Guidance for Recognizing and Responding Safely to Child Maltreatment

VEGA
FAMILY VIOLENCE
EDUCATION RESOURCES

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The guidance in this document summarizes the evidence about interventions for identifying and responding to child maltreatment. Use of these strategies will be influenced by variations in provincial/territorial and local context, culture, and resources/service availability. For more information about the processes used to create this guidance, see here.

Healthcare and social service providers need to follow legislative requirements for mandatory reporting of child maltreatment.

1. Ask questions about child maltreatment when potential indicators are present.

Healthcare and social service providers should, without putting the child at increased risk, ask about child maltreatment when potential indicators are present, including 1) signs and symptoms in the child (e.g., injury, depression), 2) behavioural and emotional indicators in the child (e.g., markedly oppositional behaviour) or caregiver (e.g., caregiver fails to follow up on treatment), or 3) evidence-based risk factors in the caregiver (e.g., alcohol/drug misuse) or situation (e.g., high family stress). Universal screening of child maltreatment is not recommended based on available evidence.

2. Offer immediate support to those who disclose child maltreatment.

In addition to mandatory reporting obligations, if healthcare and social service providers suspect or confirm that a child is experiencing maltreatment or the consequences of this exposure, assessment by a specifically trained professional is required. This can be within their typical work setting or another that is accessible. Immediate support characterized by the following should be offered: respectful, nonjudgmental interactions, active listening, compassion and good communications skills.

3. Consider cognitive behavioural therapy (CBT) with a trauma focus for children (age two and older) who have experienced sexual abuse and have post-traumatic stress disorder (PTSD) symptoms.

CBT with a trauma focus refers to different manualized CBT therapies that focus on trauma. The essential principles of these therapies include the ability to reflect on, make connections among and change maladaptive trauma-related thoughts, feelings, and behaviours. CBT with a trauma focus that has been designed for children who have experienced sexual abuse is recommended for children age two and older who have experienced sexual abuse and have PTSD symptoms; sessions should be at least eight weeks in duration and include children and non-offending caregivers (with some joint sessions) when possible, but child-only CBT with a trauma focus is also effective.

4. Consider parent-child interaction therapy (PCIT) for children (ages 2-12) who have experienced physical abuse or neglect and have externalizing symptoms and their parents.

PCIT has two sequential phases known as child-directed interaction and parent-directed interaction. Each phase teaches parents communication skills that foster positive parent-child relationships. PCIT skills are taught via direct coaching of parents while they are interacting with their children, as well as with didactic presentations. PCIT is recommended for children ages 2 to 12 who have experienced physical abuse or neglect and have externalizing symptoms; sessions should be at least 12 weeks in duration. PCIT does not address issues related to sexual abuse and so is not recommended to address this exposure specifically.

5. Consider referral to other evidence-based interventions.

Following a comprehensive assessment by a qualified provider, children may need to be referred to evidence-based treatments for specific symptoms or conditions (e.g., depression) or other concerns (e.g., substance use). There is insufficient evidence to refer children to any other interventions simply on the basis of exposure to one or more types of child maltreatment; referrals to interventions should be based on an assessment of the needs of children and families. This is based on the review of a number of interventions that were directed at children who experienced maltreatment and were found to not be supported by evidence at this time.

How this guidance was created

VEGA developed this guidance by engaging expert child maltreatment clinicians and researchers, who formed an evidence review group (ERG). The ERG set the scope of evidence to be collected, analyzed and evaluated in coordination with the mandate set by the Public Health Agency of Canada (PHAC): safe and effective strategies to identify, relate to and support those who have experienced family violence. Systematic reviews were conducted and analyzed by an independent team of experts, the McMaster Evidence Review and Synthesis Team (MERST), in consultation with an expert from the MacGRADE team. The GRADE (Grading of Recommendations, Assessment, Development and Evaluations) methodology was then applied to create the above guidance statements. These guidance statements were reviewed by VEGA's National Guidance Implementation Committee (NGIC), which is composed of representatives from 22 key Canadian healthcare and social service professional organizations invited to participate in VEGA by the federal minister of health.

For further information

Please refer to VEGA's online education resources about child maltreatment, including the Recognizing and Responding Safely to Child Maltreatment Module and the Handbook Section on child maltreatment (https://vegaeducation.mcmaster.ca/).

Sources

1. World Health Organization. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental Health Gap Action Programme (mhGAP)--Version 2.0 [Internet]. Geneva, Switzerland: World Health Organization; 2016. Available from: https://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/

2. World Health Organization. Responding to children and adolescents who have been sexually abused [Internet]. Geneva, Switzerland: World Health Organization; 2017. Available from: http://www.who.int/reproductivehealth/publications/violence/clinical-response-csa/en/

3. World Health Organization. Update of the mental health gap action programme (mhGAP) guideline for mental, neurological and substance use disorders [Internet]. Geneva, Switzerland; 2015. Available from: https://www.who.int/mental_health/mhgap/guideline_2015/en/