Child protection

Child maltreatment: every nurse’s business

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Abstract

Every nurse has a responsibility for protecting children, even those who do not work directly with children. However, many nurses are afraid of child maltreatment issues because they do not want to get things wrong or make a situation worse. The aim of this article is assist nurses in their child protection role. It describes the different types of child maltreatment, the risks, and its potential consequences. The nurse’s role in recognising and responding to suspected child maltreatment is discussed.

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**Aims and intended learning outcomes**

This article aims to inform the reader about child abuse and neglect (collectively referred to as maltreatment), with particular emphasis on the nurse’s role in relation to recognition and response of maltreatment. After reading this article and completing the time out activities you should be able to:

1. Describe the different types of child maltreatment.
2. Identify the risk factors for maltreatment.
3. List the effects that maltreatment may have on the child.
4. Describe the nurse’s role in recognising and responding to suspected child maltreatment.

**Introduction**

Child maltreatment takes different forms. ‘It constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power’([Butchart *et al* 2006](#_ENREF_2)).

It is difficult to determine the prevalence of child maltreatment. Victims often do not disclose abuse (Allnock and Miller 2013) and so the extent of the problem is hard to assess accurately. Drawing on published government statistics from all four countries of the UK, we know that, as of March 2013 (September 2013 in Scotland), 50,732 children were undergoing formal child protection assessment and intervention in the UK (National Society for the Prevention of Cruelty to Children (NSPCC) 2014a). In the most recent UK research into prevalence, one in four young adults reported having been severely maltreated in childhood ([Radford *et al* 2011](#_ENREF_10)). Drawing on figures derived from reliable sources, experts agree that between one (NSPCC 2014b) and three children ([Gilbert *et al* 2008](#_ENREF_5)) dies at the hands of their parents every week in the UK. This is far more than those who die from measles or meningitis for example (Daniel *et al* 2011).

Health professionals – including nurses – are afraid of child maltreatment issues, it is claimed: we do not want to get things wrong or to make things worse (Daniel *et al* 2011). However, every nurse has a responsibility for protecting children; it is everyone’s business. This is the case for all nurses, even those who do not work directly with children (Taylor and Corlett 2007). This article sets out some of the key issues about child maltreatment, outlines factors for nurses to be aware of and offers advice on how to recognise and respond to suspected child maltreatment.

Complete time out activity 1.

Time out 1

Thinking about your own area of practice, list the different points of contact that you might have with children. Whether or not your role is focused on children’s health, contact with children is likely to be frequent. [End time out]

**Types of maltreatment**

Children can be harmed in numerous ways (Table 1) and reflecting this there are various generally agreed definitions of maltreatment (Department for Education 2013, Scottish Government 2014). Children experiencing one sort of maltreatment often experience multiple forms (Ofsted 2011).

Table 1

Types of maltreatment

|  |  |
| --- | --- |
| Emotional abuse. | Persistent emotional maltreatment likely to cause severe and persistent adverse effects to a child’s development. |
| Neglect. | Persistent failure to meet a child’s basic physical and/or psychological needs likely to result in serious impairment to the child’s health or development. |
| Physical abuse. | Abuse which may include hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise casing physical harm to a child. |
| Sexual abuse. | Forcing or enticing a child or young person to take part in contact and non-contact sexual activities. |
| (Adapted from [Department for Education 2013](#_ENREF_4)) | |

In addition to these categories, there is growing recognition of the harm caused by living with domestic abuse and increasingly this is being recognised as a category of maltreatment (for example, in Canada, Australia, some European countries as well as some parts of the US) (McConnell *et al* 2014). Child maltreatment is indiscriminate; potentially any child can be a victim. However, some groups of children are particularly at risk. Children under the age of five years are most at risk, with those under one year experiencing the most abuse: eight times more than older children (Jütte *et al* 2014). There is increasing recognition that adolescents are also an extremely vulnerable group (Rees *et al* 2011). Additionally, disabled children and children from some minority ethnic groups are over-represented in the care system (Jütte *et al* 2014).

Complete time out activity 2.

Time out 2

Some children are more at risk of maltreatment than others. Analyse why this may be the case. There are plenty of indicators in this article to help you. [End time out]

**Risk factors for abuse**

Despite scientific advances and a wealth of research, our understanding of why some adults hurt children is poor. A range of risk factors is known to exist (Table 2), but none of these is predictive in and of themselves. There are risk factors in the parent, in the child, and in the wider environment (Taylor and Lazenbatt 2014). What is known is that, the more risk factors there are present, the greater risk of danger there is for a child; when it comes to child maltreatment, ‘multiples matter’ ([Spratt 2012](#_ENREF_11)).

Table 2

Risk factors for abuse and neglect

|  |  |
| --- | --- |
| Domestic violence. | Witnessing (watching and hearing) domestic abuse is terrifying for children. Even where a parent does their best to protect the child, it is still emotionally damaging. Often children are hurt intervening or used as a pawn to hurt the other parent. The abused parent may not have the emotional space or ability to provide a safe and nurturing parenting environment. |
| Alcohol and drug misuse. | Living with a parent addicted to drugs or alcohol can lead to a damaging environment for children. Poor parenting decisions can be made and children can be exposed to risky adults and impulsive behaviours. |
| Untreated mental illness. | Parents with a mental health illness often cannot care for themselves, much less their children. The illness may make them withdrawn or impulsive or quick to anger and children do not understand why. |
| Lack of parenting skills. | Some parents have never learnt or been shown how to be good parents, or may have been abused themselves. They may have trouble playing with a child, not recognise cues for feeding or distress or have unrealistic expectations. |
| Stress and lack of support. | While most parents love their children and want to do the best for them, sometimes the stresses of having a child can be too great a burden. Raising children without support from friends or family, while dealing with financial or relationship difficulties, can be distressing. |

Of these risk factors, the most toxic combination is living with domestic abuse, parental mental ill health and parental substance misuse (Brandon *et al* 2012). Each of these affects the parenting environment and behaviour, and two or more of these factors are present in over a third of cases where a child is fatally harmed (Brandon *et al* 2012). Yet adult services such as those for addictions or mental health consistently fail to enquire sufficiently about children; those working with children often do not know enough about the parents (especially fathers or other men in the household); and there is a lack of communication between child and adult services (Sidebotham *et al* 2010). Therefore where nurses work with adult patients or clients it is important to take account of those wider parental and contextual factors that might also be affecting the environment at home.

**Effects of maltreatment**

Child maltreatment has serious and long-term consequences on children’s health, development and wellbeing, and there is a now a strong evidence base that demonstrates both short and long term effects (see for example Butchart *et al* 2006, Daniel *et al* 2011, Norman *et al* 2102). While death from immediate injury or neglect is perhaps the most obvious, survivors of childhood maltreatment can experience multiple sequelae into the long term. A recent meta-analysis found a causal relationship between non-sexual child abuse and a range of mental health disorders, drug misuse, sexually transmitted diseases and risky behaviours ([Norman *et al* 2012](#_ENREF_8)).

It is known that maltreatment affects all aspects (cognitive, social, brain) of child development, and there is increasingly innovative work using tomography to map neurodevelopment impairment by tomography (Taylor and Lazenbatt 2014). The effects of maltreatment show in childhood through attachment and self-regulation disorders, in adolescence through internalising (negative behaviours directed at the self, such as withdrawal, sadness and loneliness) and externalising behaviours (directed at others, such as aggression and destruction of property) and in adulthood through disruptive or violent behaviours, addictions, mental health problems, anxiety and depression (Lazenbatt *et al* 2012).

Complete time out activities 3 and 4.

Time out 3

Read the overview on effects of maltreatment at: <https://www.childwelfare.gov/pubs/factsheets/long_term_consequences.pdf>. Now write a list of the consequences of maltreatment. How might these affect your patients or their patients’ children? [End time out]

Time out 4

Consider whether adults who have experienced abuse as a child are likely to become perpetrators of abuse. Is it possible to come to a definitive answer? [End time out]

Abuse and violence often continue in cycles through generations (Dixon *et al* 2005). However, none of these effects are inevitable; some children fare better than others, and studies of resilience and protective factors are encouraging (Taylor and Lazenbatt 2014). Therefore any definitive answer to Time out 3 would be ‘False’. Many adult perpetrators of abuse have themselves been abused as children and, as indicated in Table 2, exposure to maltreatment as a child can impact negatively on future parenting skills. However, most children who have been abused do not go on to perpetuate abuse (Dixon *et al* 2005). It is important to understand this difference and to be aware of the protective factors in relation to child maltreatment.

Complete time out 5 before continuing on to read about recognition.

Time out 5

Why are victims likely to conceal maltreatment? Draw two columns on a piece of paper. In the left-hand column, write down the reasons that you have identified. Leave the right-hand column blank for now (we will use this list again in Time out 6). [End time out]

**Recognition of child maltreatment**

As is clear from recent high profile cases such as the Operation Yewtree enquiry ([Gray and Watt 2013](#_ENREF_6)) investigating the Jimmy Savile circumstances, most abuse is known only to the victim and to the abuser. Many children and young people do not know where to go for help, feel afraid and guilty, fearing for their lives and those of their families; some feel complicit in the abuse (Allnock and Miller 2013). Neglected children in particular do not know any different and fail to recognise maltreatment for what it is (Daniel *et al* 2011). Very young children or those with communication difficulties rely even more on others to recognise that something is wrong. So overall it is important to understand that a great deal of maltreatment is never disclosed. The nurse, however, may be the person to pick up this. For example, a school nurse talking to a teenager about repetitive urine infections; a clinical research nurse completing a skin fold assessment on a ten year old; or a mental health nurse visiting a client who is still in bed and the children answer the door.

Complete time out 6.

Time out 6

In Time out 5 you made a list of the reasons why victims are likely to conceal maltreatment. Now in the right-hand column write down some ways in which you think nurses can help to address each reason. [End time out.]

In time out 6 you may have identified the importance for nurses of creating a safe environment, being non-judgemental and portraying a professional, caring attitude. It is these types of strategies that have been shown to increase the chances of disclosure (Allnock and Miller 2013), whereby a child tells someone, either directly or indirectly, about abuse. However, it is important to recognise that, even when disclosure does take place, adult responses are often unhelpful and inappropriate. An analysis of interviews with 60 children who had been (mostly sexually) abused showed that 80% of them had disclosed abuse to an adult, either directly or indirectly, but no action had been taken subsequently ([Allnock and Miller 2013](#_ENREF_1)). A systematic review of recognition and response to neglect found that most practitioners could recognise a neglected child when they saw one but that few knew how to respond ([Daniel *et al* 2011](#_ENREF_3)).

Complete time out activity 7.

Time out 7

Read the case of Daniel Pelka. Think about the signs and risk factors for child maltreatment already covered in the article. What should the adults responsible for Daniel have picked up on? [End time out]

**The case of Daniel Pelka**

Daniel died age four and a half from a head injury in 2012 ([Judiciary of England and Wales 2013](#_ENREF_7)). Coventry Safeguarding Children Board carried out a serious case review into the circumstances of Daniel’s death (2013). The report detailed how Daniel attended school with bruises and unexplained marks. He had been stealing food from other children’s lunchboxes, and appearing at school and in health centres with facial injuries. His mother was known to a range of health and social services and domestic abuse was an issue within the family. Daniel was starved, beaten, locked in his room, force-fed salt and had his head held underwater in the bath.

Daniel’s behaviours and injuries were seen by different school staff members, but despite all the signs no-one looked at the whole picture or reported concerns to authorities. The school responded to his behaviour by hiding food. As Daniel grew thinner his teachers became increasingly worried and, along with the school nurse, help was sought from the GP and community paediatrician.

Daniel was seen in February 2012 by a community paediatrician, but his behaviours regarding food and low weight were linked to a possible medical condition. The potential for emotional abuse or neglect as possible causes was not considered. The paediatrician was unaware of the physical injuries that the school had witnessed.

Daniel’s case highlights how physical, emotional abuse and neglect are often interconnected and are associated with contextual factors such as domestic abuse. Although single professionals and agencies were concerned about Daniel, communication was poor and there was a collective failure to protect him.

**Role of the registered nurse**

The role of every registered nurse is clear when dealing with child abuse or neglect: in the draft code currently under review, if there is any suspicion at all that a child is experiencing any form of maltreatment, you must take appropriate action (Nursing and Midwifery Council 2014). This article has explored how children are reluctant to disclose abuse and, even when they do, they are often ignored. It has also discussed how many practitioners do not know how to respond when faced with a case of suspected child maltreatment.

There are a number of things that can assist nurses in formulating appropriate responses. First, being attuned to the risk factors (Table 2) for maltreatment and signs (Box 1) may assist in accurate and timely recognition. This is the starting point of having the knowledge and confidence to take action. A crucial point is not to wait until you are certain; that is likely to be too late. Remember that you may be the only person who does something for that child or young person.

Box 1

Signs that a child may be experiencing maltreatment

* Excessively withdrawn, fearful, anxious or watchful.
* Shows extremes in behaviour.
* Doesn’t seem to be attached to caregiver.
* Acts either inappropriately adult or inappropriately infantile.
* Frequent injuries or unexplained bruising.
* Shies away from touch, flinches at sudden movement.
* Afraid to go home.
* Inappropriately dressed (unfit for the weather; filthy clothing).
* Poor hygiene.
* Untreated illnesses and injuries.
* Frequently unsupervised, left alone or playing in unsafe settings.
* Constantly seeks food.
* Has trouble walking or sitting.
* Inappropriately sexualised behaviour or knowledge for age.
* An STD or pregnancy, especially before age 14 years.
* Runs away from home. [End box]

Action can take a number of forms, and it is important not to feel isolated in the decision-making process. An initial step is to share the concern with a colleague. This should provide a mechanism to decide what happens next. Helpful questions to ask include:

* Share your concerns with other practitioners.
* Ask yourself: ‘What does this child need from me right now?’
* Ask yourself: ‘What does this child need from others right now?’
* Follow your organisation’s child protection guidelines.
* Ensure you take all possible action to protect the child.
* Inform your line manager or nurse consultant child protection or designated lead for child protection.
* Record all appropriate information.
* If you think the child is in immediate danger, then call the police or social services immediately.
* If you are really not sure and want to talk it through, call the NSPCC adult helpline on 0808 800 5000.

It is important to follow organisational child protection guidelines and to inform an appropriate person within the organisation. This will be a line manager, a nurse consultant for child protection or the designated lead for child protection. It is absolutely crucial that accurate and contemporaneous records are made; it is likely that these will be required to assist in future decision making and, in some cases, records can be subpoenaed. Precision and detail are therefore crucial.

If a child is deemed to be in immediate danger, police or social services should be contacted as a matter of urgency. Overall, there are a number of actions that need to be considered, and much will depend on the context. The only response that is never acceptable in the case of suspected child maltreatment is non-response (National Institute for Clinical Excellence 2009).

Complete time out activity 8.

Time out 8

There are many ways that assist in keeping a child or young person safer, even when living in a risky environment. Consider what these might be then check your understanding at: http://www.cyf.govt.nz/keeping-kids-safe/if-you-are-worried/looking-out-for-at-risk-children-and-families.html [/](http://www.aifs.gov.au/cfca/pubs/factsheets/a143921/) [End time out.]

**Next steps**

The aim of this article has been to discuss the different aspects of child maltreatment and to explore the nurse’s role in relation to recognition and response. In doing so the article has provided the reader with information to allow them to describe the different types of child maltreatment and to identify the risk factors associated with them. However, this learning should not be an end in itself. As we have discussed, many nurses and other health professionals worry about the issue of child maltreatment; how to identify it and how to respond in suspected cases. We hope therefore, that the insights gleaned from reading this article and engaging with the activities within it will help increase nurses’ confidence in this important area of nursing practice.

At the beginning of the article you were encouraged to consider your own area of practice and to identify the points at which you are likely to have contact with children. Many nurses – most obviously paediatric nurses and health visitors – have a role with explicit focus on children. It is likely that these nurses have engaged in education, training and continuing professional development which covers many of the issues addressed in this article. For other nurses, however, contact with children may form a tangential part of their work and they may not recognise the importance of their role in protecting children. The National Institute for Clinical Excellence (2009) has useful guidance on what to do when you suspect abuse. Familiarise yourself with these pathways and make sure to keep updated.

**Conclusion**

In this article we have discussed the types, risk factors and effects of child maltreatment and highlighted the nurses’ role regarding recognition and response. What we hope to have emphasised above all, is that protecting children is not solely the remit of a certain group of nurses. It is important that *all* nurses are aware of how to recognise and respond to suspected child maltreatment. It really is every nurse’s business.

Time out 9

Now that you have completed the article, you might like to write a reflective account. Guidelines to help you are on page 62. [End time out]

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