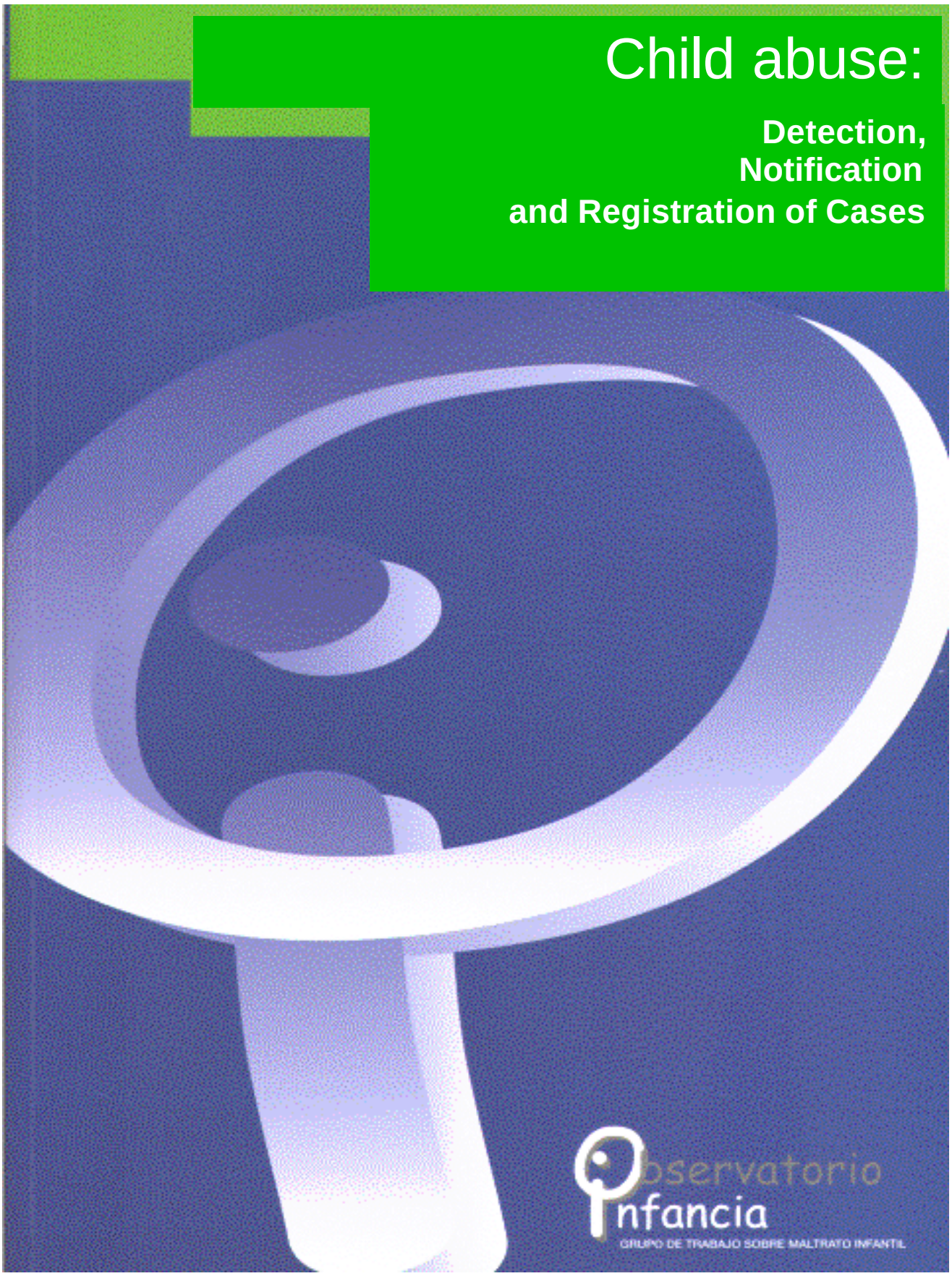
Child abuse:

Detection, Notification and Registration of Cases



MINISTRY OF
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SECRETARIAT GENERAL
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OF SOCIAL ACTION, THE
CHILD AND THE FAMILY

CHILD ABUSE:
DETECTION, NOTIFICATION
AND REGISTRATION OF CASES

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CHILD ABUSE: DETECTION AND NOTIFICATION AND REGISTRATION OF CASES

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PRESENTATION

In recent decades, there has been an increase not only in the amount of research carried out to improve our understanding of the phenomenon of child abuse, but also in the introduction of experimental programmes (on prevention and treatment) and in the effort made by all elements involved in this problem. However, we have yet to achieve out basic objective of making available to intervening professionals a unified system of detection, notification and registration of cases, which would make quantification easier and would enlighten us on the true dimensions of the problem.

An investigation which commences with the suspicion and discovery of abuse should proceed with a formal accusation (and communication to the competent entities) so that monitoring protocol is established and all the pertinent information is collected. The aim of this is to ensure that subsequent decision-making is more effective and will offer greater guarantees, thereby securing the protection of the child.

The Childhood Observatory is a body within the Department of Labour and Social Affairs that involves the participation of all the Autonomous Regions, relevant public entities in childhood issues and many other related institutions, and also represents social initiatives. Its main aim is the construction of an information system with the capacity to monitor the degree of well-being and the standard of living of the child population. Therefore, the Childhood Observatory is the ideal framework for the execution of studies and projects directed at improving information collecting systems and the registration of risk and child abuse cases.

With the participation of everyone, the Observatory will thoroughly fulfil the responsibilities entrusted to it. These responsibilities include the collection and analysis of information available in the diverse national and international sources on childhood, whose aim is to contribute to a systemized collection of information which permits the planning of Public Administration procedures.

In Madrid, October 2001

SECRETARIAT GENERAL OF SOCIAL AFFAIRS

Directorate General of Social, Child and Family Action Programmes

Teresa Mogín Barquín
General Director
Social, Child and Family Action Programmes

INTRODUCTION

There is no doubting the importance of registration systems and unified criteria in the detection of situations of risk and desertion of children. This is a concern which has given rise to diverse initiatives which, for the time being, have not reached a clear consensus.

The aim of the Childhood Observatory Working Group on child abuse is to make a proposal for the unification of general criteria on the concept of child abuse and intervention in the same. It also proposes a model for notification forms for detected cases which, on the one hand facilitate the procedure, and on the other, the maintenance of epidemiological vigilance systems. By using the same criteria and categories, these would increase our knowledge of the phenomenon of child abuse.

This document was written by a team of professionals who belong to the *Madrid Office of Child and Family Affairs of the Department of Social Services, Madrid*; to the *Sectorial Sectretariat of Social, Child and Family Action Programmes of the Department of Work and Social Policy of Murcia*; to the *Directorate General of Social, Child and Family Action Programmes of the Ministry of Work and Social Affairs*; to the *Department of Social Services of the Valencia Autonomous Region* in representation of the *Spanish Federation of Municipalities and Provinces*; to the *Reina Sofía Centre for the Study of Violence*; to the *Platform of Children's Associations*; to the *Federation of Associations for the Prevention of Child Abuse (FAPMI)*; and to the *Directorate General of the Family, Child and Adoption Affairs of the Social Welfare Department of Valencia*.

The quest for consensus was one of the fundamental premises of this multidisciplinary working group comprising social workers, psychologists, teachers, doctors and university graduates in nursing. This is reflected in the final document. Gratitude also goes to the many other professionals from all over Spain and from diverse institutions who have generously and valuably contributed to the document.

The aim of the present report-manual, which includes all of these contributions, is to serve as a guide or reference so that the different Autonomous Regions can gradually converge in their protocol of detection and intervention when faced with situations of child underprotection.

Finally, we must not forget, together with the above, the importance of the development of training programmes on child abuse in the different professional areas related, either directly or indirectly, to child protection.

In Valencia, October 2001

Agustín Domingo Moratalla

Director of Family, Child and Adoption Affairs
Department of Social Welfare
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Coordinator. Working Group on child abuse
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I. CHILD ABUSE

CHILD ABUSE

Treatment that has been given to children has not been uniform either throughout the ages or in different cultures. This is because neither the explicit or implicit status given to childhood nor its duration have been uniform. For example, not very long ago, childhood was conceived only as a stage prior to adulthood, whose worth consisted solely as a time of preparation or learning for adult life. Childhood had to be used and taken advantage of in order to become 'worthwhile men'. It is not too long ago either that 12-year-old humans were considered sufficiently prepared to participate in working life.

Nevertheless, with the passing of the centuries, and as a result of the slow and progressive development of values on what a child *is* or *should be*, today we have arrived at a concept of childhood as a substantive period, which is qualitatively different from other moments in life.

Nevertheless, whatever the uses and customs in different cultures may be, in all of them there usually appear ways of treating children that transcend socially acceptable limits. If this manner of behaviour with children is called *abuse*, we can say that child abuse has been a *historical constant*. We can even say with De Mause that, the further we go back into the past, the more exposed children were to violent death, abandonment, blows, terror and sexual abuse, that is to say, the lower the level of childcare.

Concept

Defining abuse in childhood would seem straightforward, however, in practice it is complex. There is a consensus regarding the great Syndromes of the Abused Child and situations of social alarm, but other circumstances are not so obvious. Professionals themselves have different criteria that result in the existence of multiple definitions.

The concept of child abuse initially referred to physical abuse, with a predominance of medical-clinical criteria, and reference to labour exploitation and child labour. This concept has developed to the current situation in which definitions are based on the needs and rights of children.

Article 19 of the United Nations Convention on the rights of children refers to child abuse as:

All forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

Spanish legislation defines legal desertion, Civil Code Art, 172, as:

A situation which is produced due to the failure to fulfil, or the impossible or inadequate use of rights of protection established by the law for the custody of children, when the latter are deprived of the necessary moral or material care.

Causes when intervention by child protection services are deemed necessary are listed in the chart below:

Causes	Fulfilment of guardianship duties
Orphanhood Imprisonment of parents Illness or admittance into hospital	Impossible
Total desertion Desertion by the mother Non-recognition by the parents	Failure to fulfil
Abuse or physical abandonment Abuse or emotional abandonment Abuse and sexual exploitation Begging and laboral exploitation Incapacity for control	Inadequate

Based on these concepts, child abuse is defined as:

A non-accidental action, omission of or negligent treatment, which deprives the child of his/her rights and welfare, which threatens and/or interferes with his/her ordered physical, psychic and/or social development, whose perpetrators could be people, institutions or society itself

This definition includes what is done (action), what is not done (omission) and what is done inadequately (negligence), which causes the child not only physical, psychological – emotional and social harm, but, considering him/her as a person-object by right includes his/her *rights* and well-being, and whose perpetrators can be persons (relatives or not) and institutions – administrations (institutional abuse).

Types of abuse

Abuse is not an isolated fact but is a process which is determined by the interaction of numerous social, family, and personal factors which are not always defined quantitatively or qualitatively. Its classification only means the determination of the problem which is developing or more relevantly that which affects the child. However, we should not forget the existence of multiple causes (abuse contexts).

Abuse can be classified from different points of view. These perspectives are as follows:

- According to the moment when the abuse occurs
- According to the perpetrators of the abuse
- According to the concrete actions which constitute the abuse inflicted.

The resulting typology of abuse can be according to:

The moment when it occurs	• **Prenatal**, when the abuse occurs before the birth of the child • **Postnatal**, when the abuse occurs during extra uterine life
The perpetrators	• **Family**, when the perpetrators of the abuse are relatives of the child, mainly first-degree relatives (parents, biological or not, grandparents, brothers or sisters, uncles or aunts, etc.) • **Extra familial**, when the perpetrators of the abuse are not members of the child's family, or the degree of kinship is very distant (second-degree relatives) or there is no family relationship. • **Institutional**, this is abuse caused by public institutions, whether they be sanitary, educational, etc. • **Social**, when there is not a concrete subject responsible for the abuse, but there is a series of external circumstances in the life of the parents and the child that make adequate attention and care of the child impossible.
The action or specific omission which is occurring	• **Physical abuse**: any voluntary physical action that causes or can cause physical injury to the child. • **Negligence**: to fail to attend to the needs of the child or the obligations of guardianship and protection or the inadequate care of the child. • **Emotional abuse**: any action, normally verbal, or any attitude towards a child that causes, or can cause in him/her, psychological harm. • **Sexual abuse**: any behaviour in which the child is used by an adult or another child as a means of obtaining stimulation or sexual gratification.

Prenatal abuse, in some cases the effects on the child are obvious, in others they are debatable, and in others it is advisable not to blame the mother. In any event, the fact that these circumstances are debated is proof of the value that society gives to childhood and the importance it gives to children.

Postnatal abuse is that which affects the child in his/her extra uterine life, and its typology is much wider.

Physical abuse through action, the easiest to detect from a clinical point of view and, therefore, that which is most frequently diagnosed. It is defined as any non-accidental intervention which causes physical harm or illness to the child or places him or her in grave danger of suffering from it.

Physical abuse can present itself in the following forms: skin wounds, (chafing, ecchymosis, wounds, bruises, scolds, burns, bites, alopecia), fractures, shaken baby, mechanical suffocation, straining, intoxication,…, and Münchausen syndrome by Proxy.

Chart 3. Typology of child abuse.

<table>
<tr><th colspan="2">Type</th><th>Action</th><th colspan="2">Omission</th></tr>
<tr><td colspan="2">PRENATAL</td><td>Circumstances in the life of the mother in which there is willingness which influence negatively or pathologically on the pregnancy and affect the foetus.
• Forms: Toxic habits of the mother: alcoholism (foetal alcohol syndrome), drug addiction (neonatal abstinence syndrome)</td><td colspan="2">Lack of attention to the needs and care of pregnancy which have repercussions on the foetus
• Forms: Pregnancies without medical care, deficient diet, excess of physical labour</td></tr>
<tr><td rowspan="3">POSTNATAL</td><td>PHYSICAL</td><td>Any non-accidental act which causes physical harm or illness to the child or which places him/her in grave danger of suffering from it.
• Forms: skin wounds (ecchymosis, injuries, bruising, chafing, burns, bites, traumatic alopecia), fractures, shaking, mechanical suffocation, straining, intoxication, Münchausen syndrome by Proxy</td><td>NEGLIGENCE</td><td>Neglecting the needs of the child and the duties of custody and protection or inadequate care of the child.
• Forms: neglect, abandonment, non-organic growth retardation, ‘Street children’, constantly dirty, physical problems or ignored medical needs or the absence of routine medical care (vaccinations).</td></tr>
<tr><td>EMOTIONAL</td><td>Any action capable of causing psychological – psychical clinical patterns due to an effect on his/her needs according to the different stages of development and characteristics of the child.
• Forms: to reject, ignore, terrorize, isolate, corrupt or involve the child in anti-social behaviour</td><td colspan="2">Omission and negligence in attention to the emotional needs of the child
• Forms: lack of affection, not attending to the affective need of the child (loving care, stability, security, stimulation, support, protection, family role, self-esteem, etc.), pedagogical abuse</td></tr>
<tr><td>SEXUAL</td><td>Sexual abuse: involvement of children in sexual activities, to satisfy the needs of an adult
• Forms:
- With physical contact: rape, incest, sodomy, pornography, child prostitution, touching, sexual stimulation
- Without physical contact: indecent solicitation of a child or explicit verbal seduction, the carrying out of sexual acts or masturbation in the presence of the child, exposure of sexual organs to a child, promoting child prostitution, pornography</td><td colspan="2">Not attending to the needs of the child and his/her protection in the area of sexuality
• Not believing the child, ignoring a request for help, not educating in assertiveness, a mother who prefers “not to see it” – passive consent to incest, lack of information/information, lack of protection,…</td></tr>
</table>

Negligence as a form of child abuse consists of leaving or abstaining from attending to the needs of the child and the duties of guardianship and protection or inadequate care of the child.

The maximum degree is **abandonment** which has psychological and symptomatic characteristics and, one could even mention the specific sanitary situation of those that are attended to in child protection institutions (foundling homes, orphanages, homes).

“**Street-Children**” are those who do not have a home and families to care for them, they live alone or even having a family they are continually or provisionally in the street. Due to the labour obligations of their parents, they remain alone for the majority of the day in possession of a key to get into the house but without there being an adult present for their attention/care. They are children without schooling, they commit criminal acts, do marginalised work and are child prostitutes, etc.

In developed societies, it might be thought that **labour exploitation** is not a frequent occurrence. But the use of children to reap benefit, which involves economic exploitation, and the carrying out of any job which impedes their education, or is harmful to their health or their development does not only occur in poor or developing countries. Begging and professional work by children also occurs in our society.

All forms of abuse have repercussions on the psychological – emotional side of the child. Moreover, **emotional abuse** is of clinical importance in its own right and is defined as all action, omission or negligence of an affective nature which is capable of giving rise to psychological – psychiatric clinical patterns, due to their effect on the child’s needs depending on his/her stage of development and characteristics.

One form of presentation of abuse through omission is **Non-organic Growth Retardation** in children who do not increase their parameters of weight-height growth with normality in the absence of organic illness. Their aetiology

is inadequacy or lack of attention to the child's psychic–affective and social needs which have physical consequences, affecting their growth and development, and their psychosocial stability.

Pedagogical abuse is suffered by a child who, through academic demands and the obligation to attend additional classes, without taking into account his/her possibilities, is prevented from having time for rest and play due to the desire for greater achievement in a progressively competitive environment**.** The outcome is serious scholarly stress which becomes apparent through more frequent illness, diverse psychosomatic disorders and emotional upsets which require a doctor's opinion.

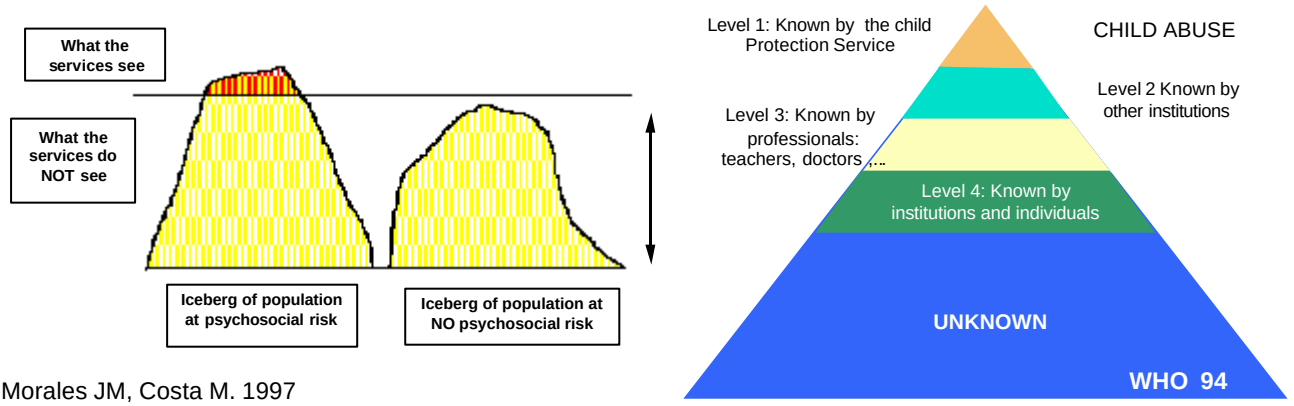
Sexual abuse, one of the most frequent forms of child abuse, is defined as the involvement of children in sexual activities, in order to satisfy the needs of an adult. Forms of sexual abuse include, *with contact*, rape, incest, pornography, child prostitution, sodomy, touching, sexual stimulation, and, *without physical contact*, indecent solicitation of a child or explicit verbal seduction, carrying out sexual acts or masturbation in the presence of a child, exposure of the sexual organs to a child, the promotion of child prostitution and pornography.

Institutional abuse falls within the typologies of child abuse and is derived from any legislation, programme, procedure, action or omission by public authorities that involves abuse, negligence, detriment to the health, security, emotional well-being, correct maturity or which violates the basic rights of the child.

Frequency

The true prevalence of child abuse is unknown, since the majority of cases are not detected. The very nature of the problem, which largely occurs within the family itself, fear of accusation, insufficient training of professionals, that the victim is a child, etc., conditions awareness of the number of cases. Different experts liken the situation to an iceberg by estimating that detected cases are only a part of real cases (Figure 1).

Figure 1. *Icebergs* of abuse



Morales JM, Costa M. 1997

There are a series of myths and false beliefs that influence this lack of knowledge about the real magnitude of the problem (Gutiérrez P, 1997). The most frequent *myths* are:

Myths	False beliefs
Abuse is infrequent	There is a deeply-rooted belief in the family as a centre of affection where it is difficult to believe that violence occurs
Violence and love do not coexist in families	It is thought that if there is an atmosphere of family violence it is on-going. However, there are many children, that in spite of the abuse received, who love their parents, and this coexistence of violence and love makes the child believe that violence is acceptable
Abuse is only committed by people with mental illness, psychological disorders or under the effects of alcohol or drugs	There is the underlying belief that *normal* people do not mistreat their children. As a matter of fact, there does not exist a pattern of an *abusive parent* with stable, uniform features which are easily-distinguishable from parents who do not mistreat their children. It does seem as though there are some characteristics which are more frequently found, such as: - Low tolerance to frustration and inappropriate expressions of anger - Social isolation - Lack of parenting skills - Feelings of incapacity or incompetence as parents - Unrealistic expectations for their children - The perception of their children's behaviour as stressful
The notion of " generational transferral of abuse"	The dogmatic formula that erroneously maintains that all abused children will be abusers and vice versa

Child abuse is fundamentally physical abuse	The restrictive view of the problem created and fomented through the mass media which give preferential importance to cases with physical injuries and sexual abuse. As a contrast to this, there is high tolerance to 'slight' physical or psychological abuse.
Abuse does not exist in upper social classes	Abuse in childhood exists in *all* social classes. More cases are diagnosed among lower social classes because the use of private social and health resources prevents disclosure of risk situations which occur in upper social classes.
Psychosocial issues are not true medicine	If the attainment of knowledge in psycho affective areas is not considered important, we will not be in a position to understand and to diagnose abuse in childhood.
The diagnosis of abuse should be confirmed before any intervention can take place	It prevents the registration of events and risk factors in medical records which could bring about preventive or early action.

Factors that are influential in the lack of awareness of the magnitude of the problem are the lack of epidemiological studies and the omission of professionals to communicate cases (Table 4 a and b).

Table 4.a. Factors which influence real knowledge of abuse: they are not detected (Martínez C, 1997)

- Their diagnosis is not easy, many cases are not even suspected
- The absence of an omni comprehensive definition, which allows easy recognition
- In many cases, the difficulty of differentiating injuries from those which occur accidentally
- Professional training which is received before and after graduation is either scarce or non-existent and prevents detection of injuries.
- The personal criteria of the professionals themselves:
  - They can form part of the social, cultural or religious customs that the professional shares
  - Physical punishment is considered as a disciplinary measure and not as mistreatment
  - All accidents in childhood are inevitable, and therefore they would be abuse and vice versa

Table 4.b. Factors which influence real knowledge of abuse: It is identified but not reported

- Injuries are not considered as serious
- It is not known with certainty, although it is suspected, how it was caused (fear of making a mistake)
- Fear of thinking that issuing an injury report is the same as making a formal accusation
- Concerns of the professional of a personal nature: *legal* (obligation to give evidence), *economic* (loss of working hours, loss of clients), *convenience* (getting to court if you have to give evidence), *fear* (reaction of the parents)
- Previous experience, in which in spite of informing the Authorities of the suspicion of abuse, the child was handed over to the parents, without the prior pertinent social processing
- On reporting a suspicion of the existence of abuse, many professionals think that it is worse for the child rather than better because:
  - the aggressor sees in the child the reason for the investigation or the interrogation and will subsequently act with more violence.
  - bad parents are preferable to a good Institution
  - they consider they should not interfere in the private affairs of other families

In Spain, a variety of groups worked in the decade of the 80s to sensitise public opinion, professionals, politicians and renowned figures in society to the existence of child abuse, as well as the need to analyse its dimensions, factors which favour it and its repercussions.

In recent years, studies have been carried out to determine the frequency of abuse in our country. Amongst these, the studies carried out in Catalonia, Andalusia, Guipúzcoa, Madrid, Castilla y León and Valencia stand out; and those on a national scale that analyse the records which exist in the child protection services which belong to the Social Services departments of the Autonomous Regions. (Table 5).

Table 5. Detection percentages by typology and incidence estimated in studies carried out in Spain

	Catalonia		Andalusia 1995	Spain 1995 [1]	Guipúzcoa 1995 [2]	Madrid 1995 [1]	Castilla – León 1993 [3]	Valencia 2000 [5]	Sexual abuse 1994 [6]
	1991	2000							
Negligence	78,5 %	50.4%	72,2 %	79,1 %	49,4 %	47.5 %	92 %	89.4 %	-
Emotional abuse	43,6 %	26.5%	45,4 %	42,5 %	17,4 %	9.1 %	82-65 %	12.8 %	-
Physical abuse	27 %	10.5%	22 %	30,1 %	8,1 %	18.5 %	31 %	19.6 %	-
Labour exploitation	9,3 %	1.7%	9,4 %	4,2 %	0,5 %	1.3 %	4,0 %	-	-
Begging	-	--	14,3 %	9,3 %	1,2 %	-	-	-	-
Corruption	-	1.2%	16 %	4,2 %	1,5 %	-	-	-	-
Sexual abuse	2,8 %	6.6%	3,6 %	4,2 %	1,8 %	0.5 %	-	4.9 %	20 %
Prenatal abuse	3,1 %	2.8	-	5,0 %	-	1.6 %	-	-	-
Rate of incidence	5 λ	5,6 λ	15 λ	0,44 λ	15 λ	3,5 λ	11,5 % [4]	0.86 λ	-
Number of cases	7.590	6.524	4.714	8.575	189	3.888	848	1.379	2.100
Number of dossiers	-	-	-	32.483	-	4.916	-	3.565	-

[1] Child protection dossiers
[2] Potential accusations calculated through different professionals.
[3] Here disabled children are investigated based on child protection records.
Within this typology, the difference is made between an active modality (emotional abuse, 65 per cent) and a passive modality (emotional abandonment, 82 per cent).
[4] 11 per cent represents the prevalence of child abuse in the disabled population in the guardianship of Castilla y León.
[5] Child protection proceedings initiated in the Region of Valencia in the years 1997-98 (Reina Sofía Centre for the Study of Violence, 2000)
[6] A survey carried out on 1,200 people of both sexes over 18 years old on sexual abuse experiences in childhood

In spite of this disparity of results, there is a certain concordance in Spanish studies in a series of conclusions on personal and family characteristics and on the social circumstances which surround cases of abuse. This uniformity can, on occasions, be extended to data which is found in other international publications. These points of agreement are as follows:

- Abuse is something which is more frequent amongst boys than amongst girls.
- It has been confirmed that many abused children have suffered more than one type of abuse.
- Abuse occurs in children of all ages. Physical abuse is more frequent in children younger than 2 and sexual abuse is more frequent from 9 onwards, especially between 12 and 15.
- In all cases there is an accumulation of risk factors such as scarce support resources. Factors have also been cited which include being a premature child, suffering from frequent illness or hyperactivity; and, above all, socio-familial circumstances such as unemployment, family break-up, environments lacking in affection, alcoholism, drug addiction or poor housing.

II. LEGAL REGULATIONS [1]

[1] Text revised by Ligia Flores Escobar. Directorate General of Social, Infant and Family Action Programmes

LEGAL REGULATIONS

The legal framework and safeguards in our country are compiled in the :

SPANISH CONSTITUTION OF DECEMBER 27, 1978

which stipulates the right to life and to physical and moral integrity (art. 15), to education (art. 27), to health (art. 43)..., and specifically in article 39:

1. Public authorities guarantee the social, economic and legal protection of the family.
2. Likewise, public authorities guarantee the integral protection of children, these being equal before the law regardless of their filiation and the marital status of their mothers. The law permits investigation of paternity.
3. Parents should provide all kinds of care for their children whether they were born within or outside marriage, during the age of childhood and in other cases which are legally appropriate.
4. Children will be protected by international agreements which safeguard their rights.

The following stand out in international texts:

- **UNITED NATIONS CONVENTION ON CHILDREN'S RIGHTS** of November 20, 1989, ratified by Spain in November 1990 and incorporated into the internal set of laws.
- The European Letter of Children's Rights, approved by resolution A-301712/92, of July 8, 1992 of the European Parliament.

General laws which directly affect childhood include:

- Civil Code (especially in Book I and, within the latter Heading VII on filial-paternal relationships).
- Law 21/87, of November 11, through which certain articles of the Civil Code and the Law of Civil Prosecution on the subject of adoption and other forms of child protection are modified.
- Act of Parliament 1/1996, of January 15, Law of Legal Child Protection and partial modification of the Law of Civil Prosecution.
- Act of Parliament 10/1995, of November 23 of the Penal Code.
- Act of Parliament 11/1999, of April 30, of modification of Title VIII of Book I of the Penal Code (Crimes against freedom and sexual indemnity).
- Act of Parliament 14/1999, of June 9, of modification of the Penal Code of 1995, on the subject of the protection of abuse victims and the Law of Criminal Prosecution.
- Act of Parliament 1/1982, of May 5, of Civil Protection of the Right to Honour, to personal and family privacy, and to one's own image.
- Act of Parliament 5/2000, of January 12, regulatory of the penal responsibility of children.
- Act of Parliament 4/2000, of January 11, on rights and duties of foreigners in Spain and their social integration.
- Act of Parliament 8/2000, of December 22, reform of Act of Parliament 4/2000, of January 11, on rights and duties of foreigners in Spain and their social integration.
- Law 14/1986, of April 25. General Health
- Act of Parliament 8/1985, of July 3, regulatory of the Right to Education (LODE).
- Act of Parliament 1/1990, of October 3, of General Law of the Education System (LOGSE).
- Law 7/1985, of April 2, of Basis of Local Scheme.
- Law 13/1982, of April 7, of Social Integration of the Disabled.
- Royal Legislative Decree 1/1995, of March 24, through which the Redrafted Text of the Law of the Statute of Workers is approved.
- Law 25/1971, of June 19, of the Protection of Large Families (although a large part of its content has been tacitly revoked)

The Constitutional Text, in article 148.1 20º, authorises Autonomous Regions to assume full competence in the area of social assistance for which they have developed the corresponding laws which refer to childhood:

LEGISLATION OF THE AUTONOMOUS REGIONS ON THE SUBJECT OF CHILD PROTECTION

Autonomous Region	Rank	Nº	Date	Title	Date of Publication
Andalusia	Law	1	20/4/98	On the Rights and Care of Children	BOJA 24/6/98 BOE 24/6/98
Aragón	Law	10	14/12/89	On the Protection of Children	BOE 5/1/90
	Law	12	02/07/01	On Childhood and adolescence in Aragón	BOA 20/07/01
Asturias	Law	1	27/1/95	On Protection of Children	BOPA 9/2/95
	Decree	139	16/9/99	On Organisation and Functions of the Asturian Institute of Social Attention to Childhood, the Family and Adolescence	BOPA 18/9/99
	Decree	46	1/6/00	Through which the Regulation of Fostering and the Adoption of Children is approved	BOPA 14/6/00
Balearic Islands	Law	7	21/3/95	On the guardianship and protection of deserted children.	BOE 19/5/95
	Decree	16	30/1/97	Creates the Office of Defence of the Rights of Children	BOCAIB18/2/97
Canary Islands	Law	1	7/2/97	Integral attention to Children	BOC 17-2-97
	Decree	54	17/4/98	Through which acts of the protection of children are regulated	BOC 6/5/98
	Decree	105	25/5/99	Through which the constitution, composition and functions of the Inter Administrative Commission of Children is regulated	BOC 9/6/99
Cantabria	Decree	66	7/9/92	Through which the Regulation on administrative dossiers on Adoption, Tutelary, Guardianship, and Fostering of Children is approved	BOC 28/9/92
	Law	7	28/4/99	Protection of Childhood and Adolescence	BOE 28/5/99
Castilla y León	Decree	57	7/4/88	Through which regulations on the protection of children are pronounced	BOC Y L 14/4/88
Castilla-La Mancha	Decree	143	18/12/90	On procedure on the subject of the protection of children	BOCM 26/12/90
	Mandate		10/2/98	It regulates the programme of the fostering of children in the Autonomous Region of Castilla - La Mancha	BOCM 20/2/98
	Law	3	31/3/99	On the Child	BOCM 16/4/99
Catalonia	Law	37	30/12/91	On protection measures of deserted children and of adoption	BOE 21/2/92
	Decree	188	28/6/94	On the creation of the Non-profit making Commission of Advice and Supervision of Individuals who have the guardianship of children or the disabled assigned to them	DOGC 5/8/94
	Law	8	27/7/95	On the care and protection of children and adolescents and of modification of Law 37/91	BOE 30/8/95
	Decree	2	7/1/97	Through which the Regulation of the Protection of Deserted Children and adoption is approved	DOGC 13/1/97
	Decree	22	30/1/97	Modifies the final regulation of Decree 2/97, of January 7, through which the Regulation of protection of deserted children and adoption is approved.	DOGC 31/1/97
	Decree	127	27/5/97	Partially modifies Decree 2/97 of January 7, through which the Regulation of protection of deserted children and adoption is approved	DOGC 30/5/97
	Law	13	19/11/97	Creation of the Catalan Institute of Fostering and Adoption	DOGC 27/11/97
Valencian Autonomous Region	Decree	31	18/2/91	Through which Decree 23/88 of protection measures of children in a situation of desertion is modified	DOGV 4/3/91
	Law	7	5/12/94	On Childhood	BOE 25/1/95

Autonomous Region	Rank	Nº	Date	Title	Date of Publication
Extremadura	Law	4	10/11/94	On the protection and care of children	BOE 27/12/94
	Decree	68	5/5/98	It establishes the authorisation of collaborating entities for the development of housing programmes for the care of children and the regulation of the activity organised by the Department of Social Welfare on this subject	DOE 14/5/98
Galicia	Law	3	9/6/97	of Galicia on the Family, Childhood and Adolescence.	DOG 20/6/97
	Decree	42	7/1/2000	Through which the regulation is revoked	DOG 6/3/00
Madrid	Mandate	300	15/4/91	relative to the procedure for the custody of children	BOCM 22/4/91
	Decree	71	12/11/92	through which Decree 121/88 regulatory of the procedure for the constitution and the practice of guardianship and custody of the child is modified	BOCM 19/11/92
	Law	6	28/3/95	which guarantees the Rights of Children and Adolescents in the Region of Madrid	BOCM 7/4/95
	Law	18	29/4/99	Regulatory of the Departments of Care of Childhood and Adolescence.	BOCM 19/5/99
Murcia	Law	3	21/3/95	on Childhood	BOE 2/6/95
Navarra	Formal Decree	90	25/3/86	Norms on adoption, fostering and care of children	BON 7/4/86
Rioja, La	Law	5	18/3/98	Law of the Child	BOE 2/4/98
Basque Region					
Álava	Decree	207	2/7/85	They transfer the services of the common Institutions on the subject of protection, guardianship and social reform of children to the Historic Territory of Álava	BPV 18/7/85
Guipúzcoa	Decree	209	2/7/85	They transfer the services of the common Institutions on the subject of protection, guardianship and social reform of children to the Historic Territory of Guipúzcoa	BPV 18/7/85
Vizcaya	Decree	211	2/7/85	They transfer the services of the common Institutions on the subject of protection, guardianship and social reform of children to the Historic Territory of Vizcaya	BPV 18/7/85

III. PROCEDURE IN CASES OF CHILD ABUSE

PROCEDURE IN CASES OF CHILD ABUSE

Introduction

The aim of this Working group is to make a proposal of Unification of Detection Forms and Registration of cases of risk and child abuse.

The aim is not to establish a model for the functioning of the system of child protection or procedure in cases of child abuse, although the present work could have implications in this respect.

Nevertheless, it is deemed necessary to establish what general principles should guide all institutional responses to the phenomenon of child abuse and, therefore, how they are developed in the present paper.

Procedure in the face of child abuse should:

1. Be included within general plans,
2. Contemplate basic principles of intervention.
3. Establish procedure, and
4. Draw up manuals containing the contents of the programme.

1. *Procedure in cases of child abuse* is encompassed within the *Protocol of procedure in the face of child abuse drawn up by the Childhood Observatory within the Programme for the Improvement of Social Attention to Childhood (Ministry of Work and Social Affairs) and the corresponding programmes of each Autonomous Region*.

Current systems of social attention to childhood are based on rights and needs, welfare and social promotion as opposed to models of protectionism and charity.

2. *Good practices in social protection* would be determined by *criteria of procedure* considered as optimal for the achievement of set results according to the established objectives.

Procedure in circumstances of child abuse should fulfil a series of basic intervention criteria, including:

A. Children have the right to have their basic needs covered. Family, schooling, social services, health..., and adults in general are responsible for children being able to live in conditions which allow them to meet their needs.

B. Institutions and services should not only exist for cases of severe deficiency, but should be responsible for children being able to develop their possibilities to the utmost.

C. Children are especially defenceless and needy. They are unable to provide themselves with the most suitable response to their needs nor protect themselves from risks.

D. The family is the institution which can best answer to basic needs and protect children.

E. The family alone cannot meet all the needs of the child. Schooling, health and social services..., should answer to the basic needs of children which are within their responsibility in a complementary way to the family.

F. When parents are incapable of or do not wish to protect their children from abusive circumstances or they themselves are the perpetrators of the abuse, the community should intervene to protect the children.

G. When children suffer deficiencies and risks which threaten their adequate development, all adults and public institutions have the obligation to report it and offer the help and requests for help which are most efficient.

H. Institutions and public services with responsibility in child protection are the context to which the community turns in order to protect children and so that they can live in suitable developmental conditions.

I. Children, on whose behalf it is necessary to take protective measures, have the right to a plan which should have as its priority keeping them within their family and reuniting them after a time (always as short as possible) with the family.

J. The best interests of the child should be the principle on which decision-making is based.

K. The offer made by the community to children who have had to be separated from the family (foster parents, those in charge of a centre, those in charge of child protection services) must fulfil the child's needs better than the family of origin was doing.

L. The procedure plan should provide for the best possible collaboration between the parents and the child him/herself.

M. The best way of protecting children from abuse is by helping parents or carers to acquire or to assume the functions of protection and care of their children again.

N. Parents affected by protection measures should receive help which facilitates their collaboration. The closest contact possible should be maintained with the parents and between the parents and the children, except where it is specifically indicated that this could entail serious drawbacks for the child.

O. In cases of definitive separation, conditions should be provided so that the child can establish other stable links, whether it be through adoption or permanent fostering.

3. The procedural process should be the *theoretical framework* which serves as a reference point and guides work in the field of child protection.

The Protocol of the Working Group on child abuse of the Childhood Observatory establishes a process to child abuse which guides procedure in different stages.

4. The development of the programme should seek the participation of the different institutions and professions involved in this problem and their consensus by drawing up a document which serves as a reference point.

The creation of the Manual includes the contributions of the different Autonomous regions and the Ministries of Work and Social Affairs, Health and Consumer Affairs, Justice, the Home Office, the Platform of Childhood Associations, the Reina Sofia Centre for the Study of Violence and the bibliography consulted.

Procedure in cases of child abuse

The aim of the *Protocol of procedure in the face of abuse in childhood* is

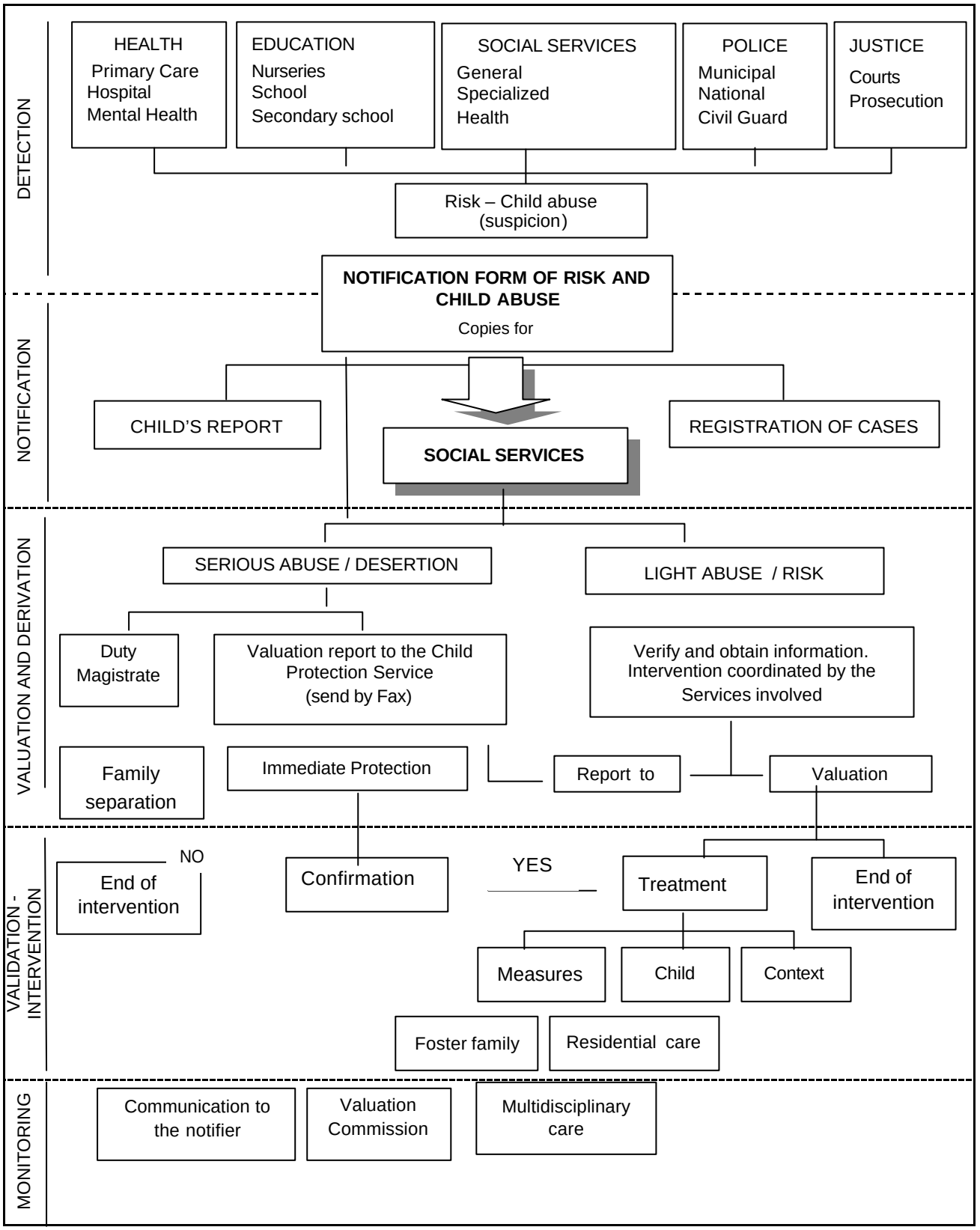
- to collect in an ordered an systematic way procedure to be carried out in cases of child abuse
- to put into a document the work of the different teams and services
- to create a work proposal for the operating system for the health area.

The *procedure in cases of child abuse* which we present here is a work proposal for the different areas of attention to childhood and the work areas to which this programme is directed.

The procedure in cases of child abuse is a basic scheme of interdependent stages which do not necessarily follow a lineal direction. For example, the seriousness of some cases could require, as a first step, the taking of measures to guarantee the safety and protection of the child such as hospitalisation or admittance into a Foster Home for emergencies. (Table 6).

The plan that we are presenting could coincide or not with that which is being carried out in each one of the different Autonomous Regions, but it gives us a general idea of the *procedure* (detection, reception, investigation, evaluation, planning, intervention, evaluation, end of intervention) and of the *bodies / services* that could be involved (health, social, educational, police, judicial, fiscal,...) according to the current *system of protection of children* (the disappearance of judicial involvement and the responsibilities of the social services and the Autonomous Regions).

Table 6. Procedural stages in risk and child abuse cases



(*) Communication to social services is always compulsory as they have responsibility in child protection matters.

(**) Report on injuries or for the guardianship of children when unable to contact the services of the Autonomous Regions that are responsible for child protection.

(***) When the following is required: the intervention of the Child Prosecutor with duties in child administration or the police, in cities, the GRUME (Child Group of the Judicial Police) and in rural areas the EMUME (Women's and Children's Group of the Civil Guard)

Detection/ Diagnosis

The detection – diagnosis of child abuse consists of recognising or identifying a situation of possible child abuse.

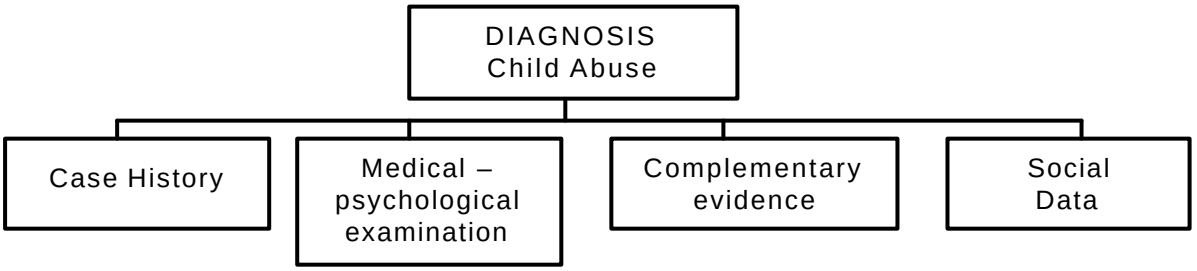
Detection - diagnosis.

- this is the first condition to be able to intervene in cases of child abuse and to thus give help to the family and the child that are suffering this problem. It is obvious that if we do not detect abuse situations, we will not be able to act on the causes that gave rise to this situation and protect the child.
- this should occur as early as possible in order to avoid serious consequences for the child and to increase the chances of success in the intervention, treat the after-effects, prevent the recurrence, etc.

Detection of a case of child abuse should be based on four elements (Table 7):

- *Case History*- data provided by the child him or herself, other professionals (teacher, doctor, police, social worker,..) and/or other people (neighbours, friends, relatives,....).
- *Psychological – medical examination*: the existence of physical and behavioural clues in the child and the behaviour of the aggressor / companion
- *Complementary evidence*: the completion of medical tests (X-rays, analysis,..), psychological tests (tests, interviews..), .. in order to confirm or to carry out differential diagnosis with other processes.
- *Social data*: risk factors which are present and which act as facilitators of the existence of child abuse, which will help us to understand why this situation occurred and guide us in decision-making and intervention.

Table 7. Detection- diagnosis of abuse



It is very important that professionals have sufficient knowledge about signs, symptoms, complementary evidence, etc., which are necessary to suspect and establish this diagnosis as well as the indicators which are present in this problem.

Indicators include that information derived from the case history, the medical-psychological examinations and the social history which point to the possible existence of abuse.

The aforementioned indicators are presented below:

- physical and behavioural indicators in the child and in the behaviour of the aggressor / companion which could be present in different forms of child abuse: physical, negligence, emotional and sexual abuse.
- according to professions / areas of child care: indicators have been selected which are easily detectable from different professional and child care fields without resorting to those which refer to schooling and health aspects, etc., which are included in the corresponding sections.

Physical and behavioural indicators in the child and in the aggressor / companion.

	Physical in the child	Behavioural in the child	Behaviour of the carer
PHYSICAL ABUSE	*Bruises or contusions*: on the face, lips or mouth; in different stages of healing; in large areas of the torso, back, buttocks or thighs; abnormally grouped or with the mark of the object that caused it ; in a variety of different areas indicating that the child has been hit from different directions. *Burns*: of cigars or cigarettes; burns which cover the whole surface of the hands (glove) or the feet (sock) or round burns on the buttocks, genitals, which indicate immersion in a hot liquid: burns on arms, legs, neck or torso caused by being tightly tied up with string, burns with objects which leave a clearly defined mark: grill, iron, etc. *Fractures*: of the skull, nose or jaw: spiral fractures in long bones (arms or legs); in diverse stages of healing; multiple fractures; any fracture in a child younger than two. *Wounds or scratches*: on the mouth, the lips, gums and eyes: on the external genitals; on the back of arms, legs or torso. *Abdominal injuries*: swelling of the abdomen, localised pain, constant vomiting. *Human bite*: the mark of an adult with a separation wider than 3 cms. between canines. *Intoxication*: from the swallowing of chemical substances (medicine)	Show caution with respect to physical contact with adults Is apprehensive when other children cry. Shows extreme behaviour: aggressiveness, or extreme rejection. Seems to be afraid of his/her parents, of going home, or crying when classes finish or he/she has to go to school or nursery. He/she says that his/her father/mother have hurt him/her. Over-dressed and refuses to get undressed in front of others. She/he is withdrawn and does not participate in activities and communal games.	He/she was subjected to abuse in childhood. Uses severe discipline which is inappropriate for the age and condition of the child or the misdeed committed. He/she gives no explanation for the injury of the child or the explanation is illogical, unconvincing or contradictory. He/she does not seem concerned about the child. He/she perceives the child in a significantly negative way, for example he/she is seen as bad, perverse, a monster, etc. Psychotic or psychopath Abuse of alcohol or other drugs. He/she tries to hide the injury or protect the identity of the person responsible for it
	Münchausen's Syndrome by Proxy: recurring symptoms, invented, inexplicable, they disappear when the child separates from his family and reappear again with contact, disagreement between the case history, the clinic and the analysis.	Numerous admissions in different hospitals Brothers and sisters with strange, inexplicable or 'never seen' illnesses	*Mothers:* · They frequently visit the child, · They worship the child or show overprotection · They have studied as doctors, nurses, clinical assistants… · Kind, attentive, ... · · They collaborate with doctors to find the false diagnosis *Family:* Violent conflicts within the couple, a tendency towards drugs and self-medication *Parents*: a history of autolysis
	– Delay in the search for medical help – Children who are generally babies or younger then 3 – Unacceptable, conflicting or contradictory history – Bruises in different stages of development. Other associated injuries. – Medical assistance by rotating between health centres. – Signs of deficient hygiene, malnutrition, localization of injuries in hidden areas – Psychomotor deficiency, behavioural disorders. Average weight-height retardation.		

	Physical in the child	Behavioural in the child	Behaviour of the carer
NEGLIGENCE – ABANDONMENT	· Lack of hygiene · Growth retardation · Recurring or persistent slight infections · Frequent visits to emergency services due to a lack of medical treatment · Unexplained bruising · Frequent accidents due to a lack of supervision in dangerous places · Noticeable chronic illness which is not cause for a visit to the doctor · Inadequate clothing for climatic conditions ·Meals and/or habits at unsuitable times · Maturity retardation · Learning problems at school	· Self gratifying behaviour · Drowsiness, apathy, depression · Hyperactivity, aggressiveness · A tendency to fantasise · School absenteeism · Usually falls asleep in class · Arrives at school very early and leaves very late · He/she says there is no-one to care for him/her · Behaviour aimed at attracting the attention of an adult. · Antisocial behaviour (e.g. vandalism, prostitution, drug addiction)	· Chaotic home life · Shows evidence of apathy and uselessness · Mentally ill or has a low intellectual level · Has a chronic illness · Was subjected to negligence in childhood
EMOTIONAL ABUSE	· 0-2 years: Short stature, non-organic growth retardation, psychosomatic illnesses, retardation in all or some areas of maturity. · 2 to 6 years: Short stature, psychosomatic illnesses, language retardation, a reduction in concentration capacity, socio emotional immaturity. · 6 to 16 years: Short stature, psychosomatic illnesses	· 0-2 years: excessive anxiety or rejection in psycho affective relationships (primary tie disorders); easily frightened, shy, passive, negative or aggressive behaviour, an absence of response to social stimulation · 2- 6 years: language retardation, a reduction in concentration capacity, socio emotional immaturity, hyperactivity, aggressiveness, lacking in discrimination and passivity in social relationships · 6 - 16 years: learning reading/writing problems, lack of self-esteem, lacking in capacity and skill in conflictive circumstances, socio emotional immaturity, few social relationships, compulsive behaviour and/or self-inflicted injury, serious sphincter problems	· Blames or despises the child · Is cold or indifferent · Refuses love · Treats brothers and sisters unequally · Does not seem concerned about the problems of the child · Makes demands on the child beyond his/her physical, intellectual, psychic capacities · Completely tolerates all the child's patterns of behaviour without setting limits
SEXUAL ABUSE	· Difficulty in walking and sitting down · Torn, stained or bloody underwear. · Complains of pain or itching in the genital area · Contusions or blood in the external genitals, vaginal or anal area · Has a sexually transmitted disease · The cervix or the vulva are swollen or red · Has semen in his/her mouth, in the genitals or on clothing · Presence of strange objects in the urethra, bladder, vagina or anus · Pregnancy (especially at the onset of adolescence) · Repeated urinary infections	▪ Behavioural · Says that he/she has been sexually abused by a parent/carer · Shows unusual, strange, sophisticated sexual behaviour or knowledge ▪ Psychosomatic: · Sleep and eating disorders · Diverse: abdominal algia, headaches, neurological, respiratory, sphincter disorders, etc., which cause intense medical treatment without finding the cause ▪ Psychic: · Chronic depression, attempts self-inflict injury, self-mutilation · Bodily under valuation: obesity, anorexia · Behaviour problems: running away, scholarly and professional failure · Sexual promiscuity, transvestism, development towards homosexuality, masculine or feminine prostitution · Criminality (frequently in the form of sexual abuse). Violence	· Extremely protective or jealous of the child · Encourages the child to get involved in sexual acts or prostitution in the presence of the carer · Suffered sexual abuse in childhood · Has marital difficulties · Drug or alcohol abuse · Is frequently absent from home

Source: Le Boeuf, CM (ed.). The role of the educator in the prevention and treatment of child abuse and neglect. Community Council on Child Abuse & Neglect. 1982:8 (modified)

- Indicators according to professions/ areas of infant care

Professional	Indicators
Obstetrics Matron (risk)	Pregnancy exposed initially to voluntary termination The possibility of giving the child up for adoption 1st visit to the doctor > 20 week of gestation Less than 5 medical visits during the pregnancy Young couples with characteristics of immaturity Poor self-esteem, social isolation or depression Numerous family crises Unwanted child or little contact with parents Mental illness in parents, drug addiction
Neonatology Matron (risk)	Mother is not happy with the child Deception due to the sex Crying by the child uncontrolled by the mother Expectations of the mother above the possibilities of the child Mother ignores the demands of the child to be fed Mother feels repulsion towards faeces Lack of excitement in naming the child Negative reaction of the father towards the child
Surgery (Primary care, nursing)	Failure to attend doctor's appointments Insistence on hospital admittance Unjustified inadequacy of the diet Inadequacy of clothing to weather conditions Disregard for vaccination calendar, treatments Inexplicable growth / maturation retardation Family deceit as regards health, social issues, .. Recurrence of accidents The accounts of the child him/herself Fearful attitude towards his/her parents
Hospital	Families that unjustifiably abandon the child, more concerned about the television, social relations..., than about caring for the child Visits by parents of short duration Reluctance to talk to doctors Non-submission of written data about other admittances Negligent, aggressive methods of correction in public Comments by the child on the behaviour of his/her parents Child adapts too soon or too easily to hospital Expresses a desire to not return home
Emergencies	Delay in going to the medical centre Urgency in medical attention for minimal accidents Injuries which are incoherent with the mechanism explained Worsening of untreated chronic illnesses Accidents caused by family negligence Difficulty in taking off the child's underwear Going to different hospitals Inexplicable behavioural manifestations Attitude of self-aggressiveness or self-stimulation Difficulties in socialization in the presence of the family
Mental health	*Development disorders*: learning, speech, emotional, mental retardation, school failure... *Psychosomatic and functional:* headaches, enuresis, encopresis, sleep disorders, anorexia, bulimia,.. *Behavioural*: compulsive masturbation, inappropriate sexual games for his/her age, isolation, withdrawal, aggressiveness, running away from home, antisocial behaviour, hyperactivity,... *Psychiatric*: self-mutilation, autolysis, psychosis *Neurotic*: obsessive structures, phobias, depression, anxiety, regression,...

School Indicators in the child	Recurrent Physical Signs (bruises, burns,...) Dirty, foul-smelling, unsuitable clothing Significant change in school behaviour without any apparent cause Explicit sexual behaviour, games and sexual knowledge inappropriate for the age, compulsive masturbation or in public Frequent manifestations of unspecified pain without apparent cause Frequently misses class without reason Retardation in physical, emotional and intellectual development Antisocial and runaway behaviour, vandalism, pilfering,... Regressive infantile behaviour for the age,..)
Indicators in the parents	They are not concerned about the child, they do not attend meetings They despise and devalue the child in public They do not allow the child to have social contact (social isolation) They are always away from home (they never have time for...) They compensate for the scarce personal / affective relationship that they have with their children with material goods They are jealous and over-protect the child
General Social Services	Negligent appearance in hygiene and clothing. Precarious/Overcrowded housing Low and unstable income. Regular consumption of alcohol / drugs. Conflictive conjugal relationships. The existence of psychiatric symptoms. The absence of functional support (family, friends, neighbours, etc.) Difficulties in access to resources (educational, health, etc.) Manifestation of relationship problems with the child (he/she is hyperactive, introverted, provocative, etc.) Manifestation of control problems over the child (he/she does what he/she wants, he/she is naughty, disobedient, etc.) Absence of supervision over the child's activities (lack of knowledge of what he/she is doing, where he/she goes, if he/she goes to class, who his/her peer group is, etc.) Use of the child as habitual help at work and in housework (caring for brothers and sisters, etc.) Child manifests difficulties in relating to peers; complains of marginalisation by friends. Parents create difficulties to prevent contact between professionals and the child.
Police	*Related to a lack of careful supervision and/or control on the part of adults* • Wandering around alone or with other children in school hours or out of school hours, especially at night. • Use of clothing unsuitable for the climatic conditions or little hygiene • Alcoholic poisoning and consumption of alcohol or drugs. • Running away from home. • Labour abuse and exploitation or begging. *Related to the presence of abusive activities.* • Prostitution / child pornography, possession or exhibition of pornography to children. • The use of children in public shows which are of an exhibitionist/pornographic nature. • Manifestations of sexual abuse: Torn clothing, stained or bloody. • Use of vocabulary and sexual behaviour unsuitable for the age. • Compulsive masturbation in public. *Related to the presence of rebellious acts and/or antisocial behaviour.* • Aggressive and violent behaviour in the classroom against teachers and pupils. • Acts of vandalism, racism or xenophobia. *Mainly related to the family or carers.* 1. Related to the explanation and/or perception of the problem and the child. Manifestations on abuse, sexual abuse or negligence. 2. Related to the vital circumstances of the family. Unusual behavioural changes, (aggressive behaviour, school failure, sadness, unsuitable sexual behaviour, fear).

The diagnosis of abuse in a child can require medical examination which in the case of child abuse should be especially careful as:

- it can cause reliving the trauma
- it should avoid unnecessary re-examination
- it should include the participation of a forensic doctor in cases of genital and anal examination in sexual abuse.

Notification

The notification of the case is the transmission of the information which refers to the allegedly abused child and the informant him/herself. What is asked of the professional is that he/she detects "reasonable signs to suspect" and reports them.

The Social Services should **always** be notified and other institutions depending on the cases.

The notification is:

- A necessary condition in order to be able to facilitate intervention in cases of child abuse
- A legal and professional obligation

Not only should the most serious and obvious cases be notified, but there is also a legal obligation to report those which are apparently child and risk situations.

Nevertheless, we must be strict since if numerous erroneous cases are reported, the services become saturated, efficiency is lost, institutions lose credibility and irreparable damage can be done to the children and their families.

The following institutions should be notified:

- *General social services (municipal)* directly or through the social services within the work area in which the professional who carried out the diagnosis/detection works.
- *Services with responsibilities in child protection* in those cases which require urgent measures: Social Services with responsibility in child protection in Autonomous Regions.
- *Duty Magistrate* in cases regulated by the Law in which communication is required through an injury report or in those circumstances in which it is not possible to contact the social services with responsibilities in protection matters in the Autonomous Region.

The notification should include:

- information on the child
- information on the informant
- information on the case

Treatment / Intervention

Procedure in cases of child abuse, regardless of the level at which it takes place, should fulfil minimum requirements. It should:

- act on the problem as a whole, on all the previously available, influential and modifying circumstances in its presentation, intensity and development of the abuse. It cannot be isolated and only the symptom be treated.
- consider the person as a whole, as a bio-psycho-social combination and his/her family environment. It should not be limited to the child, but to the child, his/her family and the medium.
- be carried out by a team of professional with specific training in family problems and in childhood, with knowledge of resources and strategies appropriate to these situations (a specialised team, not a group of specialists).
- involve coordinated work, in a team with scientific bases, and not from good intentions.

Procedure in cases of child abuse involves the following fields:

Health	• Detection of children at risk and/or child abuse • Treatment of injuries and diagnostic verification of the aetiology • Notification of social services
Education	• Evaluation with an educational team / management and notification of social services and/or • Coordinated work with social services • Monitoring of the child/family
Police	• Detection • Coordinated work with social services • Communication to the Judge and/or Protection services.
Social Services	• Detection • Social intervention and where appropriate the child protection service. • Immediate and urgent attention

Care of an abused child has special characteristics and should:

- attend to injuries (health care, diagnostic verification, validation of declarations) be accompanied by emotional support and psychological treatment. Clinical care of injuries does not differ from that of similar injuries from other causes, therefore as far as purely medical-surgical treatment is concerned there are no differences.
- consider the treatment of the crisis (injuries, associated health problems, possible after-effects, repetition of the abuse) and after the crisis (short and long-term effects)
- emotional support
- Multi professional team (intervention of the social services, mental health, …)
- coordination
- carry out subsequent monitoring of the child and his/her family
- prevention

*Validation (*diagnostic verification) should determine the validity of the notification by evaluating:

- the truth of the accusation/notification
- the seriousness of the harm inflicted on the child
- the risk of abuse or harm and its severity, and,
- the causes (aetiology) which brought about the abuse situation (existing risk factors),
- the degree to which basic needs are covered and the family and social resources surrounding the child.

Emotional support is essential in child abuse since the consequences and psychological-emotional after-effects will always be present in this problem in the short, medium and long-term.

Child abuse is a multi factorial problem with numerous repercussions which affect the child and his/her family which require treatment by a multi professional team.

A request for intervention by the social services can be:

- to request information for diagnostic confirmation
- to facilitate support, help
- to take the necessary child protection measures
- to obtain knowledge as regards social work

This phase should include a protocol of work / investigation of the social services in accordance with the role and the tools proper to this profession.

Coordination is a key word in cases of child abuse which result in the carrying out of joint health and social work which are essential for the detection, diagnosis and treatment of cases of child abuse. Each professional area is responsible for the activities relevant to their area.

There should be subsequent monitoring of the child and his/her family which is not limited to the treatment of the crisis.

Prevention is the common effort of society as a whole, not only of the professionals and institutions involved.

To sum up, we should remember the importance of:

MOTIVATION	Sensitisation is fundamental in the intervention of child abuse by avoiding false beliefs
OBLIGATION	Apart from a moral-deontological obligation, there is also a legal duty to report/intervene in cases of risk (suspicion) and obvious child abuse
MONITORING	Intervention requires action according to the different risk factors which exist and throughout time
COORDINATION	The different bodies and professionals that treat the child and the family should act jointly and in a coordinated way.
GOOD TREATMENT	The concept of child abuse should be considered from the premise of what **good treatment** is or should be and from the procedural principles ranging from the **help** that should be given via social services as those responsible in the field of child protection, in order to act on the risk factors that facilitated the occurrence of the abuse.

IV. DOCUMENTATION

DOCUMENTATION

Protocol on detection and notification of child abuse

Documentation related to child abuse sent to the Working Group

Autonomous Region	Document
Andalusia	1. Instrucciones sobre prevención y atención por los Centros Docentes en caso de maltrato a menores. 1997 2. La atención a la infancia en Andalucía. Dirección General de Atención al niño. (Directorate General of child care) 1993 3. Jiménez J, Moreno MC, Oliva A, Palacios J, Saldana D. El maltrato infantil en Andalucía. Consejería de Trabajo y Asuntos Sociales. (Department of Work and Social Affairs) 1995 4. Sánchez EM, Cañas M, Muriel R, Ponce JA, Valdecantos R (dir).Guía de atención al maltrato infantil. Sevilla: ADIMA, 1993
Aragón	5. Guía sobre maltrato infantil. Diputación General de Aragón. (County Council of Aragón) 6. Programa de intervención familiar. Documento de trabajo. Dirección General de Bienestar Social. (Directorate General of Social Welfare) 7. Casión JM, Mur MJ, Gómez JD, Lahoz J et al. Detección del maltrato infantil. Análisis de la realidad y propuestas de actuación del Programa de Prevención y Detección de Situaciones de desprotección y maltrato infantil en Aragón. 2001 8. El maltrato a menores en la ciudad de Zaragoza. Diputación General de Aragón–Equipo de Investigación Sociológica EDIS. 1992 (County council of Aragón – Sociological Reseach Team)
Asturias	
Balearic Islands	9. Carrión A, Mercadal A, Michelena A. Maltractament infantil. Guia per mestres. 10. Michelena A, Cerezo MA. Maltrato infantil en las Islas Baleares: Fomento de su detección y mejora de la intervención desde el servicio de menores. Govern Balear. 1998 11. Programa experimental de prevenció del maltractament infantil des de l'ámbit escolar. Memoria curs 98/99. Govern de les Isles Balears. 2000
Canary Islands	12. Hoja de comunicación de posible situación de desamparo. 13. Hoja de denuncia de posible situación de desamparo. 14. Grande J (de). Protocolo de facilitación de la detección de los malos tratos a mujeres y menores. Servicio Canario de Salud. 1999 (Canarian Health Service)
Cantabria	15. García M, Lozano MJ (dir). Malos tratos en la infancia. Instituto Nacional de la Salud. Cantabria. 1990 16. Plan de coordinación para la asistencia inmediata a víctimas de agresiones sexuales. CAVAS. 2000
Castilla La Mancha	
Castilla y León	17. Modelos de Hoja de notificación y de Informe sobre situaciones detectadas de desprotección infantil 18. Consejería de Sanidad y Servicios Sociales. (Department of Health and Social Services) Detección y notificación ante situaciones de desamparo y de riesgo en la infancia. Junta de Castilla y León. 19. Consejería de Sanidad y Servicios Sociales. (Department of Health and Social Services) Investigación y evaluación ante situaciones de desamparo infantil. Junta de Castilla y León. 20. Verdugo MA, Gutiérrez B, Fuertes J, Elices JA. Maltrato y minusvalía. Ministerio de Asuntos Sociales. (Ministry of Social Affairs) 1993.
Catalonia	21. Alonso JM, Creus E, Domingo F, *et al*. El llibre d´en pau. Guia per a làbordatge del maltractament en la infància per als professionals de la salut. Generalitat Catalunya. 1996 22. Martínez Roig A. Detecció, intervenció y derivació de maltractaments infantils pels profesionals de la sanitat. Generalitat de Catalunya. 1991 23. Ingles A (dir). Els maltractaments infantils a Catalunya. Estudi actual y balance de la seva situació actual. 1991 24. Ingles A (dir). Els maltractaments infantils a Catalunya. Quants, Com, Per qué. Centre d´Estudis Juridics. Generalitat de Catalunya. 2000

Autonomous Region	Document
Extremadura	25. Hoja de notificación de la Dirección General de Infancia y Familia de la Consejería de Bienestar Social 26. Hoja de notificación del Programa Experimental para la mejora del tratamiento en los casos de riesgo de maltrato infantil 27. Ficha de Detección utilizada de los Programas de Educación por los profesionales de Educación Familiar y Apoyo a Familias Desfavorecidas y en situación de Riesgo Social. 28. Ficha de Recepción de Llamadas del Teléfono al Menor 29. Merideño F (dir). Guía de detección y notificación del maltrato infantil. Consejería de Bienestar Social. 1998 (Department of Social Welfare)
Galicia	30. Guía para a detección do maltrato infantil. Xunta de Galicia. 1999 31. Guía para a detección de situacóns de maltrato infantil. Xunta de Galicia. 1997 32. A infancia: problemas e solucións. Relatorios das xornadas. Xunta de Galicia. 2000
La Rioja	33. Escalona MJ, Navas E, Vallés P, Vallespi O. La infancia ignorada. Una aproximación a la desigualdad social en Logroño desde la perspectiva de la educación social. Instituto de Estudios Riojanos. Gobierno de La Rioja. 1995
Madrid	34. Abad D, Albeniz C, Alzu V, Casado J *et al*. Guía para la atención del maltrato a la infancia por los profesionales de la salud. Consejería de Salud. (Health Department) 1993 35. Casas F, González M, Calafat C, Fornells M. Riesgo y protección en la población infantil: factores sociales influyentes según los profesionales de la Comunidad de Madrid. Consejería de Servicios Sociales. (Social Services Department) 2000 36. Díaz Aguado MJ, Martínez R (dir). Infancia en situación de riesgo social. Un instrumento para la detección a través de la escuela. Madrid: Consejería de Educación. (Education Department) 1996 37. Díaz Aguado MJ, Martínez R (dir). La. educación infantil y el riesgo social . Su evolución y tratamiento. Madrid: Consejería de Educación. (Education Department) 2001 38. Díaz Huertas JA, Casado Flores J, García García E, Ruiz Díaz MA, Esteban Gómez J (dir). Atención al abuso sexual infantil. Madrid: Consejería de Servicios Sociales. (Social Services Department) 2000 39. Díaz Huertas JA, Casado Flores J, García García E, Ruiz Díaz MA, Esteban Gómez J (dir). Atención al maltrato infantil desde salud mental. Madrid: Consejería de Servicios Sociales. (Social Services Department) 2000 40. Díaz Huertas JA, Casado Flores J, García García E, Ruiz Díaz MA, Esteban Gómez J (dir). Atención a la embarazada de riesgo social y prevención del maltrato infantil. Madrid: Consejería de Servicios Sociales. (Social Services Department) 1999 41. Díaz Huertas JA, Casado Flores J, García García E, Ruiz Díaz MA, Esteban Gómez J (dir). Atención al maltrato infantil desde el ámbito sanitario. Madrid: Consejería de Sanidad y Servicios Sociales. (Health and Social Services department) 1998 42. Díaz Huertas JA, Casado Flores J, García E, Ruiz MA, Esteban J (dir). Atención al niño de riesgo biopsicosocial desde el ámbito sanitario. Consejería de Servicios Sociales. (Social Services Department) 1999 43. Instituto Madrileño del Menor y la Familia. Programa para la detección del riesgo social en neonatología. Madrid: Consejería de Sanidad y Servicios Sociales. (Health and Social Services Department) 1998 44. Lobo E, Duce R, García E, Martínez MR, Varona B. Guía para la escuela. La protección de los niños y niñas en situación de riesgo social. Consejería de Educación. (Education Department) 1989. 45. Oñorbe M, García M, Díaz Huertas JA (dir). Maltrato infantil: prevención, diagnostico e intervención desde el ámbito sanitario. Madrid: Consejería de Salud (Health Department) 1995 46. Procedimiento de colaboración para la atención social de menores. Instituto Madrileño del Menor y la Familia - Ayuntamiento de Madrid. 1998 47. Simón C, López JL, Linaza JL. La población infantil en situación de desamparo en la Comunidad de Madrid. Consejería de Servicios Sociales. 1998 48. Hoja de notificación de riesgo y maltrato infantil desde el ámbito sanitario 49. Hoja de notificación de riesgo social en la embarazada y el recién nacido 50. Hoja notificación escuela (E 10)

Autonomous Region	Document
Murcia	51. Parra JA, García J, Mompeán P (dir). Maltrato infantil. Protocolos de actuación. Consejería de Trabajo y Política Social. (Department of work and social policy) Murcia. 2000
Navarra	
Region of Valencia	52. El papel del ámbito educativo en la detección y abordaje de desprotección infantil y/o maltrato infantil (Advanced draft) 53. El papel del ámbito sanitario en la detección y abordaje de desprotección infantil y/o maltrato infantil. (Advanced draft) 54. El papel del ámbito policial en la detección y abordaje de desprotección infantil y/o maltrato infantil. (Advanced draft)
Basque Region	55. Paúl J (dir) Maltrato y abandono infantil. Identificación de factores de riesgo. Servicio Central de Publicaciones del Gobierno Vasco.(Basque Government Central Publications Service) 1988 56. Arruabarrena MI, Paúl J. El papel del personal de guarderías en el abordaje del problema del maltrato y abandono en la infancia. Servicio Central de Publicaciones del Gobierno Vasco. .(Basque Government Central Publications Service) 1988. 57. Martínez A, Arruabarrena MI, Paúl J. El papel del personal sanitario en el abordaje del problema del maltrato y abandono en la infancia. Servicio Central de Publicaciones del Gobierno Vasco. .(Basque Government Central Publications Service) 1988. 58. Arruabarrena MI, Paúl J. El papel del trabajador social en el abordaje del problema del maltrato y abandono en la infancia. Servicio Central de Publicaciones del Gobierno Vasco. .(Basque Government Central Publications Service) 1988. 59. Arruabarrena MI, Paúl J. El papel del Agente de Policía en el abordaje del problema del maltrato y abandono en la infancia. Servicio Central de Publicaciones del Gobierno Vasco. .(Basque Government Central Publications Service) 1988 60. Redondo E (dir). I Jornadas sobre Infancia Maltratada: Maltrato institucional. Diputación Foral de Álava. 1994 61. Los abusos sexuales a menores. Diputación Foral de Álava. 1994 62. EMAIKER. Menores en situación de riesgo en Álava. Diputación Foral de Álava. 1995 63. Aisa E, Fuente A, Garate J, García T *et al*. Maltrato y desprotección en la infancia y adolescencia. Diputación Foral de Vizcaya. Gobierno Vasco –. 2000. 64. Plan de Infancia para la atención de las situaciones de desprotección infantil. 2000 65. Protocolo de intervención policial ante situación de maltrato infantil. Diputación Foral de Álava.

Institution	Document
Ministry of Health and Consumer Affairs	66. Jornadas ante el maltrato a la infancia. Ministerio de Sanidad y Consumo. (Ministry of Health and Consumer Affairs) 1990 67. Sánchez Moro C (dir). Aproximación a un análisis cualitativo de los malos trato a la infancia. Equipo de Investigación EDIS (Research Team).1988 68. Consejo interterritorial. Protocolo de actuación sanitaria ante los malos tratos domésticos. Ministerio de Sanidad y Consumo. (Ministry of Health and Consumer Affairs) 1999
Ministry of Justice	69. Memoria de la Fiscalía General del Estado Año 2000 pags. 305-323 70. Centro de Estudios Jurídicos de la Administración de Justicia Estudios sobre violencia familiar y agresiones sexuales. 1999 Tomo I. Violencia física y psíquica en el ámbito familiar. Apuntes para una reforma. La violencia en el ámbito familiar: aspectos jurídicos y médico-periciales Tomo II. Delitos contra la libertad sexual. Aspectos jurídicos y médico legales. Proyectos de reforma legislativa. Tomo III. Características psicopatológicas del agresor y la víctima en los supuestos de violencia familiar. Protección de las víctimas de los delitos violentos y contra la libertad sexual
Ministry of the Interior	71. División de Formación y Perfeccionamiento. Curso de tratamiento policial de menores. Dirección General de la Policía. (Directorate General of the Police)

Institution	Document
Ministry of Work and Social Affairs	
Department of Women's Affairs	72. Violencia contra las mujeres. 1995
Directorate General of child and family social action programmes	73. Gracia E, Musitu G. Programa de formación para profesionales del ámbito social en materia de malos tratos a la infancia. Ministerio de Trabajo y Asuntos Sociales. (Ministry of Work and Social Affairs) 1999 74. Arruabarrena MI, Paúl J, Torres B. El maltrato infantil. Detección, notificación, investigación y evaluación. 1994 75. López F, Torres B, Fuertes J, Sánchez JM. Actuaciones frente a los malos tratos y desamparo de menores: Ministerio de Trabajo y Asuntos Sociales. (Ministry of Work and Social Affairs)1994 76. Documento sobre la violencia en el ámbito familiar. Conclusiones del Grupo de Trabajo Work material 77. (53) Programa experimental para la prevención, detección e intervención en situaciones de riesgo de maltrato no grave. Región de Murcia. 2000 78. (54) Maltrato infantil en las Islas Baleares: fomento de su detección y mejora de la intervención desde el Servicio de Menores 1995-1997 79. (55) Programa experimental de atención y tratamiento a familias con problemas de maltrato infantil. Principado de Asturias. 2000 80. (56) Experiencias de investigación de malos tratos a la infancia. Memoria del Programa experimental sobre Abuso sexual infantil. Generalitat Valenciana. 2000 81. (59) Los malos tratos en el ámbito familiar valorados por los servicios sociales comunitarios. Explotación especifica del Sistema de Información de Usuarios de Servicios Sociales en Asturias y Murcia. 2000 82. (67) Programa de integración familiar. Comunidad Autónoma de Galicia. 2001 83. (70) Leyes de Protección a la infancia de las Comunidades Autónomas. 2001 84. Observatorio de la Infancia (Childhood Observatory) 85. Catalogo de Estudios e Investigaciones 86. Estudio Delphi para la elaboración de una Hoja de Notificación de casos de maltrato infantil. Madrid: Centro Universitario de Salud Pública. 2000
Senate	87. Informe de la Ponencia para el estudio de la Problemática de los hechos y comportamientos violentos relacionados con los menores de edad, constituida en el seno de la Comisión de Interior y Función Pública. 1998 88. Informe de la Ponencia constituida en el seno de la Comisión de Relaciones con el Defensor del Pueblo y de los Derechos Humanos sobre la Problemática del Menor en España. Boletín Oficial de la Cortes Generales Senado 3 de mayo de 1989 Pág. 11953-11975 89. Informe del Defensor del Pueblo sobre Violencia escolar. Defensor del Pueblo. 1999
Reina Sofía Centre for the study of violence. Valencia	90. Sanmartín J. Violencia contra niños. Ariel. 1999 91. Maltrato infantil en la familia. Comunidad Valenciana (1997-1998). 92. Raine A, Sanmartín J. Violencia y psicopatía. Ariel. 2000 93. Materiales sobre violencia en la escuela.
Federation of Associations for the prevention of child abuse (FAPMI)	94. El maltrato infantil: guía para maestros. Asociación Murciana de apoyo a la infancia maltratada. 1996 95. I Congreso Estatal sobre Infancia Maltratada. Barcelona. 1989 96. II Congreso Estatal sobre Infancia Maltratada. Vitoria. 1991 97. III Congreso Estatal sobre Infancia Maltratada. Madrid. 1993 98. IV Congreso Estatal sobre Infancia Maltratada. Sevilla. 1995 99. V Congreso Estatal sobre Infancia Maltratada. Valencia. 1999

Institution	Document
International Society for Prevention Child Abuse and Neglect (ISPCAN)	100. IV European Congress on Child Abuse and Neglect. Padua, Italia.1993 101. VI European Congress on Child Abuse and Neglect. Barcelona, España 1997 102. VIII European Congress on Child Abuse and Neglect. Jerusalén, Israel. 1999 103. Daro D, Downs B, Keeton K, McCurdy K *et al*. World perspectives on child abuse: An international resource book. National Committe on Child Abuse Prevention Research. ISPCAN. 1992 104. Bross DC, Miyoshi TJ, Miyoshi P, Krugman RD. World perspectives on child abuse: The fourth international resource book. ISPCAN. 2000
Save the children	105. Horno P. Educa. No pegues. Materiales didácticos. 1999 106. Molino M. El menor como víctima en el proceso judicial. 107. Nyman A, Svensson B. Chicos. Abuso sexual y tratamiento. Ministerio de Trabajo y Asuntos Sociales. 2000 108. Holman K. Tratamiento de jóvenes agresores sexuales. 2001 109. Holman K. Abuso sexual infantil. Programas de prevención. ¿Cuál es el efecto del trabajo en prevención. 2001
Plataforma Asociaciones Infancia (Platform of Childhood Associations) (POI)	110. Martínez M. El niño en Europa. Representaciones sociales de los adolescentes madrileños sobre la violencia. 2000
Organización Mundial de la Salud (O.M.S.) World Health Organisation	111. WHO Regional Office for Europe. Report of the Consultation on Child Abuse Prevention WHO/HSC/PVI/99.1 Ginebra, Suiza 1999 112. WHO. First Meeting on Strategies for Chid Protection EUR/ICP/FMLY/ 01.03.01 Padua, Italia 1998 113. Child Health and Development, Division of Family Health, Injury Prevention Programme, Division of Emergency and Humanitarian Action and Division of Mental Health. Protocol for the study of interpersonal physical abuse of Children. Switzerland, World Health Organization. 1994
European Parliament	114. Decisión 293/2000/CE del Parlamento Europeo y del Consejo de 24 de enero de 2000 por la que se aprueba un Programa de acción comunitario (programa Daphne) (2000-2003) sobre medidas preventivas destinadas a combatir la violencia ejercida sobre los niños, los adolescentes y las mujeres.
Various	115. Casado Flores J, Díaz Huertas JA, Martínez MC. Niños maltratados. Madrid: Díaz de Santos. 1997 116. Ochotorena J, Arruabarrena MI. Manual de protección infantil. Barcelona. Masson. 1996 117. Child Welfare League of America. Standards for abused or neglected children and their families. 1989

Analysis of the documentation

The documentation used for the execution of the present work includes that sent by different autonomous regions and institutions which have collaborated in its creation, and other documentation that was considered to be of interest.

Obviously, this is not all the bibliography that exists in our country, it includes all those documents which have been sent, or in the opinion of the working group, were of interest for the completion of the present document.

The documentation was classified according to:

1. General	Guides – manuals on procedure in cases of child abuse which include different professional areas
2. Health	Guides - manuals – specific publications for the area of health on procedure in cases of child abuse
3. Education	Guides - manuals – specific publications for the area of education on procedure in cases of child abuse
4. Social services	Guides - manuals – specific publications for the area of social services on procedure in cases of child abuse
5. Justice	Guides - manuals – specific publications for the area of law on procedure in cases of child abuse
6. Police	Guides - manuals – specific publications for the area of police on procedure in cases of child abuse
7. Epidemiological studies	Studies on risk factors and incidence – prevalence in child abuse
8. Notification forms	Models of notification forms
9. Risk factors	Studies on risk factors and child abuse.
10. Sexual abuse	Guides - manuals – specific publications on child sexual abuse
11. Mental health	Guides - manuals – specific publications on mental health and child abuse
12. Institutional abuse	Guides - manuals – specific publications on institutional abuse and child abuse
13. Telephone	Guides - manuals – specific publications on telephone help lines for abused children
14. Childhood Plan	Integral plans on infant care
15. Child abuse programme	Specific programmes to be developed / or under development on abuse

Depending on the different autonomous regions or participating institutions in this working group, an analysis of the documentation was carried out by drawing up a table which included the number which corresponds to the document according to the documentation section. An X corresponded to documents which are not included in the documentation section as they are unpublished documents or a copy is not available.

DIAGRAM (*)

	General	Health	Education	Social Services	Justice	Police	Epidemiol. studies	Notific. forms	Risk Factor	Sexual Abuse	Mental health	Institut. abuse	Tel.	Childhood Plan	Abuse Program
Andalusia	4		1				3							2	
Aragón	5						8								6,7
Asturias															79
Balearic Islands			9,11	10											78
Canary Islands		14						12,13							
Cantabria		15								16					
Castilla La Mancha															
Castilla León	18,19						20	17						X	
Catalonia		21,22					23,24								
Extremadura	29							25,26, 27					28		
Galicia	X														82
La Rioja							33								
Madrid		34,41,42,45	36,37,44	46			47	48,49,50	35,40,43	38	39			X	X
Murcia	51		94												77
Navarra															
Region of Valencia		53	52			54	91			80					
Basque Region		57	56	58		59			55						
Diput. Vizcaya	63													64	
Diput. Álava						65	62			61		60			
Ministery															
Health		66,67					68								
Justice							69			70					
Interior						71									
Education															
Work and Social	74,75,76			73	80			86							77 to 82
Reina Sofía	90		93				91			X	92				
Platform															
Save the Children			105		106					107-109					
FAPMI	95 a 99		94												
ISPCAN	100 a 102						103,104								
WHO (OMS)		111,112						113							

(*) Number corresponds to the Document according to the Documentation section. The X to unpublished documents or that a copy was not available.

V. PROPOSED NOTIFICATION FORMS AND REGISTRATION OF CASES

PROPOSED FORMS FOR NOTIFICATION AND REGISTRATION OF CASES

The unification of forms for detection, notification and registration of cases of risk and child abuse.

Procedure in cases of child abuse requires the specification of common concepts and topology, the simplification of the notification procedure by professionals and the establishment of the registration of homogeneous cases.

The aim of this project is to solve the difficulties mentioned in the previous paragraph by *increasing the sources* through which abuse is detected in order to be able to gain a *more global vision of the problem.* In order to do this, the aim is to rely on the direct collaboration of the Social Services, of the Health Services, of teachers and the police. With this aim in mind, a series of protocols are presented which are simple and easy to fill in, for each one of these institutions, which serve to alert the corresponding services to the existence of a victim of abuse. Amongst other things, this same protocol will arrive at an entity that will register the number of cases and the types of abuse that are occurring.

The aims include:

- Filling an important gap in our knowledge of the phenomenon of child abuse which at the present time is, basically, through protection reports and, therefore, only through those cases which pass through the Social Services and show a degree of seriousness.
- Not only sensitising, but also directly involving professionals from different areas of childcare in the phenomenon of abuse.
- Making notification easier, even for professionals who do not have initial information on the child protection system (in some way or other the proposed forms are 'self-directing': who the form should go to is indicated on each copy).
- Unifying in the same printed material the detection Guide or Manual along with the hardware of the notification.
- Using the *concept of abuse* and its common typology.

Early detection of risk situations and/or child abuse should be executed by any professional or person who is in touch with the child, whatever his/her field of work. Thus, health professionals, teachers, social workers, police, psychologists etc., through their accessibility to the child and his/her socio family surroundings, are able to identify situations of this type at an early stage. Detection is a fundamental point if a response to these situations is desired.

In order to do so, the following is proposed: **forms for detection and notification of risk and child abuse for the different professional areas** (health, education, police, social services) which entail communication to services with responsibilities in the matter of child protection, the **social services**. The aim is to ensure that attention is given to the cases and also that cases are registered for **epidemiological** reasons, apart from placing it on record in the **child's report/case history**.

In practice, filling out the answers should not be strict, but should be merely orientational. It will be the evaluation carried out by the professional which will influence whether the situation is reported or not. Likewise, it must be kept in mind that in each case the indicators will have a different weight, ensuring that each situation is treated as a different problem.

Registration of cases

This will be carried out by means of an accumulative registration of cases. Through this registration, professionals are obliged to declare either cases of risk and suspicion that require the use of the social services or those that specifically present possible risk and/or child abuse.

Aim

The registration of detected cases of risk and child abuse is carried out by means of a registration form that should be filled out by the professional of the health services (primary care, hospitals, mental health, municipal health services…), social (general, specialized...), educational (nurseries, schools), police (municipal, regional, civil guard, national police), …, which detect the case.

The registration form has been designed as an instrument of collection of information for the detection of cases. It is not an instrument of diagnosis, but it is a tool that permits the communication of risk cases and their suspicion in an easy, detailed and standardised fashion for all centres. The aim of the form is to incorporate the main indicators of risk and child abuse according to diverse professional areas. The aim of this is to record the most obvious indicators and to permit the reliable and swift registration of the same.

The inclusion of communicated cases into an accumulative system will allow an estimation of incidence of risk, a study of characteristics...

Methodology

Following a review of existing literature on the issue, risk indicators that were selected were those that were easily detected by different professionals. The working group on child abuse of the Childhood Observatory, together with experts, selected, drafted and came to a consensus on the most relevant indicators. These indicators were accompanied by an explanatory description.

The initial versions of the questionnaires were submitted to a group of expert judges who evaluated the relevance of the items, their drafting and their registration system and evaluation. Said contributions were incorporated into the final version of the instrument. In the validation stage, reliability values amongst judges, validity and internal consistency will be taken into account.

Material and methods

The *Registration Forms* consist of double-sided questionnaires on carbon paper for three copies. They comprise four parts. Three on the front side and one on the back of the form (see figure 1).

The front side comprises:

1. A closed list of symptoms from which the following can be selected: their presence in the child, their seriousness and if it concerns a suspicion or a confirmation of abuse.
2. A table in which other symptoms or comments can be written which are not covered in the closed questionnaire. This is an open question.
3. An detection table in which detection information on the mother, child and notifier can be written down.

The back side comprises:

4. A series of explanatory descriptions of those indicators or symptoms that are not clear from their drafting.

Figure 1. Sides of the notification forms.

The aim of the registration form is that it be self-contained without the need for additional external material. Nevertheless, an explanatory manual accompanies the booklet of forms.

Of the three copies:

- One is attached to the case history / dossier for the monitoring of the case,
- Another is submitted to the social services of the centre for their evaluation and intervention, and
- The third is sent to the data treatment service for the accumulative registration of cases.

The booklets / blocs which comprise the notification forms contain:

• The cover	Cardboard/ hard surface that can be written on and is not copied onto the others. This includes the detection / title.
• The back cover	The back cover includes instructions on the use of the notification forms.
• Indicators	The back section of the booklet facilitates reading of those elements that identify injuries, signs and symptoms of child abuse.
• Notification forms (carbon paper)	Each notification form comprises three sheets to be sent to the case registration service, social services and for their inclusion in the report / case history.

Reference population

The reference population is all children, minors aged between 0 and 18, who have been attended to in centres of the public network of health care, social, educational, police and social services in their respective autonomous regions.

Bearing in mind that these sources of detection involve the main areas of child care and that the use of these services on the part of the child and his/her family is frequent, coverage reached should be high.

In the case of the registration of cases of social risk in the pregnancy and in the newborn, the reference population are all pregnant women who are treated by professionals in the public network of health care.

Bearing in mind that the population of pregnant women and newborns in situations of social risk attend these surgeries regularly, through different health programmes, coverage reached should be high.

Observations

The use of the registration form does not imply that other communication routes cease to be used if they are considered necessary.

Methodology

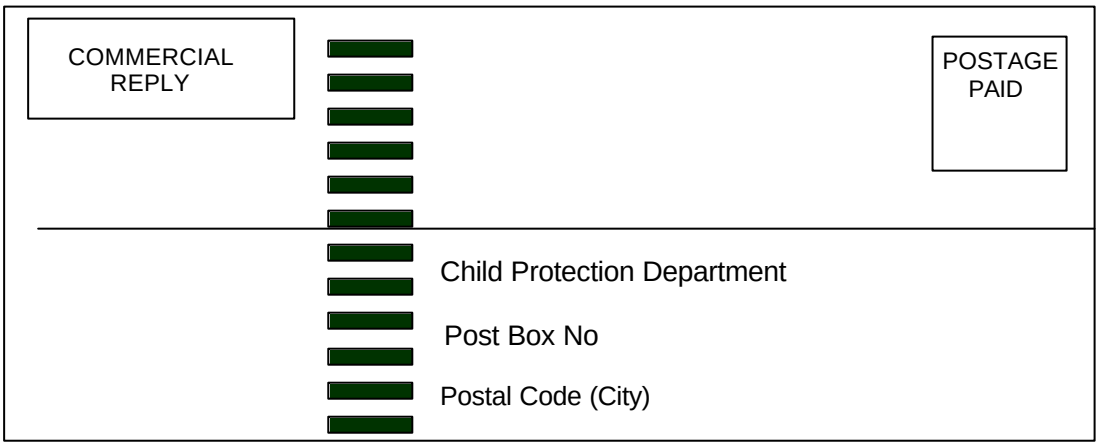
Systematic declaration by means of a carbon sheet that will record data will commence on January 1, 2002 and half-yearly reports will be made.

Collection of data

The collection of data will be carried out by a postage paid envelope.

This should be requested at the post office.

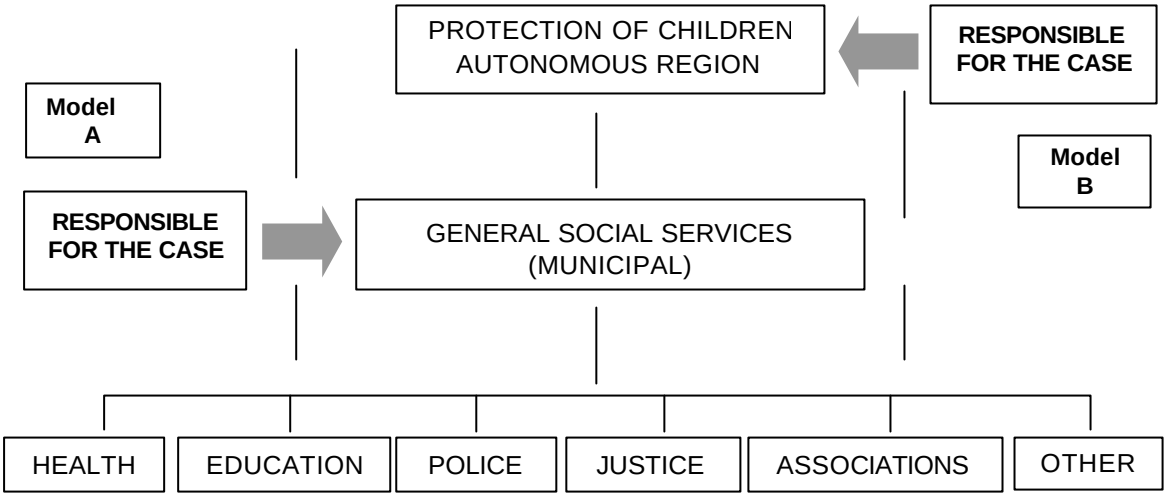
The post-office box can be used by respecting the format of the different services (health, education, police, social services...).



Considerations and system of registration of cases

There currently exist two working models for cases which are not serious that do not require immediate guardianship. These two models depend on who the cases are reported to and who assumes responsibility for them, who initiates and directs the action taken: general social services (municipal) or the child protection services of the autonomous region (Table 8).

Table 8. Intervention in cases of child abuse according to the *responsible body in the case*.



We analysed the characteristics of each option, their advantages and drawbacks and, finally, we made the proposal that seemed most appropriate to this working group.

The entity responsible for the case is that of the General Social Services (Municipal) which correspond by area

Model A

The social services of the professional area that detect the case:

- will carry out the professional interventions that they consider appropriate, and
- will always communicate the case to the General Social Services (Municipal).

The General Social Services (Municipal) when confronted with cases it is aware of:

- If they consider that there is an emergency situation they should request the adoption of urgent protection measures either from the Department or other competent bodies (Duty Magistrate's Court, Child Prosecutor,...)
- If this were not the case, the General Social Services themselves should study ("investigate") the situation to evaluate the existence of abuse and take decisions.
- If the adoption of secondary protection measures were subsequently considered necessary, the Social workers will fill out the corresponding report and make their proposals to the Department. This entity will decide on the measures to be taken by following, from this point onwards, the circuit established in model B.
- If the General Social Services themselves consider the possibility of intervention in the family, said decision will be taken by them, without any evaluation on the part of the Department, and they will intervene as long as it is considered opportune.

Advantages:

- Acknowledgement of a risk situation or abuse is much quicker and, as a consequence, intervention can take place immediately without delays caused by formal communication to the Department.
- The different services are stimulated by filling in forms and communicating situations which they consider of risk given that they have proof of the workings and the advantages of said communication because of the immediacy of its effect.
- The same forms can be used to reply to the notifying services. This, in turn, enriches and encourages not only coordination but also the notification of situations itself.
- The proximity of the institutions and the knowledge of the professionals favours coordination.
- In cases of discrepancy, or where it is considered necessary, professionals can turn to the higher level of the protection services of the autonomous region without making the issue a judicial one.

Difficulties:

- The Department, as the competent entity in the subject of child protection, will not have global knowledge of all the detected risk and abuse situations, but only those that require a report / proposal on behalf of the General Social Services. Therefore, the Department will not be able to issue valid criteria that guides and limits the interventions to be carried out, given that it will be unaware of the majority of cases that are subject to intervention.
- In the case of feeling the urgent need to take protection measure which are requested from the Department, a delay in the application of the same could occur due to the fact that, amongst other requirements, the appraisal of both entities (Department and Municipal Services) should coincide. This involves the drawing up of reports, the transferral of the case, etc.
- The weight of the decision to proceed to investigate notified situations, as well as the decision to intervene directly in the family, falls exclusively on the responsibility of the General Social Services, given that the situation is not appraised from any other level. It is doubtful that said responsibility, because of its consequences, should fall directly on the municipal social services.
- The existence of disagreement in the appraisal carried out by the subordinate services (health centre, school etc., which in turn participate in the intervention) and by the General Social Services, can in fact prevent the execution of a functional intervention as there does not exist an entity which can, from an external and hierarchically superior position, guide said intervention.
- General Social Services do not receive “legitimation” or “mandate” from the Department to “investigate” situations and/or intervene in certain families.

The entity responsible for the case is that of the Child Protection Service of the Autonomous Region (Department of Social Services) Model B

The social services of the professional area that detect the case:

- will carry out the professional interventions that they consider opportune, and
- will always report the case to the entity which is responsible for child protection in the autonomous region (Department of Social Services).

In this option, it is understood that the entity with responsibility for child protection of each autonomous region has to receive notification of all the situations of risk and abuse detected given that it is the competent entity that:

- Should know each and every one of these situations.
- Can apply protection measures in emergency cases without having to resort to another level.
- Has the authorisation to request a study of the case to the General Social Services.
- Can decide on the corresponding measures (Intervention of general services or measures of secondary protection)
- Given the case, decides on the finalisation of the measures to be taken
- Has to have its registration of situations updated for the planning of programmes and resources, studies, statistics etc.

The decision of the measures to be applied, whatever they are, will be taken by the competent body (Department of Social Services). In any case, the general social services legitimise the intervention to be undertaken.

Once the situation has been studied, a proposal can be made to the Department from the general social services. These include adopting protection measures (fostering, adoption in a family or in homes) or an intervention proposal from the general services themselves.

Advantages:

- This option comprises a process which seems logical regarding responsibilities for child protection. That is to say, that the Department should have knowledge of all the situations (not only to decide on the measures, but also for statistical knowledge of the reality of each region, planning of programmes and resources, etc.).
- On the other hand, in emergency cases, it is able to apply protection measures immediately.
- On requesting a report from the general social services, the Department ‘legitimises’ the intervention to be carried out from these services regarding ‘investigating’ the situation.

- Subsequently, the competent entity is that which decides which measures to take. If these measures involve the intervention of the General Social Services, it is still the Department that 'legitimises and moves' the intervention.

Difficulties:

- The compulsory notification of the Department can delay not only studies of the case but also, when the time comes, the intervention itself of the general social services, with the risk that this involves.
- Compulsory notification of the Department can serve as a 'brake', for different services, due to the completion of the form and an added demand for 'greater strictness'. This effect would not occur if the form were sent directly to the Social Services with which there is regular contact.
- Immediacy in attention to the case is lost, which could seem a drawback to the subordinate area services.
- The same notification form cannot be used to respond to / or to acknowledge receipt to the service that has identified the case.

Proposal of the Working Group

In the opinion of this Working Group, the first model (A) would be most logical. That is, communication to the General Social Services through the respective professionals of the different areas of infant care and that the problems are solved on each level by communicating to the Child Protection Services only those cases in which it is considered that intervention should be carried out according to the responsibilities of each Entity.

According to the system of three carbon copies (copies for the report-case history, worker/social services of the professional area and protection services of the Autonomous Region) proposed in:

- Model A: the copy directed to the services of the Autonomous Region will only be for epidemiological purposes. It has no validity as a notification of the case for intervention purposes.
- Model B: the copy directed to the services of the Autonomous Region serves a double purpose: firstly, as notification for intervention purposes and secondly, for epidemiological purposes.

Notification forms are proposed for:

- Social Services
- Health
- Education
- Police
- Detection of social risk in the expectant mother and the newborn (prevention of child abuse)

SOCIAL SERVICES:
PRIVILEGED OBSERVATORY FOR THE DETECTION OF CHILD ABUSE

The detection of an abuse situation is surrounded by numerous difficulties. Maybe the main one refers to the establishment of limits beyond which the normalised development of a child should be the object of intervention on the part of the social protection services. Nevertheless, aside from this basic difficulty, we can identify other more functional impediments in abuse detection:

- The abuse occurs in a 'private' environment. Therefore, it is not easily seen in a direct way. Detection has to be carried out through indicators.
- Physical abuse is detectable from the marks that are left on the child's body. Therefore, they are direct and visible indicators. The same thing does not occur in cases of emotional abuse and negligence (except in cases of malnutrition or chronic neglect) given that their effects are dormant.
- Attributing abuse to different cultural causes and respect for the privacy of the family, makes detection work considerably more complex.

One consequence of the difficulty and complexity of the detection of child abuse, is the need to involve all the services and entities susceptible to capturing the presence of any of these indicators. From this perspective it would seem not only logical, but even essential, to rely on the Social Services as a privileged area of detection. Some considerations which support them are:

1. The most recent studies on the problem of abuse use, as an explanatory theory, the *ecological model*, which posits the intervention of numerous factors (characteristics of the victim, and of the aggressor, environmental stress, etc.) which operate simultaneously on the appearance of any episode of family violence. Any approximation towards the problem of child abuse, from the Social Services, is necessarily a global one. In fact, 'globalisation' is one of the general principles of procedure which appear recurrently in legislation on this subject. It involves attention to the individual, in his/her family nucleus and household circumstances, immersed in a complex social reality.
2. The procedure of the Social Services is oriented towards solving those difficulties that prevent the individual from reaching full development, whether they are a consequence of his/her individual history or of the establishment of dysfunctional relationships in his/her surroundings. The field of observation and intervention of the social services is, in consequence, very wide, as it embraces difficulties which occur in the individual or familiar sphere, as well as those that prevent normalised access to resources. Given the scope of intervention, the possibility of detection of indicators of abuse of the Social Services, is evident.
3. The typology of individuals/families that are attended to by the Social Services, frequently maintain dysfunctional relationships with other services and subsystems. This is due to the fact that they do not fulfil the minimum requirements in order to access to these resources, that in the majority of cases are not explicit: care of hygiene and clothing; fulfilment of appointment times; capacity to meet deadlines; carrying out formalities; etc.. For this reason, the Social Services are a privileged resource, in as much as they are able to detect the difficulties that these kinds of families are experiencing. If we identify the impossibility or difficulty of access to resources as an important factor, we can hypothesise a greater degree of occurrence of abuse in this type of family and the need to involve the General Social Services in the detection of these situations.
4. The Social Services, identified by the population and different entities as traditional receivers of "complaints" of child abuse situations, have technically qualified personnel in their Information and Orientation Services who are able to recognise those indicators that reveal the presence of this problem. It is more difficult for other services and entities devoted to more specific areas of care to receive complaints related to abuse situations.
5. Given that the main aim established by the Social Services is user access to different resources, they periodically receive information obtained from different entities and services (schools, health centres, etc.) that have little contact with each other. This permanent coordination of the Social Services with other services provides them with important information about each case, which makes the detection of child abuse much easier.

Different autonomic legislation on Social Services bestows the responsibility of General Social Services to local corporations, that is to say, to organisations which are closer to the social reality and the running of the life of the citizens. The Regularized Plan for the Undertaking of Basic Services of the Social Services on the part of the Local Entities has contributed to setting up, in the whole state, a network of General Social Services or Primary Care which convert them, through all the municipalities and communities, in a privileged Observatory of the social needs of each community and, consequently, in an essential instrument when the time comes to detecting child abuse.

NOTES ON THE PROTOCOL FOR ABUSE DETECTION FROM WITHIN THE SOCIAL SERVICES

1. Main objectives.

1. Detection of situations of child abuse.
2. To facilitate communication / transferral to responsible entities.
3. To aid in incidence estimation, profile studies, etc., to orient research, planning, etc.

2. Place of completion of forms

This registration form was drawn up to be filled in from within the General Social Services. This does not invalidate, by any means, the fact that it can be used by the Specialized Social Services.

The General Social Services believe that this registration form should be filled in by the professionals of the "*Information and Orientation Service"*. This consideration is based on the fact that:

1. Aside from the programmes and services provided by the Municipal Centers of Social Services (basic equipment of the General Social Services) which depend on different autonomic legislation, the Information and Orientation Service is one of the basic services of the Regularized Plan and, consequently, is present in the whole network of State General Social Services.
2. In addition, the Information and Orientation Service is considered as the gateway to the system of General Social Services. This aspect guarantees uniformity in this area in all general social services, not only due to its condition as the first level of attention and contact with users, but also for the content of the service itself.
3. Therefore, the completion of registration in the Information Service will guarantee, on the one hand, the maximum scope for detection that can be carried out by the General Social Services and, on the other, the contrast/comparison between the quantitative and qualitative aspects of this identification.
4. Some Autonomous Regions internally provide the Social Services Centre with programmes and professionals who are specialized in attention to the specific problems of families and childhood. Completion of this registration form by these services has not been ruled out in spite of the fact that:
   - This structure is not widespread amongst all general social services of all autonomous regions.
   - Transferal to said internal child care service, is usually carried out by the Information Services themselves, once the risk situation for the child has been evaluated.

3. Criteria of elaboration and application.

1. The difficulty of detecting abuse influences in the request to responsible professionals to evaluate a reality which is probably, from the level of General Social Services, only suspected, given that its verification necessarily requires more complex means. The degree of subjectivity involved in assuming an evaluation of this kind is justified by the seriousness of the situation in question and by the possibility of increase in the number of situations that, without being labelled as abuse, could require preventive intervention.
2. Therefore, the process of completion of this registration form should start with the intuition/evaluation of the professional related to the care that the responsible adults could be giving the child, while the professional fills in the corresponding social index card in the Information and Orientation Service. This initial evaluation will guide subsequent requests for information from the family, in which it is possible to focus more specifically on the difficulties that the family is having in the care and supervision of the children.
3. The information contained in this registration form should not exceed that which can be obtained from one, or at the most, two interviews. In completing this registration form, a response to all and every one of the items should not be insisted upon, as this could mean an excess workload and dedication of the service responsible for the detection. Giving more tasks to services which are already saturated could result in the objection of the professionals to the task requested.
4. The professionals responsible for the completion of the registration form should be informed of the destination of the information contained therein, with the aim of being able to inform the user of its evaluation regarding the risk situation and the need for intervention of other services that have more suitable resources and technical means.
5. Communication to the user of the completion of the detection protocol, and even of its content, will prevent the occurrence of situations of defenselessness which do not favor subsequent interventions, and in any case should imply an offer of specialized support.

NOTIFICATION FORMS

OF

RISK AND CHILD ABUSE

FROM THE

SOCIAL SERVICES

GRUPO DE TRABAJO SOBRE MALTRATO INFANTIL

LOGO

OF THE AUTONOMOUS REGION

LOGO AUTONOMOUS REGION

NOTIFICATION FORM OF RISK AND CHILD ABUSE OF THE SOCIAL SERVICES

Mark with an X where applicable

For a detailed explanation of the indicators, see reverse side

Suspicion ○
Abuse ○

General family indicators

○ Monoparental [1]	○ Reconstructed family [2]
○ Teenage pregnancy [3]	○ Child does not live with biological parents [4]
○ Neglect of hygiene and clothing [5]	○ Insufficient or unstable income [6]
○ Overcrowding and/or poor housing [7]	○ Consumption of alcohol and/or drugs [8]
○ Conjugal conflict [9]	○ Psychiatric symptomatology [10]
○ Absence of functional support [11]	○ Dependence / extended family conflict [12]

Minimum care

○ Feeding difficulties [13]	○ Timetable difficulties (meals, sleep, nursery) [14]
○ Difficulty following medical instructions [15]	○ Difficulties following school instructions [16]
○ Difficulties accessing the health system [17]	○ Development retardation / Recurrent illness [18]

School situation

○ Difficulties accessing the education system [19]	○ School underachievement/ school failure [20]
○ School absenteeism [21]	○ Behaviour disorders in the classroom [22]

Family nucleus

○ Difficulties in relating to the child [23]	○ Absence of supervision of activities [24]
○ Labour of domestic exploitation [25]	○ Inappropriate expectations [26]
○ Absence of behavioural control [27]	○ Approval of physical punishment [28]

Social surroundings of the child

○ Absence of supervision of activities [29]	○ Difficulties in relating to peer group [30]
○ Marginal peer group [31]	○ Offences and/or crimes commission [32]

Type of abuse (Professional global evaluation) (Mark that which is applicable)

Physical[33] (L) (M) (S)	Emotional[34] (L) (M) (G)	Negligence[35] (L) (M) (G)	Sexual abuse[36] (L) (M) (G)

Evaluation of possibilities of intervention

	Low				High
Evaluation of the degree of awareness of the abuse situation	1	2	3	4	5
Evaluation of the potential for change in the family	1	2	3	4	5

Source/sources of detection (Institution that the case stems from)

○ Social services	○ Health	○ Mental health	○ School	○ Police
○ Judge	○ Child prosecutor	○ Associations	○ Others (specify):	

Communicated to

○ Child protection	○ Judge	○ Prosecutor	○ Others (specify):

Observations

DETECTION OF THE CASE

Detection of the child

Surname 1 | Surname 2 | Name

Sex (M / F) | Nationality | Date of Birth (day day month month year year)

Town | Date of notification (day day month month year year)

Address | Post code | Telephone

Detection of the notifier

Surname 1 | Surname 2 | Name

Centre | Telephone

ANNEX

L (Low): circumstances which require monitoring,

M (Moderate): needs support / help of the social, health, educational services,...

G (Serious): requires the urgent intervention of the social services .

Indicators

1. The family nucleus is made up of one of the parents and the child(ren)
2. Only one of the members of the couple is biologically related to the child.
3. The mother was pregnant before the age of 20.
4. The child usually lives with relatives or friends of his/her biological parents.
5. The member of the family making the accusation is negligent in his/her dress and/or hygiene.
6. None of the members of the family is in regular employment. Family income that can be justified and is documented does not exceed --- dollars in yearly per capita income.
7. The house that the family lives in is uninhabitable, and/or the size is small in relation to the household size.
8. The consumption of alcohol or drugs is suspected. The member of the family who makes the accusation reports that one or both consume or have consumed.
9. The user reports the existence of relationship problems between the parental couple.
10. One of the members of the family is in treatment by the Mental Health Team. The speech of one of the parents is incoherent, is excessively nervous, and the parent cries constantly, etc.
11. The members of the parental couple manifest lack of family and/or neighborly support to solve their difficulties.
12. The members of the parental couple communicate the existence of conflictive relationships with one or both extended families. The family nucleus necessarily needs the support (financial, care of children, etc.) of one or both extended families.
13. ,14,15,16. The parental couple answer inadequately to questions related to food, timetable, sleep, administration of medication, school tasks, etc. They refer to the fact that the child presents difficulties in one of these areas.
17. The members of the family lack health cover. The members of the family do not use Primary Care services and regularly visit emergency departments. They refer to "comprehension" problems with health personnel.
18. Retardation in size and weight, psychomotor problems, recurring illness or frequent hospitalization are suspected.
19. The members of the parental couple answer inadequately to questions related to the schooling of the child: they do not know the year he/she is in, name of the teacher, if he/she has homework, etc.
20. The user reports problems of school achievement, retardation, etc.
21. The school reports unjustified non-attendance. The members of the parental couple admit absenteeism.
22. The school or the members of the parental couple admit behaviour disorders: absence of habits, distraction, provocative behaviour, attacks, etc.
23. The parental couple refers to relationship problems with the child: "hyperactivity", excessively introverted, provocative behaviour, ..
24. The child spends most of the day alone or outside the home.
25. The child "helps" his/her parent on a daily basis in his/her work. The child is responsible for caring for his/her younger brothers and sisters.
26. The members of the parental couple demand inappropriate behaviour from the child for his/her age and/or characteristics.
27. The members of the parental couple manifest that the child is "uncontrollable", "naughty", he/she does not obey", etc.
28. The members of the parental couple consider physical punishment as a form of education.
29. The members of the parental couple are unaware of the activities of the child, if he/she goes to class or not, who makes up his/her peer group, places he/she usually goes to, etc.
30. They refer to the violent behaviour of the child with his/her peers.
31. The members of the parental couple refer to the fact that the child spends time with a peer group with characteristics of marginalisation: absenteeism, incipient drug consumption, criminal activities, etc.
32. The child has committed a crime.
33. Any non-accidental act that causes physical harm or illness to the child or place him/her in a situation of severe risk of suffering from it: injuries, bruises, fractures, bites, burns ,...
34. The adult responsible for the guardianship acts, deprives or provokes in a serious way feelings which are negative to the self-esteem of the child: he/she continually underrates him/her, scorn, insults, intimidation and discrimination, threats, corruption, interruption or prohibition of continued social relationships. Fear of the adult. Growth retardation without a justifiable organic case. Overprotection
35. Neglect the needs of the child and the obligations of custody and protection or inadequate case of the child.
36. Sexual abuse: involvement of children in sexual activities, to satisfy the needs of an adult

Professional evaluation : The professional is asked to typify the abuse observed and its degree.

Evaluation of the degree of awareness of the abuse situation: The professional is asked to mark, on a scale of 1 to 5, the degree of concern and/or awareness of the family about the problem presented, in such a way that:

1 = The family make other accusations and only attend to the problems related to the child from the basis of the professional approach.

5 = The problems of child care cause the accusations. The members of the family are willing to try diverse solutions.

Evaluation of the potential for change in the family: The professional is asked to mark on a scale of 1 to 5 the potential for change in the family:

1 = The family is not dissatisfied with the current situation which is similar to that of their parents, grandparents, etc. The members of the family do not possess personal resources, educational, etc. to make it possible for an intervention to generate change in the situation.

5 = The family is dissatisfied with the current situation. It iswilling to follow professional instructions to change it. It is considered that the family has sufficient resources to manage to modify the situation.

The information contained herein is confidential. The aim of this form is to facilitate the detection of abuse and to make attention possible.

The information contained herein will be computerized with the guarantees established by law:

- Act of Parliament 15/1999, of 13 of December, on the Protection of data of a personal nature
- Directive 95/46 CE of the European Parliament and Council of 24 of October, 1995, relative to the protection of individuals regarding the treatment of personal data and its free circulation.
- Royal Decree 994/1999, of 11 of June through which the regulation on security measures of automated files that contain data of a personal nature is approved
- Laws corresponding to the autonomous regions on the regulation of the use of computing in the treatment of personal data

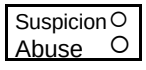
Instructions for use of the Notification form

This instrument is a questionnaire for the notification and collection of information on cases of child abuse and abandonment. This questionnaire is not a diagnostic instrument but a standardised notification form of obvious abuse cases or suspicion of abuse that can appear in our doctor's practices.

To use the questionnaire, you should mark with an X all the symptoms that are evident as well as those that are suspected, you should fill out the detection card and send the questionnaire by post.

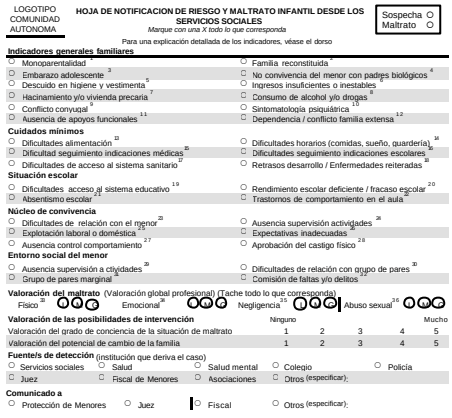
The questionnaire consists of an inventory of symptoms, a box for comments, an explanatory legend of the symptoms and a section on the detection of the case.

The inventory of symptoms is divided into sections on typologies. These are: symptoms of physical abuse, symptoms of negligence in the treatment of the child, symptoms of emotional abuse and symptoms of sexual abuse. It is important to stress that *the symptoms are not mutually exclusive*. It will frequently be necessary to use one or various indicators from the different sections of symptoms to outline the case.



The first section to be filled in is in the top right hand corner. In this box you should mark with an X if it is an *evident case of abuse* or if only *the suspicion* of abuse exists. In the legend, there is a definition of what is meant by *suspicion*.

The registration form comprises 32 items: three professional items; detection data on the children.



Regarding the *items* it must be pointed out that:

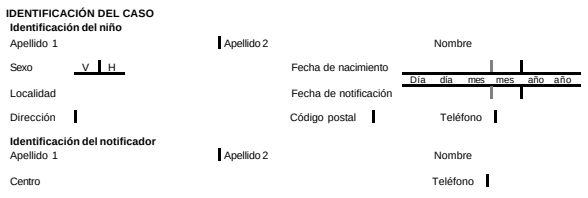
- The 12 initial items refer to completion of the social index card of the kind that is usually completed in the Information and Orientation Services.
- The 20 remaining items refer to the accusation against the family or to the professional approach to the possible issues that appear in the collection of information on the social index card.
- Specific indicators referring to possible physical or sexual abuse are not included, given that they are not easily accessible or visible in these general social services.

The indicators include an explanatory note, which is indicated by a number. The explanation is on the back of the questionnaire itself. It is advisable to read these notes when the indicator is not clear. If there were other symptoms or indicators not included in the list, they should be listed in the comments section.

Regarding *professional evaluations:*

- In the evaluation of types of abuse, the classification L (light), M (moderate) and S (serious) is used.
- For the other two evaluations, a scale of 1 to 5 is used.

There is a table in which other symptoms or indicators can be noted which are not reflected in the original questionnaire. It is also possible to write comments here that may be pertinent to the clarification of the case or suspicions (for example of a biographical kind referring to the credibility of the account narrated by the subject or to the recurrence of symptoms and visits) that led the professional to report the case.



Finally, there is a section given over to the detection of the person who reports the case. It is essential to complete this section so that the notification takes effect. The information included in this and other sections is confidential and is protected by Act of Parliament 15/1999, of 13 of December, on the Protection of data of a personal nature. The information collected in the section on the detection of the notifier is not remitted to the database of the accumulative registration of cases and is used exclusively to ensure the veracity of the information in the notification.

Each notification form comprises three carbon copies. One copy should remain in the case history for monitoring of the case if it were necessary, another copy should be sent by post to the data processing services and a third copy should be given to the professional of the social services.

IMPORTANT: Each notification should be carried out on a new questionnaire, even when it refers to the same case on dates subsequent to the first detection.

The efficiency of this Notification form depends to a large extent on the quality of the notification and the care with which it is used. Careless completion could invalidate the notification of the case. Good use of the questionnaire is fundamental for the reliability of the answers and any subsequent action that could be required.

For clarification of any of the above points, contact:

THE HEALTH SERVICES:
A PRIVILEGED OBSERVATORY FOR THE DETECTION OF CHILD ABUSE

Child abuse, the worst possible form of desertion and underprotection, is an extremely important social and health problem. Health professionals are in a privileged position to assist in its prevention, detection and intervention.

Abuse in children, in its different forms – negligence, physical, emotional and sexual abuse – represent a significant cause of death, especially in the early years of life. The medical pattern, originally described by the paediatrician, Henry Kempe, as the Syndrome of the Battered Child, currently includes moderate, serious and light forms of abuse and negligence in which physical abuse may be absent. The diagnosis of abuse, its intervention and prevention correspond to multidisciplinary teams in which health professionals play a fundamental role.

Not only is the concept of child abuse under scrutiny from the perspective of what is and what should be **good treatment**, but also the procedural principle of **help** that should be provided via the social services (Law 21/87, Law 1/96). The social services are the responsible element in issues of the protection of children as they can act on the risk factors that resulted in abuse.

The area of health is a privileged observatory for the detection of cases of child abuse. The child population, especially children under fives, at some time attend Primary Care health centres (appointments for problems of health, routine check-ups as part of the Healthy Child Programme), hospital services, emergency services, mental health, municipal health services (The children's social risk programme), in the different areas of care (doctor, nurse, midwife, psychologist, psychiatrist, social worker...).

The health area frequently only diagnoses serious or recurrent physical abuse, which although it is the most evident form, is the least frequent. It is not only the physical indicators but also the emotional or behavioural evidence in children and their carers which should guide towards the diagnosis since specific indicators exist within the different areas of health care, such as *pathognomonic* signs and symptoms of child abuse.

The complexity of this problem also requires complex solutions that cannot be tackled from only one field of action. The social problems that affect children cannot be separated or removed from their environment. The coordination of all the institutions involved is essential in order to tackle the situations from a global standpoint and also through integral programmes that involve institutions and professionals that work with children and families.

Inter institutional coordination and cooperation is fundamental in procedure in cases of child abuse in order to avoid not only a lack of assistance but also the doubling up of services and common/similar protocol within the autonomous region.

All action programmes on child abuse should consider prevention as a fundamental strategy. This should not only be oriented towards preventing cases of abuse but also towards early detection and the prevention of recurrence and after-effects.

We should bear in mind that, in recent years, attention to abused children has undergone fundamental changes that affect care within the health field. These include:

1. *The obligation to communicate risk situations.* In the past, professionals were only obliged to notify cases of injury through the corresponding report to the Duty Magistrate according to the Law of Criminal Prosecution (Arts. 259,262,264,355). Professionals are also currently obliged by the Law of Legal Protection of the Child (Law 1/96) to also report situations of *risk* and suspicion to services responsible for child protection issues.
2. *Responsibility of the social services*. Social services are responsible for issues of child protection, even the withdrawal of parental custody, which in the past was exclusive to the legal authorities. At the current time in Spain, it is the responsibility of the child protection service of each autonomous region to withdraw parental custody and to assume guardianship.
3. According to the United Nations Convention on the Rights of the Child, the *best interests of the child* should be the principle on which all decisions are based.
4. Children, on whose behalf it is necessary to take protection measures, have the right to a *plan* that, as a priority, should do its utmost to *keep them in their own family,* ensuring the greatest collaboration between parents and the child him/herself.

NOTES ON PROTOCOL ON THE DETECTION OF ABUSE BY THE HEALTH SERVICE

1. Main objectives.

1. Detection of situations of child abuse.
2. To facilitate communication / transferral to responsible entities.
3. To assist in estimations of incidence, profile studies, etc., to guide research, planning, etc.

2. Place of completion.

This registration form was drawn up for its completion by Primary care, hospitals, and mental health... and by any health professional. Health professionals are those that undertake their professional activity in the field of health care. (Doctor, nurse, midwife, psychologist, psychiatrist, social worker...).

3. Criteria for elaboration and application

1. Difficulty in the detection of abuse affects the request to the responsible professionals of evaluating a reality which, except in the case of injuries in the area of Health Services, is probably only suspected, given that its verification necessarily implies more complex means. The level of subjectivity involved in carrying out an evaluation of this type is justified by the seriousness of the situation under attention and by the possibility of the number of situations increasing which, without being labelled as abuse, could require preventive intervention.
2. Therefore, the process of completion of this registration form should be based on the intuition/evaluation of the professional related to the attention that responsible adults could be giving to children, while the professional fills in the corresponding medical case history. This first evaluation will guide subsequent requests for information to the family in which it is possible to focus, in a more concrete way, on the difficulties that the family has in the care and supervision of children.
3. The information contained in this registration form should not exceed that which can be obtained from one, or at the most, two interviews. This registration, in its completion, does not require an answer to all and every one of the items as this could mean an excess of work and dedication on the part of the service in charge of detection. The adjudication of new tasks to services, which are already saturated, could result in reluctance on the part of the professionals when faced with the task in hand.
4. The professionals responsible for the completion of the registration form should be informed of the destination of the data contained herein with the aim of being able to inform the user of his/her evaluation as regards the risk situation and the need for intervention of other services that have the most suitable resources and technical means.
5. Communication to the user of the completion of detection protocol, and even of its content, will avoid the creation of situations of defencelessness that do not favour subsequent intervention, and in any case should involve an offer of specialised support.
6. The procedure principles of the current system of protection of children, (settling problems out of court, the responsibility of the social services, intervention in risk situations, not separating the child from the family, everything done according to the best interests of the child) means attention to cases of child abuse according to the needs of the child by breaking with false beliefs and previous models based on the Guardianship of Children.
7. The general criteria for reporting would be those cases that require help and, therefore, the communication / inter consultation is carried out with the social services.

NOTIFICATION FORMS

OF

RISK AND CHILD ABUSE

FROM THE

HEALTH AREA

GRUPO DE TRABAJO SOBRE MALTRATO INFANTIL

LOGO AUTONOMOUS REGION

LOGO
AUTONOMOUS
REGION

NOTIFICATION FORM OF RISK AND CHILD ABUSE FROM THE HEALTH SERVICES

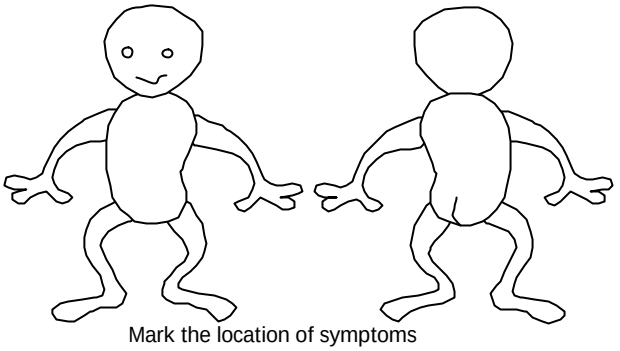
L = Light **M** = Moderate **G** = Serious

For a detailed explanation of indicators, see reverse

Suspicion ○
Abuse ○

PHYSICAL ABUSE

(L)	(M)	(S)	Contusions or bruises [1]
(L)	(M)	(S)	Burns [2]
(L)	(M)	(S)	Bone fractures [3]
(L)	(M)	(S)	Injuries [4]
(L)	(M)	(S)	Internal injuries [5]
(L)	(M)	(S)	Human bites [6]
(L)	(M)	(S)	Forced intoxication [7]
(L)	(M)	(S)	Shaken child syndrome [8]



Mark the location of symptoms

NEGLIGENCE

(L)	(M)	(S)	Little hygiene [9]
(L)	(M)	(S)	Lack of supervision [10]
(L)	(M)	(S)	Tiredness or permanent apathy
(L)	(M)	(S)	Physical problems or medical needs [11]
(L)	(M)	(S)	He/she is exploited, overworked [12]
(L)	(M)	(S)	He/she does not go to school
(L)	(M)	(S)	He/she has been deserted

EMOTIONAL ABUSE

(L)	(M)	(S)	Emotional abuse [13]
(L)	(M)	(S)	Physical, emotional, intellectual retardation [14]
(L)	(M)	(S)	Suicide attempt
(L)	(M)	(S)	Excessive care / Overprotection [15]

SEXUAL ABUSE

(Y)	Without physical contact
(Y)	With physical contact and without penetration [16]
(Y)	With physical contact and with penetration
(Y)	Difficulty in walking and sitting down
(Y)	Underwear torn, stained or bloodied
(Y)	Pain or itching in genital region
(Y)	Contusions or bleeding of external genital region, vaginal or anal region
(Y)	Swollen or red cervix or vulva
(Y)	Sexual exploitation
(Y)	Semen in the mouth, genitals or on clothes
(Y)	Venereal disease [17]
(Y)	Pathological anal opening [18]

Configuration of the hymen [19] ____

Other symptoms or comments:

DETECTION OF THE CASE (Delete or complete where appropriate)

Detection of the child

Fatal case (death of the child) Yes

Surname ____ Name ____

Address Town Telephone

Sex M F Date of Birth (day day/month month/year year) ____

Accompanied by Father ☐ Mother ☐ Tutor ☐ Police ☐ Neighbour ☐ Other (Specify) ____

Detection of the notifier

Date of Notification (day day/month month/year year) ____

Centre: Service / Practice:

Name: Sanitary Area ____

Professional | Doctor | Nurse | Social worker | Midwife | Psychologist | Collegiate No. ____

ANNEX

Suspicion: There is no objective data, only the suspicion, which is deduced from a non-credible or contradictory clinical case history, or from excessive delay in the appointment.

L (Light): circumstances which require monitoring,

M (Moderate): needs support / help in the social, health, educational services...

S (Serious): requires the urgent intervention of the social services

[1] Contusions or bruises in different stages of healing, on the face, lips or mouth, in extensive regions of the torso, back, buttocks or thighs, with abnormal shaping, grouped or like the sign or mark of the object they have been injured with, in different areas, indicating that the child was struck from different directions.

[2] Cigar or cigarette burns. Burns that cover the whole surface of the hands (like a glove) or the feet (like a sock) or round burns on the buttocks, genitals, indicative of immersion in hot liquid. Burns on arms, legs, neck, or torso caused by having tied up tightly with rope. Burns with objects that leave a clearly defined mark (grill, iron, etc.).

[3] Fractures of the skull, nose or jaw. Spiral fractures in long bones (arms or legs), in various stages of healing. Multiple fractures. Any fracture in a child younger than 2.

[4] Wounds or scratches in on the mouth, lips, gums or eyes. In the external genitals, on the back of arms, legs and torso.

[5] Internal injuries (abdominal, thorax and/or brain). Swelling of the abdomen. Localised pain. Constant vomiting. These are suggestive of duodenal bruising and pancreatic haemorrhaging, or sensory alterations without apparent cause.

[6] Signs of human bites, especially when they seem to be of an adult (more than 3 cm of separation between the canine marks) or they are recurrent.

[7] Forced intoxication of the child by the swallowing or administration of drugs, faeces or poison

[8] Retinal of intracraneal haemorrhaging, without fracture.

[9] Constantly filthy. Scarce hygiene. Hunger or thirst. Inadequately dressed for the climate of the season. Injuries caused by over-exposure to the sun or the cold (sunburn or freezing of the acra members).

[10] Constant lack of supervision, especially when the child is doing dangerous activities or during long periods of time.

[11] Unattended physical problems or medical needs (e.g. Uncured or infected wounds) or an absence of routine medical care: disregard for the vaccination calendar, other therapeutic instructions, extensive dental decay, localised alopecia due to prolonged stay in the same position, flattened skull.

[12] Includes children who accompany adults that "beg", traffic light sellers, and all those who do not go to school and should.

[13] Situations in which the adult responsible for guardianship behaves, deprives or provokes in a chronic way feelings which are negative for the self-esteem of the child. This includes continual contempt, under valuation, verbal insults, intimidation and discrimination. It also includes threats, corruption, interruption or prohibition of social relations in a continued way. Fear of the adult.

[14] Growth retardation without justified organic cause. It includes psychical, social and speech retardation and retardation of global and fine motility.

[15] Overprotection that deprives the child of learning in order to be able to establish normal relationships with his surroundings (adults, children, play, school activities).

[16] It includes the mutilation, surgical ablation of the clitoris, which will have to be specified in the section “Other symptoms or comments"

[17] Sexually transmitted diseases by sexual abuse. It includes non-neonatal gonococcus and syphilis. Suspicious of sexual abuse: Chlamydia, condyloma acuminatum, vaginal trychomona, herpes type I y II.

[18] It includes anal fissures (they are not always abuse), scars, bruises, and acuminatum is highly suggestive of sexual abuse: anal mucous tearing, changes in colouring or excessive dilation (>15 mm, having explored the lateral anus decubitus, especially with an absence of faeces in the rectal ampulla). The presence of condyloma acuminatum is highly suggestive of sexual abuse.

[19] Normal, imperforated.

The information contained herein is confidential. The aim of this form is to facilitate detection of abuse and the possibility of attention.

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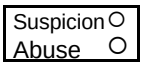

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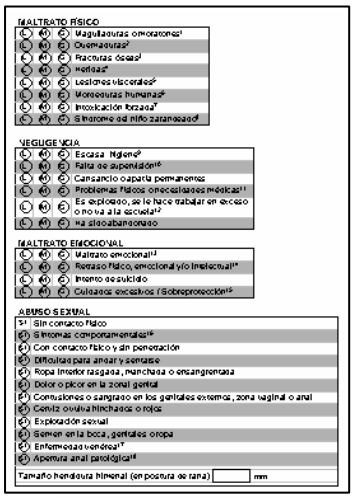


The inventory of symptoms serves as a reminder of the most frequent symptoms of abuse. It is possible to choose various indicators from each and every one of the sections. The indicators are not mutually exclusive.

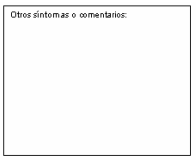
In the first three sections (physical abuse, negligence and emotional abuse), the degree of seriousness of the symptom can be chosen. The seriousness is chosen by marking the "L" if it is light, the "M" if it is moderate and the "S" if it is serious. If only a suspicion exists, the pertinent symptoms should be marked as light.

In the section on sexual abuse, the indicators of which there is evidence or suspicion should be marked. Indicators of sexual abuse are frequently associated with symptoms of emotional abuse. When it is pertinent, the configuration of the hymen and/or the size of the hymenal groove should be filled in in millimetres.

Some of the symptoms have an explanatory note, which is indicated by a number. The explanation is on the reverse of the questionnaire. It is advisable to read these notes when the indicator is not clear, until you are familiar with the indicators.

If there were other symptoms or indicators not included in the list, they should be listed in the comments section.

The anatomical drawing should be used to indicate the location of the symptoms. It is sufficient to shade in the area of the figure where the symptom can be seen. If you should wish to indicate various symptoms and there location on the drawing was not clear enough from the context of the indicator, the indicator that the shading refers to can be marked with an arrow.



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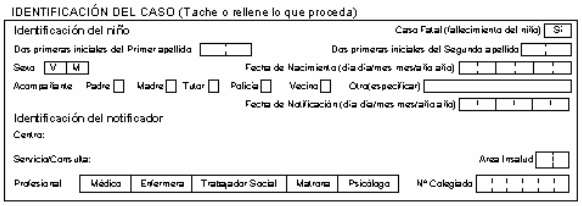
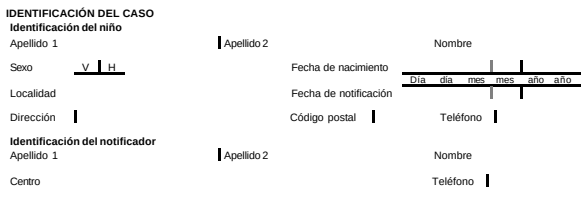


The detection section includes data that permits the location and description of the subject in the accumulative database. It is essential to fill in the patient's initials, sex and date of birth (if known).

If the notification is derived from the decease of the subject, the corresponding box should be marked.

The date of notification should be recorded, as there could be several notification of the same case in the same centre or in different centres.



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IMPORTANT: Each notification should be carried out on a new questionnaire, even when it refers to the same case on dates subsequent to the first detection. The efficiency of this Notification form depends to a large extent on the quality of the notification and the care with which it is used. Careless completion could invalidate the notification of the case.

Any queries related to this subject can be made by telephone to Administrative Information 012.

THE EDUCATIONAL SERVICES: A PRIVILEGED OBSERVATORY FOR THE DETECTION OF CHILD ABUSE

School is a privileged place for the detection of child abuse, as it is one of the fundamental contexts of socialisation for the child. All children pass through it and it is in the school context where children spend most of the day and the teacher is the active agent who spends most time in contact with the children. This allows him/her to be a witness to the socio-emotional and intellectual development of the child: to observe and get to know the behaviour of the child in the classroom, interaction with peers...

Child abuse is a community problem whose solution requires action at said level. School centres, as a service immersed in the community, must commit themselves on an institutional level as well as on the level of the individual teacher, to act to solve the problem.

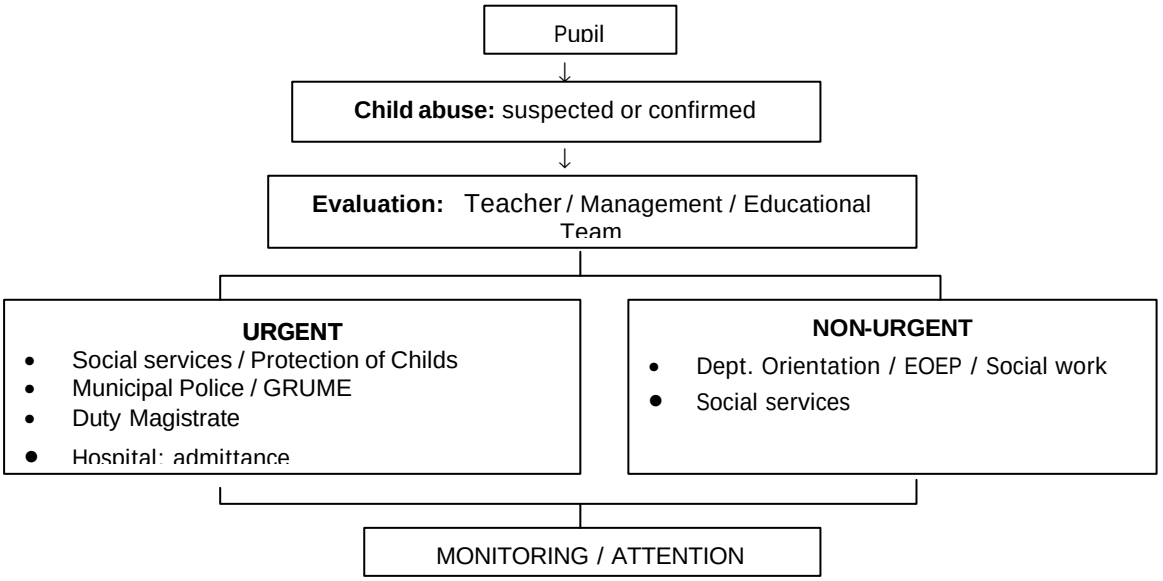
School centres constitute one of the ideal place or community settings with more possibilities for the tasks of detection, treatment and prevention of child abuse.

Abuse received by the child on the part of his/her carers has serious consequences on his/her development. Said consequences can determine success or failure not only in the scope of school learning but also in the social competence of the child and in important aspects in the subsequent social adaptation of the subject. The training of education professionals is important in that it helps them to detect cases of abused children, to better know intervention strategies, what to do with the child, how to direct the interview with the parents, where to go in the event that specialised agents have to intervene, etc.

Some children are afraid of talking about what is happening to them because they think that nobody will believe them. At other times, they do not realise that the abuse inflicted on them is abnormal behaviour and thus they learn to unconsciously repeat this "model". The lack of a positive family model and the difficulty there is in growing and developing by copying it increases the ability to become an adult with the capacity to relate to other people. They may not see the true root of their emotional problems until they reach adulthood and look for help to solve them.

The diagnosis of risk/or child abuse, suspected or confirmed, should be made on the basis of information on: the physical state and behaviour of the child; the behaviour and attitudes of the parents through interviews and the regular contact that the educational personnel maintains with them; and, the general family situation.

The teacher should: evaluate if the seriousness of the case needs the investigation and support of the social services (in the event of doubt, comment on it with an expert); treat the parents with respect and comprehension; report cases of abuse to the area social services; and, act according to the cases:



GRUME: Children's Group of the Judicial Police. EOEP: Educational and Psycho pedagogical Orientation team

NOTES ON PROTOCOL ON THE DETECTION OF ABUSE BY THE EDUCATIONAL SERVICES

1. Main objectives.

1. Detection of situations of child abuse.
2. To facilitate communication / transferral to responsible entities.
3. To assist in estimations of incidence, profile studies, etc., to guide research, planning, etc.

2. Place of completion.

This notification form was drawn for its completion by educational centres (kindergartens, schools, leisure and free time activity centre...), by the different professionals (teachers, primary teachers, educators) and by all those that intervene in the educational activity such as the Orientation Department (psychologist, pedagogue), Educational and Psycho pedagogical Orientation Team (EOEP), social work.

3. Criteria for elaboration and application

1. In order to report a case, it is not necessary to be absolutely sure, but it is enough to have a reasonable suspicion.
2. The relationship between the teacher and his/her pupils is fundamental. A close relationship with pupils allows the teacher to have a better view of what is happening. Moreover, when the teacher is in tune with the youngsters and with the signs of abuse, it is not that difficult to detect abuse. If a teacher knows his/her pupils well, he/she is immediately aware of any changes in his/her behaviour.
3. If we consider that child abuse is a complex problem, in which next to the attacked child the adult aggressor has to be considered, apart from the family trauma, the social and cultural environment in which the interaction is taking place …, an intersectorial approach is the only possible way to plan the integral response that the issue requires. From the above, the relevance of coordination between the different sectors that intervene in case of child abuse becomes clear.
4. For many children that suffer abuse, the violence of the abuser becomes a way of life. They grow up thinking that people that hurt are a part of daily life. This behaviour, therefore, becomes 'acceptable' and the cycle of abuse continues when they become parents and abuse their children and they their own, thus continuing a vicious cycle through generations.
5. When the need to report the case has been evaluated in those cases where it is possible, it is advisable to inform the parents that the school has noticed problems in the child.

   On some occasions, there could be reasons not to inform the parents because they refuse to accept the situation or a s aggressive response... because it could harm the child or create the hostility of the parents which could make it more difficult to offer support in the future from the school.
6. It will not always be the parents who are responsible and, to sum up, what the notification involves is a request for the necessary support (*help*) to solve the problems that caused the situation that negatively affects the child. It is important to make clear that with the notification of a case, not only is the child being protected, but the aim is to rehabilitate the aggressors so that the child can return home as soon as possible, danger-free, by working on the factors that caused the family instability. It must be realised that the later the case is reported, the more chronic the situation will be and the more serious the physical and psychical after-effects that the child will suffer.
7. The source and the information should be confidential and anonymous without at any time ceasing to maintain the best interests of the child.

NOTIFICATION FORMS

OF

RISK AND CHILD ABUSE

FROM THE

EDUCATIONAL AREA

GRUPO DE TRABAJO SOBRE MALTRATO INFANTIL

LOGO AUTONOMOUS REGION

LOGO AUTONOMOUS REGION

DETECTION FORM OF RISK AND CHILD ABUSE WITHIN THE SCHOOL ENVIRONMENT

L = Light **M** = Moderate **S** = Serious

For a detailed explanation of the indicators, see reverse

Suspicion ○
abuse ○

Physical abuse (L) (M) (S)	Occasional	Frequent
Shows repeated signs of injury, blows, burns,.., which are difficult to justify [2]	○	○
Says he/she has been assaulted by his/her parents [3]	○	○
Hides the aggression and/or gives evasive or incoherent answers [4]	○	○
Negligence [5] (L) (M) (S)		
Extremely careless physical appearance, foul-smelling, unsuitable clothing, repeated ***parasitosis [6]	○	○
Inadequate physical (growth retardation), emotional and /or intellectual development [7]	○	○
Arrives at the Centre without breakfast and/or is extremely hungry [8]	○	○
Seems tired, he/she falls asleep in class [9]	○	○
Comes to school ill, dos not receive suitable medical treatment [10]	○	○
School absenteeism. Plays truant. Irregular class attendance. Arrives late [11]	○	○
Consumes alcohol or other drugs [12]	○	○
Parents do not attend meetings, do not turn up to appointments or collaborate with the teacher [13]	○	○
Returns home alone [14]	○	○
Emotional abuse [15] (L) (M) (S)		
Steals objects in class, asks for food [16]	○	○
Presents problems / retardation in reading, writing and speech [17]	○	○
Does not control sphincter for age of having had control loses it [18]	○	○
Fearful, silent attitude, shows sadness [19]	○	○
Avoids talking about him/herself and/or family [20]	○	○
Shows extreme swings in school achievement / behaviour [21]	○	○
Parents have a negative image of the child and blame, scorn or devalue him/her in public [22]	○	○
Does not want to return home [23]	○	○
Attracts or tries to attract attention [24]	○	○
Sexual abuse [25] (L) (M) (S)		
Presents pain / itching in anal / genital region [26]	○	○
Sexual knowledge inappropriate for age [27]	○	○
Provocative, seductive or sexually explicit behaviour [28]	○	○
The child is seen to be accompanied by different adults [29]	○	○
Shoes discomfort in walking or sitting down [30]	○	○
Pregnant girl or adolescent (especially if she refuses to identify the father) [31]	○	○
Compulsive masturbation or in public [32]	○	○
Violence amongst peers [33] (L) (M) (S)	○	○

Observations:

DETECTION OF THE CASE (Delete or complete where appropriate)

Detection of the child

Surname 1 _____ Surname 2 _____ Name: _____

Sex M F Nationality _____ Date of birth _____

day day / month month / year year

Place _____ Date of notification _____

Detection of the notifier

Centre _____ Address _____ Tel.: _____

Surname 1 _____ Surname 2 _____ Name: _____

L (Light): Circumstance that require monitoring,
M (Moderate): needs support / help of the social, health, and educational services...
S (Serious): requires the urgent intervention of the social services.

Sometimes: Noticed occasionally
Frequently: Usually noticed. In spite of drawing the parent's attention to the situation, it continues.

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1 Any non-accidental act, which causes physical harm or illness to the child or places him/her in a situation of serious risk of suffering it: injuries, bruising, fractures, bites, burns ...

2 Especially when there was delay in medical assistance, presents different injuries located in traditional punishment regions, the account is incongruous or unacceptable, strange explanations as regards the injury, etc.

3 Refers to being the object of aggression

4 Attributes obvious injuries to chance accidents, does not answer immediately, excuses parents, and avoids getting undressed in public.

5 Ignores the needs of the child and the duties of custody and protection or inadequate care of the child.

6 Inadequately dressed for the climate or the season. Injuries caused by excessive exposure to the sun or the cold (sunburn, freezing of the acra members).

7 Growth retardation without justifiable organic cause. Includes psychical, social, speech retardation, of global motility and fine motility.

8 Presents lack of basic care through negligence which is manifest in a lack of food (not caused by economic problems) goes to the school centre without breakfast, says he/she did not have a meal the previous day,

9 Is usually tired, Sometimes falls asleep in class. Finds it difficult to concentrate.

10 Unattended physical or medical needs (e.g. Unhealed or infected wounds) or absence of routine medical care: disregard for the vaccination calendar, or other therapeutic indications, extreme dental decay, localised alopecia caused by prolonged duration in the same position (flattened skull).

11 The school centre communicates unjustified absenteeism. Parents/guardians admit absenteeism Misses school through lack of family interest

12 Under 16 and consumes alcohol. Smells of alcohol and presents poisoning / alcoholic coma, symptoms of drug consumption, inhales glue of solvents

13 Parents of guardians respond inadequately to questions related to the schooling of the child: they do not know the year he/she is in, if he/she has homework, etc. The parents smell of alcohol or show symptoms of taking drugs

14 Children that should be accompanied by adults due to their age and/or distance home from school

15 The adult responsible for guardianship acts, deprives or provokes in a chronic way feelings that are negative for the self-esteem of the child. It includes continual scorn, devaluation, insults, intimidation and discrimination, threats, corruption, interruption or prohibition of social relationships in a continued way. Fear of the adult. Growth retardation without justified organic cause. Overprotection.

16 Shows antisocial behaviour. Does not seem to feel guilty following unsuitable behaviour. Pilfering.

17 Shows difficulty in verbal expression. Has learning problems.

18 Regressive behaviour that affects development. Shows infantile behaviour for his/her age

19 Seems to be afraid of his/her parents. Has once spoken of committing suicide. Says that nobody loves him/her. Plays or wanders around alone. Does not have any friends. Cries without reason.

20 Avoids talking about him/herself. Is reserved and keeps things to his/herself.

21 Changes in behaviour/mood without apparent reason (school failure, sadness, fear, aggressive behaviour, etc.)

22 Verbal rejection of the child. Tendency to blame him/her or look down on him/her. They are the cause of hi/her low self-esteem. Very demanding with the child.

23 The child spends too long alone when he/she is outside school without anyone to attend to him/her.

24 Is hyperactive. Continually trying to attract attention. Disruptive behaviour. Lies frequently

25 Sexual abuse: involvement of children in sexual activities, to satisfy the needs of an adult

26 Presents unspecific abdominal pain, complains of discomfort / bleeding in the genital - anal region with no apparent cause

27 Shows excessive concern about sex. Shows strange, sophisticated or unusual sexual knowledge.

28 Play unusual sexual games for his/her age.

29 Shows indication of sexual problems with adults. Displays seductive behaviour with adults of the opposite sex.

30 Displays anxiety when changing clothes in the presence of others.

31 Pregnancy in adolescents in which , related to incest if she refuses to identify the father

32 Displays unsuitable sexual behaviour with him/her self in public / in a compulsive way

33 They refer to violent behaviour of the child with his/her peers, provocative, aggressive behaviour, etc.

The information contained herein is confidential. The aim of this form is to facilitate detection of abuse and the possibility of attention.

The information contained herein will be computerised with the guarantees established by Law:

- Act of Parliament 15/1999, of 13 of December, on the Protection of data of a personal nature
- Directive 95/46 CE of the European Parliament and Council of 24 of October of 1995, Relative to the protection of individuals as regards the treatment of personal details and the free circulation of the latter.
- Royal Decree 994/1999, of 11 of June by which the regulation of security measures on automated files which contain data of a personal nature is approved

Laws corresponding to the Autonomous regions on the regulation of the use of computers in the treatment of personal data.

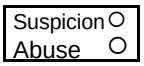
Instructions for use of the Notification form

This instrument is a questionnaire for the notification and collection of information on cases of child abuse and abandonment. This questionnaire is not a diagnostic instrument but a standardised notification form of obvious abuse cases or suspicion of abuse that can appear in our doctor's practices.

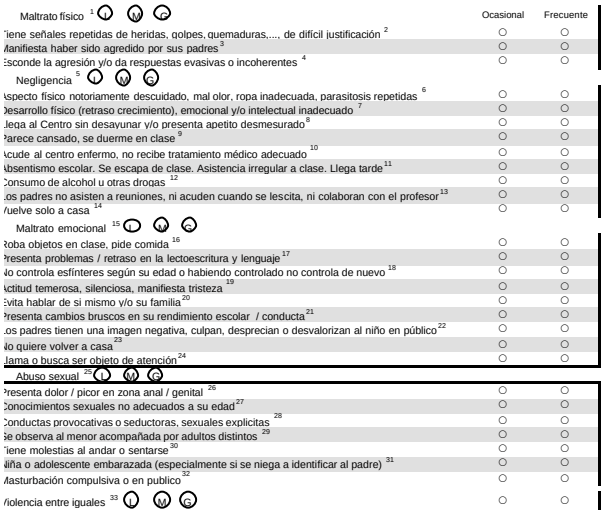
To use the questionnaire, you should mark with an X all the symptoms that are evident as well as those that are suspected, you should fill out the detection card and send the questionnaire by post.

The questionnaire consists of an inventory of symptoms, a box for comments, an explanatory legend of the symptoms and a section on the detection of the case.

The inventory of symptoms is divided into sections on typologies. These are: symptoms of physical abuse, symptoms of negligence in the treatment of the child, symptoms of emotional abuse, symptoms of sexual abuse and of violence amongst peers. It is important to stress that *the symptoms are not mutually exclusive*. It will frequently be necessary to use one or various indicators from the different sections of symptoms to outline the case.



The first section to be filled in is in the top right hand corner. In this box you should mark with an X if it is an *evident case of abuse* or if only *the suspicion* of abuse exists. In the legend, there is a definition of what is meant by *suspicion*.



The indicators have an explanatory note, which is indicated by a number. The explanation is on the reverse of the questionnaire. It is advisable to read these notes when the indicator is not clear. If there were other symptoms or indicators not included in the list, they should be listed in the comments section.

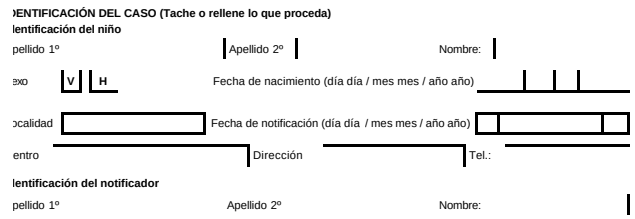
The seriousness is indicated by marking the "L" if it is light, the "M" if it is moderate, and the "S" if it is serious. If there is only a suspicion, the pertinent symptoms should be marked as light.

In the section on sexual abuse, you should mark those indicators of which you have evidence or suspicion of their presence. The indicators of sexual abuse will frequently be associated with the symptoms of emotional abuse.

The symptoms have an explanatory note, which is indicated by a number. The explanation is on the reverse of the questionnaire. It is advisable to read these notes when the indicator is not clear, until you are familiar with the indicators.

If there were other symptoms not included in the list, you should use the comments section and list them there.

There is a table in which you can write other symptoms and indicators that are not reflected in the original questionnaire. It is also possible to reflect here comments that are pertinent to the clarification of the case or suspicion (for example, of a biographical type which refer to the credibility of the account narrated by the subject or due to the recurrence of symptoms and visits) that led the professional to report the case.



Finally, there is an area devoted to the detection of the person who is making the notification. It is essential to complete this section so that the notification takes place. The information contained in this and other sections is confidential and is protected by the Act of Parliament 15/1999, of 13 of December, on the Protection of data of a personal nature. The information included in the section on the detection of the notifier is not remitted to the database of the accumulative registration of cases and is used solely to ensure the veracity of the information contained in the notification.

Each notification form comprises three carbon copies. One copy should remain in the medical case history for monitoring in the event that it were necessary, another copy will be sent by post to the data processing service and a third copy will be handed to the professional if the social services.

IMPORTANT: Each notification should be carried out on a new questionnaire, even when it refers to the same case on dates subsequent to the first detection.

The efficiency of the Notification form depends to a large extent on the quality of the notification and on the care with which it is used. Careless completion may invalidate the notification of the case. Good use of the questionnaire is fundamental for the reliability of the answers and the subsequent action that could be required.

Any queries should be directed to:

THE POLICE FORCE: A PRIVILEGED OBSERVATORY FOR THE DETECTION OF CHILD ABUSE

The main aim and function of the police force is to take charge of ensuring the well being of citizens by defending their integrity with the provision of security and protection. Children are the most vulnerable and unprotected sector of the population.

The Police Force not only intervenes when the events have already taken place but they also play an important role in the prevention of child abuse through detection and communication to the social services of risk situations by encouraging and participating in an active way in community activities aimed at prevention.

In their work, police officers must get involved in those cases in which children are the victims of crimes, above all, in those which occur within the family environment and which are difficult to detect.

Police officers play a fundamental role in the detection of cases of child abuse, always bearing in mind that the main aim of intervention is that of protecting the child, even before that of punishing the perpetrator.

Police officers are:

- The professionals or childhood protection service most well-known by the population at large,
- They are easily identifiable,
- Normally professionals and citizens turn to them first
- The permanent cover of their service at the disposition of citizens, being able to respond quickly, almost immediately, to any request and at all times, and
- They collaborate with health, social, educational services... in different procedures.

The intervention of the Police Force – National Police, Local Police and Civil Guard- can occur in order to:

- Collect testimonies and evidence aimed at verifying or disproving the existence of a crime or infringement towards a child on the part of a child
- Adopt measures relating to protection / control / sanction and the referral of the case to the Legal System or Child protection if it is pertinent
- Detect children who live in family and social circumstances of risk
- Detain children without a stable address
- Collect notifications or complaints by citizens, professionals, institutions, parents, children, etc., relative to children in situations of risk or underprotection.
- Protect and support the specialists of the child protection services in the execution of procedure and administrative measures when there is or the opposition of the parents is foreseen or, where appropriate, the transportation of the child in care to the allocated centre.

Procedure in cases of child abuse by the Police Force in general and GRUME is characterised by:

- One-off intervention, no monitoring of cases whose responsibility is assumed by the social services.
- Twenty-four hour priority and permanent attention to the child
- Transferral to health centres if there are injuries
- Removal of the child from the family context and admittance into a protected Children's Home or submittal to a family different to that which perpetrated the abuse
- Investigation of the abuse case: perpetrator, collection of evidence, taking of declarations...
- Coordination with other care departments such as education, health, social services, legal, associations, NGOs, etc.

Moreover, there should be close collaboration with the legal system, social services, health services, school centres...

NOTES ON THE PROTOCOL ON THE DETECTION OF ABUSE BY THE POLICE SERVICES

1. Main objectives.

1. To detect situations of child abuse.
2. To facilitate communication / referral to responsible entities.
3. To enable estimations of occurrence, profile studies, etc., to guide research, planning, etc.

2. Place of completion.

This notification form was drawn up for its completion within centres belonging to the National Police, Civil Guard and Local Police

3. Criteria for elaboration and application

1. In order to report a case, it is not necessary to be absolutely sure, but it is sufficient to have a reasonable suspicion.
2. Difficulty in the detection of abuse affects the request to the responsible professionals of evaluating a reality which, except in the case of injuries in the area of Health Services, is probably only suspected, given that its verification necessarily implies more complex means. The level of subjectivity involved in carrying out an evaluation of this type is justified by the seriousness of the situation under attention and by the possibility of the number of situations increasing which, without being labelled as abuse, could require preventive intervention.
3. Therefore, the process of completion of this registration form should be based on the intuition/evaluation of the professional related to the attention that responsible adults could be giving to children, while the professional fills in the corresponding report. This first evaluation will guide subsequent requests for information to the family in which it is possible to focus, in a more concrete way, on the difficulties that the family has in the care and supervision of children.
4. The information contained in this registration form should not exceed that which can be obtained from one, or at the most, two interviews. This registration, in its completion, does not require an answer to all and every one of the items as this could mean an excess of work and dedication on the part of the service in charge of detection. The adjudication of new tasks to services that are already saturated could result in reluctance on the part of the professionals when faced with the task in hand.
5. The professionals responsible for the completion of the registration form should be informed of the destination of the data contained herein with the aim of being able to inform the user of his/her evaluation as regards the risk situation and the need for intervention of other services that have the most suitable resources and technical means.
6. If we consider that child abuse is a complex problem, in which by the side of an assaulted child there is an adult aggressor, apart from the family trauma, the social and cultural environment in which the interaction is happening… an intersectorial approach is the only possible way to plan the integral responses that the issue requires. From this, the relevance of coordination between different sectors that intervene in cases of child abuse becomes clear.
7. For many children who suffer abuse, the violence of the abuser becomes a way of life. They grow up thinking and believing that people that hurt are part of daily life; therefore, this behaviour becomes “acceptable” and the cycle of abuse continues when they become parents who abuse their children and there their own, thus the vicious cycle continues through generations.
8. On some occasions, there could be reasons for not informing parents because they refuse to accept the situation, a possible aggressive response... because it may harm the child or may provoke the hostility of the parents that could make future support action to be carried out from the school more difficult.
9. It will not always be the parents who are responsible and, to sum up, what the notification means is to request the necessary support (*help*) to solve the problems that caused this situation that negatively affects the child. It is important to explain that with the notification of a case, not only is the child being protected, but the aim is also to rehabilitate the aggressors so that the child can return home as soon as possible and free of danger, by working on the factors that caused the family instability. It must be kept in mind that the later the case is reported, the more chronic the situation and the more serious the physical and psychical after-effects that the child will suffer.
10. *Coordination* is a key word in the intervention of cases of child abuse. The result of this coordination is the joint execution of health and social work that is essential detection, diagnosis and treatment of cases of child abuse. Each professional area is responsible for the action that pertains to their activity.
11. A *subsequent monitoring of the child and his/her family* should take place. It should not be limited only to the crisis.

NOTIFICATION FORMS

OF

RISK AND CHILD ABUSE

FROM THE

POLICE AREA

LOGO AUTONOMOUS REGION

LOGO AUTONOMOUS REGION

NOTIFICATION FORM OF RISK AND CHILD ABUSE FROM THE POLICE AREA

Para una explicación detallada de los indicadores, véase el dorso

Suspicion ○
Abuse ○

PHYSICAL ABUSE [1]

L M S	Contusions or bruising [2]
L M S	Burns [3]
L M S	Bone fractures [4]
L M S	Wounds, scratches or grazes [5]
L M S	Human bites [6]
L M S	Symptoms of drug intoxication [7]

NEGLIGENCE [8]

L M S	Aggressive and violent behaviour in the classroom with teachers and pupils [9]
L M S	Acts of vandalism, racism or xenophobia [10]
L M S	Wandering around the streets during and outside school, especially at night [11]
L M S	Scarce hygiene [12]
L M S	Inadequate clothing for climatic conditions [13]
L M S	Alcohol poisoning and alcohol consumption [14]
L M S	Abstinence syndrome and drug consumption [15]
L M S	Running away from home [16]
L M S	Labour exploitation [17]
L M S	Begging [18]

EMOTIONAL ABUSE [19]

L M S	Suicide attempt [20]
L M S	Unjustified crying [21]
L M S	Sadness, depression, apathy [22]
L M S	Manifestations of unhappiness at home [23]

SEXUAL ABUSE [24]

○	Manifestations of sexual abuse [25]
○	Abdominal pain or genital bleeding [26]
○	Torn, stained or bloody clothing [27]
○	Use of vocabulary unsuitable for the age [28]
○	Sexual behaviour unsuitable for the age [29]
○	Compulsive or public masturbation [30]
○	Child prostitution [31]
○	The use of children in public shows of an exhibitionist or pornographic nature [32]
○	Images of child pornography, possession of pornography or exhibition of pornography to children [33]

Comments

DETECTION OF THE CASE (Delete or complete where appropriate)

Detection of the child

Surname 1 | Surname2 | Name:

Sex M F | Nationality | Date of birth (day day /month month/ year year)

Address | Date of notification

Place | Postal Code | Telephone

Detection of the notifier

Police: National | GRUME | Civil G. | EMUME | Municipal | Regional | | Plaque No

Centre | Telephone

L (Light): circumstances which require monitoring,
M (Moderate): needs support / help of the social, health , educational services...
S (Serious): requires urgent intervention of the social services.

1 Any non-accidental act which causes physical harm or illness to the child or places him/her in a situation of serious risk of suffering from it: injuries, bruising, fractures, bites, burns ...

2 Contusions or bruising in different stages of healing, on the face, lips or mouth, in extensive regions of the torso, back, buttocks or thighs, with abnormal shapes, grouped or like the sign or the mark of the object with which they have been hurt, in several different areas, indicating that the child was struck from different directions.

3 Cigar and cigarette burns, which cover the whole surface of the hands (in a glove) or the feet (like a sock) or round burns on the buttocks, genitals, indicative of immersion in hot liquid. Burns on arms, legs, neck or torso caused by having been tied up tightly with rope, with objects that leave a clearly defined mark (grill, iron etc.).

4 Fractures of the skull, nose or jaw. Spiral fractures of long bones (arms or legs), at different stages of healing. Multiple fractures. Any fracture in a child younger than 2.

5 Wounds or scratches on the mouth, lips, gums or eyes. In the external genitals, on the back of the arms, legs or torso.

6 Signs of human bites, especially when they seem to be from an adult (more than 3 cm separation between the canine marks) or they are recurrent.

7 Forced intoxication of the child through the swallowing or giving of drugs, faeces or poisons.

8 Ignore the needs of the child and the duties of custody and protection or inadequate care of the child.

9 They refer to the violent behaviour of the child with his/her peers, provocative or aggressive behaviour etc.

10 Brutality, lack of civility. They justify / participate in situations of segregation, discrimination and/or extermination which depend on racial criteria, hatred –repugnance towards foreigners

11 All those who do not receive schooling and should do.

12 Constantly filthy, Scarce hygiene. Parasite (lice,...)

13 Unsuitably dressed for the climate or the season. Injuries from excessive exposure to the sun and the cold (sunburn, freezing of the acra members). Wears dirty, torn or unsuitable clothing and is foul-smelling.

14 Consumes alcohol with under 16s. Smells of alcohol, and presents intoxication / alcoholic coma.

15 Symptoms of drug consumption, inhales glues or solvents.

16 The child runs away from home as a consequence of the aggression or through lack of care / supervision

17 The child obligatorily does work (whether it be domestic or not) which exceeds normal limits, unsuitable for his/her age, which should be done by adults and which clearly interferes with his/her scholarly activities or needs

18 Includes children who accompany adults who “beg”, traffic light sellers.

19 The adult responsible for the guardianship acts, deprives or provokes in a chronic way feelings which are negative for the self-esteem of the child. It includes continual scorn, under valuation, insults, intimidation and discrimination, threats, corruption, interruption or prohibition of social relationships is a continuous way. Fear of the adult. Growth delay without any justified organic cause. Overprotection

20 Suicides / suicide attempts related to situations of abuse, negligence or sexual abuse.

21 Children that spontaneously and for no reason use crying as an expression of their family-personal abuse situation

22 Emotional displays which affect the emotional state of the child and/or require psychological-psychiatric care

23 The child refers to situations of family violence, relationship problems,

24 Sexual abuse: involvement of children in sexual activities, to satisfy the needs of an adult

25 Children that mention having been the object of sexual abuse: being touched, propositions, sexual acts...

26 Presents undetermined abdominal pain, complains of discomfort / bleeding in the genital-anal area with no apparent cause.

27 Presents signs of sexual aggression

28 Uses sexual expressions unsuitable for his/her age.

29 Manifests strange, sophisticated or unusual sexual knowledge. Shows excessive concern for sex. Plays games of a sexual nature which are unusual for his/her age. Manifests seductive behaviour with adults of the opposite sex.

30 Presents unsuitable sexual behaviour with his/herself in public / in a compulsive way

31 Makes sexual contacts in exchange for money / presents or through coercion / threats.

32 Uses children in shows in activities of an obscene or indecent nature

33 Handles pornographic material. Child pornography through internet

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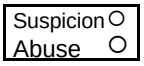

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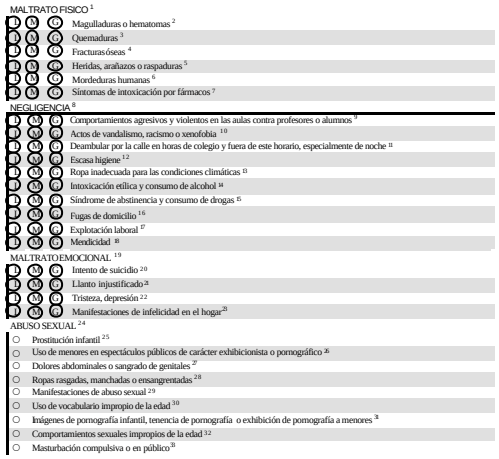


The indicators have an explanatory note, which is indicated by a number. The explanation is on the reverse of the questionnaire. It is advisable to read these notes when the indicator is not clear. If there were other symptoms or indicators not included in the list, they should be listed in the comments section.

The seriousness is indicated by marking the "L" if it is light, the "M" if it is moderate, and the "S" if it is serious. If there is only a suspicion, the pertinent symptoms should be marked as light.

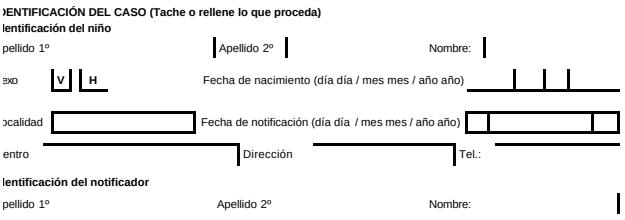
Likewise, they will be differentiated according to the frequency in which the symptoms occur: occasionally or frequently.

In the section on sexual abuse, you should mark those indicators of which you have evidence or suspicion of their presence. The indicators of sexual abuse will frequently be associated with the symptoms of emotional abuse.

The symptoms have an explanatory note, which is indicated by a number. The explanation is on the reverse of the questionnaire. It is advisable to read these notes when the indicator is not clear, until you are familiar with the indicators.

If there were other symptoms not included in the list, you should use the comments section and list them there.

There is a table in which you can write other symptoms and indicators that are not reflected in the original questionnaire. It is also possible to reflect here comments that are pertinent to the clarification of the case or suspicion (for example, of a biographical type which refer to the credibility of the account narrated by the subject or due to the recurrence of symptoms and visits) that led the professional to report the case.



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Each notification form comprises three carbon copies. One copy should remain in the medical case history for monitoring in the event that it were necessary, another copy will be sent by post to the data processing service and a third copy will be handed to the professional of the social services.

IMPORTANT: Each notification should be carried out on a new questionnaire, even when it refers to the same case on dates subsequent to the first detection.

The efficiency of the Notification form depends to a large extent on the quality of the notification and on the care with which it is used. Careless completion may invalidate the notification of the case. Good use of the questionnaire is fundamental for the reliability of the answers and the subsequent action that could be required.

Any queries should be directed to:

CARE OF EXPECTANT MOTHERS AND NEWBORN BABIES: A PRIVILEGED OBSERVATORY FOR THE PREVENTION OF CHILD ABUSE

Child abuse in children is an extremely important social and health problem and its prevention is a main objective which should be included, as a fundamental strategy, in all programmes on procedure in cases of child abuse which are oriented not only towards early detection and avoidance of repetition and after-effects, but also fundamentally oriented towards the appearance of cases.

The *detection of social risk in expectant mothers and newborn babies, prevention of child abuse,* is a work project aimed at promoting care of the child, mother and her family from *good* treatment in order to prevent abuse by attending to them according to their needs and rights such as acting on factors of risk, detection and the development of protection factors which serve to help the child, mother and family.

The detection of social risk in expectant mothers and in the new born of possible child abuse consists of recognising and identifying certain circumstances in the mother, the housing and the newborn with favour the possible appearance of situations of child abuse.

The well being of the child will be directly related to the well being of the mother, which on certain occasions will require help and social and health support during and following the pregnancy.

Pregnancy is a period of contact with the mother, the family, with the health system which allows for the early detection of factors and risk situations and the submittal of information on the fragility and the maturative characteristics of the child, the advantaged of breast feeding, health and social resources of the district and the possibilities it has etc.

Social risk factors influence negatively on the development of the child, such as biological risk factors (low birth weight, prematureness, malformation syndromes, neuro-sensual problems, chronic diseases, affective and emotional deprivation…) and certain circumstances in the pregnancy.

All these factors can affect the child right from his/her life in the uterus and can be directly related to a lack of care and possible poor treatment or child abuse.

Not all risk factors act in the same way on the child, but the fact is that the earlier it takes place the more harmful it can be and can negatively affects more areas. It is therefore essential to carry out interventions and activities as early as possible.

The importance of preventive medicine in current day obstetrics and in research in the field of medico-social sciences are essential elements for the attainment of a greater and better state of materno-foetal and neonatal health.

Through the consulting rooms of obstetricians and midwives, the aim is to systematically incorporate the *detection of psychosocial risk* into the protocol of the care of expectant mothers as well as the intervention of the social services in those cases where it is considered necessary.

The notification of the case is the transmission of information which refers to the expectant mother, the newborn and the informer him/herself. The health worker is asked to detect “reasonable indications for suspicion” and report them.

Notification should always be made to the social services and, through these, to the institutions which are considered necessary for the security and support that they can provide. These include the Directorate General of Women, early care teams, the child prosecutor, the Police, the Children Group of the Legal Police (GRUME), maternity, paediatratics, the family doctor, The Children Protection Service of the Autonomous Region...

Social workers are important for their direct responsibility as well as for their coordination of the different professionals and resources related to the case.

NOTES ON SOCIAL RISK DETECTION PROTOCOL IN THE EXPECTANT MOTHER AND THE NEWBORN

1. Main objectives.

1. To prevent child abuse by means of the detection and procedure in the face of social risk situations in the expectant mother and the newborn.
2. To facilitate communication / referral to responsible entities.
3. To enable estimations of occurrence, profile studies, etc., to guide research, planning, etc.

2. Place of completion.

This notification form was drawn up for its completion in obstetrics consulting rooms, by midwives, paediatricians, nurses, visiting nurses ..., and by all those who intervene in the care of the expectant mother and the newborn.

3. Criteria for elaboration and application

1. Difficulty in the detection of abuse affects the request to the responsible professionals of evaluating a reality which, except in the case of injuries, at a professional level, is probably only suspected, given that its verification necessarily implies more complex means. The level of subjectivity involved in carrying out an evaluation of this type is justified by the seriousness of the situation under attention and by the possibility of the number of situations increasing which, without being labelled as abuse, could require preventive intervention.
2. Therefore, the process of completion of this registration form should be based on the intuition/evaluation of the professional related to the attention that responsible adults could be giving to children, while the professional fills in the corresponding medical case history. This first evaluation will guide subsequent requests for information to the family in which it is possible to focus, in a more concrete way, on the difficulties that the family has in the care and supervision of children.
3. The information contained in this registration form should not exceed that which can be obtained from one, or at the most, two interviews. This registration, in its completion, does not require an answer to all and every one of the items as this could mean an excess of work and dedication on the part of the service in charge of detection. The adjudication of new tasks to services that are already saturated could result in reluctance on the part of the professionals when faced with the task in hand.
4. The professionals responsible for the completion of the registration form should be informed of the destination of the data contained herein with the aim of being able to inform the user of his/her evaluation as regards the risk situation and the need for intervention of other services that have the most suitable resources and technical means.
5. Communication to the user of the completion of the detection protocol , and even of its contents, will prevent the creation of situations of defencelessness which do not favour subsequent interventions, and in any case should involve an offer of specialised support.
6. The procedural principles of the current system of protection of children (removal from the judicial system, responsibility of the social services, intervention in risk situations, not separating the child from his/her family, everything according to the best interests of the child) mean attention to the cases of child abuse according to the needs of the child by breaking with false beliefs and previous models based on the Guardianship of Children.
7. The general criteria for reporting would be of those cases which require help and, therefore, the communication / inter consultation is carried out with the social services.
8. *Coordination* is a key word in the intervention of cases of child abuse. The result of this coordination is the joint execution of health and social work that is essential for the detection, diagnosis and treatment of cases of child abuse. Each professional area is responsible for the action that pertains to their activity.
9. Not only should the most serious and obvious cases be reported, but there is also an obligation to report those which are apparently light and risk situations.

   We should be strict since the notification of numerous erroneous cases saturates the services, efficiency is lost, the institutions lose credibility and irreparable damage can be done to the children and their families.
10. A *subsequent monitoring of the child and his/her family* should take place. It should not be limited only to the crisis.

NOTIFICATION FORMS

OF

SOCIAL RISK

IN THE

EXPECTANT MOTHER

AND THE

NEWBORN

GRUPO DE TRABAJO SOBRE MALTRATO INFANTIL

LOGO AUTONOMOUS REGION

LOGO AUTONOMOUS REGION

NOTIFICATION FORM OF RISK IN THE EXPECTANT MOTHER AND THE NEWBORN

Mark if the indicator is considered as positive. On the contrary, leave blank
For a detailed explanation of the indicators, see reverse

PRENATAL

○ Initial intention of voluntary interruption of pregnancy [1]	○ Unwanted child [7]
○ Considering giving the child up for adoption [2]	○ Numerous family crises [8]
○ 1st medical visit > 20 weeks of pregnancy [3]	○ Single / father unknown [9]
○ Fewer than 5 doctor's appointments during the pregnancy [4]	○ Drug addictions [10]
○ Births less than 18 months apart [5]	○ Poor self-esteem, social isolation or depression [11]
○ Young couples (younger than 21) [6]	
Prenatal Global Valuation (L) (M) (S)	

CHILD

○ Malformations, congenital defects [13]	○ Mental deficiency [16]
○ Premature child, underweight [14]	○ Disturbance of sleeping/waking rhythms [17]
○ Neurological diseases [15]	○ Impossibility of breast feeding [18]
Child Global Valuation (L) (M) (S)	

POSTNATAL

○ Mother is not happy with the child [19]	○ Lack of excitement on naming the child [25]
○ Deception as regards the sex [20]	○ Negative reaction of the father towards the child [26]
○ Child's crying uncontrolled by the mother [21]	○ intense stress [27]
○ Mother's expectations far above the possibilities of the son or daughter [22]	○ Separation of more than 24 hours after birth / early neonatal period [28]
○ Mother ignores the demands by the child to be fed [23]	○ Difficulties to establish mother-child bonding [29]
○ Mother feels repulsion towards faeces [24]	
Postnatal Global Valuation (L) (M) (S)	

HOME VISIT

○ Overcrowding [30]	○ Deficient level of habitability [34]
○ Infectious diseases [31]	○ Scarce hygiene [35]
○ Lack of equipment [32]	○ Rejection, no visit [36]
○ Adaptation of the house to the child [33]	○
Global Home Valuation (L) (M) (S)	

Comments

DETECTION OF THE CASE (Delete where appropriate)

Detection of the mother

The two first letters of the first surname ☐☐ The two first letters of the second surname ☐☐

Date of birth (day day / month month / year year) ☐☐☐☐☐☐ Telephone ☐☐☐☐☐☐☐☐☐

Address Postal Code ☐☐☐☐☐

Detection of the child

The two first letters of the first surname ☐☐ The two first letters of the second surname ☐☐

Date of birth (day day / month month / year year) ☐☐☐☐☐☐ Sex M F

Detection of the notifier

Centre National Health Area ☐☐

Service / Practice Name:

Professional Doctor | Nurse | Midwife | Psychologist | Social worker Collegiate No. ☐☐☐☐☐☐

L (*Light*): circumstances which require monitoring
M (*Moderate*): needs support/help of the social, health, educational services…
S (*Serious*): requires urgent intervention of the social services

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1. Intention to abort according to legal parameters or not, due to rejection of the pregnancy
2. Unwanted pregnancy, ideas contrary to or the impossibility of abortion results in consideration of adoption
3. Through concealment of the pregnancy, lack of interest, negligence …, 1st medical visit takes place after 20 weeks of pregnancy
4. In the whole of the pregnancy control and birth preparation, there are fewer than 5 doctor's appointments
5. No spacing between pregnancies. Could be related to promiscuity,
6. Immaturity. No preparation for maternity
7. Unplanned pregnancy, unwanted, rejected
8. Family violence, abuse towards the mother and/or other children, history of abuse in childhood
9. Lack of family support. In the case of adolescents, the refusal to identify the father could be an indication of possible sexual abuse (incest)
10. Especially alcoholism (mother and/or father)
11. Psychological, personality, development, relationship problems, lack of social support
12. Father / mother with mental health problems that could affect the pregnancy and the care of the child
13. Malformation and congenital problems which affect from the birth of the child: great dependency on health and care, life expectation and the mother/father.
14. Children that will need special care and demand more attention
15. Neurological, motor or sensorial disorders which cause disablement
16. Problems of deficiency / mental retardation which are detected at an early stage (Denver test…)
17. Child which is usually restless, does not respect night -time pattern, continual crying
18. No breast feeding due to health problems or rejection of the mother
19. The mother dos not show or verbalise happiness/excitement/affection for her child
20. The fact that the sex of the child does not coincide with that wanted causes rejection in the mother and/or father
21. Child cries excessively or is thus perceived by the mother who cannot control the crying of the child
22. Idealisation, fantasies or problems in the child which lead to frustration and rejection by the mother as expectations are not met
23. The mother does not respond adequately to the demands /crying of the child, feeding times… In the case of artificial feeding, preparation is carried out without following the indications of the bottles
24. Insufficient hygiene and nappy changing which causes hygiene problems in the child (e.g. nappy rash)
25. They do not show an interest in registering the child in the Civil Register or in naming him/her. When there is friction in the couple caused by this issue
26. Father who rejects his situation and his responsibilities. Lack of attention/ indifference towards the child and the mother. Does not collaborate in the care of the child.
27. Postnatal depression
28. Newborns who require care in an incubator / intensive care, or through family, social or medical reasons which have nothing to do with the mother
29. Rejection of breast feeding
30. With social implications which affect the child and his/her care: HIV., ETS.,
31. Lack of space, cohabitation of several family groups
32. Lack/ scarcity of social, educational, health, recreation, religious centres,… in the district
33. No changes in the house caused by the arrival of the child
34. Poor housing, slum
35. Lack of cleanliness and hygienic habits in the house
36. Mother whose negative attitude to a home visit is considered as a risk indicator

NOTE: Notification should be carried out in those cases in which the different factors induce the professional to consider the situation as one of risk and therefore requires the monitoring and the attention of the social services.

The information contained herein is confidential. The aim of this form is to facilitate detection of abuse and the possibility of attention.

The information contained herein will be computerised with the guarantees established by Law:

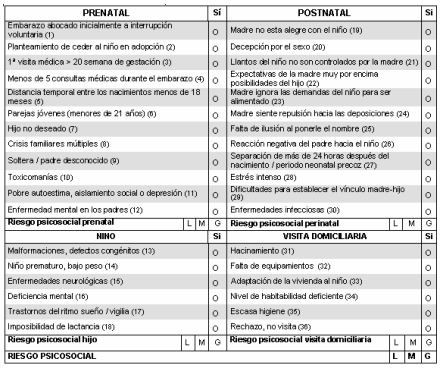
- Act of Parliament 15/1999, of 13 of December, on the Protection of data of a personal nature
- Directive 95/46 CE of the European Parliament and Council of 24 of October of 1995, Relative to the protection of individuals as regards the treatment of personal details and the free circulation of the latter.
- Royal Decree 994/1999, of 11 of June by which the regulation of security measures on automated files which contain data of a personal nature is approved
- Laws corresponding to the Autonomous regions on the regulation of the use of computers in the treatment of personal data

Instructions for use of the Notification form

This instrument is a questionnaire for the notification and collection of information on cases of expectant mothers at social risk. This questionnaire is not a diagnostic instrument but a standardised notification form of expectant mothers at social risk or suspected which can appear in our consulting rooms.

To use the questionnaire, you should mark with an X all the symptoms that are evident as well as those that are suspected, you should fill out the detection card and send the questionnaire by post.

The questionnaire comprises 4 inventories of indicators, a scale of risk valuation for each inventory of indicators, a box for comments, an explanatory legend of the symptoms and a section on the detection of the case.



PRENATAL	Sí	POSTNATAL	Si
Embarazo abocado inicialmente a interrupción voluntaria (1)	O	Madre no esta alegre con el niño (19)	O
Planteamiento de ceder al niño en adopción (2)	O	Decepción por el sexo (20)	O
1ª visita médica > 20 semana de gestación (3)	O	Llantos del niño no son controlados por la madre (21)	O
Menos de 5 consultas médicas durante el embarazo (4)	O	Expectativas de la madre muy por encima posibilidades del hijo (22)	O
Distancia temporal entre los nacimientos menos de 18 meses (5)	O	Madre ignora las demandas del niño para ser alimentado (23)	O
Parejas jóvenes (menores de 21 años) (6)	O	Madre siente repulsión hacia las deposiciones (24)	O
Hijo no deseado (7)	O	Falta de ilusión al ponerle el nombre (25)	O
Crisis familiares múltiples (8)	O	Reacción negativa del padre hacia el niño (26)	O
Soltera / padre desconocido (9)	O	Separación de más de 24 horas después del nacimiento / periodo neonatal precoz (27)	O
Toxicomanías (10)	O	Estrés intenso (28)	O
Pobre autoestima, aislamiento social o depresión (11)	O	Dificultades para establecer el vínculo madre-hijo (29)	O
Enfermedad mental en los padres (12)	O	Enfermedades infecciosas (30)	O
Riesgo psicosocial prenatal L M G		**Riesgo psicosocial perinatal** L M G	
NIÑO	**Si**	**VISITA DOMICILIARIA**	**Si**
Malformaciones, defectos congénitos (13)	O	Hacinamiento (31)	O
Niño prematuro, bajo peso (14)	O	Falta de equipamientos (32)	O
Enfermedades neurológicas (15)	O	Adaptación de la vivienda al niño (33)	O
Deficiencia mental (16)	O	Nivel de habitabilidad deficiente (34)	O
Trastornos del ritmo sueño / vigilia (17)	O	Escasa higiene (35)	O
Imposibilidad de lactancia (18)	O	Rechazo, no visita (36)	O
Riesgo psicosocial hijo L M G		**Riesgo psicosocial visita domiciliaria** L M G	
RIESGO PSICOSOCIAL		L **M** G	

The central body of the questionnaire comprises 4 inventories of indicators, each one of the inventories corresponds to a different situation. The indicators are included in the four situations that can affect the psychosocial risk of the child: the prenatal situation, the postnatal situation, the situation of the child and the situation as regards the home visit. The situations are not mutually exclusive and should be evaluated depending on the situation of risk detection.

The inventories of indicators serve as a reminder of the most frequent indicators of abuse. It is possible to choose various indicators from each and every one of the sections. It will often be necessary to use various indicators from the different sections to outline the case. *The indicators are not mutually exclusive.*

Under the indicators of each situation there is a scale to value the importance of the indicators selected by the notifying person. It should be chosen by marking the "L" if it is light, the "M" if it is moderate, and the "S" if it is serious. If there is only a suspicion, the pertinent symptoms should be marked as light.

Finally, there is a global valuation scale or 'PSYCHOSOCIAL RISK'. On this scale you should gauge the global valuation of the case.

The indicators have an explanatory note, which is indicated by a number. The explanation is on the reverse of the questionnaire. It is advisable to read these notes when the indicator is not clear. If there were other symptoms or indicators not included in the list, they should be listed in the comments section.

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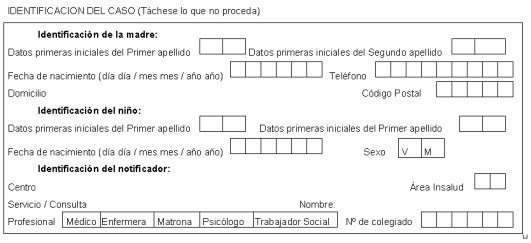

In the section on the detection of the case, data is included which facilitated the location and description of the subject in the accumulative database. It is essential to collect the initials of the mother. If the child has already been born, the initials, sex and date of birth (if known) should be collected. The date of notification should also be included as there could be various notifications of the same case in the same or in different centres.

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