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Recognizing and Responding to Child Maltreatment: An Overview

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Introduction

Child maltreatment is a significant public health problem with many potential deleterious consequences. Authors in this series provide concise overviews of key concerns and policy implications related to child physical abuse,[1] child neglect,[2] child sexual abuse,[3] child emotional abuse[4] and children's exposure to intimate partner violence (IPV).[5] Also offered is an overview of what is known about the prevention of child maltreatment and associated impairment,[6] as well as a summary of the epidemiology of child maltreatment,[7] including information about prevalence and incidence rates in Canada. Each author draws attention to the complexity of maltreatment, the importance of understanding risk and protective factors that must be addressed in order to effectively prevent or respond to maltreatment and key policy implications regarding specific types of maltreatment. In addition to these important overviews, we draw attention to educational resources for healthcare and social service providers seeking to recognize and safely respond to children exposed to maltreatment.

Recognition of maltreatment

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Across each overview, authors note the challenges of identifying children who have experienced maltreatment. Trocmé[7] notes that physical injuries due to maltreatment are relatively rare, with the 2008 Canadian Incidence Study finding physical injuries in 8% of the 26,339 cases of substantiated maltreatment involving newborns to five-year-olds. However, Chaiyachati and Christian[1] discuss the complexities of receiving an accurate account of injuries when physical abuse is a consideration. The authors note that many children are too young or too ill to provide details about their experiences of abuse and if older, may be too frightened to give an account of what happened. In addition, caregivers may not know about the physical abuse experiences. Caregivers may also be unwilling to provide accurate information if they themselves have caused an injury, if they are worried about the consequences of disclosing what occurred, or if they are fearful of another adult who is using violence in the home. Dubowitz and Poole[2] note the difficulty in identifying child neglect and suggest identification should be based on jurisdiction-specific laws regarding children's basic unmet needs and any potential or actual harm resultant from unmet needs. Wekerle and Smith[4] note the challenges in identifying emotional abuse given that there are no physical indicators as there are for other forms of maltreatment. They also draw attention to the high co-occurrence rates of emotional abuse with other forms of maltreatment, as well as the serious impairment that can result from emotional maltreatment. In spite of the difficultly of identifying emotional maltreatment, Trocmé[7] notes that most cases of abuse and neglect reported to child protection services involve current experiences or significant risk of emotional harm. Collin-Vézina and Milne[3] note the complexity of identifying children who have experienced sexual abuse, given that most children delay disclosures or never tell.

The signs and symptoms of maltreatment can be, for these reasons (and others), difficult to recognize; they often overlap with manifestations of other potential environmental concerns in the child's life, such as poverty or parental substance abuse. Howarth[5] notes that evidence regarding different strategies to identify children exposed to IPV is generally weak and that in the absence of good evidence, it is recommended that professionals use a case-finding approach (versus universal screening). Case-finding involves being alert to signs and symptoms of maltreatment, as well as providing a tailored response based on the child's presenting concerns and any safety considerations.

Prevention and interventions

A clear message across the child maltreatment overviews is the need for a public health approach to child maltreatment, involving primary prevention (preventing maltreatment from occurring),

preventing the recurrence of maltreatment after identification, and preventing impairment associated with maltreatment. As noted by the authors of each overview, prevention efforts involve mitigating risk factors and enhancing protective factors at each socioecological level, such as individual risk factors (e.g., child or parent characteristics, such as social isolation or parental history of maltreatment), family risk factors (e.g., lack of parent-child attachment), community risk factors (e.g., high levels of unemployment), and societal risk factors (e.g., policies that lead to poor living standards). For example, Dubowitz and Poole[2] note that prevention of child neglect requires addressing neglect-related risk factors of poverty and unemployment, whereas flexible employment opportunities can be a protective factor for families. Wekerle and Smith[4] note that policies are required that promote the safety, wellbeing, and rights of children to live free of all forms of violence. The also suggest that resilience-oriented programming may help dampen the effects of emotional maltreatment. Collin-Vézina and Milne[3] note that girls are at higher risk of experiencing child sexual abuse, but this may partially be due to boys' reluctance to disclose. In addition, risk for sexual abuse rises with age, with the highest number of victims being between 12 and 17 years of age. Howarth[5] notes that exposure to IPV can occur in any relationship, but women, transgender and gender non-binary persons are at increased risk of experiencing IPV.

Prevention efforts also involve attention to the coordination of services across sectors and political will. Chaiyachati and Christian[1] note that while the argument for primary prevention is compelling, children have little power to advocate for effective prevention programs and "solutions require comprehensive programs with collaboration between child welfare, law enforcement, courts, health and education." The authors therefore argue that reducing the impact of maltreatment requires political will to focus attention and policies on prevention of maltreatment efforts.

Barlow[6] describes many limitations in the current evidence base regarding interventions seeking to prevent maltreatment and associated impairments, such as the paucity of rigorous research designs that can be useful for assessing program effectiveness, the wide variation in measurement outcomes used within and across studies, the over-reliance on parental self-report and proxy measures of an outcome, and the lack of research overall in low- and middle-income countries. In spite of these research limitations, Barlow[6] does draw attention to some promising programs, such as Triple P or Nurse Family Partnership for primary prevention of maltreatment; Parent-Child Interaction Therapy and SafeCare for prevention of recurrence; and trauma-focused cognitive behavioral therapy for children who have experienced sexual abuse and have post-traumatic stress symptoms.

In spite of these limitations in the current evidence, some authors in this series discuss good practice skills that providers can use to assist children and families when maltreatment is suspected or confirmed. For example, Dubowitz and Poole[2] discuss the following six principles that can guide providers in tailoring services to children and families' unique needs: "1) address the contributors to the problem, 2) forge a helping alliance with the family, 3) establish clear achievable goals and strategies for reaching these goals, with the family, 4) carefully monitor the situation and adjust the plan if necessary, 5) address the specific needs of neglected children and those of other children in the home, and 6) ensure that interventions are coordinated with good collaboration among the professionals involved. These types of skills are helpful for providers to consider while we await advances in research about effective evidence-based programs for preventing maltreatment and associated impairments.

Training for healthcare and social service providers

While the authors of each overview emphasize that the best way to help children is to prevent maltreatment from ever happening (primary prevention), healthcare and social service providers need support to care for and protect children who are currently experiencing maltreatment. Thanks to funding from the Public Health Agency of Canada, the VEGA (Violence, Evidence, Guidance, Action) Project[8] (see https://vegaproject.mcmaster.ca/whyvegavideo) has created pan-Canadian guidance and educational resources to assist healthcare and social service providers with recognizing and responding safely to those experiencing family violence, including child maltreatment. VEGA[8] includes a platform for evidence-based guidance and an accreditable curriculum comprised of learning modules (e.g., care pathways, scripts, how-to videos), interactive educational scenarios, and a handbook to better equip providers (including students) across a range of settings to provide safe and effective care to those who may have experienced family violence. Modules address 1) epidemiology of maltreatment (rates of maltreatment, definitions, health and social impacts, and risk and protective factors), 2) strategies to create safe interactions and environments through trauma- and violence-informed care, including patient/client physical, emotional, and cultural safety and 3) strategies for identifying children experiencing maltreatment and safely responding. VEGA educational resources were developed based on results from extensive systematic reviews, which were conducted in coordination with the World Health Organization (WHO) officials and parallel WHO child maltreatment guidance development. In addition to evidence-based information, like the principles detailed by Dubowitz and Poole,[2] VEGA contains many guiding principles of good practice when responding to children

experiencing maltreatment. For example, VEGA suggests that before asking children questions that might result in them disclosing exposure to child maltreatment, certain conditions of safety must be achieved, such as a private space to speak with the child separately from the caregiver. Additional good practice information is available regarding strategies for identification, ways to inquire safely about maltreatment, ways children disclose about maltreatment, safe responses to disclosures of maltreatment, strategies to fulfill reporting duties, principles of comprehensive assessment, considerations for documentation, and more.

Conclusion

Child maltreatment has major human and economic costs, given the potential physical and mental health consequences of these exposures. Policy efforts should address prevention of maltreatment, as well as mitigation of risk factors associated with maltreatment (e.g., poverty, employment). Research on effective interventions for prevention of maltreatment and associated impairment is limited, but a few promising programs are available. While prioritizing prevention is a key concern, the VEGA Project offers helpful educational resources for healthcare and social service providers so that they may effectively recognize when children may be experiencing maltreatment and safely respond to these children.

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