CHILD ABUSE: NURSE IDENTIFICATION OF AT-RISK CHILDREN

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Abstract

"Child abuse is a problem for children, for families and for society as a whole, as the abused child may have life-long emotional and behavioural problems" (Murray, Baker & Lewin, 2000, p. 47). The nurse, often the first health care professional to see the abused child, must be alert to the physical, emotional and behavioural signs of abuse and know how to intervene.

Risk assessment should be standard practice for Registered Nurses offering paediatric health care. There is a triad of factors that serve as predictors of increased risk of abuse. To further aid New Zealand health care professionals where child and/or partner abuse is suspected, identification and response strategies are outlined in the Family Violence Intervention Guidelines (Ministry of Health, 2002).

Nurses have an opportunity to assess children for abuse through the nursing observation, physical examination and history taking. The nurse's actions to promote the hauora/wellbeing of each child in her/his practice may be the crucial determinant in the identification of and intervention for the abused child.

Key Words: Child, abuse, family, nurse

Introduction

New Zealand has "...levels of child maltreatment deaths that are four to six times higher than the average for the leading (Organisation for Economic Co-operation and Development) countries" (UNICEF, 2003, p. 2). Maltreatment is the "Physical, sexual or psychological abuse or neglect of a child by any person" (Ministry of Health, 2001b, p. 9). The same document continues with assertions that "Physical abuse includes acts of violence that may result in pain, injury, impairment or disease... (and) ...may include under/over medication", and "Psychological/emotional abuse includes any behaviour that causes anguish or fear...and...exposing the child to the...abuse of another person".

Legislative policy in New Zealand is reflecting the changing social and cultural mores, as evidenced by the Care of Children Bill (2003). This bill recognises the diversity of family

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arrangements in Aotearoa, and also emphasises parental "*responsibilities*" to provide daily care, whereas the previous terminology was parental "*rights*". This legislation strengthens the rights of children/tamariki, and improves New Zealand's compliance with international obligations as set out in the United Nations Convention on the Rights of the Child and the Ottawa Charter for Health Promotion (cited in Ministry of Health, 1998).

Durie (1998) sees wellbeing/hauora as having four dimensions of health, and compares these to the four supporting walls of a house/whare, with each 'wall' being a necessity and each 'wall' influencing and supporting the other dimensions. He describes these 'walls' as taha tinana/physical wellbeing, taha hinengaro/mental and emotional wellbeing, taha whanau/social wellbeing and taha wairua/spiritual wellbeing. The abused child often shows the linkage of these dimensions of wellbeing/hauroa - for example the physically abused child commonly has emotional and behavioural problems, which may be demonstrated as aggressive, violent and antisocial behaviours (Ministry of Health, 1998). Therefore, for a child health-assessment it is essential that the nurse assess the whole child which includes, as well as physical, emotional and mental status, the child's relationship to his/her family and community

Discussions about child abuse involve factors such as who abuses, who is abused, predisposing causes, historical aspects, education, warning factors and signs, cultural considerations, symptoms of abuse and intentional or unintentional injuries. As these aspects are extensive this paper is confined to two only - the identification of predisposing causes and nursing prevention of abuse.

Identifiers of child abuse

"Questioning about suspected child abuse and neglect in high risk groups…is recommended" (Ministry of Health, 2002, p. 27). The children in 5 percent of New Zealand families are estimated to be at high risk, with another 45 percent of families at risk if additional adverse circumstances arise (Ministry of Health, 1998). A triad of factors in the family situation are identified as predictors associated with an increased risk of abuse/neglect (Pillitteri, 1999). These are a 'special' child, a 'special' parent and a 'special' circumstance. For the remainder of this discussion, the special-parent term will be replaced by 'special' caregiver, as this includes babysitters, parents' partners and other adult extended-family members.

The **'special' child** is one who the caregiver sees as being 'different', such as one who was premature or had prolonged separation after birth (failure of bonding/attachment) or is disabled (Pillitteri, 1999). Eleven per cent of European and 16% of Maori tamariki have an intellectual, sensory, psychiatric or physiological disability, and therefore fall into this identifiable higher risk category (Statistics New Zealand, cited in Ministry of Health, 1998). Thus the

first predictor, the 'special' child, may be easy to identify in some circumstances, although not all have obvious disabilities. For example, in New Zealand the average age of children when diagnosed with foetal alcohol syndrome is five and a half years old, with the diagnosis predominately made because of neuro-behavioural problems (Leversha, Rowley & Marks, 2001). The latter study also states that most of these children already have several agencies involved in their care by the time of diagnosis.

The **'special' caregiver** may be an excessive user of drugs and/or alcohol, have had depression or mental illness during pregnancy or during the last six months, have been an abused child him/her self, have a history of criminality or be socially isolated (Pillitteri, 1999). However, as these can occur in all socio-economic levels and cultures and are not always obvious, it may be difficult for the nurse to identify the 'special' caregiver as being in a higher risk category, particularly if the professional nursing interaction is brief.

The **'special' circumstance** is broadly termed stress, which may arise because of socio-economic issues such as housing, poverty and unemployment (Ministry of Health, 1998). Tamariki Maori and Pacific children have worse health than non-Maori/tau iwi children, and socio-economic factors are a major contribution to these disparities (Ministry of Health, 1998). This third predictor, the 'special' circumstance, may also be difficult to identify, as it can depend on personal disclosure and on the individual's (subjective) level of stress. In addition, multiple 'small' issues may compound an individual's stress, and stress can be resolved or exacerbated rapidly.

Adult-to-adult violence in the home, regardless of the presence or absence of abuse predictors, justifies the immediate referral to the New Zealand Department of Child, Youth and Family (NZCYF). In families where spousal abuse is occurring, child abuse is more likely to occur (Ministry of Health, 1998). In fact, witnessing the abuse of a parent is seen as (psychological) child abuse, as these children have emotional and behavioural problems similar to those of children who are physically abused (Browne & Hamilton, 1999).

Identification of children at risk; prevention of abuse

"The high number of victims of child abuse who present to health care settings yet who remain undetected indicates that more direct efforts are required to identify and address the problem, so that the health and safety needs of victims may be adequately met" (Ministry of Health, 2002, p. 27). Nurses in all areas of health care have opportunities to detect indicators of abuse and families with high risk of child abuse, through the nursing observation, the physical examination and the history taking of the child.

Pillitteri (1999) states that 10% of all children presenting at Emergency Departments with traumatic injuries are victims of abuse. In New Zealand

in 2001, of the 38 children under two years of age who were notified as having subdural haematomas, 46% (12) were from child abuse and another 19% (5) were from suspected child abuse (Kelly, 2001). Murray, et al. (2000, p. 47) state "In over 80% of child abuse, the perpetrator is a family member", with pre-school age children having the highest incidence of abuse. However the literature also suggests that pre-school age children in day-care/pre-school centres are relatively safe (Coury, 2000).

When the child presents, nursing observation will yield information about the child-parent interaction, the general state and behaviour of the child, and possibly also about abnormal behaviour and development. The physical examination by the nurse may reveal physical, behavioural and developmental signs and/or symptoms that could, depending upon circumstances, raise the suspicion of abuse or neglect. The Ministry of Health (2001a, 2002) has an addendum that lists and describes patterns of injuries that can help identify abuse or differentiate accidental and non-accidental injuries, with an example of the latter being burns in unusual distribution such as glove and sock patterns.

A recommendation in the Family Violence Intervention Guidelines is that "...a thorough history for child abuse and neglect be taken in high risk groups..." with open-ended non-judgemental questions about parenting and discipline (Ministry of Health, 2002, p. 24). Thus the history taking needs to include a discussion of discipline used, the type of discipline, the age appropriateness of the discipline, and alternative disciplinary measures. The Crimes Act of 1961 (Section 59) states "Every parent of a child...and person in the place of the parent of a child is justified in using force by way of correction towards the child, if the force used is reasonable in the circumstances". However the words "reasonable" and "force" are not clarified in this Act, and physical abuse, as noted in Ministry of Health (1998), can occur in the context of corporal punishment. Thus, if corporal punishment is used, as part of the discussion of discipline, the nurse needs to elicit if an instrument or hand is used, if the hand is open or closed, what part of the body is targeted and if marks are left.

When there are physical injuries, Benger and Pearce (2002) state the history taking should ascertain whether the delay between injury and presentation is appropriate and if the history is consistent (between the verbal report of the child and caregiver or between caregivers). The lack of an explanation of the child's injuries is seen to be significant by Coury (2000, p, 10) who states that "...almost 20% of head injuries in hospitalised children were caused by abuse, and that in more than half of the abuse cases, family members reported no history to account for the injuries". In addition, other injuries should be looked for, their presence or absence noted, and if found the compatibility

of the history to the injury should be considered.

The disclosure of abuse by the child, the relevant observations, the history and the physical assessment need to be written, objective, timely, factual, concise, signed and dated. Interviewing and investigations are done by the appropriate specialists (such as CYPF or the Police Child Abuse Team) to reduce additional trauma to the child, as could arise from multiple questioning and assessments (New Zealand Children and Young Persons Service, 1996). If the child abuse case is handled in family court, where the issues are child safety (versus guilt or innocence as in criminal court) the child's health record should be sufficient.

The Ministry of Health has published a process for recognition and reporting of suspected child abuse (2001a, 2001b, 2002). This process suggests family advisement of the health concerns with possible referral made (e.g. Plunket, Early Start, Family Start, Children's Health Camps) if there is concern about the child's care but not about abuse/neglect. Peer consultation is suggested when child abuse/neglect is a possibility but the person making the assessment is uncertain what to do. If there are concerns for safety, either that of the child or the nurse, the guidelines recommend Police notification. If there is a strong suspicion of child abuse/ neglect but not concern about the child's immediate safety then Child, Youth and Family notification is more appropriate. Any person who, in good faith, reports suspected child abuse "...is protected from civil, criminal or disciplinary proceedings" (Children, Young Persons, and their Families Act, 1989, p. 5). This supersedes the Privacy Act of 1993 (Principle 11), which restricts personal information disclosure unless there is a serious and immediate threat to the life or health of another.

Although in New Zealand reporting of abuse is voluntary, not mandatory, there are processes and guidelines available to educate and support health care professionals to help keep children safe (Ministry of Health, 2001a, 2001b, 2002, New Zealand Children and Young Persons Service, 1996). Although health-care professionals may have concerns about erroneous reporting of cases of abuse, the safety of the child is paramount. The Ministry of Health (2001a, p. 4) states that "It is better to refer on suspicion. If you wait for proof, serious harm can occur".

To aid the identification of children at high risk of abuse or neglect, a risk assessment (including safety and needs if appropriate) should be performed and documented as part of the routine nursing assessment of each child. This could incorporate a chart 'flagging' system with a 'flag' for each one of the triad of markers for increased risk of abuse found to be present. A single 'flag' would mean enhanced re-evaluation at the next visit, with the family/whanau contacted if they do not return. Murray, et al. (2000) recommend a time lapse of not more than six months if the child is under three

years old. Two or three 'flags' require an intervention of family advisement, consultation or notification.

Given Pillitteri's (1999) indicators, theoretically, most child abuse could be prevented before it occurs, through identification of at-risk children and their families/whanau. However this theory presumes the sequence that the family presents for health care, one or more of the triad of predicting factors is present and is identified, appropriate referral is made and that the interventions of child welfare, social welfare or parenting help are effective. As some factors of the triad may be found in families who would never abuse their children/tamariki, the framework should be used only as an aid in decision making, rather than being seen as definitive. It is sound as an educational tool to help the nurse make an informed professional decision.

The presence of factors such as strong bonding and strong social/whanau supports are child-protective factors in all families - including those experiencing multiple social and economic disadvantages (Ministry of Health, 1998). The Child Health Strategy identifies home visiting (Family Start), co-ordination of services (Strengthening Families) and injury prevention as having the greatest potential to reduce abuse and neglect (Ministry of Health, 1998). Nursing has a prime role to aid children at risk, through the delivery of health care, early childhood health education and parenting education.

Conclusion

New Zealand's high levels of child maltreatment deaths make early detection of child abuse a high priority. The nurse, who may be the first health professional to see the abused child, must be alert to the physical, emotional and behavioural signs of abuse, and know how to respond promptly and appropriately. In this paper two complementary sources of guidance for nurses' decision making have been reviewed. Both warrant careful attention. Awareness of Pillitteri's set of predictors 'special' child, 'special' caregiver and 'special' circumstance will sensitise the nurse to these danger signals, and aid decision making with respect to intervention. The Ministry of Health (2002) guidelines for family violence intervention are more prescriptive about reporting. They warn health care providers that "... your role is to keep the child safe" (p. 47).

This paper has underlined the nurse's pivotal role in child abuse attention. Risk assessment is promoted as a standard of practice for all nurses whose work brings them in contact with children and families, thereby ensuring early detection. The nurse who is knowledgeable about intervention pathways and available services is better equipped to prevent or break the cycle of abuse. Actions undertaken by nurses to safeguard the hauora/well being of children encountered in their practice are likely to be crucial in identification of, and intervention for, the abused child.

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