



HOITOTYÖN TUTKIMUSSÄÄTIÖ

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IDENTIFICATION OF AND INTERVENTION IN CHILD MALTREATMENT A clinical practice guideline

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BACKGROUND

Child maltreatment is a sensitive and complex issue both in terms of clinical practice and research. It is a matter of concern for both child protective services and health services. Health professionals have knowledge of child maltreatment, but the identification of the problem is complicated by its sensitive nature, high time pressure, and the absence of uniform guidelines. Interventions may be further complicated by conceptions of family privacy, fear of false allegations, and the ensuing loss of trust. (Paavilainen et al. 2002ab, Paavilainen et al. 2006.) Child maltreatment causes a great deal of human suffering among children and generates sizeable costs, difficult to calculate (Sadler et al. 1999).

Although Finnish children enjoy relatively good health and high levels of safety, the possibility of child maltreatment still exists, and health professionals and others working with children need to consider this possibility in their work. Physical abuse and clear neglect of care of children are easier to identify than emotional abuse. It is important for health professionals to be capable of identifying child maltreatment and intervening expertly. Health professionals need to acknowledge their responsibility for the situation, respond to the case and initiate further investigations in a sensible, straightforward, and expert manner and be prepared to engage in multidisciplinary cooperation. This marks the beginning of the helping process with all the treatment and investigation processes within a multidisciplinary framework (Taskinen 2003, Child Welfare Act 2007). The intervention in and investigation of maltreatment are associated with ethical, legal, and child protection issues which may, together with the methods of investigation, have long-term effects on the lives of those involved.

Children subjected to violence usually do not seek help actively because they may regard the behavior of their family as normal. And even if they were aware of the abnormality of violence, they lack the means to solve the problem. Help-seeking is further complicated by secrecy and shame associated with maltreatment. (Paavilainen & Pösö 2003.) Studies have shown that interventions in child maltreatment are insufficient and lack determination, and that for instance health professionals need continuous training, clinical supervision, attitude change at the individual level, and coherent tools for identifying and intervening in cases of child maltreatment. (Hopia et al. 2004, Sanders & Cobley 2005, Ziegler et al. 2005).

The guideline is based on the notion that the problem of child maltreatment needs to be recognized as a social fact (Brown et al. 1998, Leventhal 1999, McAllister 2000). The United Nations Convention on the Rights of the Child (www.unicef.fi) states that children under the age of 18 years need to be protected against all kinds of violence, negligent treatment and abuse. Of the UN member states, only 18 have adopted legislation that explicitly prohibits all forms of violence against children (www.lapsiasia.fi). Daro and Connelly (2002) noted that over the past three decades, the child maltreatment prevention efforts can be characterized by both apparent progress and shortcomings: the problem of child maltreatment has been oversimplified,

and there has been a failure to determine the proper scale for prevention efforts and establish an effective cooperation between service providers. Besides prevention, identification of and intervention in the problem are important (Thurston 2006). WHO suggested the use of the ecological model in the prevention and treatment of violence (Tenney-Soeiro & Wilson 2004). Knowledge of the ecological model (Bronfenbrenner 1986) facilitates identification and enables practitioners to use a variety of intervention approaches (MacLeod & Nelson 2000, Little & Kaufman Kantor 2002). The model implies that child maltreatment can be examined at the individual, family, community and society level. The relationship level stresses positive interaction within the family. Community-level measures seek to activate communities and focus, for example, on helping the victims. Societal approaches emphasize economic conditions, cultural norms, and broad engagement and communication efforts at the societal level. A variety of measures need to be implemented simultaneously at the different levels to enable the intervention in and prevention of child maltreatment.

The activities taken at these levels can be described in the following way. The Child Welfare Act has been amended, and it provides the framework for action. The new Act, which came into force at the beginning of 2008, clearly allocates duties to health services and emphasizes the importance of multidisciplinary cooperation. The Act also specifies the responsibilities of municipal government and stresses the involvement of children and families. The practice guideline for investigating child physical abuse (Taskinen 2003) can also be regarded as an example of a state-level policy, while the policy for identifying and investigating child abuse, developed at Tampere University Hospital (Paavilainen et al. 2002ab, Paavilainen & Merikanto 2003, Flinck et al. 2007), can be viewed as a community-level model. The evidence from follow-up studies shows that this model is an adequate tool for identifying and treating cases of child abuse. The model is further developed through educational interventions and by developing tools to aid in the identification process. These may include, for example, questionnaires designed to assess the situation (see Macmillan 2006). The service organizations of the city of Tampere have also developed a policy for identifying and treating maltreated children based on a multidisciplinary approach (www.tampere.fi/sosiaalipalvelut/materiaalipankki). The systematic review conducted by Peters and Barlow (2003) indicates that there is a lack of adequate instruments for reliably detecting or predicting future child maltreatment.

The policies and guidelines mentioned above are used to help individual families and children in a way that meets the needs of the situation and the child. The identification of and intervention in maltreatment are interlinked and form a totality; for an intervention to take place, there must be a suspicion of maltreatment and the problem must be identified. At the same time, suspicion and identification already signify intervention. The child maltreatment guideline treats this totality as a process (see also Flinck et al. 2007, www.tampere.fi/sosiaalipalvelut/materiaalipankki). The guideline does not cover treatments (e.g. various therapies) or preventive measures. The guideline focuses particular attention on how the activities of practitioners can

improve the process of identification and intervention as part of multidisciplinary cooperation.

The identification of and intervention in child maltreatment are complicated by attitudes, excessive caution, and shortcomings in the professional training of different occupational groups (Leventhal 1999, Truman 2000, Lazenbatt & Freeman 2006). Sometimes even extremely severe injuries can produce relatively few symptoms, emotional abuse is difficult to identify, and the fear of false allegations makes practitioners cautious. The child maltreatment clinical guideline seeks to facilitate the identification of and intervention in maltreatment. The guideline offers principles, tools, and methods based on current research and evidence to identify child maltreatment and encounter children and families as part of a multidisciplinary team. Although the guideline is specifically intended for use by nurses in nursing practice, it is also recommended for use by other professionals working with children and families with children.

The child maltreatment guideline is intended to be used as a national guideline especially in nursing practice. Nursing leaders and other managers responsible for child welfare services across sectors should contribute to the implementation of the guideline. The guideline is also helpful while developing curricula for undergraduate and continuing education programs. The Nursing Research Foundation is responsible for the dissemination, printing, distribution, and introduction of the guideline.

DEFINITION OF CHILD MALTREATMENT

The concept of child maltreatment covers all types of violence against children and young people. The concept of child abuse or violence against children is often used in an analogous manner. Child maltreatment is an umbrella term covering different types of harmful acts or the failure or omission by a caregiver to supply a child with necessary care. (Paavilainen et al. 1996, Paavilainen 1998, McAllister 2000, Paavilainen & Pösö 2003.) In this guideline, child maltreatment means intra-familial physical or emotional abuse and neglect of children.

Different forms of maltreatment often coexist, and intimate partner violence is strongly related to child maltreatment (Bethea 1999, Nair et al. 2003, Hopia et al. 2004, Tenney-Soeiro & Wilson 2004). Child maltreatment may either involve direct abuse of children or influence children indirectly through domestic violence. Maltreatment touches all family members, because they are either victims of abuse or bystanders who witness abuse inflicted on others.

Child maltreatment occurs in all societies and social classes. In Finland, Sariola and Uutela (1992) have studied violence against children. Of the children and young people who participated in the study, 72 % reported

having been subjected to mild parental violence, while 8 % reported severe parental violence. (Sariola & Uutela 1992.) Statistics regarding violence against children vary considerably between countries, which makes them virtually non-comparable. In the US it has been found that the incidence of child maltreatment increased by 150 % between 1980 and 1995, and rates of reported child maltreatment have increased in Japan as well. Among Finnish youth the overall likelihood of becoming a victim of violence has diminished (Ellonen, Kivivuori & Kääriäinen 2007). The Unicef survey (2007) on the welfare of European children noted that more information is needed on intra-familial child abuse. In Finland, a survey of children and young people subjected to abuse will be conducted in 2008.

Physical abuse is an act that causes a child pain or impairs a child's physical functioning either temporarily or permanently. This includes bruises, burns, head injuries, fractures, internal injuries, and gashes. Abuse often results in permanent injuries such as scars, pain, or a neurological impairment. Child physical abuse may even result in the death of a child. In such cases it has often been found that the abuse had persisted for a long period of time before death. (Loiselle 2002.) No precise statistics exist about child maltreatment deaths (Jenny & Isaac 2006).

Physical abuse includes, among other things, slapping, kicking, burning with a cigarette, pulling hair, and suffocating. (Loiselle 2002) **Munchausen by Proxy** is a special form of physical abuse where parents, usually a mother, deliberately use a variety of methods to inflict harm on a child to gain attention from medical personnel (Fulton 2000, Thomas 2003, Galvin et al. 2005). **Chemical violence**, where children are given tranquilizers, alcohol, or narcotics to make them sleep, or the failure to provide for prescribed medications or follow a necessary dietary regimen, is in this context defined as physical abuse. (Loiselle 2002) Lately, special attention has been paid to **baby shaking** as a form of physical abuse. Education on the harmful effects of baby shaking has been arranged for health professionals, and an information leaflet, "Handle with care", has been developed to be distributed to parents through child welfare clinics (Suomen Lastenlääkäriyhdistys 2006).

Emotional abuse may involve terrorizing or ridiculing a child, humiliation, belittling, and other forms of psychological threat to the extent that the child's emotional well-being and development are placed at risk. Physical punishment and other types of physical abuse are always associated with emotional abuse. Emotional abuse is always a feature of sexual abuse and child neglect but it can also exist independently of other forms of abuse. In such cases it may be difficult to recognize and determine it. (Hart et al. 1996)

Sexual abuse (sexual exploitation) is a form of child physical abuse mainly directed at a child's sexual organs and sexual characteristics. It may also involve an actual or attempted sexual intercourse or other forms of sexual acts violating the child's bodily integrity, for example, touching of sexual organs. Child sexual abuse may also involve engaging children in sexual behavior that is inappropriate for their age and development, exposure to sexual stimuli, or using a child as a model to make pornographic materials.

The majority of sexual abuse victims are girls and perpetrators are men, but attention has lately been focused on the sexual abuse of boys by mothers and other female caregivers. (Taskinen 2003.)

Child neglect involves the failure to provide appropriate care or protection, and failing to adequately provide for the child's physical and emotional needs. Neglect can vary in type, severity, or duration. As a result, child neglect may impact the child's overall development. Neglected children have even been found to exhibit more problems compared with those exposed to physical abuse. (Grouch & Milner 1993) Neglect is a multi-faceted issue, and there is no uniform definition of it (Allin et al. 2005).

Of the sub-types of child maltreatment, the main focus of this guideline is on the identification of and intervention in physical abuse, emotional abuse, and child neglect. Any of the forms of maltreatment may be found either separately or in combination, and it is often difficult to make a clear distinction between them (Grietens et al. 2004, Scher et al. 2004). The target population addressed in the guideline comprises all minors under the age of 18. Child sexual abuse was omitted from the guideline because it was found that it differs from other forms of abuse and has distinct characteristics. There exists a Current Care Guideline (www.kaypahoito.fi; Investigation of sexual abuse of a child) on this form of abuse.

IMPLEMENTATION OF THE CLINICAL PRACTICE GUIDELINE PROJECT

Research questions

A systematic literature review (Paavilainen & Flinck 2007) was conducted to serve as a basis for the clinical practice guideline. Systematic review is defined as a scientific technique to frame and develop research questions, to search for existing studies through systematic literature searches, to appraise the level of the evidence identified, to compile the evidence, and to interpret the results (Khan Khalid et al. 2003).

The literature review (Paavilainen & Flinck 2007) is intended to answer the following research questions:

1. How does the existing literature portray the identification of child maltreatment?
2. How does the existing literature portray the intervention in child maltreatment?

After completing the systematic review, the following question will be answered:

3. What types of recommendations portray the identification of and intervention in child maltreatment?

Data collection

A systematic literature review (Paavilainen & Flinck 2007) of all existing high quality studies on the topic was carried out to serve as a basis for the clinical practice guideline (Khan Khalid et al. 2002, Kääriäinen & Lahtinen 2006). Assistance with selecting databases and constructing search strategies was provided by an information specialist at the Department Library of Health Sciences, University of Tampere. We identified research evidence on how health professionals working in different health care settings can identify different forms of child maltreatment and what types of early intervention practices targeted at children and families can be used to influence the health and well-being of children and families when a child is at risk of being exposed to maltreatment and there is a suspicion or proof of maltreatment.

Database search: phase 1

In Spring 2005, the search was carried out in the following way:

Databases, search strategies and search terms:

The following electronic databases were searched for published articles in January–February 2005: Cinahl, Medline, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials, Journals of OVID Full Text, MEDIC, TAMCAT, LINDA, EBM Reviews-Database of Abstracts of Reviews of Effects (DARE), and British Nursing Index. The search covered the years 1998–2005.

The search terms included the following free-text terms or MeSH terms and their combinations:

(child abuse **OR** child maltreatment **OR** physical abuse **OR** emotional abuse **OR** child abuse, sexual **OR** child neglect) **AND** (prevention **OR** early intervention) **AND** (nursing **OR** primary care setting **OR** health care **OR** pediatric care **OR** social services)

(child abuse **OR** child maltreatment **OR** physical abuse **OR** emotional abuse **OR** child abuse, sexual **OR** child neglect) **AND** (education **OR** training)

(child abuse **OR** child maltreatment **OR** physical abuse **OR** emotional abuse **OR** child abuse, sexual **OR** child neglect) **AND** (practice guidelines **OR** handbook **OR** manual) **AND** nursing*

(child abuse **OR** child maltreatment **OR** physical abuse **OR** emotional abuse **OR** child abuse, sexual **OR** child neglect) **AND** treatment

(child abuse **OR** child maltreatment **OR** physical abuse **OR** emotional abuse **OR** child abuse, sexual **OR** child neglect) **AND** (systematic review **AND** controlled trial)

(child abuse **OR** child maltreatment **OR** physical abuse **OR** emotional abuse **OR** child abuse, sexual **OR** child neglect) **AND** (prevention **OR** early intervention **OR** diagnosis **OR** recognition)

*The search term “nursing” was confined to the following MeSH terms: school nursing **OR** maternal-child nursing **OR** community health nursing **OR**

legislation, nursing OR nursing care OR pediatric nursing OR education, nursing OR public health nursing OR emergency nursing OR neonatal nursing OR nursing, practical

Sexual abuse is included in the search terms because it was not decided to exclude it from the guideline until the search had been initiated. However, it was important not to omit the word "sexual" from the search because studies of sexual abuse often comment on the other forms of maltreatment falling within the scope of the guideline.

Search results

The first phase of the search yielded a total of 6220 results (Figure 1), that is, research reports or other articles. In all, 623 articles were selected by title, and their abstracts were reviewed. Studies and expert papers or treatment guidelines that addressed child maltreatment and focused on the identification of and intervention in child maltreatment were included by abstract. Attention was also paid to the extent of the reference lists of articles and hence the scientific quality of the article. Following review of abstracts, 224 full-text articles were obtained and reviewed by the two reviewers (AF, EP).

At this stage, we decided to exclude purely medical studies and studies focusing solely on methods of treating maltreated children, for instance, forms of therapy or prevention of maltreatment. Non-research-based discussion papers or commentaries were also excluded at this stage. The reference lists of the identified articles were also checked to identify other relevant material which had possibly been omitted from the search.

After reviewing the search result and the articles and after the meeting of the steering group on April 19, 2005, a decision was made to confine the scope of the guideline to the identification of and intervention in child maltreatment so as to keep the review in reasonable limits. Therefore a refined search was carried out in June 2005, using the following search strategy. The search was repeated once more in 2007.

Database search: refined phase 2

SEARCH TERMS: (child abuse OR child abuse, sexual OR child neglect OR child maltreatment) AND (identification OR detection OR diagnosis OR early intervention) AND nursing,

Systematic searches were carried out on **Ovid MEDLINE® and Ovid MEDLINE daily update, Ovid MEDLINE ® in-Process, Other Non-Indexed Citations, CINAHL, EBM Reviews, Cochrane Central Register of Controlled Trials, EBM-Database of Abstracts of Reviews of Effects, EBM-Cochrane Database of Systematic Reviews, CDSR, ACP Journal Club, DARE, and British Nursing Index, from 1998–2005.**

The search yielded 2065 results (Figure 1), and it was decided to further limit the search in the following way: review papers in English from 1998–2005 and full-text articles. **The repeat search yielded 1126 titles which were further limited to review articles: 222 results.** Of these, **115** papers were selected by title, of which **47 papers** were included by abstract, and the full text of each paper was examined by the two reviewers.

An update search for years 2006– was carried out in February 2007 to include the latest literature on the topic. We used the same set of search terms and databases. **The search yielded 70 titles whose abstracts were reviewed. On the basis of these, 43 full text articles were retrieved for review.** None of these articles were included because they clearly overlapped with the ones selected previously.

The search strategies yielded a total of 7416 titles => 808 articles (abstracts), and the full text of 314 papers was retrieved for review. Two reviewers examined the articles using an appraisal sheet jointly approved by the guideline development groups of the Finnish Nurses Association. As a result, a decision was made whether the study or paper was acceptable to serve as a basis for the guideline and finally, other possible comments were added. A total of 77 papers were selected (Appendix 1). In addition, the papers were classified as either research papers (n = 38) and systematic reviews or expert papers (n = 39). The following inclusion and exclusion criteria were used at the different stages of the search.

Papers were included in the review if they met the following inclusion criteria:

- study (RCT, quasi-experimental study, other quantitative or qualitative study), review article, systematic review, expert paper, if based on research evidence or tested evidence
- different forms of intra-familial maltreatment of children or young people aged 0–18: confined to physical and emotional abuse or neglect
- research focusing on professionals encountering maltreatment: teachers, nursing staff, social worker, day care staff etc.
- intervention in maltreatment
- identification of maltreatment
- scientific publication (excluding articles in professional journals)
- other relevant literature in the field (such as practice manuals or Current Care Guidelines based on current research and expert knowledge)
- article in English, Swedish, and Finnish
- year of publication 1998–2007

Papers were excluded from the review if they met the following exclusion criteria:

- purely medical study
- research paper or other article focusing solely on prevention or treatment methods
- research paper or other article focusing solely on sexual abuse

Rating scheme for the strength of the evidence: levels of evidence

- A (I)** Evidence from meta-analyses, well-conducted systematic reviews
- B (II)** Evidence from systematic reviews, one randomized controlled trial (RCT) or several well-conducted quasi-experimental studies demonstrating overall consistency of results
- C (III)** Evidence from one well-conducted quasi-experimental study or several other quasi-experimental studies demonstrating overall consistency of results
OR Several quantitative descriptive or correlative studies demonstrating overall consistency of results
OR Several well-conducted qualitative studies demonstrating overall consistency of results
- D (IV)** Evidence from other well-conducted studies, case studies, consensus reports, and expert opinions
(Results through Evidence-Based Nursing Manual, www.sairanhoitajaliitto.fi, Current Care Guidelines Manual, www.kaypahoito.fi)

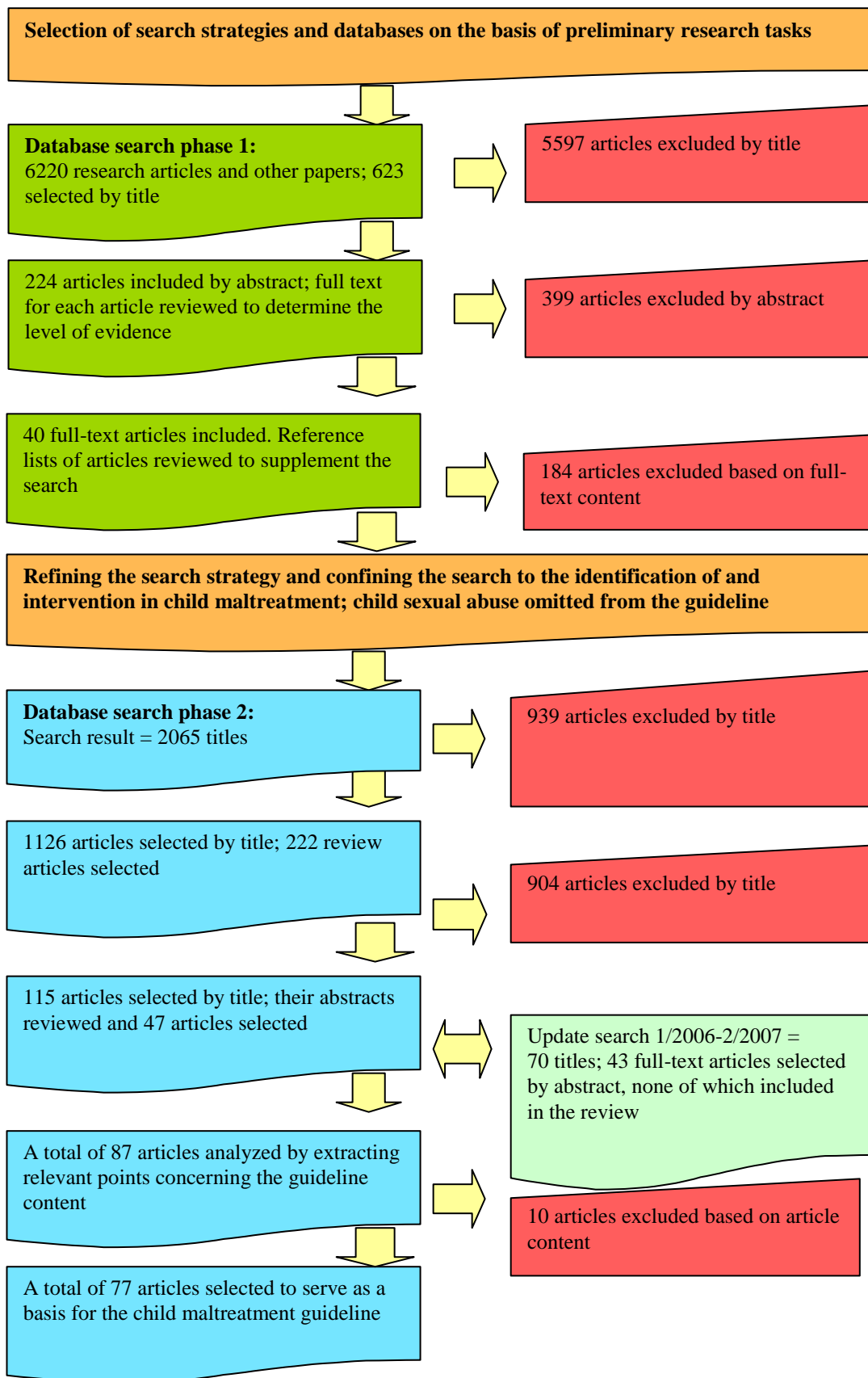


Figure 1. Data collection and selection procedure for systematic review.

Data analysis

The child maltreatment guideline is based on a systematic review of international research articles or expert papers identified by using the search strategies and electronic databases described above. To be considered for inclusion in the clinical guideline, the articles had to meet a series of predetermined inclusion criteria. On the basis of separate exclusion criteria, some studies and review articles were excluded from the review. Eleven of the articles were nursing research articles or reviews, while 66 articles represented other disciplines (among others medicine, psychology, social sciences). The papers were analyzed by extracting from each study relevant points concerning the identification of and intervention in child physical abuse, emotional abuse, and neglect.

Problems associated with database search and selecting articles

The development of the clinical guideline was complicated by the breadth of the topic, the large heterogeneity of the interventions, and the absence of high quality experimental and quasi-experimental studies. Owing to the nature of the guideline topic, it is difficult to conduct experimental studies of the problem. Because of this, there exist only a handful of experimental studies on the topic, and the only evidence available is from descriptive studies with a low level of evidence. Apart from experimental research, a topic such as this calls for descriptive research to elicit its important experiential aspects.

Search term refinement and creating the right search strategy were equally difficult. It was noticed in the first phase of the search that the wide variety of terms describing child maltreatment and the multi-dimensionality of the issue gave rise to problems with defining the scope and clarifying the boundaries of the search. It was therefore necessary to continually refine the search process, while at the same time trying to keep track of search terms that would help preserve the rich diversity of the issue. An effort was made to identify all suitable studies using repeat searches and refinements. A large number of papers with very homogenous results were included in the review. The purpose of including several studies with homogenous results was to try to validate the evidence produced by the systematic review and hence the grade of the recommendations. (Khan Khalid et al. 2003, Kylmä et al. 2004)

CLINICAL PRACTICE GUIDELINE

As shown by the systematic review and analysis of the existing literature (Paavilainen & Flinck 2007), the following issues are relevant to the identification of and intervention in child maltreatment (physical abuse, emotional abuse, neglect of care). The guideline recommendations are based on these issues. The level of evidence (on a scale of A-D, where A is based on the best or strongest evidence and D is based on the weakest evidence) for each study, and subsequently the grade of evidence of each recommendation are given brackets.

KNOWLEDGE AND APPRAISAL OF RISK FACTORS

1. Knowledge of risk factors in children and their behavior facilitates the identification of and intervention in child maltreatment. (B)

Risk factors include:

- complications associated with pregnancy or birth: preterm birth, low birth weight (Brown et al. 1998 (B), Bethea 1999 (D), McAllister 2000 (B), Peck & Priolo-Kapel 2002 (D))
- handicapped child (Bethea 1999 (D), McAllister 2000 (B), English 1998 (D), Peck & Priolo-Kapel 2002 (D))
- poor language development (Brown et al. 1998 (B))
- age: the younger the child (Tenney-Soeiro & Wilson 2004 (B), Tupola & Kallio 2004 (D), English 1998 (D))
- behavioral problems (English 1998 (D), Peck & Priolo-Kapel 2002 (D))
- weepiness of the child (Newton & Vandeven 2005 (D), Ricci et al. 2003 (D), Reijneweld et al. 2004 (D), Peck & Priolo-Kapel 2002 (D))
- irritability of the child (Kayama et al. 2004 (C), Ricci et al. 2003 (D))
Irritation factors in children include: misbehavior, defiance, disobedience, the child triggers childhood memories for the mother, the child dislikes/rejects the mother, the child offends the mother, the child fails to live up to the mother's expectations (grade of evidence C)
- special risk factors for baby shaking include (Kivitie-Kallio & Tupola 2004 (D), Newton & Vandeven 2005 (D)): premature baby, twins, male child, the child cries a lot
- special risk factors for Munchausen Syndrome by Proxy include (Fulton 2000 (D), Thomas 2003 (D), Galvin et al. 2005 (D)): the child is under 2 years of age, the mother is perpetrator of violence, often also complicated medical history or sudden death of a sibling

2. Knowledge of risk factors in parents and their behavior facilitates the identification of and intervention in child maltreatment. (B)

Risk factors include:

- substance abuse (Nair et al. 2003 (B), Bethea 1999 (D), McAllister 2000 (B), Väisänen & Väisänen 2000 (D), Tupola & Kallio 2004 (D), English 1998 (D), DiLauro 2004 (D), Locke & Newcomb 2004 (B), Sprang et al. 2005 (D), Bernet 1997, Ricci et al. 2003 (D), Peck & Priolo-Kapel 2002 (D))
- low level of parental involvement in child care (Brown et al. 1998 (B), Bethea 1999 (D), English 1998 (D))
- emotional coldness (Brown et al. 1998 (B), McAllister 2000 (B), Perez-Albeniz & de Paul 2004 (D))
- serious illness (Brown et al. 1998 (B), Väisänen & Väisänen 2000 (D))

- smoking (Toomey & Bernstein 2001 (C), Murphey & Braner 2000 (D))
- criminal record (Ricci et al. 2003 (D))
- low educational level (Brown et al. 1998 (B), McAllister 2000 (B), Tenney-Soeiro & Wilson 2004 (B), DiLauro 2004 (D), Toomey & Bernstein 2001 (C), Murphey & Braner 2000 (D))
- young parents (Nair et al. 2003 (B), Brown et al. 1998 (B), Bethea 1999 (D), Kivitie-Kallio & Tupola 2004 (D), Tenney-Soeiro & Wilson 2004 (B), Tupola & Kallio 2004 (D), Toomey & Bernstein 2001 (C), Peck & Priolo-Kapel 2002 (D))
- single parent (Nair et al. 2003 (B), Brown et al. 1998 (B), Bethea 1999 (D), Toomey & Bernstein 2001 (C), Peck & Priolo-Kapel 2002 (D), Murphey & Braner 2000 (D))
- parental history of maltreatment as a child (Bethea 1999 (D), McAllister 2000 (B), Tupola & Kallio 2004 (D), English 1998 (D), Toomey & Bernstein 2001 (C), Ertem et al. 2000 (D), Locke & Newcomb 2004 (B), Peck & Priolo-Kapel 2002 (D))
- emotional immaturity (Bethea 1999 (D), McAllister 2000 (B), English 1998 (D), DiLauro 2004 (D), Perez-Albeniz & de Paul 2004 (D), Ricci et al. 2003 (D))
- unwanted pregnancy/denial of pregnancy (Bethea 1999 (D), Kivitie-Kallio & Tupola 2004 (D))
- mental health problems (Nair et al. 2003 (B), Brown et al. 1998 (B), Bethea 1999 (D), Kivitie-Kallio & Tupola 2004 (D), McAllister 2000 (B), Tenney-Soeiro & Wilson 2004 (B), Väisänen & Väisänen 2000 (D), Tupola & Kallio 2004 (D), DiLauro 2004 (D), Bernet 1997 (D), Peck & Priolo-Kapel 2002 (D))
- divorce (McAllister 2000 (B))
- difficulty coping with demanding situations (Tenney-Soeiro & Wilson 2004 (B))
- extreme over-protectiveness (Paavilainen & Tarkka 2003 (D), Väisänen & Väisänen 2000 (D))
- poor compliance with treatment (Väisänen & Väisänen 2000 (D), English 1998 (D), Peck & Priolo-Kapel 2002 (D), Murphey & Braner 2000 (D))
- low level of appointment keeping (Paavilainen & Tarkka 2003 (D), Väisänen & Väisänen 2000 (D), Peck & Priolo-Kapel 2002 (D))
- authoritarian parenting and related disciplining practices (Tupola & Kallio 2004 (D), DiLauro 2004 (D), Bernet 1997 (D))
- parental experience of lack of social support (Bethea 1999 (D), English 1998 (D))
- unrealistic expectations of child behavior (Bethea 1999 (D), DiLauro 2004 (D), Ricci et al. 2003 (D), Peck & Priolo-Kapel 2002 (D))

3. Knowledge of risk factors in family situation or family behavior facilitates the identification of and intervention in child maltreatment. (B)

Risk factors include:

- several children in the family (Bethea 1999 (D), Toomey & Bernstein 2001 (C), Murphey & Braner 2000 (D))
- low income (Kivitie-Kallio & Tupola 2004 (D), McAllister 2000 (B), Tenney-Soeiro & Wilson 2004 (B), English 1998 (D), DiLauro 2004 (D), Peck & Priolo-Kapel 2002 (D))
- socioeconomic disadvantage (Kivitie-Kallio & Tupola 2004 (D), McAllister 2000 (B), Tenney-Soeiro & Wilson 2004 (B), English 1998 (D), DiLauro 2004 (D))
- history of child protective interventions (Kivitie-Kallio & Tupola 2004 (D), DiLauro 2004 (D), Peck & Priolo-Kapel 2002 (D))
- intimate partner violence (Nair et al. 2003 (B), Bethea 1999 (D), Tenney-Soeiro & Wilson 2004 (B), Väisänen & Väisänen 2000 (D), DiLauro 2004 (D), Bernet 1997 (D), Toomey & Bernstein 2001 (C), Ricci et al. 2003 (D), Peck & Priolo-Kapel 2002 (D), Rumm et al. 2000 (D), Tajima 2004 (C))
- unemployment (McAllister 2000 (B), Tenney-Soeiro & Wilson 2004 (B), English 1998 (D), DiLauro 2004 (D), Peck & Priolo-Kapel 2002 (D))
- family stress or crisis (McAllister 2000 (B), English 1998 (D), Sprang et al. 2005 (D))
- quarreling (Brown et al. 1998 (B), Mollerström et al. 1992 (D))
- lack of togetherness between family members (Mollerström et al. 1992 (D))
- low level of child-parent interaction (Paavilainen & Tarkka 2003 (D), Peck & Priolo-Kapel 2002 (D))

- parental reluctance to engage in conversation with health professionals (Paavilainen & Tarkka 2003 (D))
- social isolation or marginalization (Brown et al. 1998 (B), Paavilainen & Tarkka 2003 (D), Mollerstrom et al. 1992 (D), Peck & Priolo-Kapel 2002 (D))
- welfare dependence (Brown et al. 1998 (B))
- family perception of lack of social support (Bethea 1999 (D), Mollerstrom et al. 1992 (D), Peck & Priolo-Kapel 2002 (D))
- immature empathic skills both generally and within the family (Perez-Albeniz & dePaul 2004 (D))

4. None of these risk factors or signs alone is not necessarily sufficient for substantiating the occurrence of child maltreatment but, on the contrary, the totality of the child and family needs to be considered. When some type of maltreatment has been substantiated, it is reasonable to suspect the presence of other types of maltreatment as well (Howes et al. 2000 (D), Grietens et al. 2004 (C), Scher et al. 2004 (D)). **(C)**

Combinations of risk factors accounting for maltreatment:

- parental depression, alcohol abuse, and history of intimate partner violence (Berger 2005 (D))
- maternal isolation (e.g. dissatisfaction with support received, unhappiness, or negative attitude towards the situation), the mother's emotional problems (e.g. inappropriate expectations concerning the child's behavior or lack of self-esteem) and communication problems (nature of family climate, the way the mother handles the baby) (Grietens et al. 2004 (C))
=> these should be noted as early signs of concern during home visits and appointments
- low income, lack of social support, personal experience of child maltreatment, and single-parent family (Hall et al. 1998 (C))
- mother's smoking during pregnancy, more than two children in the family, single parent, and low birth weight infant (Wu et al. 2004 (D))
- low maternal educational level, failure to attend the antenatal clinic during pregnancy, single parent, multiple births, smoking, several children in the family (Murphey & Braner 2000 (D))
- maltreating mothers comprise an extremely heterogeneous group (Wilson et al. 2005 (D))

5. The accumulation of risk factors tends to increase the risk of child maltreatment. Knowledge and appraisal of the quantity and nature of risk factors facilitate identification of maltreatment (Nair et al. 2003 (B), Brown et al. 1998 (B), Hall et al. 1998 (C), Ricci et al. 2003 (D), Wu et al. 2004 (D)). **(B)**

SIGNS OF CHILD MALTREATMENT

6. Knowledge of signs and symptoms associated with child maltreatment facilitates the identification of and intervention in child maltreatment. (B)

Physical signs:

- bruises on cheeks, thighs, torso, upper arms (Truman 2000 (D))
- bruises on buttocks (Kim 1999 (D), Bernet 1997 (D))
- bruising in a child under 9 months of age (Truman 2000 (D))

- bruises/lacerations in the shape of an object (Kim 1999 (D), Mudd & Findlay 2004 (D), American Academy of Pediatrics Committee on Child Abuse and Neglect 2002 (D))
- multiple bruises (Kim 1999 (D))
- perineal injuries (Kim 1999 (D))
- cigarette burns (Kim 1999 (D), Mudd & Findlay 2004 (D), Bernet 1997 (D))
- sharply demarcated burns in the shape of an object, burns resembling sock-like markings (Kim 1999 (D), Mudd & Findlay 2004 (D), American Academy of Pediatrics Committee on Child Abuse and Neglect 2002 (D), Bernet 1997 (D))
- injuries in different stages of healing (Bernet 1997 (D), Mudd & Findlay 2004 (D)), e.g. bruises of different colors
- skin injury (Kim 1999 (D), Mudd & Findlay 2004 (D), Tenney-Soeiro & Wilson 2004 (B), American Academy of Pediatrics Committee on Child Abuse and Neglect 2002 (D))
- head injury (Kim 1999 (D), Tenney-Soeiro & Wilson 2004 (B), Newton & Vandeven 2005 (D), Toomey & Bernstein 2001 (C), Chang et al. 2004 (D))
- skeletal injury (Kim 1999 (D), Tenney-Soeiro & Wilson 2004 (B), Bernet 1997 (D), Newton & Vandeven 2005 (D), Toomey & Bernstein 2001 (C))
- abdominal injury (Kim 1999 (D), Bernet 1997 (D))
- passivity, seizures, vomiting, sleepiness, respiratory arrest (Starling et al. 2004 (C))

Other signs:

- emotional burden, fear (Paavilainen & Tarkka 2003 (D))
- psychosomatic symptoms, e.g. abdominal pain and headache (Paavilainen & Tarkka 2003 (D))
- depression (Tenney-Soeiro & Wilson 2004 (B))
- adjustment problems (Tenney-Soeiro & Wilson 2004 (B), Lansford et al. 2002 (C))
- school attendance problems (Lansford et al. 2002 (C))
- substance abuse (Tenney-Soeiro & Wilson 2004 (B), Lansford et al. 2002 (C))
- other long-term emotional or behavioral problems (Lansford et al. 2002 (C))
- signs of neglect in the child (development delays, a variety of physical health problems, manifestation of signs associated with child age) and in the home (e.g. untidiness, clutter) (Cowen 1999 (D), Paavilainen & Tarkka 2003 (D), Straus & Kaufman Kantor 2005 (D))
- recurrent clinic visits (Paavilainen & Tarkka 2003 (D))
- reports of pain without a clear cause (Chaney 2000 (D))

PRINCIPLES AND METHODS OF IDENTIFYING AND INTERVENING IN CASES OF CHILD MALTREATMENT

7. Knowledge of the following principles facilitates the arousal of suspicion of child physical maltreatment:

- location, age and severity of the injury are inconsistent (impossible/incredible) with the explanation given and with the child's age-appropriate development stage (Kim 1999 (D), Mudd & Findlay 2004 (D), Truman 2000 (D), Tupola & Kallio 2004 (D), American Academy of Pediatrics Committee on Child Abuse and Neglect 2002 (D), Bernet 1997 (D), Newton & Vandeven 2005 (D)) (C)
- the younger the child suffering an injury (fracture, skull trauma, bruising, burn), the more certain it is that the injury is caused by abuse (Truman 2000 (D), Tupola & Kallio 2004 (D), Jenny & Hymel 1999 (C), Chang et al. 2004 (D)) (C)
- non-specific symptoms in a child are indicative of maltreatment (Kim 1999 (D), Newton & Vandeven 2005 (D)) (C)
- delayed medical care for an injury is indicative of maltreatment (Kim 1999 (D), Mudd & Findlay 2004 (D), Tupola & Kallio 2004 (D)) (C)
- changing explanations are indicative of maltreatment (Kim 1999 (D), Tupola & Kallio 2004 (D)) (C)

- belittling parental attitude is indicative of maltreatment (Kim 1999 (D)) (D)
- history of repeated injuries or clinic visits is indicative of maltreatment (Mudd & Findlay 2004 (D)) (D)
- careful physical examination of the child is important (Kivitie-Kallio & Tupola 2004 (D), Chaney 2000 (D), McAllister 2000 (B)) (PHYSICIAN'S DUTY) (C)

8. When identifying and intervening in cases of child maltreatment, health professionals need to consider a number of issues associated with the child and family: background, child, adults, their relationship) (Little & Kaufman Kantor 2002 (D), Sprang et al. 2005 (D)), and show caution and consistency in their reasoning (Bernet 1997 (D), Sprang et al. 2005 (D)). (C)

9. Family violence needs to be assessed during postnatal checks for healthy children, and mothers who have experienced intimate partner violence need to be informed about the effects of violence on children (McFarlane et al. 2003 (C)) (C)

Discussion with a parent at the prenatal and postnatal clinic about how the family raises and disciplines children can direct the discussion to the possibility of maltreatment (Gaffney et al. 2002 (D), Kayama et al. 2004 (C), Straus 2000 (D), Straus et al. 1998 (B)). Attitudinal modification to prevent physical punishment is also important (Straus 2000 (D)).

Questions:

- How did your own mother/father raise you as a child? Do you recall having experienced protection/unpleasant things? If yes, please specify. How did your parents discipline you and how do you intend to discipline your own child?
- What form of discipline do you use with your child? Discuss attitudes towards and forms of discipline, and consider them with the parents. Determine whether maltreatment is caused by educational disciplining or because a parent loses control. If necessary, discuss with a multidisciplinary team. Make sure that parents are properly informed and that they have, for example, the phone numbers and contact information for the service agency if they feel overexerted.
- Does your child irritate you (see irritation factors above)
=> often gives rise to a lively debate
- Ask parents to describe their attitudes towards child discipline; do they approve the use of physical punishment?
- If necessary, ask directly about maltreatment, using tangible questions
- Clarify whether parents are aware of the normal stages of child development and other age-related issues, e.g. the obstinate stage. Parents should also know that it is "normal" for a baby to cry: e.g. a one month old cries 1-5 hours a day (Reijneweld et al. 2004 (D)).

10. Parents should be asked about child care and their spousal relationship (Bethea 1999 (D), Reijneweld et al. 2004 (D)) (D):

- What is it like to care for this child?
- Who is available to help you/both parents?
- Do you make enough time for yourself/yourselves?
- What do you do when the child's behavior makes you nervous?
- What do you do when the child cries?
- Are you experiencing difficulties feeding the child or putting him/her in bed?
- Do your children attend a daycare center?

- What is the quality of your spousal relationship?
 - How do you cope with the daily routine of family life?
11. **When there is a suspicion of child maltreatment, it is also essential to ascertain, besides the child's injuries and symptoms, parental behavior by asking parents directly about their behavior** (Straus et al. 1998 (B), Straus & Kaufman Kantor 2005 (D), Wilson et al. 2005 (D)). **(C)**
 12. **When working with parents who have been maltreated by their own parents, it is essential to ascertain and ask direct questions about how they raise their own children and how they act as parents** (Locke & Newcomb 2004 (B), Sprang et al. 2005 (D)). **(C)**
 13. **It is worthwhile to ask direct questions about child maltreatment because when asked, parents often admit having maltreated the child** (Sharon et al. 2001 (D), Kerker et al. 2000 (D)). **(C)**
 14. **Children benefit from early home interventions (e.g. family guidance on child development, concrete aid and support, parenting skills training, supporting an increase in positive interaction between the child and parent in the home environment) for high-risk families where maltreatment is likely** (Nair et al. 2003 (B), Rubin et al. 2001 (C), Thomlinson 2003 (B), Dawson & Berry 2002 ((D)). **(B)**
 15. **Long-term family interventions, the family's commitment to them, shared goals, a trusting provider-family relationship, and that the family accepts the support offered, are essential for intervening in child maltreatment** (Betha 1999 (D), Paavilainen & Tarkka 2003 (D), Dawson & Berry 2002 ((D), Toomey & Bernstein 2001 (C), Howes et al. 2000 (D), DePanfilis & Zuravin 2002 (D), Thomlinson 2003 (B), Grietens et al. 2004 (C), Macmillan 2006 (B)). **(B)**
 16. **Carefully planned and implemented home visits by health professionals or other professionals are useful tools for the identification of and intervention in child maltreatment** (Rubin et al. 2001 (C), Eckenrode et al. 2000 (B), Leventhal 1996 (D), Olds et al. 1997 (B), Olds 2002 (B), Fraser et al. 2000 (C), Chaney 2000 (D), Centre for Reviews and Dissemination 2005 (A), Cerny & Inouye 2001 (D), Duggan et al. 2004 (B)). **(B)**
 - early home visits during pregnancy and early childhood reduce maltreatment by mothers, whereas home visits do not affect the magnitude of other forms of family violence. If the rate of violence in the family is high, home visits fail to reduce child maltreatment. (Eckenrode et al. 2000 (B), Olds et al. 1997 (B), DePanfilis & Zuravin 2002 (D)) **(B)**
 - during long-term follow-up (25 years), home visits may reduce maltreatment if they are suitable for families and nurses doing home visits receive training (Olds 2002 (B)). Planned and strength-oriented supportive home visits over a lengthy period of time reduce maltreatment (MacLeod & Nelson 2000 (A)). Poorly implemented and designed home visits may even increase maltreatment (Murphey & Braner 2000 (D)) **(B)**
 - the best time to assess high-risk (=multiple risk factors) families through home visits is immediately upon birth (Fraser et al. 2000 (C)) **(C)**

- a positive relationship between the client and nurse makes home visits an effective way to assess the family situation (Cerny & Inouye 2001 (D)) (D)
- home visits do not necessarily reduce child maltreatment (Duggan et al. 2004 (B), (Rubin et al. 2001 (C), Centre for Reviews and Dissemination 2005 (A)) (B)

Criteria for a successful home visitation program (Leventhal 1996 (D)):

- home visits begin as early as possible
- home visits occur frequently enough (family and provider learn to know one another)
- the main purpose of home visits is to create a therapeutic relationship with parents
- the practitioner discusses the possibility of maltreatment and its signs
- the practitioner is capable of offering a model of appropriate parenting
- the practitioner does not ignore the needs of the child
- the practitioner is capable of offering the family tangible services
- service delivery involves all members of the family
- home visits are personalized to meet the individual needs of families instead of offering "one-size-fits-all" services

17. Multidisciplinary cooperation facilitates the identification of and intervention in child maltreatment (Bethea 1999 (D), American Academy of Pediatrics Committee on Child Abuse and Neglect 2002 (D), Sharon et al. 2001 (D), Bernet 1997 (D), Little & Kaufman Kantor 2002 (D), Jenny & Hymel 1999 (C), Galvin et al. 2005 (D), Grietens et al. 2004 (C), Cowen & Reed 2002 (D), Leventhal 1999 (D), Sadler et al. 1999 (D), Murry et al. 2000 (D)). (B)

18. The role and communication skills of nurses are highly relevant to the identification of and intervention in child maltreatment (Paavilainen & Tarkka 2003 (D), Little & Kaufman Kantor 2002 (D), Cowen & Reed 2002 (D), Peck & Priolo-Kapel 2002 (D), Kim 1999 (D), Sharon et al. 2001 (D), King & Reid 2003 (D), Chaney 2000 (D)). (C)

The nurse's duties include:

- observation and documentation of injuries, signs and situation: date, description of injury (including photographs), appraisal of the etiology of injury, issues associated with the child's growth (e.g. nutritional status) and development
- appraisal and safeguarding of patient/client safety in and after the situation
- reporting of findings to the rest of the team
- observation of child and parent behavior (e.g. whether verbal communication fails to match nonverbal communication, the quality of the child-parent relationship)
- gathering information from families by asking questions
- listening to families
- identifying family risk factors
- making arrangements for continuing care
- primary nursing is important with regard to encountering children/families, and treatment
- systematic documentation is important: e.g. flow charts and check lists might be useful. Training should be provided to assist practitioners in using these tools. (Ranger & Pearce 2002 (D))

19. Joint training (e.g. the phenomenon per se, methods of identification and intervention, documentation and legislation) covering a wide spectrum of topics for different occupational

groups is a central means of improving the identification of and intervention in child maltreatment (Bannon & Carter 2003 (D), Cerezo & Pons-Salvador 2004 (C), Elders 1999 (D), Leventhal 1999 (D), Little & Kaufman Kantor 2002 (D), Renger & Pearce 2002 (D), King & Reid 2003 (D)). **(C)**

SUMMARY AND APPLICATION OF THE GUIDELINE

The clinical practice recommendations presented here are based on moderate evidence (Kahn Khalid et al. 2003). The systematic review (Paavilainen & Flinck 2007) serving as a basis for the guideline included 77 research reports or other high quality scientific papers from various disciplines. The recommendations have been grouped into appraisal of risk factors, signs of maltreatment, and principles and methods of intervention in child maltreatment. The guideline provides a summary of the relevant literature on child maltreatment in the form of principles promoting the identification of and early intervention in child maltreatment. The risk factors of maltreatment have been studied extensively, and their role and the significance of accumulation are emphasized in this guideline. However, practitioners should avoid labeling families as perpetrators of child maltreatment on the basis of these risk factors, and it should be borne in mind that different forms of maltreatment may occur in very different families.

The recommendations can be used in a variety of ways in community health care facilities, hospitals and other multidisciplinary contexts serving children, young people and their families. The research evidence collected and analyzed in the guideline is applicable to situations where a suspicion of child maltreatment has risen. The evidence needs to be applied together with the practitioner's clinical experience and with the experiential knowledge obtained from the child and his/her family, or with other relevant information pertaining to the situation. Equipped with research-based knowledge, practitioners can expand their knowledge base of the topic and be better prepared to discuss it in multidisciplinary teams. This gives practitioners the courage to intervene in cases of child maltreatment which have earlier been easier to ignore in the absence of necessary knowledge and courage (Paavilainen & Pösö 2003). The experiences of maltreated children and young people should also be heard and taken into consideration. There is currently not enough research knowledge about these experiences, and further studies are needed to explore this area.

The guideline can serve as a basis for professional training designed for nurses and other professionals, as well as for training related to multidisciplinary cooperation at different levels. The guideline is also intended to be used for classroom purposes in undergraduate and continuing education, and should be considered in the design and implementation of educational programs concerning children, young people, and their families. The guideline should be taken into consideration when organizing and managing multidisciplinary cooperation practices in and between different sectors. Unit-based, local, and regional policies concerning child

maltreatment and early identification should be further developed (Flinck et al. 2007), and the guideline content contributes to this development work. Sprang et al. (2005) also point out the need to develop versatile appraisal methods for the identification of and intervention in child maltreatment.

The recommendations can be used as a tool for discussing parental attitudes towards discipline, physical punishment and disciplining practices in Finland and also elsewhere. The guideline can promote discussion about the support needs of parents and families and about parental coping to prevent child maltreatment resulting from parental exhaustion and inability to cope.

The identification of and intervention in child maltreatment are an extremely complex topic, and it is not easy to provide comprehensive guidelines based on research evidence. Nevertheless, these recommendations highlight what is known about the topic on the basis of existing research evidence, and the recommendations can serve as the basis for client work. The application of these recommendations needs to be accompanied by provider education and training. In addition, it is necessary to record and pay attention to the experiences of children and families, and also to the clinical experience and related practice-based evidence of professionals working with children.

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