prolonged masturbation causes trauma; • Sexually explicit themes recur in conversations, play, drawings, or other activities; • Interest in sexual behaviour becomes repetition, imitation of certain adult sexual activities, movements; • Attempts to insert objects/toys into other child's genitals, anus. Simulation of oral sex during play. Hypersexualised play is repetitive and may continue after reprimands or other interventions; • Insistently touch intimate body parts of other children or adults; • Behaviour involves injury to self or others; • Child's behaviour involves coercion, threats, secrecy, aggression.

15 Adapted from The Lucy Faithfull Foundation (UK) materials and guidelines: https://www.parentsprotect.co.uk/traffic-light-tools.htm

Sign:	Description:
3. Child displays signs of sexual abuse (continued)	**Signs of suspicious behaviour of adults or older siblings:** • Refuses to provide for the child's right to privacy; • Insist on physical affection, such as kissing, hugging, wrestling, or tickling even when the child does not want it; • Are overly interested in the sexual development of the child; • Discuss or share sexual jokes or sexual material with the child; • Treat a particular child as a favourite, making them feel 'special' compared with others in the family; • Buy the child expensive gifts or give money for no apparent reason. **Note.** Unlike physical abuse, for example, where the signs of abuse are often obvious, sexual abuse is almost always a gradual process rather than an isolated event. The more we understand how and why child sexual abuse happens, the more effectively we can prevent or stop it from happening. You should refer sexual abuse even if you have mixed feelings about referring or feel uncomfortable referring something that might have happened between an adult and a child. Trust your observations and refer, even if you only know a few details or are not sure what the real situation is.
4. The caregiver visits the childcare facility under the influence of intoxicating substances	A parent/caregiver brings or comes for a child while obviously under the influence of alcohol or other intoxicating substances (e.g., noticeable difference from usual behaviour, smell of intoxicating substance, cannot stand, sit up straight, lacks coordination).
5. A member of staff is informed directly by the child's primary caregiver that the child is not being looked after or is being left alone at home	The employee is directly informed by the primary caregiver: • The child is being looked after by an unsuitable caregiver (e.g., another young child, immobile adult); • The child is not being looked after and is left alone. **Note.** This is a life-threatening situation for young children.

QUICK SCREENING

Sign:	Description:
1. The child is often dressed in dirty clothes and/or is unclean/unhygienic for a month.	The child arrives with dirty clothes, dirty body, with body odour. Has scabies, head lice. Lack of cleanliness/hygiene endangers the child's health (e.g., rashes and other skin disorders).
2. The child appears undernourished and/or does not grow.	The child has difficulty gaining weight or is losing weight, is not growing taller, is eating less than usual or not eating well due to stomach problems. The child can be less active or playful due to a lack of energy.
3. The child does not receive basic health care (e.g., is not being treated for fever, does not have eyeglasses if needed).	**Parents or caregivers:** • Fail to provide the child with the treatment prescribed by a doctor; • Repeatedly fail to take the child to a medical practitioner for health check-ups, immunisations, and/or health care appointments that are essential for the child's health/development; • Is available but repeatedly fails to provide the child with dental care and treatment by a dentist; • Fails to follow-up with repeated medical appointments or consultations which poses a risk to the child's health and well-being, e.g., child needs glasses, the child is in discomfort or is frequently in pain, the child has skin infections. Medical specialist can diagnose health problems properly. However, in this case the focus is on those signs that childcare professionals can visually observe daily.
4. The child does not reach the expected developmental milestone.	Please see section "AN OUTLOOK ON TYPICAL DEVELOPMENT AND CHILD ABUSE" for expected developmental millstones in different age groups and signs for concern.
5. The child suddenly regresses in achieved developmental milestones (e.g., suddenly stops talking).	The child's behaviour seems to have suddenly regressed and plays and behaves like a much younger child. Regression of language, toileting, eating, self-care, or motor skills. Please see section "AN OUTLOOK ON TYPICAL DEVELOPMENT AND CHILD ABUSE" for expected developmental millstones in different age groups and signs for concern.

Sign:	Description:
6. The child hurts themself.	The child bites themself, hits their head or another part of the body, pulls their hair out or otherwise deliberately tries to hurt themself.
7. The child appears physically fearful (e.g., it defends itself when frightened, as if for fear of being hit).	The child reacts defensive, trying to shrink out of sight or hiding when given a sudden fright.
8. The child has suddenly experienced stuttering and/ or body tics.	Sudden starts to stutter. The child's eyes, mouth, nose, or legs twitch. Monotonous rocking, extensive finger sucking.
9. The child "freezes" at the sight of a caregiver.	Suddenly show obvious fear of caregiver and expresses it passively, for example, seems “frozen” or detached in their appearance and exhibits an overwhelming fear of the primary caregiver.
10. The child reacts with fear and/ or anguish in the presence of the caregiver.	The child avoids, cries, or appears frightened or worried in the presence of the parent/caregiver. Refuses to come to the parent, hides from the primary caregiver. Afraid to go home.
11. The caregiver interacts with the child with coldness or indifference.	The caregiver refuses to talk to the child or ignores the child and/ or does not look at the child.
12. The caregiver often has visible bruises and/or grazes.	Visible physical signs of domestic abuse on caregiver’s face, neck, and/or hands. If a child witnesses domestic abuse, it manifests as emotional child abuse and affects children negatively (for example, the sense of safety is damaged, and children cannot develop properly when lacking a safe environment).

IN-DEPTH QUESTIONNAIRE

Sign:	Description:
1. The caregiver forgets to pick up the child, arrives very late, or child is absent from the childcare facility for unjustified reasons.	This sign specifically indicates educational neglect. The caregiver forgets to pick up the child, arrives very late for drop-off or pick-up. The child does not go to childcare facility regularly for unjustified or trivial reasons (e.g., "I was not in the right mood for dropping off the child", "I was hungover"). Parents who, due to work/study/other commitments, take their child to the childcare facility irregularly and/or regularly often bring the child very early or pickups them very late should not be too worrying. However, it is important to find out the reasons for irregular attendance.
2. The child's health problems and symptoms are not treated appropriately or not treated at all.	This sign specifically indicates medical neglect. The caregivers: • Fail to provide the child with the treatment prescribed by a doctor; • Repeatedly fail to take the child to health check-ups, immunisations and/or health care appointments that are essential for the child's health/development; • Is available but repeatedly fail to provide the child with dental care and treatment at a dentist; • Fail to provide repeated medical appointments or consultations that pose a risk to the child's health and well-being, e.g., child needs glasses, the child is in discomfort or frequent pain, the child has skin infections.
3. The child is very hungry.	The child regularly has an unsatisfied appetite. Hunger is especially seen after weekends, absences, holidays. Children who cannot yet speak may express hunger or thirst by crying. The child craves, begs, steals, hides food to satisfy hunger. Parent/caregiver provides information that: • The child is restricted from food or drinking at home as a method of discipline (for example, no dinner as a punishment). Restricted access to sweets or various snacks (crisps) as a method of disciplining the child is not considered to be a worrying sign; • The child is provided with meals that are inadequate for the child's age and potentially harmful (for example, food that presents a choking hazard for toddlers, liquid-only food for toddlers, extreme or inadequate dieting in family that is imposed on child as well).

Sign:	Description:
4. The child is dressed in very dirty and/ or threadbare or ripped clothes.	The child arrives with dirty clothes, dirty body, body odour. Has scabies, head lice. Lack of cleanliness/hygiene endangers the child's health (e.g., skin irritation).
5. The child appears dressed inappropriately for the season.	The child wears the same clothes every day. The child is often dressed in summer clothes or no winter clothes during winter. Often wears shoes that are too small. Inappropriate clothing creates health risks for the child, like frostbite.
6. The child tends NOT to move, crawl or walk.	The child does not reach age-appropriate movement milestones. Please see section "AN OUTLOOK ON TYPICAL DEVELOPMENT AND CHILD ABUSE" for expected movement millstones in different age groups and signs for concern.
7. The child does NOT explore the surrounding environment (e.g, no interest in new objects, sounds, people).	The child does not reach for toys, does not look at new objects, does not react to new sounds, does not show interest when entering a new room, or going outside.
8. The child refuses or does not want to speak (including, bubbling).	The child refuses or does not want to communicate with others.
9. The child appears too scared, anxious without apparent reason.	The child is on high alert or (hyper-)watchful or "walking on eggshells" for fear of something bad happening.
10. The child cannot sustain attention to the objects, toys, people, although seemingly trying to focus.	Although young children have a short attention span, a worrying sign is when the child tries to hold their attention on toys or people but struggles even for a very brief moment.
11. The child rapidly alternates between emotions and moods without apparent reason.	Very rapid changes in mood and emotions, for example quickly moving from being happy to sad and back to happy in a short time and with no obvious change in the environment or situation.
12. The child is apathetic, emotionally detached, and/or lacking in motivation.	The child's facial expression does not change with the content of the conversation (e.g., when talking about something good, funny, or sad) or the activity in which they is engaged. If the other person initiates a cuddle or a smile, the child does not respond or avoids contact.

Sign:	Description:
13. The child refuses or does not engage in play.	The child avoids different types of playing activities or is unable to engage in any type of playing effort.
14. The child gets very frightened when they hears loud noises or sees sudden movements (e.g.sudden hand gestures).	The child starts crying, flinches or otherwise reacts in an agitated way to sudden loud noises, rapid or sharp movements by others, for example when someone raises their hand rapidly and the child reacts with fear.
15. The child is aggressive and/or violent towards objects (e.g., breaks, bites, throws toys, uses violent, swear words).	Excessive aggressive behaviour towards different objects. Violent, physically intense play that is repetitive and not resolved during play, lack of empathy during violent play. The child uses language that is inappropriate for their age (e.g., many swear words, violent words). The mere removal of clothing from dolls or playing "washing the doll" is not a cause for concern.
16. The child becomes rigid, freezes or has an empty gaze when interacting with known adults and/or peers.	The child displays obvious fear of adults and expresses it passively, for example, seems "frozen" or detached in their appearance and behaviour. The child is afraid and/or hesitant in interacting with adults known to them.
17. The child does not show a need for comfort when frightened or injured.	When a child is injured, does not show pain, or ignore it. Does not seek adult comfort when frightened or injured, which is typical for children his/her age. The child does not allow a parent/caregiver to comfort him/her when distressed or injured. Avoids touching.
18. This child cries intensely, almost violently, and is inconsolable.	The child cries wildly, almost violently in situations where such reactions are exaggerated. Also, particularly long episodes in which the child finds it difficult to calm down.
19. The child hurts himself/herself (e.g., banging the head).	The child bites himself/herself, hits his/her head or another part of the body, pulls his/her hair out, or otherwise deliberately tries to hurt himself/herself.
20. The child actively avoids contact with the caregiver by moving away, crying, appearing frightened, or stiffening in the presence of the caregiver.	The child avoids, cries, or seems frightened or worried in the presence of the parent/caregiver. Refuses to come to the parent, hides from the caregiver. Afraid to go home.

Sign:	Description:
21. The child acts conflicted or confused towards the caregiver (e.g., moving towards the parent, then withdrawing).	In the presence of the primary caregiver, the child acts with peculiar disorientation, by showing: • dispersed attention and detachment; • loss of purpose of the action; • somewhat as though in an altered state of consciousness. This disorganised behaviour requires the simultaneous presence or rapid succession of actions that are incompatible with each other. Notable cases are those in which children move towards the primary caregiver while looking away to avoid their eye contact or those in which the request for closeness is immediately followed by clear manifestations of fear, of sudden immobility or flight.
22. The caregiver ignores the child (e.g., does NOT smile, talk to, show affection, and/ or cuddle the child).	The parent/caregiver avoids eye contact with the child. The parent/caregiver does not smile, hug, or otherwise show emotional attachment to the child when saying goodbye/ meeting the child. Does not comfort the child when the child is upset or crying. The primary caregiver demonstrates indifference toward the child, their needs, or problems.
23. The caregiver talks about the child in a negative sense (e.g., child as "burden", "problem", comparing critically with other children).	Speaks of their child with dislike ("problem", "bad", "silly", "different", "out of control", "a burden"). Describes the relationship with the child in only negative terms. Blames the child for his/her problems and needs. Rejects the child. Prefers one child over the other.

Additional explanation 1: How to distinguish between physical abuse and injuries resulting from an unintentional accident[16]

Where is the injury on the child's body?

Accidental injuries are most often found on the knees, elbows, shins, forehead - parts of the body that can be injured when a child accidentally falls or bumps into an object. Parts of the body that are less protruding and more protected (back, thighs, private parts, buttocks, back of legs, face) are much less likely to be injured when a child comes into inadvertent contact with an object that can cause injury.

16 Adapted from the California State Training Programme for Preschool Teachers.

How many injuries does a child have?

Are there multiple injuries occurring at the same time or at different times? The greater the number of injuries, the greater the cause for concern about physical abuse. Unless the child has been in a serious accident (e.g., car accident), there is little chance that the child has several different unintentional injuries. Injuries at different stages of healing may indicate the presence of chronological abuse signs.

What is the size and shape of the injury?

Many intentional injuries are inflicted on a child with objects familiar to us all (a belt, a hairbrush, a stick, a hand); the imprints they leave clearly show the object that was used.

Does the description of the situation, how the injury was sustained, seem plausible?

If the injury is unintentional, there must be a reasonable explanation of what happened and this must be consistent with the severity, type, and location of the injury. If the explanation for the injury and what the injury looks like do not seem to fit, then there is cause for concern, for example, could a fall from a chair onto a carpet cause abrasions and sores all over the body?

Is the injury compatible with the child's developmental skills?

By the age of 2-3, a child's mobility increases, and curiosity goes beyond the skills of risk assessment, the ability to reach, step and hold on; this curiosity also results in access to many objects that can be dangerous for children. As the child grows, the child's skills and ability to engage in activities that may cause injury to the child increase. A child who is learning to walk and run is more likely to bruise his/her knees or forehead. If the injury is an accident, there should be a clear and understandable explanation of how the accident happened.

Additional explanation 2: What is the line between disciplining and abusing a child? [17]

The real meaning of the word "discipline" is "instruction" or "teaching", which should also be the basis for guiding a child's behaviour, rather than using "discipline" as a punishment for a child's behaviour. Recommendations for disciplining a child have changed over time. Parents and childcare professionals alike may have received and followed outdated child-rearing advice during their life experience that is now forbidden by current knowledge, evidence, and legal frameworks, judged to be harmful to a child's development, or simply ineffective methods.

Disciplining a child becomes violent when:

- The child has physical injuries (e.g., abrasions, bruises, swelling);
- Punishment is designed to instill fear rather than to educate the child;
- The adult loses control and restraint;
- Discipline is inappropriate for the age and developmental abilities of the child;
- The adult makes unreasonable demands or expectations of the child;
- The adult keeps absolute control over the smallest choices of the child and robs the child of reasonable independence and development (e.g., overprotection).

17 Adapted from Hamilton County Job and Family Services.

Additionally, talking to parents to get their perspective can help to better discern whether discipline has become abusive. For example, as a parent:

- Do I feel good about this kind of discipline for my child?
- Did I teach my child an important lesson?
- Does my child know that I love him/her?
- Is there mutual respect or fear between me and my child?
- Do I behave in a way that I want my child to imitate?

Note. It is not the staff member's goal to interfere with parents' appropriate and harmless disciplining of their children, but to intervene and refer when extreme, inappropriate, or harmful disciplining of a child is being used.

Additional explanation 3: Is poverty the same as neglect? [18]

Children at risk of poverty are exposed to different types of suffering due to poverty. However, this should not be confused with neglect and other forms of child abuse. Poor family conditions are when the parents/caregivers do not have the resources to provide full care for the child. Child neglect is when the caregivers have resources and, despite this, they do not provide the necessary care for the child. In this sense, it is important to underline that neglect is a matter of responsibility more than a matter of means. This distinction, however, does not mean that a childcare professional should not intervene if a child does not receive appropriate care due to poverty. Intervening in the best interest of the child is always fundamental and appropriate. When extreme poverty conditions are detected, the intervention designed together with and/or by the appropriate agencies (e.g., Social Services) will aim at supporting the family as a whole to face the difficulties derived from poverty.

18 Adapted from the California State Training Programme for Preschool Teachers.

APPENDIX 2: COUNTRY-SPECIFIC LEGAL ASPECTS OF REFERRAL PROCEDURES

LEGAL ASPECTS – BELGIUM

There are no legal obligations to screen for signals of domestic violence (and trauma) in childcare settings. However, it is strongly advised for childcare services to provide a procedure when unacceptable behaviour occurs in the child's home environment. When a disturbing or troubling situation is noticed, a referral can be made. There is no legal obligation to do so but is generally seen as an implicit obligation of childcare services.

To do so, the Trust Centre for Child Abuse [Vertrouwenscentrum Kindermishandeling] developed a procedure to screen and refer cases of domestic violence. This protocol is called the ABC-step plan (see below). The plan provides an overview of the three steps to eliminating concerns and detecting child abuse in childcare services early.

The first step (of the ABC-step plan) is a non-standardized and non-protocolized observation, after which a childcare professional immediately verifies and investigates their observations with the parents. If either the observation or the conversation with the parent(s) worries the childcare professional or if the worries remain, the childcare professional should record the date, the specific worries, and a summary of the conversation with the parents. Subsequently, the childcare professional is encouraged to talk about their worries with the childcare service supervisor (part of Step 2A).

Step 2 of the ABC step plan includes consulting the coordinator or seeking advice at the Trust Centre for Child Abuse. If a childcare professional still has concerns} after talking to the parents, the protocol suggests talking about these concerns with the supervisor of the childcare service (i.e. the supervisor) or at a team meeting with colleagues (Step 2A). Note that childcare professionals have no professional confidentiality. If a childcare professional has no direct colleagues, he or she can also contact a colleague of the regional sector. This step is sometimes skipped as some childcare professionals have no/little professional network with whom they can talk about their concerns. If a childcare professional still has concerns after consulting with his/her colleagues, or if he/she was not able to consult his/her network, he/she can seek information and/or advice at Kind & Gezin (hereafter: K&G), the Flemish agency. This is noted in the files of K&G agency.

The childcare professional can also seek information and/or advice from the 'Trust Centre for Child Abuse' where it is always possible to seek advice without disclosing private information regarding the child's or the family's identity (Step 2B).

After/during consulting the 'Trust Centre for Child Abuse', the childcare professional can decide to refer the case to the Trust Centre for Child abuse (and officially disclose the private information of the family) (Step 2C). In this step, the centre will ask the childcare professional to fill out documents to officially inform the centre about the suspicion of child abuse.

In Step 3, regardless of the decision taken during Step 2, childcare professionals are asked to discuss their concerns with the parents. In case of Step 2A and 2B, childcare professionals can find that parents are responding well and that their concerns are thus fading. Also, the childcare professionals might find out that the parents are already seeking help through other services (e.g., psychosocial aid, help at home specific for domestic violence, etc.) and they can decide not to include another organisation through referral. In this case, it is recommended that childcare professionals continue their Step 1 observations (and discussing their worrying observations with parents).

If the childcare professional is not satisfied with the outcome of the conversation with the parents they proceeds to Step 2C. If step 2C is called for, childcare professionals are asked to inform parents they have referred their concern to the Trust Centre for Child abuse and inform the parents that they will be contacted by this centre.

Note: Training on how to talk with parents (Step 3) is provided to childcare professionals in an online module at the website of the K&G agency.

When the Trust Centre for Child Abuse takes over:

- The Trust Centre for child abuse will then assume responsibility for the file. They will contact the parents to arrange a meeting and will then work with the parents in a non-mandatory (yet highly recommended) manner.
- If the parents voluntarily cooperate with the Trust Centre, the Centre will agree on a plan in co-operation with the parents and will mainly refer to other centres to provide specialised care (according to this plan). Sometimes the centre will monitor and evaluate the case further. Mostly, however, the centre will leave this monitoring and evaluation (which is not standardised) to the other care centres (to which they have referred the family).
- If such consultations are blocked by the parents, the Centre will forward the file to a youth court that can impose help. From this point, the parents are subject to the order of the youth court that can impose, for instance, a mandatory 'out of home placement'.

The childcare professionals are usually no longer involved in the file after the referral has been registered. There is only occasional or little exchange of information.

The Belgian criminal code does contain several provisions that specifically serve to punish perpetrators of child abuse. Punishing the perpetrator is not always the best solution. Assistance can also be offered to improve the living environment of the child and the child's relationship with the parents. In a voluntary youth assistance programme, parents and/or the child ask for help or agree to and cooperate in the programme.

The overall focus is on voluntary help. The K&G agency wants to stimulate assistance voluntarily as much as possible. Only when the parents do not want to cooperate can a legal procedure be started and a youth court will decide if compulsory help is needed. If deemed necessary, some punitive initiatives can be taken (e.g., a parent can be 'stripped' of their parental responsibility, the child will then be allocated).

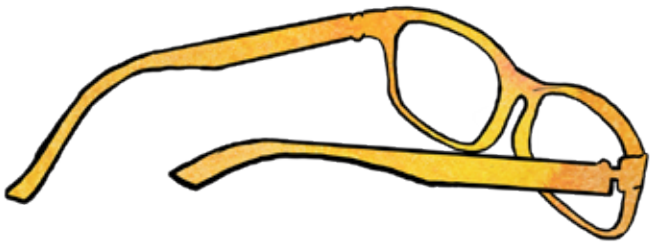
Childcare professionals can seek legal advice and information from the K&G agency, the Trust Centre for Child Abuse, and with the Support Centre Youth Care [Ondersteuningscentrum Jeugdzorg, OCJ].

Childcare professionals who come into possession of information regarding other individuals during their profession, may not disclose this information to anyone. This is called professional secrecy. It concerns all professionals for whom the existence of a relationship of trust with the client is indispensable for the performance of their function. Professionals are permitted to disclose information to other colleagues that are also bound by professional secrecy.

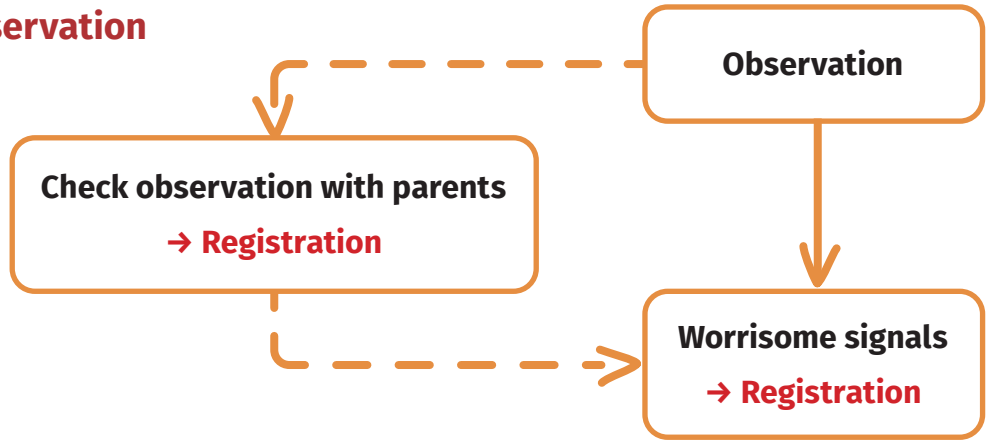
Professional secrecy implies that information may not be disclosed to the police and judicial services. If a childcare professional chooses to do so, the professional secrecy is broken. This may be done in exceptional cases, and only when all the following conditions are met:

- When it is in the interest of a minor or a vulnerable adult;
- When there is a serious and imminent danger;
- When you have seen the client or someone has informed you of their situation;
- When you cannot guarantee safety yourself or with the help of others;
- After you have consulted with your colleagues.

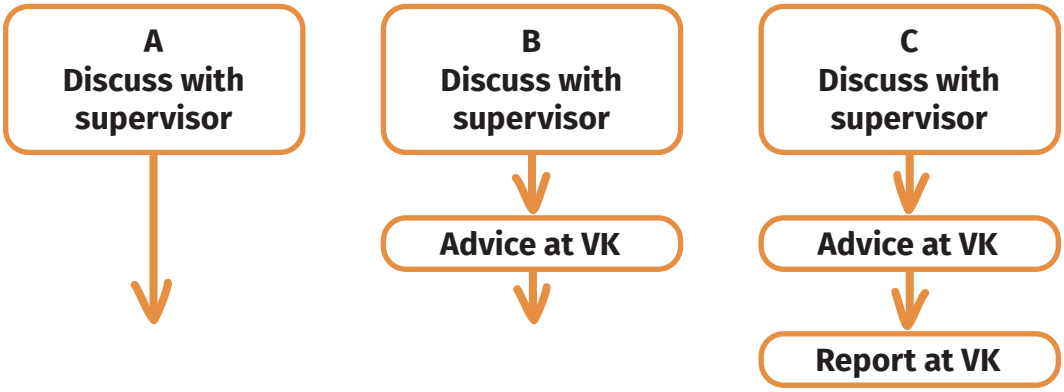
When there is an imminent and acute emergency for anyone, breaking professional secrecy is possible with police or judicial services without first consulting your colleagues.



1. Observation

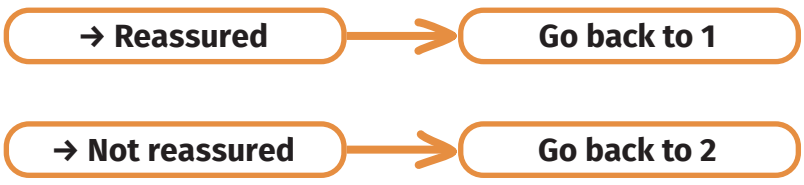


2. Consultation and advice



3. Talking with parent

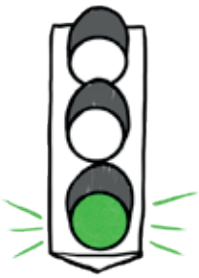
4. Decision making



Note. Adapted from Vertrouwenscentrum Kindermishandeling (2018). Het ABC-Stappenplan in de kinderopvang. https://bit.ly/3xe1Ftf

LEGAL ASPECTS – HUNGARY

GREEN ACTION MODE



Score from 0 to 31

Compare the outcome of the screening with colleagues.

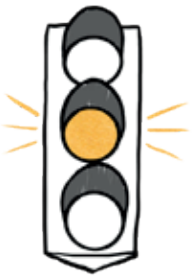
- **If agreed, repeat the screening a month later.**
- **In case of disagreement, evaluate the prevalence of the screenings, possibly involving the head of the facility.**
- **If the GREEN scores prevails, follow this Flowchart.**
- **If another case prevails, see the appropriate Flowchart in the "Referral Protocol" section.**

After a month:

Compare the outcome of the screening with colleagues.

- **If the score is GREEN again, repeat the procedure.**
- **If the score turns AMBER, see the appropriate Flowchart in the "Referral Protocol" section.** 
- **If the score turns RED, see the appropriate Flowchart in the "Referral Protocol" section.** 

AMBER ACTION MODE



Score from 32 to 49 OR worsening situation OR positive answer to item 4 of the "Red flags"

Report to the head of the childacre facility to evaluate the appropriateness of referral to the Local Child Welfare Services based on the gravity of a situation of potential harm to the psycho-physical health of the child.

The obligation to report derives from §17 of the Hungarian Child Protection Act,. This provision establishes a reporting system with the obligation to refer suspected cases. Institutions that offer personalised care services and those that offer education form part of this reporting system, and as such childcare professionals are obliged to report.

Activation of interventions to support parenthood through the involvement of social services

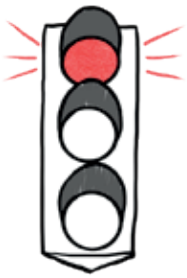
The Local Child Welfare Services will evaluate the situation of the child and the family and send a feedback to the childcare institution within 15 days.

If the "endangerment" (Hungarian legal terminology) of the child is not considered as serious, the case responsible works with the family on a voluntary basis. In case of children between 0-3 years of age the health visitor also has to work closely together with the family. Organizing the cooperation between the social worker, the health visitor and other important actors in the child's life (family pediatrician, nursery teacher, family members) is the responsibility of the child welfare services, thus the case manager.

If the child is regarded to be at a moderate or high risk of abuse or neglect

If the endangerment is considered as moderate or high level, the cooperation of the family with the local child welfare services is not voluntary anymore: in this case the Guardianship Office renders the child under official protection. At this point the cooperation with another assigned social worker, the "case manager" is obligatory.

RED ACTION MODE



Score of 50 and above AND/OR positive answer to at least one among items 1, 2 and 3 of the "Red flags" (alleged crime)

Report without delay to the head of the childcare facility to proceed with referral to the Local Child Welfare Services or the police.

Visiting the family

The social worker of the Local Child Welfare Services visits the family and evaluates the situation. The visit must be organised within 24 hours, 48 hours or a week, depending on the seriousness of the reported/suspected endangerment.

Immediate removal

In case of serious endangerment the police must be informed as well, and the child must be taken to a foster care center, instead of being sent home with his/her parents.

Failure to report the alleged crime to the Local Child Welfare Services constitutes a crime because childcare professionals are part of the reporting system established by the Hungarian Child Protection Act, §17

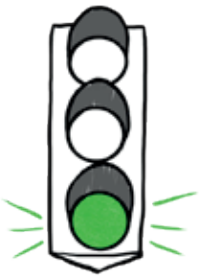
The written report must contain all the essential elements and information relating to the fact, without personal or third-party opinion, specification of the date the information and personal data relating to the minor and parents were acquired.

The most frequent offenses that require referral to the Local Child Welfare Services concern mistreatment (physical and psychological violence), injuries, and sexual abuse.

LEGAL ASPECTS – ITALY

A more detailed version of the referral protocol specifically based on the Italian laws is presented.

GREEN ACTION MODE



Score from 0 to 31

Compare the outcome of the screening with colleagues.

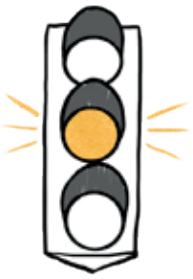
- **If agreed, repeat the screening a month later.**
- **In case of disagreement, evaluate the prevalence of the screenings, possibly involving the head of the facility.**
- **If the GREEN scores prevails, follow this Flowchart.**
- **If another case prevails, see the appropriate Flowchart in the "Referral Protocol" section.**

After a month:

Compare the outcome of the screening with colleagues.

- **If the score is GREEN again, repeat the procedure.**
- **If the score turns AMBER, see the appropriate Flowchart in the "Referral Protocol" section.** 
- **If the score turns RED, see the appropriate Flowchart in the "Referral Protocol" section.** 

AMBER ACTION MODE



Score from 32 to 49 OR worsening situation OR positive answer to item 4 of the "Red flags"

Report to the head of the childacre facility to evaluate the appropriateness of referral to Social Services and/or to the Juvenile Court based on the seriousness in the presence of a situation of potential harm to the psycho-physical health of the child.

The obligation to report derives from the qualification "public service officer" which is attributed by law to childcare professionals.

Activation of interventions to support parenthood through the involvement of social services

In this case, the child's parents must be notified and involved after evaluating the times and methods with the Social Service.

In these situations within the competence of Social Services or the Juvenile Court there is no obligation of secrecy.

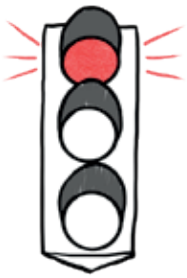
If the situation of prejudice is very serious, evaluate a direct report to the Juvenile Court which will activate the Social Services

Situations of potential prejudice concern neglect, situations of suffering or discomfort which are believed to be capable of undermining the psycho-physical health of the child.

The report must be written jointly (with the help of all childcare professionals who have relevant information) and contain a description of all the elements useful for assessing the situation of prejudice. Referral without direct evidence, or based only on information reported by third parties is not allowed.[20]

19 **Art. 358 of the Italian Criminal Code.** Person in charge of public service: "For the purposes of criminal law, those who, for whatever reason, perform a public service". Public service is defined as an activity disciplined in the same forms as the public function but characterised by the lack of the powers typical of the latter, and with the exclusion of the performance of simple duties of order and the provision of merely material work".
The head of the facility and childcare professionals are in charge of a public service when they carry out their activities and have a duty (Article 362 CP) to report without delay any suspicion of crime of which they become aware in the exercise or because of their service. They also have the duty to report any situations that are prejudicial to the psycho-physical health of the minor (Article 328 of the Criminal Code).

RED ACTION MODE



Score of 50 and above AND/OR positive answer to at least one among items 1, 2 and 3 of the "Red flags" (alleged crime)

Report without delay to the head of the childcare facility to proceed with referral to the judicial authority (JA).

Contextual referral to Social Services.

No communication to parents or third parties (who might have reported information)

The case, starting from the moment of notifying the JA, Is covered by preliminary secrecy. Parents and/or individuals who have provided information should not be updated.

Only the JA can involve the childcare professional if they need further information and if they believe that the testimony could be useful in ongoing investigations. In these cases, full cooperation must be provided.

You must report to the JA if you are pressureed or threatened or if you become aware of pressure or threats aimed at the child.

Failure to report the alleged crime to the JA constitutes a crime because childcare professionals hold the qualification of persons in charge of a public service

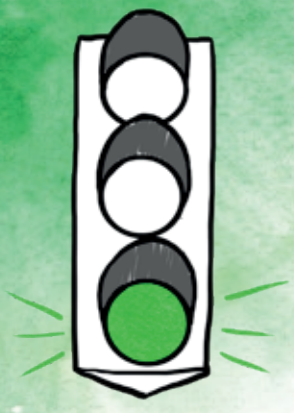
The written report must contain all the essential elements and information relating to the fact, without personal or third-party opinion, specification of the date of acquisition of the information and personal data relating to the minor and parents.

The most frequent offences that require referral to the JA relate to mistreatment (physical and psychological violence), injuries, and sexual abuse.

LEGAL ASPECTS – LATVIA

Law on the Protection of the Children's Rights states:

- "Every person must inform the police or another competent authority about violence or any other criminal offence directed against a child. Failure to do so will result in the persons at fault being held liable under the law." (Section 51(3))
- "Managers and employees of child care, educational, health care, and other such institutions where children are staying, organisers of events for children and such events in which children take part, persons who perform voluntary work in the above-mentioned institutions and events or provide a service according to an agreement entered into with such institutions, shall be liable for the protection of the health and life of the child, that the child be safe, that he or she is provided with qualified services and that his or her other rights are observed" (Section 72(1)).
- "All inhabitants must ensure the safety of their own and other children and to inform no later than the same day the police, the Orphan's and Custody Court, or other institution for the protection of the rights of the child about any abuse of a child or criminal offence or administrative violation against a child, violation of the rights of the child or other threat to a child, also if a person has suspicions that the child has articles, substances, or materials which may be a threat to the life or health of the child himself or herself or of another person." (Section 73(1))
- "Health care, educational, social work or police employees, and elected State and local government officials who have received information on violations of the rights of the child and who have failed to inform the above-mentioned institutions thereof, shall be held liable pursuant to the law for such failure to inform." (Section 73(2))
- Detailed referral protocol based on the Latvian legislative system is available below.



FURTHER ACTION IN GREEN MODE

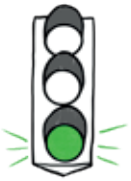
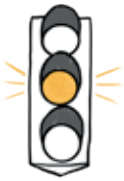
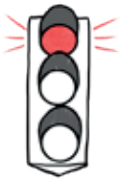
1. **Screening score between 0 and 31**

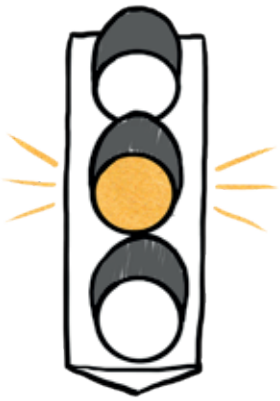
If the screening score is between 0 and 31, this indicates that there is no cause for concern about the risk of violence. Please follow this flowchart for guidance.

2. **Inform parents about the screening results if they prefer.**

Regular communication is a prerequisite for building positive relationships with parents in the long term. Regular communication about screening results (including those that are not of concern!) is one way to build relationships. Please see Section for suggestions on how to better prepare and manage the conversation with parents and how to build good communication.

3. **Have a routine screening after a month**

New screening result unchanged in green mode	New screening result worsens and reaches amber mode	New screening result deteriorates rapidly and reaches red mode
		
Continue routine screening every month in green mode. Inform parents of the results if they wish.	**Switch to amber mode for further action**	**Follow the red action mode**



FURTHER ACTION IN AMBER MODE

1. Screening score between 32 and 49.

If the screening score is between 32 and 49, this indicates that there is the risk of concern. Please follow this flowchart for guidance.

2. Meeting with other staff involved and the head of the childcare facility.

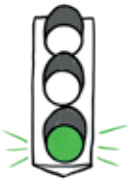
The purpose of the meeting:

1. To inform the responsible staff member of the results of the screening.
2. To find out whether other employees have also noticed similar signs OR compare the results if multiple specialists have screened.
3. Prepare for a meeting with parents about the screening results.
4. Arrange for close monitoring of the child for the next month.

3. Meeting with parents about the screening results, which seeks solutions to the identified risk. New screening after a month.

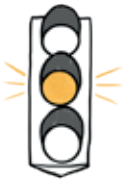
For suggestions on how to better prepare for and conduct a conversation with parents and how to build good communication, please see the next protocol's section.

New screening results improved and reaches green mode.



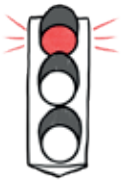
Continue routine screening after a month. Inform parents of results.

New screening result unchanged and remains in amber mode.



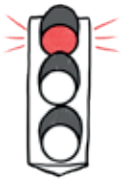
Repeat steps 2 and 3 of this diagram.

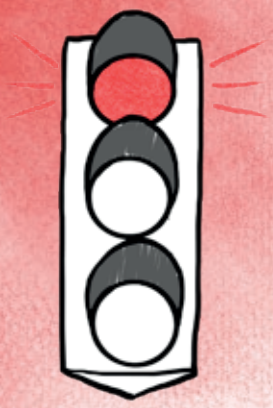
New screening result worsens and reaches red mode.



Follow the red action mode.

If the result of the next screening remains in amber mode and there is no improvement, switch to red mode for further action.





FURTHER ACTION IN RED MODE

If the screening result is 50 or more OR at least one of the red flags is identified, this result indicates the need to report to the responsible services. Please follow this flowchart for further action.

1. Screening score 50 and more

and/or

Red flag(s)

2. Joint meeting with other staff members involved and the head of the childcare facility.

The head or other designated responsible staff member reports.

Suspected or known emotional violence. ↓

1. Letter to the social services.

2. Inform parents about a legal duty to report in order to receive support services.

Parent visits a childcare facility under the influence of intoxicating substances. ↓

1. Phone call to the municipal police.

2. Inform the parents of the legal requirement in this situation.

Child has a health problem. ↓

1. A phone call or email to your child's GP.

2. Inform parents of the report made.

Suspected or known physical or sexual violence. ↓

1. Letter to three recipients at the same time: social services, orphanage court and the State Police.

2. Consult specialists or/when/how to inform parents about the report. In this case, careful consideration should be given to ensure that this decision is in the best interests of the child's safety.

Suspected or known neglect; parenting difficulties; parents with mental disorders; emotional difficulties in the family (e.g., mourning, divorce). Screening results that cannot be linked to a specific form of violence, but are equally worrying. ↓

1. Initiating an multi-agency meeting, jointly agreeing on further action and communication with the parents OR contacting the social services.

Child not being looked after or left alone at home. ↓

1. If possible, immediate communication about placing the child in the hands of another caretaker. Letter to the social services and the orphanage court at the same time.

2.If this is not possible, a phone call to one of the polices to inform them that the child's life is in danger.

The purpose of the meeting:

1. To inform the responsible staff member of the results of the screening.
2. To discuss and prepare the report.
3. To consider the decision on parental notification (if inform/when) and ensuring the safety of the child. In case of uncertainty, consult the responsible service if/when to inform the parents.

WHAT WILL HAPPEN AFTER I HAVE REFERRED?

Worry and uncertainty about what will happen after referring are one of the most significant barriers to referral. Explanations and suggestions on how to engage further with the services responsible will help to lower this barrier.

What to expect from the responsible authorities during the case assessment:

Upon receipt of the referral, the Social Services will initiate an assessment of the family, clarifying any unclear information if necessary. The Services will focus on cooperation with the childcare facility and will most often be the primary point of contact. We recommend that you continue to contact Social Services for feedback and any further steps. It is recommended you seek feedback if the responsible services do not identify a threshold of violence or offer suggestions on other available support for the family.

The Orphanage Court will contact the Social Services after receiving the referral so that the authorities can coordinate their actions and keep the family in their care.

In some cases, you may be contacted by a representative of the State Police and may be asked for additional evidence, if available.

In your contacts with any of the authorities, you should continue to provide additional information whenever you become aware of any further facts that support your suspicion of abuse in each case.

Further information on the duties and responsibilities of each authority involved is available here: https://drosaberniba.lv/emacibas/kursi/modulis-7.

How will the childcare facility be involved in case of confirmed child abuse?

Please follow the guidelines for trauma-sensitive care, which will allow you better to support the child who has suffered from abuse.

What should I say to staff, other parents, and children when I'm asked about what happened?

What to say to staff: when referring, try to contact the authority to find out what will happen next. The family has a right to privacy. Information about a family is private unless the family has given permission for the information to be shared with specific staff in the childcare facility. You can inform staff who are in contact with the child about the referral and what can be expected next.

What to say to parents of other children: if other parents know something about the case or have concerns and insist on sharing information about the case, it is important to remind them that other children are not at risk if they are not aware of the details of the situation, which, it should be stressed, is private information. Alternatively, you can allay the concerns of other parents by emphasising that their concerns are understandable and that the privacy of the information makes it impossible to share anything more about the situation. You can also remind them of the legal obligation of staff in educational institutions to refer child abuse.

What to say to other children: if the child leaves the childcare facility, you can tell the other children that the child has left and will be missed. If the child is receiving extra attention from staff, you can explain to the other children that we are taking care of the child for the time being to make him/her feel better again and that it takes a little more time and attention. It can be stressed that we would help another child just as much if they needed help.

What should I do if the authorities do not find child abuse after my referral, but the signs and concerns about abuse persist or the situation worsens?

If you are not satisfied with the response of the authorities and you still see the situation appears unchanged or worsen, refer again with a new description of your observations. Similarly, if the situation improves for a while but after a while, you again suspect abuse, refer again.

Can I share information with colleagues when I refer and further engage in multi-agency cooperation in a case of violence against a child?

Effective information sharing between professionals and institutions is essential for early identification, assessment, and provision of services to ensure children's safety. Professionals should actively share information as early as possible to help identify, assess, and respond to risks or signs of abuse. Personal Data Processing Law and the General Data Protection Regulation (GDPR) do not prevent information sharing where child safety and protection are involved. Fears about sharing information must not be allowed to hinder protecting children from abuse!

Debunking some of the myths[20] about information sharing that often get in the way of providing help and protecting children from abuse:

- Data protection legislation prevents information sharing

No! The personal Data Processing Law and the General Data Protection Regulation do not prohibit the collection and sharing of personal data, but rather provide a systemic framework for appropriate and correct information sharing. The Law and the Regulation balance the rights of the information subject (the person about whom information is obtained) and the possible need to share information about that person.

- Consent is required to share personal data

No! You do not need consent to share personal data. This is one way of complying with data protection law, but not the only way. The General Data Protection Regulation provides several grounds for sharing personal data. You do not need to ask for consent to share information for child protection and promoting the welfare of a child where there is a lawful basis for processing any personal data needed. In such a situation, a legal ground such as 'legal obligation' or 'public task' involving the performance of a task in the public interest or the exercise of an official authority may apply to data sharing.

- Personal data collected by one organisation must not be disclosed to another organisation

No! This is not true unless the information is used for purposes incompatible with the original purposes of the data collection. For children in need or at risk of abuse, it is difficult to imagine circumstances where legal requirements are a barrier to sharing personal information with other practitioners to protect children.

20 Adapted from UK Government (2018). Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents, and caregivers. Available: https://bit.ly/3ulLiIZ

HOW CHILDCARE FACILITY CAN ORGANISE A MULTI-AGENCY MEETING TO DISCUSS A POSSIBLE CASE OF CHILD ABUSE?

Experience has shown that inter-agency meetings allow for a more efficient and quicker resolution of suspected and confirmed cases of child abuse. There are municipalities where inter-agency meetings are already well established and the participation of childcare facility staff is an integral part of these meetings. If your childcare facility has not yet started participating in inter-agency meetings, you have every right to organise them on your own initiative. Below are suggestions to help you do this successfully, especially if you are doing it for the first time.

Before the inter-agency meeting:

- Decide who you want to invite (representatives from Social Services, Orphan Court, municipal or State Police, etc.). You don't have to invite representatives from all organisations, only those who you think could help in the specific situation.
- Write a joint letter (e-mail would work) with an invitation to an inter-agency meeting. Offer time (at least 1-2 weeks after the invitation) and place for the meeting. Plan the meeting for no longer than 2 hours. In one or two sentences describe the reason for the meeting and the subject of concern, mentioning the child in need, so the other specialists can review whether their institutions have worked with specific families before or are currently working with specific families.

During the inter-agency meeting:

- It is expected that the initiator of the meeting will lead the meeting and organise that another staff member writes meeting minutes.
- Initiator of the meeting:
  - Once again explains the reason for the meeting
  - Introduces specialists present
  - Agrees on meeting agenda and time allocated for the meeting
  - Outlines the specific situation (concerns, observations, challenges and needs)
  - Explores the matters with specialists
- At the end of the meeting, an agreement is drawn up on the joint approach in supporting the family and what each institution will do according to the agreed-upon joint approach, time frame, if/when the next meeting is necessary.
- Depending on the case, most likely the next multi-agency meeting would be organised by Social Services as they would take over the case management.

After the meeting:

- Send meeting minutes with agenda, discussion points, agreed-upon tasks, time frame, and next meeting to all meeting participants.

HOW CAN DOUBTS AND CONCERNS BE MINIMIZED IF THEY ARISE BEFORE THE REFERRAL IS DRAFTED?

It can be difficult to be in a situation where you need to refer suspected or known child abuse. These feelings are understandable. Referring child abuse can be difficult, and there may be feelings of worry, fear, or uncertainty. To ensure that doubts and fears do not stop you from helping the child, here are some answers to questions that may arise in times of doubt.

Why should I refer?

The main reason for referring is to protect the child. Referring can also provide an opportunity to protect other children in the family and it can allow help to be given to the possible abuser. Referring abuse can be a catalyst for change in the family, which can reduce the risk of further abuse.

What if I make a mistake when referring?

It is possible to talk to the parent beforehand to check any suspicions. The decision must be discussed with colleagues and the administration beforehand. The referral is carried out by the head of the childcare facility. Referral is done pursuant to screening guidelines. It would be much worse not to refer later to conclude that we have made a mistake and missed an opportunity to help the child to escape the abuse. Similarly, staff in educational institutions are among those who are held legally responsible for failing to refer when they have known about possible abuse.

Am I able to say what is or is not child abuse?

Although one may feel uncomfortable about the need to judge other people, as a member of staff in an educational establishment who has been trained in the use of this protocol and can thus recognise the signs of violence, you are in the best position to identify and refer violence, especially among the youngest children. If not the childcare professional who sees the child every day, who then? The decision must be made by a team where everyone feels equally safe and protected.

Will my referral be confidential or anonymous?

It won't be but given that we are referring from the institution and following the guidelines, we are acting in the best interests of the child. The identity of the reporter (in this case, the institution) and the content of referral are only disclosed to the responsible authorities and professionals involved in the assessment, investigation, assistance, and prosecution of the abuse.

How will I feel if the referral I make leads to the end of my relationship with the parent?

It is important not to be guided by personal feelings and put the relationships aside. We act as professionals, guided by principles. Our focus, our duty, and responsibility are the safety of the child and protecting him/her from possible abuse.

If available, supervision or coaching support can help. Feelings can be manageable by sharing them with someone else, especially when thinking about the teacher-parent relationship in the future.

Sometimes professionals have the misconception that referring is punishment to the family. It is much more useful to see referring as necessary to protect the child (and, in the long-term, the parents) by providing the necessary help and support.

What should I say to the parent who is the possible perpetrator of child abuse?

We can start by asking: how can we help you? We are worried about the child, his/her development, his/her health. We have questions that allow us to get objective information about what we have seen/heard/observed. Based on this information, we have a conversation with you. We want to help your child. We also have a legal duty to refer any reasonable suspicion of child abuse.

If the situation permits and it does not pose a risk to the child, informing the parent avoids the following unhelpful approaches:

- Threatening - threatening to refer gives the impression it is being used as punishment and may prevent the family from seeking the help they need.
- "Bargaining" - e.g., "I won't refer this time, but if it happens again, I will be forced to refer". Sentences like this or similar convey the message to the possible abuser that sometimes being abusive is not so wrong, but other times it is. This double approach is confusing and can result in escalation of child abuse.
- "Abandoning the family" - after making a referral, do not ignore the child or their family. Provide the necessary support to both the child and the family.
- Arguing - parents may not agree with the assertion that they are being abusive, for example, by comparing it to what they experienced from their own parents. In this situation, ask the parent to describe the abuse they experienced from their parents as a child and then explain that many things have changed, including how abuse is defined and statutory referral obligations. Explain that if his/her parents' abusive behaviour were carried out today, it would be referred as child abuse.

Should I always inform the potential abuser of my intention to refer?

We are not legally obliged to inform parents. It's best to discuss it with your colleagues, with whom the decision to inform the parent is made together as a team. Do not make the decision alone. The responsible authorities can be consulted to ensure that parental notification is not detrimental to the child's safety and wellbeing.

What should I do if a colleague/manager/parent tries to influence the decision to refer or puts pressure on me not to refer?

If the pressure comes from the parent - we refer to the guidelines, repeat the need, and legal obligation to refer.

If pressure comes from colleagues, we recommend going to the administration and discussing the situation to resolve disagreements. Rely on the screening results.

If pressured by the administration - refer privately, e.g., refer to Social Services. Discuss again with the administration - if we have decided to introduce the screening tool, this tool is likely to show a real problem that needs to be addressed. The administration cannot avoid addressing the problem. There is also no legal basis for penalising you for referring; on the contrary, if an educational establishment employee has knowledge of a violation of a child's rights and fails to refer it, the employee should be held legally liable for failing to refer.

Considerations such as fear of damaging relationships with adults cannot be allowed to interfere with the protection of children from abuse.

9. What should I do if a parent threatens me?

Emphasise that this is our legal duty and we have the best interests of the child at heart and that referring IS the most necessary step for the best interests, safety, and protection of the child at this time. It is advisable to record the event of the threat, e.g., by writing down the place, time, and content of the threat. Be sure to inform the administration. Consider referring to the police.

10. Can I be sued if I refer suspected child abuse?

The abuser may well try to do so, but you have two important "protections" of protection on your side: the Law on the Protection of the Children's Rights makes it clear that (1) we have a statutory duty to refer child abuse and that (2) certain professional groups (including educational staff) are subject to statutory liability for failure to refer. There is therefore a double statutory responsibility to refer child abuse.

APPENDIX 3: PARENTS/CAREGIVERS — CHILDCARE PROFESSIONALS MEETING MINUTES FORM

Child's given name, surname: _____

Meeting place, date, time: _____

Participants

Chair of the meeting: _____

Child parents/caregivers: _____

Other participants:_____

Meeting agenda

[A clear agenda you want to discuss, such as screening results / specific issues / areas of the child's strengths and areas for improvement / progress]

Main discussion points

[The main topics and issues discussed during the meeting]

Next steps

[Agreement on further steps / actions for parents / caregivers and / or childcare facility staff. Deadline for next steps / actions]

Next meeting

Date: _____ Time:_____ Place: _____

Notes

[Any other comments that are useful for further communication / next meeting, such as inviting another specialist / to assess the child's situation / other activities]

Meeting minutes prepared by: _____

Meeting minutes sent to: _____

PARENTS/CAREGIVERS — CHILDCARE PROFESSIONALS MEETING MINUTES FORM

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Meeting date, time, place: _____

Participants

Chair of the meeting: _____

Child parents/caregivers: _____

Other participants: _____

Meeting agenda

_____

_____

_____

Main discussion points

_____

_____

_____

Next steps

_____

_____

_____

Next meeting

Date: _____ Time: _____ Place: _____

Notes

_____

_____

Meeting minutes prepared by: _____

Meeting minutes sent to: _____

“Every day, in a hundred small ways, our children ask, ‘Do you hear me? Do you see me? Do I matter?’ Their behavior often reflects our response.”

(L.R. Knost)