Preventing Child Maltreatment:

a guide to taking action and generating evidence

prevention

World Health Organization

ISPCAN

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and

INTERNATIONAL SOCIETY FOR PREVENTION
OF CHILD ABUSE AND NEGLECT

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Foreword

Common sense frequently associates the problem of violence with the security and justice systems. Only more recently, with the progressive development and engagement of professionals working with public health, has there been an increasing recognition that a broader disciplinary approach must be engaged in the struggle to end violence. A multi-disciplinary approach should ensure not only an integrated strategy to respond to violence effectively, but as importantly, a consistent and evidence-based strategy to prevent it.

This broad expertise is even more important when it comes to dealing with violence against children inside homes and families. While there is no doubt about the need to assist victims and to guarantee their safety, priority should always be given to preventive measures. The Secretary-General's Study on Violence against Children compiled many studies and examples of experiences reported by governments that indicate the definitive importance of having a preventive strategy that combines the expertise of many professionals and which is solidly anchored in reliable data collection.

The traditional "privacy barrier" between the domestic and public spheres has inhibited the evolution of policies and legal instruments to prevent violence within the family and provide services for those affected by it. The absence of accurate and comprehensive data is one of the clear indications of the presence of this veil, hampering the development and evaluation of successful strategies to address this serious problem. Despite international human rights and child rights standards, some national legal frameworks remain insufficient when it comes to establishing a clear prohibition of violence within the home.

The World Health Organization has consistently called the attention of the world to the crucial importance of preventive policies, involving the public health sector, and the urgent need to improve data collection. The International Society for Prevention of Child Abuse and Neglect (ISPCAN) combines a unique multidisciplinary global coalition of professionals that in the last two decades has lead the development of a great number of strategies to recast approaches to stopping violence against children. Most recently, ISPCAN has collaborated with a range of partners to develop instruments to improve data collection on violence against children in the family and elsewhere.

This guide combines the accumulated expertise of both organizations and provides the necessary tools and information to governments, civil society and international organizations in their efforts to prevent and respond to violence against children. Now it is in the hands of those stakeholders to make full use of it.

Paulo Sérgio Pinheiro
Independent Expert
UN Secretary-General's Study on Violence against Children

Preface

In a 1999 issue of the journal Child Abuse and Neglect, the internationally renowned child maltreatment prevention expert David Finkelhor commented on what was needed to advance an agenda for eliminating child maltreatment and what had been achieved.

> First, we need good epidemiological data to see the location and source of the child abuse problem, and also to be able to track and monitor its response to our efforts. This is something we currently do not have, at least at the level that would satisfy any even generous public health epidemiologist. Second, we need experimental studies to evaluate new and existing practices, so we can agree on what works. Currently, we have practically none, outside of a couple in regard to home visitation and couple in regard to sexual abuse treatment. There is more experimental science in the toilet paper we use every day than in what we have to offer abused children or families at risk of abuse.[1]

Seven years later, UN agencies, nongovernmental organizations (NGOs) and international professional associations have made substantial progress in raising awareness about the magnitude and severe consequences for all societies of child maltreatment. Good epidemiological data, however, remain scanty and there is a dearth of evaluated prevention practices. Most epidemiological studies since 1999 come from North America, and – except for independent studies in a few western European countries and the 1997–2003 WORLDSAFE studies in Brazil, Chile, Egypt, India and the Philippines – there are almost no methodologically sound epidemiological studies. The evidence base for prevention is even more unequally distributed, with most studies based in North America.

This failure to evaluate programmes aimed at eliminating child maltreatment has occurred at the same time as governments, NGOs and international agencies worldwide have committed themselves to addressing child maltreatment as a human rights concern within the framework of the Convention on the Rights of the Child. The *United Nations Secretary General's Report on Violence Against Children* of October 2006 notes that many governments have undertaken extensive efforts in the field of legal reform to address child maltreatment. At the same time, these efforts contrast sharply – as governments themselves have acknowledged – with the frequently minimal investment in policies, and in programmes to document the epidemiology of child maltreatment, to carry out interventions to address its underlying causes, and to monitor the impact of interventions.

There are a number of reasons for this gap between a human rights-based commitment to prevention and the actual investment in prevention policies and programmes, including the following.

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[1] Finkelhor D. The science. *Child Abuse and Neglect*, 1999, 23:969–974.

- Child maltreatment remains for many people a highly sensitive and emotive issue that is not easily discussed in private, let alone in public debate.

- Preventing child maltreatment is not a political priority, despite the scale of the problem and an increasing awareness of its high social costs. The relative lack of political will has been exacerbated by a lack of understanding of the serious, life-long health impacts of child maltreatment, its burden on society and its implications for the costs of health services. As recent studies have shown, maltreatment and other adversities in infancy and childhood are associated with a broad spectrum of health-risk behaviours. In this way, maltreatment contributes directly and significantly to some of the leading causes of death and chronic diseases.

- There is a lack of awareness of how powerful strategies for preventing disease and promoting public health can prevent child maltreatment. These prevention strategies focus on underlying causes and risk factors at the level of the individual, family, community and society. They aim to reduce the incidence of child maltreatment in the population they are targeted at. There is already strong evidence that a few of these strategies are effective and cost-effective. Others show promise but need more outcome evaluation studies, and many of the rest should theoretically be effective but remain to be evaluated.

- Investment in child maltreatment is hampered by a pervasive demand for immediate returns on public investment – a demand that cannot always be met by prevention programmes, which sometimes take years to produce their intended effects.

Intensifying child maltreatment prevention therefore requires that the seriousness of the problem should be understood. This can be achieved through good epidemiological studies that point to where and how maltreatment takes place; that measure its consequences and costs; and that, with this information, set up, carry out and evaluate prevention programmes addressing the underlying causes and risk factors.

Preventing child maltreatment: a guide to taking action and generating evidence is a joint publication of the World Health Organization (WHO) and the International Society for Prevention of Child Abuse and Neglect (ISPCAN). It aims to assist governments, NGOs and international agencies to undertake scientifically informed programmes to prevent child maltreatment. The ultimate objective is a world in which all countries routinely implement child maltreatment prevention programmes based on sound epidemiological data and on local experimental studies of what is effective in prevention.

To help in achieving this objective, this guide recommends that future efforts to study the epidemiology of child maltreatment and to implement prevention strategies be conducted with the explicit aim of expanding the scientific evidence base for the magnitude, consequences and preventability of the problem. These future efforts should thus be designed, implemented and written up in such a way that they are suitable for publication in the scientific press and can feed national and international efforts to increase investments in prevention. Because current achievements are so low, even a modest success in reaching these goals in a number of low-income and middle-income countries would do much to raise the profile of prevention efforts. Child maltreatment could then have the prominence given to other serious public health concerns with lifelong consequences that affect children – such as HIV/AIDS, smoking and obesity – for all of which investments in epidemiological monitoring and prevention are already substantial.

Etienne Krug
Director, Department of Injuries and Violence Prevention
World Health Organization, Geneva, Switzerland

Introduction

Every child has the right to health and a life free from violence. Each year, though, millions of children around the world are the victims and witnesses of physical, sexual and emotional violence. Child maltreatment is a huge global problem with a serious impact on the victims' physical and mental health, well-being and development throughout their lives – and, by extension, on society in general.

Why is this guide needed?

Developments in human rights, law, forensic medicine and public health over the last 20 years have resulted in the problem of child maltreatment becoming more visible internationally, though to a degree that is far from sufficient. The Convention on the Rights of the Child and its Optional Protocols, along with the Committee on the Rights of the Child, have played a major role in sensitizing international organizations, governments and nongovernmental organizations (NGOs) to the issue of child maltreatment, within a broader range of issues involving children's rights. The 2002 *World report on violence and health*, and the 2003 World Health Assembly resolution on implementing the report's recommendations, highlighted the public health consequences of child maltreatment and stressed the role of public health in prevention and services for victims. International NGOs, such as ISPCAN, have also campaigned prominently for greater attention to child maltreatment and for political and professional investment in its prevention. Since 2003, the United Nations Secretary General's *Study on Violence Against Children*, initially requested by the Committee on the Rights of the Child, has helped further to increase awareness at global, regional and national levels, backed up by the regional consultations and government questionnaires solicited for the Study. Without doubt, the report of the Secretary-General to the United Nations General Assembly on the Study findings, set to occur late in 2006, along with the publication and launch of the Study report, will create further attention to the problem.

The process of raising awareness has brought to the fore the need for more rigorous evaluations of interventions on child maltreatment, including of those that provide services for victims. While a handful of interventions have been scientifically evaluated, the overwhelming majority remain either inadequately evaluated or else not evaluated at all. This limited evidence base has nonetheless identified some *effective* preventive interventions – such as training in parenting and home visitation. It has also found some interventions that are *promising* – including increasing access to antenatal and postnatal services, and reducing access to alcohol. Very little, on the other hand, is known about the effectiveness of services for victims and perpetrators. In particular, little is known of the impact of some widely practised interventions, such as child protection services, child-friendly types of court proceedings, mandatory reporting and mandatory treatment of perpetrators.

There is thus an increased awareness of the problem of child maltreatment and growing pressure on governments to take preventive action. At the same time, the paucity of evidence for the effectiveness of interventions raises concerns that scarce resources may be wasted through investment in well-intentioned but unsystematic prevention efforts whose effectiveness is unproven and which may never be proven.

For this reason, the main aim of this guide is to provide technical advice for setting up policies and programmes for child maltreatment prevention and victim services that take into full account existing evidence on the effectiveness of interventions and that use the scientific principles of the public health approach. This will encourage the implementation of scientifically testable interventions and their evaluation. It is hoped that, in this way, the guide will contribute to a geographical expansion of the evidence base to include more evaluations of interventions from low-income and middle-income countries, and a greater variety of evaluated interventions. The long-term aim is to be able to prepare evidence-based guidelines on interventions for child maltreatment.

For whom is this guide intended?

A large portion of child maltreatment is never reported to child protection and law enforcement authorities. At the same time, in all countries, the health, legal and social services sectors are the most affected by the consequences of child maltreatment and most involved in efforts to deal with it. This guide is therefore intended for policy-makers and programme planners working at national, provincial and municipal levels in the sectors of health, social services and the law.

In the health sector, the relevant technical fields are those of:

- health policy and planning;
- epidemiology and health-information systems;
- public health and preventive medicine;
- family and community health;
- reproductive health;
- paediatrics;
- mental health and substance abuse;
- emergency medical services;
- medico-legal services.

In the sector of social services, the relevant technical fields are those of:

- social work;
- child protection.

In the legal sector, the relevant technical fields are those of:

- justice;
- law enforcement;
- legal medicine;
- human rights.

Research is also vital for the development of effective programmes and policies to prevent child maltreatment. It is therefore crucial to involve the broader scientific community, including:

- universities and medical schools;
- science councils;
- private non-profit research institutes and government and independent think tanks.

Overview of the guide

The United Nations Secretary-General's Study on violence against children[1] highlights the alarming extent and nature of violence against children around the world, with considerable attention devoted to the issue of child maltreatment by parents and other family members. The Study serves as a reminder that, under the Convention on the Rights of the Child of 1991, countries are legally bound to comprehensively address child maltreatment. Their obligations are clearly articulated in Article 19, Section 1 of the Convention:

> States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

It is implicit here that child maltreatment is preventable – and not inevitable – and that states have a responsibility both to reduce levels of child maltreatment through preventive measures and to provide protection, justice and care for children who may be maltreated. The full range of measures expected of states includes mechanisms to prevent child maltreatment, including social programmes for children and caregivers; and to identify, treat and follow up known cases of maltreatment.

A systematic, multisectoral approach

This guide adopts the type of approach, across a range of sectors, that is frequently encountered in the field of public health. Although sometimes referred to as "the public health model", this approach is also used in other fields – always requiring the collaboration of several sectors in implementing its various elements. With this approach, action is taken:

- to prevent the problem from occurring;
- to detect the problem and respond when it does occur;
- to minimize its long-term negative impacts.

In the case of child maltreatment, this means:

- implementing measures to prevent violence against children;
- detecting cases and intervening early;
- providing ongoing care to victims and families where maltreatment occurs;
- preventing the reoccurrence of violence.

The important elements involved in such a systematic approach to child maltreatment can be briefly listed as follows:

■ Definition

The various sectors involved in addressing child maltreatment need to develop a common conceptual definition of child maltreatment and common operational definitions to enable case identification and enumeration. They also need to have a common statistical approach to the problem, including standard indicators for measuring rates of maltreatment and the factors that increase the risk of maltreatment.

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[1] *Report of the Independent Expert on violence against children*. New York, NY, United Nations, forthcoming October 2006.

■ **Prevention**

To prevent child maltreatment, policy and programme measures addressing risk factors and protective factors need to be implemented.

■ **Services**

A comprehensive response to child maltreatment involves putting into place measures and mechanisms to detect and intervene in cases of maltreatment, and to provide services to victims and families.

■ **Information for effective action**

Mechanisms to gather information through epidemiological surveys, facility-based surveillance, monitoring and evaluation must be strengthened. The information obtained should be made widely available and used to design prevention and response interventions.

■ **Advocacy**

Efforts to prevent child maltreatment should include activities to raise awareness among decision-makers and the public of the need for investment in evidence-based prevention programmes. Campaigning efforts should also focus on the adoption of non-violent social and cultural norms, especially as these relate to parenting.

For prevention and response work to be effective, four vital processes need to be observed when designing interventions. These are:

- to **define the problem** conceptually and numerically, using statistics that describe the scale of maltreatment and the characteristics of those most affected by it;

- to **identify the causes and the risk factors** that appear to affect susceptibility to maltreatment – for example, the factors that increase a child's risk of sexual abuse, or the obstacles to delivering effective child protection services;

- with knowledge of the risk and protective factors, to **design interventions** and programmes that have a high probability of being effective in minimizing the risk factors. Whether these interventions are targeted at individuals or entire communities, they need to be evaluated to determine their effectiveness.

- to **disseminate informatio**n about the effectiveness of interventions and increasing the scale of proven effective interventions. Whether for preventing maltreatment or for improving responses, the need is for high quality, reliable information. Research, routine data collection, and monitoring and evaluation of programmes are essential to the success of a systematic approach to child maltreatment.

This guide, *Preventing child maltreatment*, thus aims to promote a systematic approach that is based on evidence and that generates new evidence regarding the effectiveness of interventions to prevent child maltreatment and provide services for victims. In particular, its aim is to help readers to:

- understand the factors influencing child maltreatment, using an ecological model to bring out the interaction of factors at the individual, relationship, community and societal levels;

- become familiar with the strategies currently being used to prevent child maltreatment and with what is presently known about their effectiveness;

- understand the value of epidemiological methods for obtaining information on child maltreatment, and of scientific approaches to conducting outcome evaluation studies of prevention programmes and victim services;

- understand the needs as regards services of maltreated children and their families, and the systems for intervening to protect children when maltreatment occurs.

It is not possible in a single document to provide suggestions that will be equally valid across all settings and subtypes of child maltreatment. This guide focuses on the maltreatment in private settings (such as people's homes) of children aged 0–14 years, by parents or other family members. The range of 0–14 years has been selected because studies show that, around the age of 14 years, the risk of violence by a parent or other member of the family is greatly surpassed by the risk of violence by peers or other non-family members. The focus on private settings is used because, unlike institutional and public settings where preventive policies and codes of conduct can be enforced and monitored, the home calls for a specific set of prevention strategies. These strategies need to balance respect for individual autonomy and privacy, on the one hand, with the need to intervene for the social good and on behalf of individual children.

Summary of contents

Chapter 1 describes the phenomenon of child maltreatment and provides an overview of its scale, consequences and costs. The chapter also sets out an ecological framework for understanding susceptibility to child maltreatment in terms of causes and risk factors at the individual, close relationship, community and societal levels.

Chapter 2 makes suggestions as to how to gather information that can be used to direct and monitor preventive action and service provision. Information systems that record data on child maltreatment cases seen by available services are to be distinguished from epidemiological studies using population-based survey methods to identify all cases of maltreatment, and not only those that present to the available services.

At the population level, the chapter recommends that large-scale surveys of children and adults should be carried out, in which information is obtained on the children's and adults' exposure to maltreatment and other adverse factors, on their health-risk behaviours and on their current health status. It is suggested that service-based information systems prioritize the recording of two types of information. The first type is information that will help ensure coherent case management and the tracking of individual cases over time and between different service providers. The second is information on a relatively small number of uniform items of data that can be recorded for all cases that enter the system.

Chapter 3 focuses on promoting the prevention of child maltreatment. It is argued that new prevention efforts should be designed with reference to the evidence base of effective, promising and uncertain interventions, and set up to meet the criteria for outcome evaluation studies. Prevention strategies at the individual, family, community and societal levels are described. Practical recommendations are given on how to design an intervention as an outcome evaluation study, with a table listing suggestions for possible immediate, medium-term and long-term outcomes.

Chapter 4 deals with services for victims of child maltreatment and their families, as well as interventions to protect abused children. The paucity of evidence for the effectiveness of child protection services is stressed.

Chapter 5 provides concluding comments and highlights the recommendations contained in the guide on using information for action, designing prevention programmes and providing services for victims. When a systematic response to child maltreatment is developed using these recommendations, the resulting interventions based on evidence will in turn generate further evidence about the effectiveness of prevention strategies and services for victims.

The nature and consequences of child maltreatment

1.1 What is child maltreatment?

Child maltreatment refers to the physical and emotional mistreatment, sexual abuse, neglect and negligent treatment of children, as well as to their commercial or other exploitation. It occurs in many different settings. The perpetrators of child maltreatment may be:

- parents and other family members;
- caregivers;
- friends;
- acquaintances;
- strangers;
- others in authority – such as teachers, soldiers, police officers and clergy;
- employers;
- health care workers;
- other children.

Child maltreatment is a complex issue. Its dynamics and the factors that drive it, as well as effective prevention strategies, all differ markedly according to the victim's age, the setting in which the maltreatment occurs, and the relationship between victim and perpetrator.

Violence against children by adults within the family is one of the least visible forms of child maltreatment, as much of it takes place in the privacy of domestic life, but it is nonetheless widely prevalent in all societies. Child maltreatment by parents and caregivers gives rise to particular difficulties when designing strategies for prevention and victim services, since the perpetrators of the maltreatment are at the same time the source of nurture for the child.

While it is not possible to make any absolute statement about the numbers of children harmed by parents and other family members, child maltreatment is recognized internationally as a serious public health, human rights, legal and social issue.

The nature and the severity of both the violence itself and its consequences can vary extremely widely. In extreme cases, child maltreatment can lead to death. In the majority of situations involving maltreatment, however, the physical injury itself has a less severe effect in terms of damage to the child's well-being than the acute psychological and psychiatric consequences, and the long-term impact on the child's neurological, cognitive and emotional development and overall health.

Typology of violence

Child maltreatment is linked to other forms of violence – including intimate partner violence, community violence involving young people, and suicide – both causally and

Child maltreatment and damage to the developing brain

In recent years there has been an upsurge of research into early brain development, including into the effects of maltreatment on the developing brain during infancy and early childhood. This research is starting to give clear indications that the brain's development can be physiologically altered by prolonged, severe or unpredictable stress – including maltreatment – during a child's early years. Such an alteration in the brain's development can in turn negatively affect the child's physical, cognitive, emotional and social growth.

Different parts of the brain develop by receiving stimulation that provokes activity in that region. Over time, the brain grows larger and denser, reaching nearly 90% of its adult size by the time a child is three years old. If stimulation and nurture are lacking – for example, if the parents or caregivers are hostile to or uninterested in the child – the development of the child's brain may be impaired. Since the brain adapts to its environment, it will adapt to a negative environment just as readily as it will to a positive one.

Chronic stress sensitizes neural pathways and overdevelops those regions of the brain involved in responses to anxiety and fear. It also often results in the underdevelopment of other neural pathways and other regions of the brain. The brains of children who experience the stress – in the form of physical or sexual abuse or chronic neglect – will focus their resources on survival and responding to threats in the environment. This chronic stimulation of the brain's response to fear means that particular regions of the brain will frequently be activated. These regions will therefore be likely to be overdeveloped at the expense of other regions that cannot be activated at the same time, such as those involved in complex thought. The end result may be that regions of the brain not connected to the fear response are not "available" to the child for learning.

The effects of experiences during infancy and early childhood on brain development create the basis for the expression of intelligence, emotions and personality. When these early experiences are primarily negative, children may develop emotional, behavioural and learning problems that persist throughout their lifetime, especially if targeted interventions are lacking. For instance, children who have experienced chronic abuse and neglect during their first few years may live in a persistent state of hyper-arousal or dissociation, anticipating a threat from every direction. Their ability to benefit from social, emotional and cognitive experiences may be impaired. To learn and incorporate new information, whether from the classroom or a new social experience, the child's brain must be in a state of "attentive calm" – one that the traumatized child rarely achieves. Children who have not been able to develop healthy attachments with their caregivers, and whose early emotional experiences, through their impact on the brain, have not laid the necessary groundwork for positive emotional development, may have a limited capacity for empathy. The ability to feel remorse and empathy are built on experience. In the extreme case, if a child feels no emotional attachment to any human being, that child cannot be expected to feel remorse for hurting or even killing someone.

Where maltreatment has already occurred, there is some evidence that intensive, early intervention can help minimize the long-term effects of this trauma on the development of the brain. However, while early intervention with maltreated children can minimize the effects of abuse and neglect, it is considerably more beneficial to prevent maltreatment before it occurs. The costs – both in human and economic terms – of trying to heal these children are much greater than the costs of preventing maltreatment and thereby promoting healthy development of the brain during the first few years of life.

Adapted from: *In focus: understanding the effects of maltreatment on early brain development*. National Clearinghouse on Child Abuse and Neglect Information, Washington, DC, 2001. Available at: <http://nccanch.acf.hhs.gov/pubs/focus/earlybrain/index.cfm> (accessed 5 May 2006).

through shared underlying risk factors. It is therefore useful to view child maltreatment within a wider categorization of violence. Following the typology presented in the *World report on violence and health*, violence can be divided into three broad categories, according to the context in which it is committed.

- **Self-directed violence** refers to violence where the perpetrator and the victim are the same person. It is subdivided into self-abuse and suicide.

- **Interpersonal violence** refers to violence between individuals. The category is subdivided into family and intimate partner violence, and community violence. The former includes child maltreatment, intimate partner violence and elder abuse. Community violence is broken down into violence by acquaintances and

violence by strangers. It covers youth violence, assault by strangers, violence related to property crimes, and violence in workplaces and other institutions.

- **Collective violence** refers to violence committed by larger groups of people and can be subdivided into social, political and economic violence.

Cross-cutting each of these categories is the *nature* of violent acts. The nature of acts can be physical, sexual, emotional or psychological, or one of neglect. The classification of violence according to both type and nature of the violent act, as shown in Figure 1.1, provides a useful framework for understanding the place of child maltreatment within the complex patterns of violence.

Figure 1.1   A typology of violence
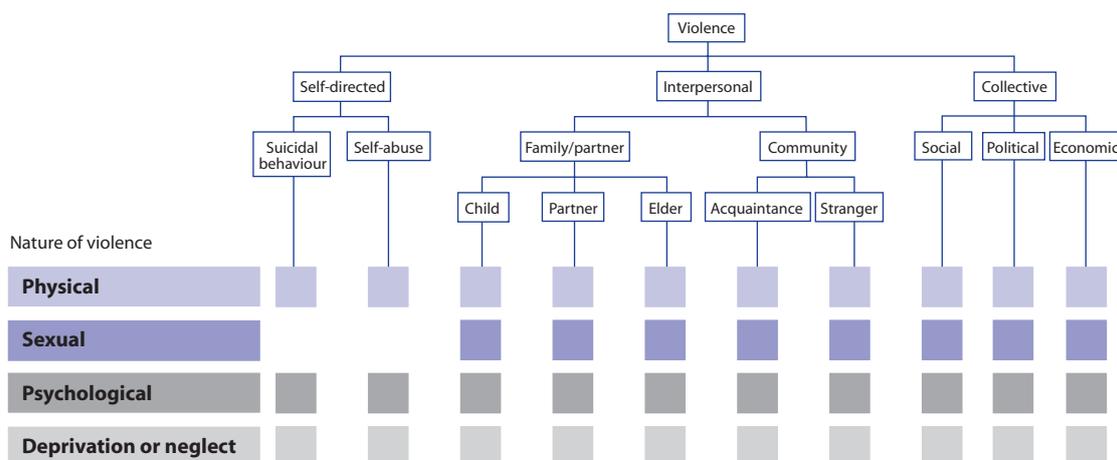
Child maltreatment often occurs alongside other types of violence. For instance, child maltreatment by adults within the family is frequently found in the same settings as intimate partner violence. Maltreated children are themselves at increased risk in later life of either perpetrating or becoming the victims of multiple types of violence – including suicide, sexual violence, youth violence, intimate partner violence and child maltreatment. The same set of factors – such as harmful levels of alcohol use, family isolation and social exclusion, high unemployment, and economic inequalities – have been shown to underlie different types of violence. Strategies that prevent one type of violence and that address shared underlying factors therefore have the potential to prevent a number of different types of violence.

Conceptual definitions of child maltreatment
Child maltreatment
Child maltreatment is defined as:

> 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.[1,2]

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[1]   *Report of the consultation on child abuse prevention, 29–31 March 1999*. Geneva, World Health Organization, 1999 (document WHO/HSC/PVI/99.1).

[2]   Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002.

As already stated, the *World report on violence and health* and the 1999 WHO Consultation on Child Abuse Prevention distinguish four types of child maltreatment:

- physical abuse;
- sexual abuse;
- emotional and psychological abuse;
- neglect.

Physical abuse

Physical abuse of a child is defined as the intentional use of physical force against a child that results in – or has a high likelihood of resulting in – harm for the child's health, survival, development or dignity. This includes hitting, beating, kicking, shaking, biting, strangling, scalding, burning, poisoning and suffocating. Much physical violence against children in the home is inflicted with the object of punishing.

Sexual abuse

Sexual abuse is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim.

Emotional and psychological abuse

Emotional and psychological abuse involves both isolated incidents, as well as a pattern of failure over time on the part of a parent or caregiver to provide a developmentally appropriate and supportive environment. Acts in this category may have a high probability of damaging the child's physical or mental health, or its physical, mental, spiritual, moral or social development. Abuse of this type includes: the restriction of movement; patterns of belittling, blaming, threatening, frightening, discriminating against or ridiculing; and other non-physical forms of rejection or hostile treatment.

Neglect

Neglect includes both isolated incidents, as well as a pattern of failure over time on the part of a parent or other family member to provide for the development and well-being of the child – where the parent is in a position to do so – in one or more of the following areas:

- health;
- education;
- emotional development;
- nutrition;
- shelter and safe living conditions.

The parents of neglected children are not necessarily poor. They may equally be financially well-off.

1.2   The scale of the problem

According to WHO, in the year 2002 an estimated 31 000 deaths were attributed to homicide among children less than 15 years of age. It is possible for child deaths due to maltreatment to be missed even in those few high-income countries that track such deaths, and for this reason these estimates underestimate the true number of deaths

from child maltreatment. Global estimates of child homicide suggest that infants and very young children are at greatest risk, with rates for the 0–4 year age group more than double those for 5–14-year-olds.

Infants and pre-school children are at the greatest risk of fatal maltreatment as a result of their dependency, vulnerability and relative social invisibility. Their cases are least likely to come to the attention of those who are in a position to monitor their care and safety and who are not family members or caregivers. The risk of fatal abuse is two to three times higher in low-income and middle-income countries than it is in high-income countries. It is also greater in societies with large economic inequalities than in those where wealth is more evenly distributed. The most common cause of death is head injury, followed by abdominal injuries and intentional suffocation. While it is not possible to specify the proportion of child homicides that are committed by parents and other family members, special studies conducted in mainly high-income countries suggest that members of the family are responsible for the majority of homicides in children aged 0–14 years.

Deaths represent only a small fraction of the problem of child maltreatment. Every year millions of children are victims of non-fatal abuse and neglect. Some international studies have shown that, depending on the country, between a quarter and a half of all children report severe and frequent physical abuse, which includes being beaten, kicked or tied up by parents. Much physical violence against children is inflicted as a punishment and is accepted by parents, prevailing social norms and even often by law as a correct means of discipline (see Box 1.2). Studies from around the world also show that approximately 20% of women and 5%–10% of men report having been sexually abused as children. Many children are subjected to psychological and emotional abuse as well as to neglect, though the extent of these phenomena worldwide is unknown. In some countries, neglect constitutes the largest proportion of reported child maltreatment cases. In general, girls are more at risk of sexual abuse and boys are at greater risk of harsh physical punishment. In some regions, gender inequality and discrimination place girls at increased risk of death stemming from maltreatment. The practices here include female infanticide, so-called "honour killings", and neglect arising from the child's gender.

1.3   The consequences of child maltreatment

The health and social consequences of child maltreatment are more wide-ranging than death and injury alone and include major harm to the physical and mental health and development of victims. Studies have indicated that exposure to maltreatment and other forms of violence during childhood is associated with risk factors and risk-taking behaviours later in life. These include violent victimization and the perpetration of violence, depression, smoking, obesity, high-risk sexual behaviours, unintended pregnancy, and alcohol and drug use. Such risk factors and behaviours can lead to some of the principal causes of death, disease and disability – such as heart disease, sexually transmitted diseases, cancer and suicide. Child maltreatment therefore contributes to a broad range of adverse physical and mental health outcomes that are costly, both to the child and to society, over the course of a victim's life (see Box 1.3).

1.4   The costs of child maltreatment

In addition to the health and social costs associated with it, child maltreatment has a huge economic impact. The economic costs include: direct medical costs, lost earnings and tax revenue due to premature death, special education, psychological and welfare

Discipline or punishment?

Discipline for children involves training and helping them develop judgement, a sense of boundaries, self-control, self-sufficiency and positive social conduct. Discipline is frequently confused with punishment, particularly by caregivers who use corporal punishment in an attempt to correct and change children's behaviour. There are several differences between discipline and punishment.

Positive strategies of discipline recognize children's individual worth. They aim to strengthen children's belief in themselves and their ability to behave appropriately, and to build positive relationships.

On the other hand, punishment involving either physical or emotional measures often reflects the caregiver's anger or desperation, rather than a thought-out strategy intended to encourage the child to understand expectations of behaviour. Such punishment uses external controls and involves power and dominance. It is also frequently not tailored to the child's age and developmental level.

Corporal punishment entails the use of physical force. It has been commonly used in many societies in the past and the exact form it takes varies according to culture and religion. Research has shown, though, that it is not effective in promoting the desired change in behaviour in any lasting way. The behavioural and emotional consequences of corporal punishment vary according to how frequently and how severely the punishment is applied, as well as to the age, developmental state, vulnerability and resilience of the child. Corporal punishment can cause relationships to break down. It serves to humiliate children and can lead to physical injury and serious impairment in development.

Any strategy addressing child maltreatment must decide what level, if any, of corporal punishment is acceptable before it becomes abuse. Factors to consider here include the age of the child, the reason for the corporal punishment and the alternatives available. It is, however, never appropriate for corporal punishment to be of such severity that it causes injury – including bruising, physical mutilation or emotional harm – to the child.

All children need discipline and it is best if children can be supported in developing their own self-discipline. An approach to discipline should be encouraged that uses alternatives to corporal punishment. These include such methods as distraction and redirection, the fixing of a cooling-off period, the setting of rules and limits appropriate to the child's age and developmental level, problem-solving and the withdrawal of privileges.

Relationship of child maltreatment and other adverse childhood experiences to leading causes of death in adults: the Adverse Childhood Experiences study

The Adverse Childhood Experiences (ACE) study, in which some 17 300 middle-aged, middle-class and mostly employed residents of the state of California participated, suggests that childhood maltreatment and household dysfunction contribute to the development – decades later – of the chronic diseases that are the most common causes of death and disability in the United States.

The study examined the long-term effects of maltreatment and household dysfunction during childhood, including: psychological, physical and sexual abuse; violence against the mother; and living with household members who were either substance abusers, mentally ill or suicidal, or else had been in prison.

A strong relationship was seen between the number of adverse experiences (including physical and sexual abuse in childhood) and self-reports of cigarette smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, attempted suicide, sexual promiscuity and sexually transmitted diseases in later life. Furthermore, people who reported higher numbers of negative experiences in childhood were much more likely to exhibit multiple health-risk behaviours, which the study suggested were adopted as coping devices. Similarly, the more adverse childhood experiences reported, the more likely the person was to have heart disease, cancer, stroke, diabetes, skeletal fractures, liver disease and poor health as an adult.

Maltreatment and other adverse childhood experiences may thus be among the basic factors that underlie health risks, illness and death, and could be identified by routine screening of all patients.

Although the ACE study and its findings relate to a specific population within the United States, it is reasonable to assume that similar trends might be found in countries with different levels of economic and social development.

Source: Felitti VJ et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine*, 1998, 14:245–258.

services, protective services, foster care, preventive services, and adult criminality and subsequent incarceration related to child maltreatment. Few studies have attempted to include in their estimates the longer-term health care costs to individuals. Existing findings, therefore, underestimate the true economic costs of child maltreatment. A study in the United States[1] that reviewed a range of sources calculated the selected annual direct and indirect costs resulting from child maltreatment to total $US 94 billion – 1% of the country's gross domestic product. Hospitalization accounted for $3.0 billion, the costs of mental health treatment were $425 million and child welfare costs came to $14.4 billion. The largest single component was adult criminality related to child abuse, which was estimated to amount to an annual sum of $55.4 billion.

1.5 Susceptibility and risk factors

No single factor on its own can explain why some individuals behave violently towards children or why child maltreatment appears to be more prevalent in certain communities than in others. As with other forms of violence, child maltreatment is best understood by analysing the complex interaction of a number of factors at different levels – an understanding that is vital for dealing effectively with the problem of child maltreatment. Figure 1.2 presents an ecological model outlining the interplay of these different factors.

Figure 1.2 Ecological model describing the risk factors for child maltreatment
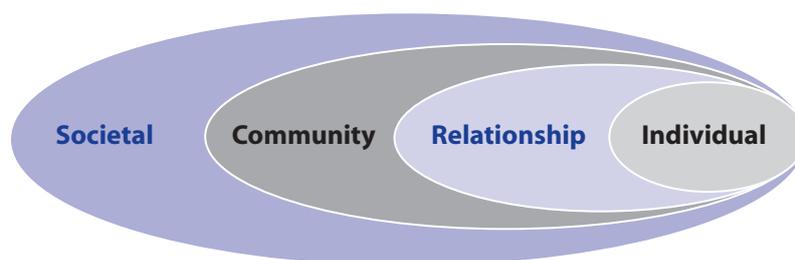
The first level of the model, that of the *individual*, deals with biological variables such as age and sex, together with factors of personal history that can influence an individual's susceptibility to child maltreatment.

The *relationship* level examines an individual's close social relationships – for instance, with family members or friends – that influence the individual's risk of both perpetrating and suffering maltreatment.

Factors at the *community* level relate to the settings in which social relationships take place – such as neighbourhoods, workplaces and schools – and the particular characteristics of those settings that can contribute to child maltreatment.

Societal factors involve the underlying conditions of society that influence maltreatment – such as social norms that encourage the harsh physical punishment of children, economic inequalities and the absence of social welfare safety nets.

Although more research is required to fully understand the dynamics of these factors at all levels of the ecological model and across different cultures, there already exists a

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[1] Fromm S. *Total estimated cost of child abuse and neglect in the United States: statistical evidence.* Chicago, IL, Prevent Child Abuse America (PCAA), 2001. Available at: <http://member.preventchildabuse.org/site/PageServer?pagename=research_reports_and_surveys> (accessed 1 June 2006).

substantial body of knowledge about what can increase susceptibility to child maltreatment.

Factors that increase susceptibility to child maltreatment are known as *risk factors*, and those decreasing susceptibility are referred to as *protective factors*. The risk factors listed below are not necessarily by themselves diagnostic of child maltreatment wherever they are detected. However, in places where resources are limited, children and families identified as having *several* of these factors should have priority for receiving services.

Individual factors

Risk factors in parents and caregivers

Increased risk of child maltreatment is associated with the presence of certain factors in the parent or other family member. These include the parent or caregiver who:

- has difficulty bonding with a newborn child – as a result, for example, of a difficult pregnancy, birth complications or disappointment with the baby;
- does not show nurturing characteristics towards the child;
- was maltreated as a child;
- displays a lack of awareness of child development or has unrealistic expectations that prevent understanding the child's needs and behaviours – for instance, interpreting the child's perceived misbehaviour as intentional, rather than as a stage in its development;
- responds to perceived misbehaviour with inappropriate, excessive or violent punishment or actions;
- approves of physical punishment as a means of disciplining children, or believes in its effectiveness;
- uses physical punishment to discipline children;
- suffers from physical or mental health problems or cognitive impairment that interfere with the ability to parent;
- shows a lack of self-control when upset or angry;
- misuses alcohol or drugs, including during pregnancy, so that the ability to care for the child is affected;
- is involved in criminal activity that adversely affects the relationship between parent and child;
- is socially isolated;
- is depressed or exhibits feelings of low self-esteem or inadequacy – feelings that may be reinforced by being unable to fully meet the needs of the child or family;
- exhibits poor parenting skills as a result of young age or lack of education;
- experiences financial difficulties.

Risk factors in the child

Saying that certain risk factors are related to the child does not mean that the child is responsible for the maltreatment it suffers, but rather that it may be more difficult to parent because it:

- was an unwanted baby or failed to fulfil the parent's expectations or wishes – in terms, for instance, of its sex, appearance, temperament or congenital anomalies;
- is an infant with high needs – one, for instance, who was born prematurely, cries constantly, is mentally or physically disabled, or has a chronic illness;
- cries persistently and cannot be easily soothed or comforted;
- has physical features, such as facial abnormalities, that the parent has an aversion to and reacts to by withdrawing from the child;

- shows symptoms of mental ill-health;
- demonstrates personality or temperament traits that are perceived by the parent as problematic – such as hyperactivity or impulsivity;
- is one child out of a multiple birth which has taxed the parent's ability to support the child;
- has a sibling or siblings – possibly close in age – who are demanding of parental attention;
- is a child that either exhibits or is exposed to dangerous behaviour problems – such as intimate partner violence, criminal behaviour, self-abusive behaviour, abuse towards animals, or persistent aggression with peers.

Relationship factors

The composition of families may vary greatly according to their own unique circumstances and to the norms of the local society. In many communities, the "traditional" nuclear family of a married mother and father with children may not be the norm. Families may be led by single mothers, single fathers, same-gender couples, siblings or elders. Risk factors for child maltreatment that may apply to relationships with family, friends, intimate partners and peers include:

- lack of parent–child attachment and failure to bond;
- physical, developmental or mental health problems of a family member;
- family breakdown – such as problems with a marriage or intimate relationship – that results in child or adult mental ill health, unhappiness, loneliness, tension or disputes over custody;
- violence in the family, between parenting partners, between children or between parenting partners and children;
- gender roles and roles in intimate relationships, including marriage, that are disrespectful of one or more persons in the household;
- being isolated in the community;
- lack of a support network to assist with stressful or difficult situations in a relationship;
- breakdown of support in child rearing from the extended family;
- discrimination against the family because of ethnicity, nationality, religion, gender, age, sexual orientation, disability or lifestyle;
- involvement in criminal or violent activities in the community.

Community factors

Characteristics of community environments that are associated with an increased risk of child maltreatment include:

- tolerance of violence;
- gender and social inequality in the community;
- lack of or inadequate housing;
- lack of services to support families and institutions and to meet specialized needs;
- high levels of unemployment;
- poverty;
- harmful levels of lead or other toxins in the environment;
- transient neighbourhoods;
- the easy availability of alcohol;

- a local drug trade;
- inadequate policies and programmes within institutions that make the occurrence of child maltreatment more likely.

Societal factors

Factors in a society that can contribute to the incidence of child maltreatment include:

- social, economic, health and education policies that lead to poor living standards, or to socioeconomic inequality or instability;
- social and cultural norms that promote or glorify violence towards others, including physical punishment – as depicted in the media, in popular music and in video games;
- social and cultural norms that demand rigid gender roles for males and females;
- social and cultural norms that diminish the status of the child in parent–child relationships;
- the existence of child pornography, child prostitution and child labour.

Protective factors

In the same way that there are factors that increase the susceptibility of children and families to child maltreatment, there are also factors that may offer a protective effect. Unfortunately, there has been very little systematic research on these protective factors and they are not well understood. Research to date has focused mainly on resilience factors – that is, factors that lessen the impact of child maltreatment on a victim. Factors that appear to facilitate resilience include:

- secure attachment of the infant to the adult family member;
- high levels of paternal care during childhood;
- lack of associating with delinquent or substance-abusing peers;
- a warm and supportive relationship with a non-offending parent;
- a lack of abuse-related stress.

Little is known about what factors protect families and children against new instances of child maltreatment. A few studies have shown that living in communities with strong social cohesion has a protective effect and can reduce the risk of violence, even when other family risk factors are present.

Based on the current understanding of early child development, the risk factors for child maltreatment and evidence of the effectiveness of certain prevention strategies, it is clear that stable family units can be a powerful source of protection for children. Good parenting, strong attachment between parents and children, and positive non-physical disciplinary techniques are likely to be protective factors. These apparently protective elements should be encouraged, especially in communities with low existing levels of social cohesion.

CHAPTER 2

Epidemiological and case-based information

Epidemiology refers to the study of how often and for what reasons a health problem occurs in specific groups of people. In the case of child maltreatment, epidemiological information is needed to plan and evaluate strategies to prevent the problem. The information is also used to deal with individuals and families where child maltreatment is already occurring. In many parts of the world, epidemiological information about child maltreatment is lacking. Consequently, decision-makers and the general public often refuse to accept that child maltreatment is a serious issue in their society. Myths have also developed around the risk factors, the characteristics of perpetrators, the likely effects of abuse and other aspects of the maltreatment. It is only through accurate information that these misconceptions can be dispelled, and facts replace conjecture.

Epidemiological information on child maltreatment and its consequences can contribute directly to preventing the phenomenon by:

- providing a quantitative definition of the problem that can be commonly used by a range of concerned groups and sectors;
- providing ongoing and systematic data on the incidence, causes and consequences of child maltreatment at local, regional and national levels;
- enabling the early identification of emerging trends and problem areas in child maltreatment so that appropriate interventions can be established before it is too late;
- suggesting priorities for prevention among those at high risk of either experiencing or perpetrating child maltreatment, as well as priorities for addressing the associated risk factors;
- providing a means to evaluate the impact of prevention efforts;
- monitoring seasonal and longitudinal changes in the prevalence and characteristics of child maltreatment and its associated risk factors;
- giving an overview of the geographic distribution of child maltreatment cases that can help in planning the location of future child protection services and other victim support services.

In contrast to epidemiological information are the data collected about child maltreatment cases that come to the attention of particular services and facilities – such as child protection services, hotlines, hospitals and the police. Access to and use of any particular service is always remarkably uneven between different groups in the population. Case-based information collected from such services and facilities can never therefore be used to measure the overall extent of the problem of non-fatal child maltreatment. All reports about non-fatal child maltreatment that use information on reported cases should therefore take care to point out the limited nature of the information and the biases that it contains.

What are the distinctive features of epidemiological information?

All too often, statistical data on child maltreatment are collected without concern for the basic criteria for epidemiological studies. These efforts to collect data may involve substantial resources and large numbers of individuals, and may appear to provide objective, accurate – and therefore useful – information for action. However, unless the work is specifically designed to meet epidemiological requirements, the findings are unlikely to survive critical scrutiny. At worst, they may present a biased and potentially counterproductive view of the phenomenon of child maltreatment. Rigorous standardization and investigative methods for quality control are an essential feature of epidemiological information. Basing information collection on epidemiological principles helps minimize any bias and increases the value of the information. If an apparent difference in child maltreatment rates emerges, the first question to ask is: "might the comparisons be biased?" Epidemiological information is informed by the following principles.

All findings must relate to a defined population. Epidemiology measures child maltreatment in relation to a *population at risk* for child maltreatment. This important feature means that epidemiological conclusions cannot be drawn from data about individuals and families where child maltreatment is already occurring. Rather, epidemiological studies begin by specifying a clearly defined target population and then questioning all individuals within the group to identify where maltreatment has occurred. Target populations can be defined in many ways. They could be: geographic populations – for example, all residents of a city or a country; groups defined by a socioeconomic indicator – such as families where an adult member receives unemployment benefits; or populations defined by a diagnostic criterion – for example, all infants below a certain birth weight. Within these broad populations, further subdivisions – such as by age range or sex – can be made.

Observations are oriented to groups rather than individuals. Epidemiological observations relate primarily to groups of people. They are of limited value in accurately describing and forecasting *individual* behaviours and outcomes. In other words, epidemiological data are strong on predicting which subgroups within the target population are likely to manifest the problem unless the underlying causes are addressed, but they are not useful for saying which particular individuals will be affected.

Conclusions are based on comparisons. Clues to the risk factors underlying child maltreatment come from comparing the incidence of maltreatment in groups with different levels of exposure to one or more risk factors. Examples might be: the incidence of child sexual abuse in infants born to single-parent teenage mothers, as against abuse in infants born to dual-parent adult mothers; or the incidence of physical abuse of children in families with or without intimate partner violence. Drawing such comparisons requires careful attention to be given to ensuring that there is no bias across the different groups when examining whether abuse occurred and whether the levels of exposure to such abuse are correctly classified.

Despite these limitations, facility-based information does serve two important purposes:

- to help ensure a continuity of information about individual cases over time and between the different agencies involved in case management;
- to help plan the provision of services – such as what the peak demand times are, what staff are required, or where the users come from.

Deaths due to child maltreatment form a special category, since they are not readily identified through population-based epidemiological studies or service-based case information recording systems. Such deaths can be reliably measured only through facility-based mortality surveillance systems (see the subsection on fatal cases of child maltreatment in Section 2.3 below).

To gain a complete understanding of child maltreatment in a particular place, the following items are necessary:

- as regards *non-fatal* maltreatment:
  — population-based epidemiological surveys;
  — case information on individual cases and communication about the cases within and between agencies;

— routine data collection of cases seen by emergency medical care facilities, child protection services and other services.
- as regards *fatal* maltreatment:
  — systems for the medico-legal investigation of all known and suspected deaths from external causes and all unexpected deaths in young children.

2.1 Operational definitions of child maltreatment

To classify and enumerate cases of child maltreatment, the conceptual definitions given in Section 1.1 must be translated into operational definitions using a universally accepted classification system. The international standard diagnostic classification for all general epidemiological purposes and many health management purposes is the International Classification of Diseases (ICD). It is used to monitor the incidence and prevalence of child maltreatment and to assess its association with other variables, including the characteristics and circumstances of the children and the families affected. This guide recommends that efforts to register and record both fatal and non-fatal cases of child maltreatment seen in health care facilities should code these cases using the ICD.

Most countries have issued official guidelines for coding and reporting, based on the International Classification of Diseases in either its 9th or 10th revision. However, such guidelines for the classification of child maltreatment cases may be used only in a limited number of facilities, and then very selectively, and the resulting coding may not be reliable. In such cases, it will probably be helpful to set up a working group to improve classification and to develop an agreed set of guidelines on how to assign ICD codes to known and suspected cases of child maltreatment.

The assignment of ICD codes to a case is done only after medical professionals have provided treatment and have done their best to reach a definitive conclusion as to the external causes of the presenting problem. Classification of cause of death is usually based on coroner reports and inquest findings. For non-fatal cases, the classification of cause of injury is generally based on information from the files recording hospital inpatient discharges and emergency department visits.

The two main components of an ICD classification concern the *nature* of the presenting condition (for instance, traumatic subdural haemorrhage) and its *external cause*. Information is also included about the relationship of the perpetrator to the victim, where this is known – for example, child battering by the stepfather.

Child maltreatment can have a wide range of health consequences – including pregnancy, sexually transmitted diseases, dental caries, skull vault fracture and burns on the leg. While it may be possible to identify certain presenting conditions that are more suggestive of child maltreatment than others, it is through the allocation of an external cause – or *E-code* – that an individual case is classified as one of known maltreatment or suspected maltreatment.

An example of the specific rules that health care providers and coders might follow in assigning ICD external cause codes are the rules developed by the United States Department of Health and Human Services, shown in Box 2.2.

2.2 Population-based epidemiological surveys

Information about child maltreatment derived from reported cases and qualitative studies provides a good starting point for establishing *whether* a problem exists. However, it does not give an understanding of *how* child maltreatment affects the overall population. Much child maltreatment is never detected or reported. Experiences of maltreat-

US Federal Government Department of Health and Human Services rules for assigning ICD-9 E-codes to known and suspected child maltreatment cases

A. Child and adult abuse guideline

1. When the cause of an injury or neglect is intentional child or adult abuse, the first listed E-code should be assigned from categories E960–E968, "homicide and injury purposely inflicted by other persons" (except category E967). An E-code from category E967, "child and adult battering and other maltreatment", should be added as an additional code to identify the perpetrator, if known.

2. In cases of neglect where the intent is determined to be accidental, E-code E904.0, "abandonment or neglect of infant and helpless person", should be the first listed E code.

B. Unknown or suspected intent guideline

1. If the intent (unintentional, self-harm or assault) of the cause of an injury or poisoning is unknown or unspecified, code the intent as undetermined, E980–E989.

2. If the intent (unintentional, self-harm or assault) of the cause of an injury or poisoning is questionable, probable or suspected, code the intent as undetermined, E980–E989.

C. Undetermined cause

Where the intent of an injury or poisoning is known, but the cause is unknown, use codes: E928.9, "unspecified accident"; E958.9, "suicide and self-inflicted injury by unspecified means"; and E968.9, "assault by unspecified means".

ment by children in the general population cannot be assumed to be the same as the experiences of children officially reported as maltreated, or who are included in the convenience samples often used in qualitative research. For a better understanding of the scale of child maltreatment and its long-term consequences, information gathering must move beyond case-based surveillance and qualitative research to population-based surveys using probability samples. Such population-based epidemiological surveys need to ask individuals about their:

- use of severe and moderate physical punishment;
- exposure to child maltreatment;
- current health-risk behaviours;
- current health status.

These surveys need to be repeated with same-age groups at periodic intervals, or else to sample different age groups in a single data collection wave. Apart from giving information on the scale and consequences of child maltreatment, they can also track how the phenomenon responds to prevention efforts. In addition, questions related to risk and protective factors can be integrated with other existing behavioural risk factor surveys, providing useful data on the risk and protective factors.

Among the many types of survey instrument used in population-based studies of child maltreatment, four are particularly suitable for yielding information that is useful for designing prevention polices and programmes. These instruments are:

- the Parent–Child Conflict Tactics Scale;
- the Adverse Childhood Experiences questionnaires;
- the Lifetime Victimization Screening questionnaire;
- the ISPCAN Child Abuse Screening Tools.

Parent–Child Conflict Tactics Scale

The Parent–Child Conflict Tactics Scale[1] is a subscale of the broader Conflict Tactics Scale consisting of 80 items developed by Straus[2] to explore family conflict and violence. The scale focuses particularly on the adults in the family. Of the 80 items, 20 are questions to the parents on their relationship with the child. Another 20 questions are directed to the parent about their partner and that person's interactions with the child. If there is no partner, these questions are not asked. The final 40 questions of the measure relate to interactions between a parent and that parent's partner.

The Parent–Child Conflict Tactics Scale assesses how a parent reacts with the child. It investigates whether, in a conflict, a parent will, for instance, try to discuss the matter calmly, shout at or insult the child, storm out of the room, or threaten to spank or try to hit the child. The questions progressively explore more coercive and aggressive behaviours. Items are rated on a seven-point scale, ranging from a score of 0 for "never" to 6 for "almost every day".

The Parent–Child Conflict Tactics Scale has been widely implemented in many high-income countries. As part of the WORLDSAFE studies, it has also been used successfully to gather data on the behaviour of parents and other family members in countries including Brazil, Chile, Egypt, India and the Philippines.

The Adverse Childhood Experiences Study

As noted in the Introduction, one of the most important scientific developments of the past decade has been proof of the links between child maltreatment, health-risk behaviours and certain chronic diseases. A blueprint for any new study investigating these links is provided by the Adverse Childhood Experiences (ACE) Study Questionnaires (see Appendix 1 for texts of the questionnaires). These questionnaires come in separate versions for male and female respondents and include the *Family Health History* and *Physical Health Appraisal* questionnaires for collecting information on childhood maltreatment, household dysfunction and other sociobehavioural factors.[3]

The *Family Health History* questionnaire consists of 68 questions examining various types of child maltreatment, childhood adversities rooted in household dysfunction, and risk factors. *All* the questions are introduced with the phrase "While you were growing up, during your first 18 years of life, …". For the different types of possible maltreatment, household dysfunction and risk factors, the questions then continue as follows.

- **Maltreatment by category**
  - *Psychological*
    Questions: Did a parent or other adult in the household …
    - often or very often swear at, insult or put you down?
    - often or very often act in a way that made you afraid that you would be physically hurt?

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[1] Straus MA et al. Identification of child maltreatment with the parent–child conflict tactics scales: development and psychometric data for a national sample of American parents. *Child Abuse and Neglect*, 1998, 22:249–270.
[2] Straus MA et al. The revised conflict tactics scales (CTS2): development and preliminary psychometric data. *Journal of Family Issues*, 1996, 17:283–316.
[3] The questionnaires can be downloaded from the web site of the United States Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/nccdphp/ace/> (accessed 7 June 2006). They are not copyrighted and there are no fees for their use, though CDC and Kaiser Permanente (a non-profit-making health care delivery organization in the United States) request copies of any articles on research conducted using the questionnaires.

— *Physical*

Questions: Did a parent or other adult in the household …

- often or very often push, grab or slap you?
- often or very often hit you so hard that you had marks on the body or were injured?

— *Sexual*

Questions: Did a parent or other adult in the household …

- touch or fondle you in a sexual way?
- have you touch their body in a sexual way?
- attempt oral, anal or vaginal intercourse with you?
- actually have oral, anal or vaginal intercourse with you?

- **Household dysfunction by category**

— *Substance abuse*

Questions: Did you …

- live with anyone who was a problem drinker or alcoholic?
- live with anyone who used drugs?

— *Mental illness*

Questions:

- Was a household member depressed or mentally ill?
- Did a household member attempt suicide?

— *Violent treatment of mother*

Questions: Was your mother (or stepmother) …

- sometimes, often or very often pushed, grabbed or slapped, or did she have things thrown at her?
- sometimes, often or very often kicked, bitten, hit with a fist, or hit with a hard object?
- ever hit repeatedly for a period of at least a few minutes?
- ever threatened with, or hurt by a knife or gun?

— *Criminal behaviour in household*

Question:

- Did a household member ever go to prison?

- **Risk factors**

— *Questions on:*

- smoking;
- severe obesity;
- physical inactivity;
- depression;
- attempts at suicide;
- alcoholism;
- drug use;
- parenteral drug use – such as injecting drug use;
- a high lifetime number of sexual partners ("high" in this context being defined as 50 or more);
- a history of having sexually transmitted diseases.

The extensive *Physical Health Appraisal* questionnaire has questions on the respondent's self-rated health, and items asking about a history of:

- ischemic heart disease (including heart attack or use of nitro-glycerine for chest pain during exertion);
- any cancer;
- stroke;
- chronic bronchitis, asthma or emphysema (chronic obstructive pulmonary disease);
- diabetes;
- hepatitis or jaundice;
- any skeletal fractures (as a proxy for risk of unintentional injuries);
- chronic headaches, back pain or abdominal pain.

At the time of writing, the ACE Study Questionnaires have been applied in China and the United States.

The Lifetime Victimization Screening Questionnaire

The Lifetime Victimization Screening Questionnaire[1] is based on a subset of items from the Juvenile Victimization questionnaire, a recently constructed inventory of childhood victimization. It contains 20 questions, covering four main areas of maltreatment of children and young people:

- physical abuse and neglect by parents and family members (four questions);
- sexual victimization (eight questions);
- witnessing family violence (two questions);
- other significant direct and indirect exposure to violence (six questions).

The questions are designed to obtain information on lifetime exposure to specific instances of maltreatment. There are follow-up questions for each item to help classify the type of event. These follow-up questions cover:

- characteristics of the perpetrator or perpetrators;
- whether a weapon was used;
- whether injury resulted;
- whether the event occurred in conjunction with another event.

The questionnaire also measures cumulative adversity in childhood through a comprehensive set of questions that cover 15 non-abusive traumatic events and chronic sources of stress, including:

- traumas not stemming from victimization – such as serious illnesses, unintentional injuries, the imprisonment of parents and natural disasters;
- adversities of a more chronic nature, such as ongoing substance use by family members, constant arguing by parents, and being persistently teased about physical appearance.

At the time of writing, this questionnaire had been applied only in the United States, where it was administered by telephone to a nationally representative sample of over 2000 children and adults.

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[1] Turner HA, Finkelhor D, Omrod R. The effect of lifetime victimization on the mental health of children and adolescents. *Social Science and Medicine*. 2006, 62:13–27.

ISPCAN Child Abuse Screening Tools (ICAST)

With support from UNICEF, ISPCAN has involved over 120 experts from more than 40 countries, including many developing countries, in an effort to design internationally applicable measurement tools for child maltreatment.[1] Three instruments have been developed that ask:

- parents about their use of different behaviours for discipline;
- young adults aged 18–24 years about their exposure to violence in childhood;
- older children about their own recent experiences of violence.

The main purpose of these screening tools is to estimate the scale of the problem from population-based samples and to calculate incidence or prevalence rates. The tools can be used by themselves. Alternatively, they can be incorporated into more extensive surveys that include assessments of other types of abuse, and an analysis of the risk factors and the consequences for health – for example, using the Adverse Childhood Experiences questionnaires described above. The instruments have been field-tested in seven developing countries from five regions and translated into several languages.

The ICAST–P (for "parent") tool is designed for surveys of parents with children younger than 18 years of age. There are 46 questions about practices conducted over the past year and during the child's lifetime, including information on possible omissions in care and acts of discipline or violence. Parents are also asked about the same set of behaviours by another parent or caregiver. The questions cover both positive and negative approaches to discipline. To assess rates of neglect, there are questions on the basic needs of the child. Rates of sexual abuse are estimated by asking if the parent is aware that the child has been touched in a sexual way or has had intercourse with an adult.

The ICAST–R ("retrospective") instrument, containing 26 questions, is designed for use with young people aged 18–24 years. It asks about experiences of sexual, physical and emotional abuse prior to the age of 18 years. The questionnaire also seeks to establish when and how often these events occurred, and who inflicted the abuse.

The ICAST–C ("child") tool is designed for use with children aged 12–17 years, and asks about their own experiences of victimization, over their lifetime and during the past year. This instrument has been the most difficult to develop, because of issues around informed consent by the children, legal reporting and other ethical concerns. There are 82 questions altogether, but investigators may choose to ask only those questions relevant to violence experienced in a particular setting, such as the home or school. Questions cover various types of verbal, physical and sexual violence as well as experiences of neglect. Because of the sensitive nature of this type of survey, it is recommended that the ICAST–C tool be administered anonymously.

Adapting survey methods to local conditions

Identical questionnaires, identical research designs and identical interviewing techniques should ideally be used for surveys in different settings, so as to obtain results that are directly comparable. In reality, though, different levels of literacy, differing familiarity with interview-based surveys, and differences in the willingness of people to talk about sensitive issues, all mean that the survey methods will require at least some adaptation to local conditions.

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[1] Further information on ICAST can be obtained from: Des Runyan, University of North Carolina, Chapel Hill, NC, United States of America <drunyan@med.unc.edu>; Michael Dunne, Queensland University of Technology, Brisbane, Australia <m.dunne@qut.edu.au>; Kimberly Svevo, ISPCAN Executive Director, Chicago, IL, United States of America <exec@ispcan.org>.

Such changes – which should be the minimum that is necessary – should be established through careful field-testing with individuals and focus groups drawn from the population to be surveyed. Because of the sensitive nature of the questions there should be thorough training of interviewers to ensure that interviews are conducted in absolute confidentiality and that the database contains no personal identifiers.

The way in which surveys methods have been changed should be clearly stated when reporting results. In addition, the possible effect of any changes should be considered when drawing conclusions based on the survey results.

Sampling strategies

Probability sampling strategies are used to sample a population that is as representative as possible of the larger population, and in so doing to maximize the degree to which the findings can be generalized to the larger population. Examples of sampling strategies include: simple random sampling; systematic sampling; stratified sampling; cluster sampling; and multistage sampling – a complex form of cluster sampling. The probability – or representative – sample chosen will determine the human and financial resources needed to carry out the survey. It will also affect the statistical significance of the results and the extent to which they can be generalized. Researchers who lack experience with sample design should consult an expert before choosing a sampling strategy.

Sample sizes

The *sampling strategy* is not the only aspect of survey methodology that affects the validity of the findings. The *size of the sample* has a strong effect on the precision of the results. Its calculation therefore calls for careful attention. The less frequent the outcome of interest is in the population, the larger the size of the sample should to be in order to measure it. Population-based epidemiological studies must ensure that they use an appropriate sample size to measure reliably the different types of maltreatment and the various consequences. Different types of maltreatment and different risk factors occur with differing frequencies. Since these things are often investigated in a single interview, the sample sizes should always be calculated with reference to the type of maltreatment or risk factor known (through other studies, in similar settings) to occur the *least* frequently.

Before calculating the appropriate sample size, it is necessary to know the following:

- the **sampling strategy** to be used. The correct sample size is usually different, for example, when using cluster sampling, compared to simple random sampling;

- an estimate of the **expected frequency of the outcomes** and the **maximum acceptable margin of error**;

- the desired **degree of precision**. Greater precision usually requires a larger sample size;

- **how the data will be analysed**. The type of statistical analysis to be used may require changes in sample size. For example, the sample size required simply to estimate the prevalence of physical abuse in the study population will be smaller than that required to detect statistically significant differences in the prevalence of physical abuse between two subgroups of the population.

As an example, completed oral, anal or vaginal intercourse is likely to be among the least frequent forms of non-fatal sexual abuse in most settings. The global prevalence of such abuse is approximately 6% for females and 2% for males.[1] It is therefore recommended that this figure be used as the basis for sample size calculations in settings where a more accurate estimate based on local studies is unavailable.

Sample size can be calculated using mathematical formulas or with statistical software packages. An example of such a package is the STATCALC program of Epi Info™.[2] Given the importance of calculating the correct sample size for a survey and the complexity required in doing so, it is strongly recommended that the calculation be carried out in consultation with a professional statistician.

Ethical considerations

Because they identify situations of serious maltreatment, surveys that question children and adults about events in the present and recent past should be considered only where there are adequate resources to guarantee a resolution of the situation or to bring it to attention of the relevant authorities. Both the Parent–Child Conflict Tactics Scale and the Lifetime Victimization Screening Questionnaire may come across current or recent maltreatment. By contrast, the ACE Study Questionnaires that ask about experiences that occurred many years prior to the interview are less likely to uncover current situations of serious ongoing victimization requiring immediate intervention. All the same, surveys should in every case be conducted in such a way that a respondent's situation is not made worse by answering the questionnaire. The design of studies, therefore, should *always* be reviewed by an ethics committee.

2.3 Case information

Case information refers to the information collected from individuals and families where maltreatment has already occurred and who are currently receiving services to deal with the effects of maltreatment. Collecting and sharing basic case information enhances the protection of maltreated children and contributes to the surveillance of child maltreatment. Even in communities where child protection systems are considered well advanced, the failure to communicate case information within and between service agencies regularly leads to the preventable suffering and death of children.

Children at risk of experiencing maltreatment, and the parents and other family members of those children, frequently interact with a number of service agencies. They may be treated repeatedly for injuries at the same or different health care facilities. Their families may have contact with social service agencies working in housing, education, welfare or child protection. Each of these interactions provides an opportunity to detect maltreatment and to intervene. Whenever a family or child encounters a service agency – in whatever sector – and child maltreatment is either confirmed or suspected, basic information on the case should be documented.

It is important to record several variables, both for the sake of case management and for surveillance. Issues of confidentiality, though, arise when handling personal information on the child and caregivers. Information should therefore be recorded in such a way that it can be removed for the purpose of surveillance. There may also sometimes be instances when confidentiality requirements prevent agencies sharing case informa-

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[1] Andrews G et al. Child sexual abuse. In Ezzati M et al, eds. *Comparative quanitification of health risk (Volume 2)*. Geneva, World Health Organization, 2004:1851–1940.
[2] Epi Info™ can be downloaded free of charge from the United States Centers for Disease Control and Prevention.

tion with one another. Such cases should be urgently addressed, so that obstacles to sharing vital information can be removed – while at the same time ensuring that strict confidentiality is maintained.

Figure 2.1 shows the variables that should be recorded for each case. Depending on the service agency and the nature of the interaction with the child and family, some of these variables may remain unknown. It is nevertheless important to capture as much

Figure 2.1 Information items to record for known and suspected cases of child maltreatment

The following information should be recorded in known and suspected cases of child maltreatment.

■ **Characteristics of the child**
— Age
— Sex
— Race or ethnicity
— Housing status
— Educational status
— Address
— Previous reports of maltreatment
— Physical or developmental disabilities

■ **Details of maltreatment**
— Source and date of allegation
— Form or forms of maltreatment
— Status of report (for example, "suspected" or "substantiated")
— Severity of harm
— Duration of maltreatment
— Investigating agencies

■ **Characteristics of alleged perpetrator or perpetrators**
— Relationship with child
— History of abuse
— Age
— Sex
— Employment status
— Address
— Race or ethnicity
— Previous allegations of similar offence
— History of drug or alcohol abuse

■ **Characteristics of caregiver, if this person is different from alleged perpetrator**
— Age
— Sex
— Relationship with child
— History of abuse
— Employment status
— Marital status
— Level of education
— Race or ethnicity
— Interaction with service agencies

■ **Characteristics of household**
— Household income
— Number of people in household
— Description of other children in household and their relationship to child
— Housing accommodation
— Previous reports of maltreatment
— Physical or developmental disabilities

Adapted from: *A Conceptual and epidemiological framework for child maltreatment surveillance*. Ottawa: Minister of Public Works and Government Services Canada, 2001.

information as possible. Structured forms designed for this purpose can improve the quality and quantity of the information recorded. A useful example is the maltreatment assessment form used by the Canadian Incidence Study of Reported Child Abuse and Neglect.[1] Documenting case information is by itself not enough to improve the protection of children; information about susceptible children must also be shared between the agencies and sectors involved.

Surveillance of reported cases
Non-fatal cases
Surveillance – or routine data collection – of child maltreatment relies on cases being reported to or detected by the authorities. It therefore misses the large number of incidents of child maltreatment that go unreported. Surveillance of reported cases of child maltreatment can point to trends in service provision and service utilization, but cannot give a proper overview of the problem. Wherever possible, surveillance systems should be supplemented by population-based surveys, as described in Section 2.1, to remedy this. Supplementing results through population-based surveys is especially important in situations where there is no strong child protection system to give data on reported cases, or where most cases are not brought to the attention of the authorities.

Routine data collection on child maltreatment must be based on accepted, standardized definitions so that categories are uniform and sets of data can be effectively compared. For good surveillance, operational case definitions should be clearly set out and agreed on between the different sectors involved in the data collection. The process of identifying and agreeing on the operational case definitions, though, is likely to take time and should be approached carefully. Case definitions should be both *sensitive* and *specific* – resulting, respectively, in few false-negative and false-positive cases – and should be simple and unambiguous. Classifying cases as "substantiated", "suspected" or "unsubstantiated", and reporting on these categories, can help ensure both that a minimum number of false-positive cases is included and that a minimum number of true cases is missed.

In many countries, one or more agencies collect and process information on reported cases of child maltreatment. Surveillance systems should build on these existing systems where possible and, ideally, coordinate existing systems used by various sectors if they are independent of each other. Much work has already been done to identify the components of a strong child maltreatment surveillance system and on how to set one up. Table 2.1 outlines the attributes of a good surveillance system. For a more comprehensive account, see the WHO–CDC *Injury Surveillance Guidelines*,[2] and the Canadian *Conceptual and epidemiological framework for child maltreatment surveillance*.[3]

Fatal child maltreatment
As already mentioned, fatal cases of child maltreatment cannot be easily measured through population-based surveys or service-based case systems that record information. Asking adults in a population-based survey questions about children who may have died through the intentional actions of a parent or other family member is unlikely to elicit honest answers. Some deaths from maltreatment are likely to occur so quickly

[1]   Trocmé N et al. *Canadian incidence study of reported child abuse and neglect – 2003*. Ottawa, Ministry of Public Works and Government Services, Canada, 2005. Available at: <http://www.phac-aspc.gc.ca/publicat/cisfr-ecirf/index.html> (accessed 28 June 2006).
[2]   Holder Y et al., eds. *Injury surveillance guidelines*. Geneva, World Health Organization, 2001.
[3]   *A conceptual and epidemiological framework for child maltreatment surveillance*. Ottawa: Minister of Public Works and Government Services Canada, 2001.

Table 2.1   What makes a good surveillance system?

Simplicity	The system should produce the data needed in the most simple and straightforward way possible.
Flexibility	The system should be able to adapt at minimal cost to changes in the operating conditions and the data required.
Acceptability	Those people who are expected to provide information, through interviews and in other ways, should be willing to participate and should be involved in the system design where possible.
Reliability	A reliable system is one that detects an overwhelming proportion of the actual cases in the target population and excludes most non-cases – that is, the system should have a high sensitivity, high specificity and high positive predictive value. This allows end users to have confidence in the accuracy of the data.
Utility	The system should be practical, affordable and increase knowledge about the problem.
Sustainability	The system should be easy to maintain and update, with adequate human and financial resources allocated to assuring its ongoing operation.
Timeliness	The system should generate up-to-date information with minimal delays.

Adapted from: *Injury surveillance guidelines*. Geneva, WHO, 2004.

that – even where the family member may have wanted to bring the child to emergency medical care – there was no opportunity to do so, and the child's body was disposed of without an official record. Accurate information about deaths from child maltreatment can therefore be obtained only in settings where:

- there is a legal obligation to report such deaths;
- this obligation is enforced;
- systems exist for the medico-legal examination of all known and suspected deaths from injuries or external causes, including all unexpected deaths in young children.

To be effective, such systems must examine *all* such deaths, and not only those that seem clearly to result from maltreatment. There is always a large proportion of deaths – particularly in the very youngest age groups – where the exact cause of death is not readily discovered, even at a postmortem examination. Further investigations are needed in these cases to arrive at a definitive conclusion. Relatively few countries have such laws and systems in place. Consequently the view most countries have of deaths from child maltreatment is incomplete, and is likely to be biased towards cases that have been prominently covered in the media. Using such information to design prevention programmes for child maltreatment and victim services is therefore not recommended.

The establishment of comprehensive medico-legal systems for the forensic identification, investigation, classification and recording of deaths is a large and costly exercise. While there is no easy solution to the problem of obtaining sound epidemiological information about fatal cases of child maltreatment in settings lacking the required medico-legal systems, some countries have found it useful to establish child fatality review teams (see Box 2.3).

Feedback to agencies that provide information

To improve the sustainability of surveillance systems for child maltreatment, agencies that provide the information should be given frequent feedback. This feedback should consist of regular reports with a basic analysis of the data received from each contributing agency. Such reports can help agencies manage their staff and other resources better

Child fatality review: an international system

An infant is reported as not breathing after falling from a sofa. Emergency personnel try life support but the child dies at the local hospital. Another hospital has records of previous falls and injuries. Neighbours know of arguments. The police have criminal records on the father. A women's group heard the mother express fears of violence. However, no one knows more than their own part of the story.

X-rays and a postmortem examination reveal evidence of possible physical abuse that is not explained by the short fall. The cause and manner of death, though, only become clear after agencies and professionals share information in a Child Fatality Review Team. The case that at first seemed to be an unintentional injury ends by being declared a homicide.

The first Child Fatality Review Team (CFRT) was formed in Los Angeles, United States, in 1978, sponsored by the Los Angeles County Interagency Council on Child Abuse and Neglect (ICAN). ICAN was later appointed as the United States' National Center for Child Fatality Review (NCFR). Other teams were set up with a similar structure, with their members including: coroners, police officers, representatives from the social services and the law courts, and health care and public health officials. Some teams included representatives from schools and from the mental health sector, and occasionally also community members.

By 2001, around 1000 such teams existed in Australia, Canada, New Zealand and the United States. The Philippines has recently added a hospital-based model that may be more appropriate for developing countries. An international network now connects ICAN–NCFR in Los Angeles with potential and early programmes in China, Estonia, Iceland, Iran, Japan, Jordan, Lebanon, the Netherlands and the United Kingdom, and interest is growing in many other countries.

Fatal abuse victims are young; about 40% are infants and 80% are under the age of six years. The most common cause of death is head trauma, followed by blunt force trauma to the body. Most injuries come from hands or feet, with no other weapon used. Data sought on these deaths include information on race, sex, age, substance abuse and relationship to perpetrator. A team review may begin with a notorious case of fatal child maltreatment and then lead to other child deaths from injury. Small local teams often review all child deaths from all causes. Better cooperation between agencies always results from these activities, and the team reports provide material for public education and prevention programmes.

Some teams cooperate across political borders with other teams. While the core model remains the same, the activities of teams will reflect local interests, culture and resources. Some countries have agency-based programmes to prevent child abuse, while others focus their work on the extended family and the community.

Following the lead of the child fatality review teams, units are now being formed to review other forms of violence, including teams on fatal domestic violence and fatal elder abuse. There are also plans to review non-fatal injuries of hospitalized children.

and match the service they supply with the demands of users. In the feedback reports, mention can also be made of how the data contributed by each agency has helped achieve particular objectives – relating, for instance, to policy development, the planning of programmes, outcome evaluation and campaign work on maltreatment.

Using information to convince policy-makers

Good analysis and interpretation of the data gathered – both population-based and case-based – and appropriate presentation and dissemination of the results are needed for action on child maltreatment to be effective. For policy-makers to be convinced of the need for strong action on child maltreatment, the analysis and reporting of data should be carried out in such a way that three important elements are brought out:

- **The size of the problem in relation to other issues**. The scale of child maltreatment in the given country can be highlighted by comparing it with:
  — the magnitude of other public health threats;
  — the scale of child maltreatment in other countries;
  — the human cost of disasters and collective tragedies covered in the media.

- **The relationships between child maltreatment and socioeconomic and environmental factors**. Showing that levels of child maltreatment are sensitive to social, economic and environmental factors calls for an analysis of the data by geographic location of where the maltreatment occurred, as well as by place of residence of the victims or perpetrators. This data should cluster cases into the same geographical units of analysis as used in the national census or other demographic surveys that map the size, wealth and health of the population. A correlation can then be looked for between measures of child maltreatment and the prevailing socioeconomic or environmental factors.

- **The possibility to prevent maltreatment**. Showing the considerable gains that good prevention programmes can achieve is important for convincing policy-makers. If, for example, a community-based outcome evaluation study showed that a combined home visitation programme and training programme for parents could reduce by 30% the number of reported new child maltreatment cases – then expanding the programme to the entire population, in a country where 250 000 new were cases reported to child protection services each year, could result in 75 000 fewer cases reported annually.

At the same time, it is vital that data on child maltreatment are presented in reports dealing *exclusively* with the problem. Statistical offices reporting crime and health information sometimes include data on child maltreatment, but they are frequently buried among many other crime or health issues, making it difficult to grasp the extent of the problem. With the data analysed in the way suggested above and presented in a focused report with simple language and clear charts and tables, this issue can be made "visible" for policy-makers and others. In a similar way, dedicated reports on child maltreatment – simply and clearly explained – should be made readily available to the media and civil society organizations. To protect the anonymity of individuals, all data presented in these reports must be stripped of the case identification numbers and any other information that could possibly allow individuals to be identified.

CHAPTER 3

The prevention
of child maltreatment

There is sufficient evidence, including in the scientific literature, to state with full confidence that child maltreatment can be prevented. Despite this, little attention in terms of research and policy has been given to prevention.

Many existing prevention efforts consist of the early identification of cases of child maltreatment and interventions to protect the children involved. This strategy is indeed a form of prevention and may well be beneficial to individual children and families. It will not, however, lead to a large-scale reduction in the incidence of child maltreatment that is possible using strategies that address the underlying causes and contributing factors.

When choosing such strategies, it is important to know which ones – based on real evidence – have achieved their intended results. In places where resources are scarce, it is even more important to know which approaches will work. Strategies based on anecdotal information and prevailing norms may often appear as if they should work – while, when examined more closely, they do not significantly affect the numbers of new cases of child maltreatment. Prevention strategies therefore need to be based on an understanding of the risk factors as well as including a mechanism to evaluate the results.

A few *effective* strategies for reducing child maltreatment rates have been identified through scientific outcome studies that measure the impact of prevention programmes. There are other prevention strategies where the evidence is *promising* and a much larger number where the evidence is *unclear*. These three terms, describing the extent to which strategies are known to work well, are defined as follows.

- An *effective* prevention programme is one that reduces the incidence of child maltreatment in the intervention population, or at least lowers the rate at which incidence is increasing. Various criteria for effectiveness have been proposed. These include:

  — an evaluation of a programme using a strong research design, either experimental or quasi-experimental;
  — evidence of a significant preventive effect;
  — evidence of sustained effects;
  — replication of the programme with demonstrated preventive effects.

  Few programmes meet all of these criteria. In this guide, the term "effective" is used for programmes evaluated with a strong research design that show evidence of a preventive effect.

- A prevention programme is said to be *promising*, if it has been evaluated with a strong design, showing some evidence of a preventive effect, but requiring more testing.

- The effect of a prevention programme is said to be *unclear* if it has been poorly evaluated or remains largely untested.

Where strategies have been evaluated, almost all the outcome evaluation studies have been conducted in high-income settings. To increase the application of prevention strategies for child maltreatment in all countries, more outcome studies are urgently needed, and especially from low-income and middle-income countries. These efforts should include attempts to replicate programmes already identified as effective, adapting them to the local context, as well as outcome evaluation studies of innovative programmes designed around promising or unclear prevention strategies.

This chapter provides an overview of child maltreatment prevention strategies, together with practical guidance on how to plan, select, design and implement prevention strategies – in such a way that they will generate evidence as to how effective they are.

3.1   An agenda and agency to prevent child maltreatment

In most countries the emphasis has been to intervene once child maltreatment has been identified. Child protection systems have therefore sometimes developed at the expense of efforts to prevent maltreatment occurring in the first place. The responsibility for prevention in these cases is thus usually left to child protection and law enforcement agencies that may have limited professional capacity and lack the mandate to influence policy on prevention or to address the many risk and protective factors. As a result, the prevention of child maltreatment tends to be addressed as if it were synonymous with child protection and victim services.

The guide recommends that this imbalance be corrected through a national child maltreatment prevention agenda. This agenda would bring together the contributions of diverse sectors working in the field and assign responsibility for leading the work to an agency with prevention as its main objective. Ideally, such an agenda to prevent child maltreatment would be developed as part of a national plan that also includes child protection. However, if it is not possible to develop prevention and protection measures jointly, they should at least be developed in parallel – and not in competition with each other.

Once an appropriate lead agency has been identified, the next step is to actively involve concerned professionals from a wide range of different sectors, who have experience of dealing with the relevant risk factors. Discussions should include civil society groups, many of which are active around the issues of child maltreatment and child protection. Special efforts should also be made to bring in agencies and community groups not traditionally considered as connected with child maltreatment, but whose activities can have a significant impact on the risk factors. Examples of such groups include:

- family planning and reproductive health services;
- housing authorities;
- child care services;
- neighbourhood community centres;
- community nursing services;
- HIV prevention programmes;
- regulatory authorities concerned with alcohol and drugs;
- agencies dealing with environmental pollution;
- programmes addressing violence against women and youth violence;
- religious institutions;
- the media.

Those involved in these institutions may not view their work as child maltreatment prevention, though they are likely to be working on policies and programmes that influence the risk factors for child maltreatment. The prevention of child maltreatment prevention may thus be an unforeseen benefit of a programme with another focus, such as the prevention of alcohol or substance misuse.

Certain practical steps can be taken to define a strategy for the prevention of child maltreatment and to create a sense of shared purpose, including:

- nominating a single lead agency, with the prevention of child maltreatment as an explicit objective;
- assigning roles to the various sectors for the prevention of child maltreatment based on consultations with them on how they can best address the risk factors;
- preparing a national report on the current state of epidemiological knowledge on child maltreatment and the efforts across sectors to prevent it;
- drawing up a document outlining the strategy on child maltreatment prevention, including a plan of action containing specific objectives, actions and indicators.

3.2 Prevention strategies for child maltreatment

Strategies for preventing child maltreatment aim to reduce the underlying causes and risk factors and to strengthen the protective factors, and in so doing prevent the occurrence of new instances of maltreatment. Although most of the scientific knowledge on the effectiveness of such strategies comes from high-income countries, an understanding of how these interventions confront the underlying causes and risk factors can help in designing interventions for low-income and middle-income countries. Child protection services and other services, described in Chapter 4, such as counselling and family therapy, are provided once child maltreatment has been identified. While the objective of these services is to respond to known instances of maltreatment, they are also preventive in that they can stop further cases from occurring.

Common features, as regards their epidemiology and risk factors, shared by different forms of maltreatment suggest that similar approaches to prevention might be adopted for physical abuse, sexual abuse, emotional abuse and neglect. It is useful to have a typology of prevention strategies in dealing with the complexities of this problem. This guide proposes a typology based on the stages of human development and the ecological model presented in Chapter 1.

Table 3.1 presents the typology of prevention strategies – including those of proven, promising and unclear effectiveness. The examples are not exhaustive, but are meant to illustrate the range of possibilities. They also underline the need to tackle child maltreatment simultaneously at different stages of human development and in different social contexts. In many cases, an intervention might have an impact on several forms of maltreatment. At the time of writing, data to show the effectiveness of most of these interventions are lacking; where sufficient data are available, they are mostly from high-income countries. Detailed practical information about the design and delivery of particular prevention strategies is available in several publications and on the Internet. This section therefore focuses on the main elements and core principles of these interventions.

Table 3.1   Strategies for preventing child maltreatment by developmental stage and level of influence

Level of intervention	Developmental Stage			
	Infanthood (<3 years of age)	Childhood (3–11 years of age)	Adolescence (12–17 years of age)	Adulthood ≥18 years of age)
Societal and community	**Implementing legal reform and human rights** • Translating the Convention on the Rights of the Child into national laws • Strengthening police and judicial systems • Promoting social, economic and cultural rights **Introducing beneficial social and economic policies** • Providing early childhood education and care • Ensuring universal primary and secondary education • Taking measures to reduce unemployment and mitigate its adverse consequences • Investing in good social protection systems **Changing cultural and social norms** • Changing cultural and social norms that support violence against children and adults **Reducing economic inequalities** • Tackling poverty • Reducing income and gender inequalities **Environmental risk factor reduction** • Reducing the availability of alcohol • Monitoring levels of lead and removing environmental toxins			
				Shelters and crisis centres for battered women and their children Training health care professionals to identify and refer adult survivors of child maltreatment
Relationship	Home visitation programmes Training in parenting	Training in parenting		
Individual	Reducing unintended pregnancies Increasing access to prenatal and postnatal services	Training children to recognize and avoid potentially abusive situations		

Societal and community strategies

At the societal level, factors that create an environment in which maltreatment can flourish include:

- economic, social, health and education polices that preserve or increase economic and social inequalities;
- social and cultural norms that support the use of violence;
- ineffective or nonexistent policies on children and the family;
- poor preventive health care;
- inadequate social welfare;
- weak systems of criminal justice.

The community level refers to the contexts in which social relationships occur – such as neighbourhoods, schools, workplaces and other institutions. Here, factors such as concentrated poverty, high residential mobility and unemployment, overcrowding and low levels of social capital all appear to increase the risk of maltreatment.

Table 3.1 lists four groups of strategies on child maltreatment prevention that cut across all developmental stages and one group of strategies specific to adulthood. All five groups of prevention strategy are likely to be effective across various types of child maltreatment. The potential for prevention of strategies at the community level can be enhanced by linking prevention programmes with other community programmes that reach out to "high-risk" groups. These include alcohol and drug rehabilitation services, programmes for children with disabilities and mental health services.

Implementing legal reforms and promoting human rights

Legal frameworks are important for providing the foundation for comprehensive responses to child maltreatment and for shaping social norms in this area.

A strong legal approach seeks to prohibit all forms of violence against children. The purpose of a strong approach by countries is not to obtain the arrest of large numbers of parents, but instead to send a clear message that parents and other family members do not have the right to abuse their children. Laws against child maltreatment may also have a deterrent effect and thereby contribute to prevention.

The Convention on the Rights of the Child committed countries to take all appropriate legislative, administrative, social and educational measures to prevent violence against children and to protect them from it. Translating the Convention into national laws and making the police and judicial systems properly able to enforce these laws are generally recommended strategies. Their effectiveness, however, is unclear as there have been no rigorous efforts to evaluate their preventive impact. Nonetheless, prohibiting the harsh physical punishment of children and establishing legal requirements to report child maltreatment have been instrumental in bringing these issues out into the open, countering the idea that child maltreatment is a private family matter. To this extent, laws have been important in changing social norms.

Social, economic and cultural rights – and the degree to which they are exist in practice – have a direct bearing on the underlying risk factors for child maltreatment. These rights include:

- the right to an adequate standard of living;
- the right to social security;
- the right to education;
- the right to equality and freedom from discrimination.

Strategies by governments to respect, protect and fulfil these rights are likely to reduce child maltreatment rates significantly, though as with the enforcement of laws against child maltreatment, outcome studies to demonstrate their preventive effect are so far lacking.

Introducing beneficial social and economic policies

The fulfilment of human rights can be improved by the existence of good social and economic policies – providing equal access to and good standards of basic items such as health care, education, employment, housing and social welfare services. Raising the quality of provision in these areas will address some of the main risk factors for child maltreatment and should consequently lead to lower rates of child maltreatment. Social and economic policies that can help prevent child maltreatment in this way include:

- the provision of early childhood education and care;
- universal primary and secondary education;
- measures against unemployment;
- good social protection systems – such as the provision of benefits for people living with disabilities, health insurance, child care, income or food supplements and unemployment benefits.

Changing social and cultural norms

Social and cultural norms are powerful contributing factors to child maltreatment. They are frequently used to justify violence against children. Legal reform – while it can influence norms – is unlikely by itself to have a substantial impact unless accompanied by a change in norms regarding the status of children, the acceptability and effectiveness of violent punishment, gender roles and family privacy. To help change social and cultural norms, public awareness and media campaigns can play an important role. These can highlight the extent and nature of child maltreatment and encourage the provision of services to children and families.

Evidence that efforts to change norms can reduce the incidence of child maltreatment is not yet available. A few studies of large-scale interventions, though, have found shifts in attitudes and norms regarding the use of violence towards infants and children. One type of programme used in the United States for preventing the sexual abuse of children offers help to those at risk of offending. It also encourages adults to look out for warning signs of child sexual abuse – and act on them – *before* an offence is committed. In these programmes, individuals voluntarily refer themselves for treatment, thereby preventing potential abuse.

Reducing economic inequalities

Numerous studies show that child maltreatment is more frequent among poorer communities and households in societies with high economic inequalities. Measures to reduce poverty and economic inequalities ought thus to have significant effects in reducing child maltreatment.

Residential mobility programmes are one example of such measures. These programmes are designed to reduce the concentration of poverty in a particular area by providing low-income families with either housing vouchers or rent subsidies, thereby giving them a choice in where they live. Although these programmes have not yet been evaluated for their impact on child maltreatment, they appear promising, as they have demonstrated positive effects on school achievements and academic performance, problem behaviours and mental and physical health. They also seem to be effective in preventing neighbourhood crime, victimization and social disorder.

Economic polices and programmes that reduce the impact of income inequality in a more general way may be valuable in child maltreatment prevention, although the scientific evidence for such interventions has not been established.

Reducing environmental risk factors

Environmental risk factors include housing density, access to safe recreational spaces, lead and other environmental toxins, and harmful substances such as alcohol and drugs.

Alcohol misuse by adults is strongly associated with fetal alcohol syndrome and increased risk of child physical and sexual abuse by parents and other family members. Reducing access to alcohol can thus be expected to have a preventive effect, and there is some evidence to suggest that increasing the tax on alcohol can be effective in reducing child maltreatment.

Excessive environmental lead levels are associated with fetal brain damage and subsequent cognitive disorders – such as attention deficit disorder and hyperactivity – that are risk factors for child maltreatment. Reducing environmental lead levels should therefore at the same time reduce the number of infants at risk for child maltreatment.

Setting up shelters and crisis centres

Existing studies from mainly high-income countries show that intimate partner violence and child maltreatment frequently occur together. Where there is a risk of maltreatment in the context of intimate partner violence, the provision of shelters and crisis centres for battered women and their children could therefore help to prevent such maltreatment. However, the preventive value of this has yet to be established through outcome evaluation studies. Anecdotal evidence from shelters that admit battered women with their children even show that, unless they are adequately supported and supervised, the women may themselves maltreat their children while in the facility.

Training health care professionals

Only a small proportion of victims of child maltreatment become adult perpetrators of maltreatment. All the same, identifying such likely future perpetrators with the help of health care professionals and referring them to the appropriate therapeutic services could help to break the cycle of violence and reduce the number of new maltreatment cases. This strategy has yet to be tested through outcome evaluation studies, and its preventive value remains unclear.

Relationship strategies

Established risk factors for child maltreatment include:

- inadequate parenting, including the failure of any infant-parent attachment;
- unrealistic expectations of child development;
- a belief in the effectiveness and social acceptability of harsh physical punishment;
- an inability to provide for high-quality child care when the parent is absent.

Conversely, various strategies that promote early and secure infant-parent attachment and non-violent modes of discipline, and that create the conditions within the family for the positive mental health development of the child, have been proved effective in preventing child maltreatment.

The evidence that programmes focusing on parenting improvement and support are effective in preventing child maltreatment is strong. The two most widely evaluated and widely applied models for delivering these strategies are home visitation programmes and training in parenting.

Setting up home visitation programmes

Home visitation programmes bring community resources to families in their homes, and are of proven effectiveness in preventing child maltreatment. A recent systematic review of mainly American outcome evaluation studies showed, on average, a 40% reduction in child maltreatment by parents and other family members participating in home visitation programmes.[1] These programmes also appeared promising in prevent-

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[1] Centers for Disease Control and Prevention. First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation. Findings from the Task Force on Community Preventive Services. *Morbidity and Mortality Weekly Report*, 2003, 52:1–9. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5214a1.htm> (accessed 7 June 2006).

ing youth violence. During home visits, information and support are offered, as well as other services aimed at improving the functioning of the family. A number of different models for home visitation have been developed and studied. In some, home visits are provided to all families, regardless of their risk status. Others focus on families at risk for violence, such as first-time parents or single and adolescent parents living in poor communities. Current research on the effectiveness of these different models indicates that the more successful programmes contain the following elements:

- a focus on families in greater need of services – as opposed to programmes that involve visits to all families regardless of risk – including families with:
  — low-birth-weight and preterm infants;
  — children with chronic illness and disabilities;
  — low-income, unmarried teenage mothers;
  — a history of substance misuse;

- intervention beginning in pregnancy and continuing to at least the second year, or as long as the fifth year, of the child's life;

- flexibility, so that the duration and frequency of visits and the types of services provided can be adjusted to a family's need and level of risk;

- the active promotion of positive physical and mental health-related behaviours and specific qualities of infant care-giving;

- broad coverage of a range of issues to address the specific needs of the family – as opposed to focusing on a single issue, such as increasing birth weight or reducing child abuse;

- measures to reduce stress within the family, by improving the social and physical environments;

- the use of nurses or trained semi-professionals.

Launching training programmes for parents

Training programmes for parents seek to educate parents about child development and help them improve their skills in managing their children's behaviour. The programmes can be delivered in the home or another setting – such as schools or clinics – where parents-to-be and new parents can be reached. While most of these programmes are intended for use with high-risk families or those where maltreatment has already occurred, it is increasingly felt that providing education and training for all parents or prospective parents can be beneficial.

Evaluations of training programmes for parents have shown promising results for their effect in reducing youth violence, but few studies have specifically examined their impact on child maltreatment rates. Instead, for many of the interventions, proximal outcomes – such as parental competence and skills, parent-child conflict and parental mental health – have been used to measure effectiveness. Analyses of successful training programmes for parents have shown that they contain the following elements:

- a focus on the parents of pre-adolescent children aged 3–12 years;
- the active review by parents of teaching materials for their children and being tested on their recall and comprehension of these materials;
- step-by-step teaching of child management skills, where each newly learnt skill forms the basis for the next skill.

Furthermore, effective training programmes for parents have been found to contain the core components of good parenting and child management, in that they:

- identify and record problematic behaviours at home;
- use positive reinforcement techniques, such as praise and points systems;
- apply non-violent discipline methods, such as the removal of privileges and time out;
- supervise and monitor child behaviour;
- use negotiating and problem-solving strategies.

Individual strategies

Strategies at the individual level to prevent child maltreatment are designed to change an individual's attitudes, beliefs and behaviours directly and can be delivered in any setting.

Reducing unintended pregnancies

Unintended pregnancy has been linked to substandard prenatal care, low birth weight, increased risk of infant mortality, child maltreatment and shortfalls in infant and child development. Efforts to reduce unintended pregnancy could help reduce child maltreatment, although such programmes have not been adequately evaluated in terms of reducing child maltreatment.

Increasing access to prenatal and postnatal services

Programmes to provide and encourage women to seek proper prenatal and postnatal care show promise in preventing the maltreatment of infants aged 0–3 years. The goal is to reduce the proportion of newborn children who are premature or have low birth weight, illness or physical and mental handicaps – all of which may interfere with attachment and bonding and make the child more susceptible to maltreatment. Promoting the use of good prenatal and postnatal care is therefore believed to be crucial in ensuring better birth outcomes. Although these interventions remain to be properly evaluated, their potential for prevention is likely to be high – especially since they could be applied to entire populations irrespective of individual-level and group-level differences in risk. The delivery of prenatal and postnatal care also provides opportunities to recruit prospective parents and new parents into home visitation and training programmes for parents – two relationship-level interventions for which there is strong and consistent evidence of effectiveness in preventing child maltreatment.

Training children to avoid potentially abusive situations

Programmes of this type are designed to teach children how to recognize threatening situations and to provide them with skills to protect themselves. The concepts underlying the programmes are that children own and can control access to their bodies, and that there are different types of physical contact. Children are taught how to tell an adult if they are asked to do something they find uncomfortable. Researchers agree that children can develop knowledge and acquire skills to protect themselves against abuse. However, there is uncertainty about whether these skills are retained over time and whether they would in fact protect a child in every type of abusive situation, particularly if the perpetrator was someone well known to and trusted by the child. There is therefore a need to demonstrate scientifically that the skills learnt are actually effective in preventing maltreatment in real-life situations.

Intervening at multiple levels: the "Triple-P" Positive Parenting Programme

Programmes may sometimes involve prevention strategies at more than one level, with their interventions intricately linked across the different levels. Such a case is the "Triple-P" Positive Parenting Programme developed in Australia. The programme's approach, on several levels, is to shape information, advice and professional support to the needs of particular families, recognizing that these needs can differ widely.

Triple-P interventions typically involve, at their different levels:

— Level 1: the provision of media messages on positive parenting;

— Level 2: information resources, such as advice sheets and videos;

— Level 3: short targeted interventions for specific behavioural problems, offered by primary care practitioners;

— Level 4: more intensive training programmes for parents;

— Level 5: the addressing of broader family issues, such as relationship conflict, parental depression, anger and stress.

A number of independent outcome evaluations of Triple-P have shown it to be effective in improving family management techniques, parental confidence in effective child rearing, and behavioural outcomes, including health behaviour and aggression. The programme – or in some cases, parts of it – has been implemented in China (Hong Kong SAR), Germany, New Zealand, Singapore, Switzerland, the United Kingdom and the United States of America.

Source: Sanders MR, Markie-Dadds C, Turner KMT. *Theoretical, scientific and clinical foundations of the Triple-P Positive Parenting Program: a population approach to the promotion of parenting competence*. St Lucia, The Parenting and Family Support Centre, University of Queensland, 2003. (Parenting Research and Practice Monograph No. 1). Available at: <http://www.triplep.net/files/pdf/Parenting_Research_and_Practice_Monograph_No.1.pdf> (accessed 7 June 2006).

3.3 Outcome evaluations of child maltreatment prevention programmes

Reviewing the evidence base of proven and promising prevention strategies is helpful in looking for strategies likely to prove effective against child maltreatment. It is therefore important to expand the evidence base by designing and implementing the intervention as an *outcome evaluation study*. This is a scientific undertaking, that should be planned before the project begins. Its steps include:

- ensuring there is sufficient scientific capacity for the project – for instance, by collaborating with an academic or research institution;
- deciding on the prevention objectives;
- developing a logic model;
- selecting outcomes and sources of outcome data;
- designing the delivery and evaluation of the intervention;
- carrying out the intervention and the outcome evaluation;
- analysing the findings and disseminating the results.

Deciding on the prevention objectives

A useful starting point is to decide on the *prevention objectives*. Here, the main consideration is to ensure that the prevention objectives can be met, given the organization's capacity to affect the relevant risk and protective factors. This in turn depends on the organization's own resources and its ability to marshal other resources.

For example, it is likely that only a national government agency could realistically aim to achieve the objective of "reducing homicide rates in children aged 0–14 years from 6.5 per 100 000 to 6.0 per 100 000". By contrast, there are examples of community-based organizations who, operating in partnership with local government

and academic institutions, successfully conduct outcome evaluation studies in low-resource settings of interventions such as home visitation and training programmes for parents.

Developing a logic model[1]

A commonly used tool for understanding a programme – what it is doing and at what point, and what it hopes to achieve – is the "logic model". The logic model is a "picture" of the structure of a programme. It shows the relationships between:

- what is put into the programme – the **resources**;
- what the programme does – the **activities and outputs**;
- what results – the **outcomes** – the programme produces over the short term and the longer term.

The logic model is often presented graphically or as a table. A logic model has several purposes, including the following.

- **Programme planning**. A logic model can be used as the programme is developed. The logic model helps think the programme strategy through – clarifying where one is, in relation to where one should be.
- **Programme management**. Because it matches resources, activities and outcomes, a logic model can help in developing a more detailed plan to manage the work. When used alongside data collected in the evaluation, the logic model helps to track and monitor operations.
- **Evaluation**. A logic model is useful for determining what to evaluate and at what point, so that resources are used effectively and efficiently.
- **Communication**. A logic model is a powerful tool in communicating activities and reporting the programme's outcomes, emphasizing the link between the two.
- **Consensus-building**. The logic model creates a common understanding among all those involved, both internally and externally, about what the programme is, how it works, and what it is trying to achieve.

While a logic model includes the critical components of the programme, it is necessarily a simplification of it. The model is not static; it can and should change over time as experience with and knowledge about the programme increases.

The components of the logic model are:

- **goals:** the overall purpose of the programme;
- **resources:** what is needed to implement the programme;
- **activities:** the actions taken to implement the programme;
- **outputs:** the direct, tangible results of the programme's activities;
- **outcomes:** the changes expected as a result of the programme.

As shown in Figure 3.1, the components of the logic model are connected by a series of "if–then" relationships: *if* resources are available to the programme, *then* programme activities can be implemented; *if* programme activities are implemented, *then* certain outputs and outcomes can be expected. It is important to think through the steps of the logic model for each programme objective as well as the programme as a whole.

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[1] This section on developing a programme logic model has been adapted from the *Logic model workbook*, published by the Innovation Network. The workbook can be downloaded from <http://www.innonet.org/> (accessed 19 January 2006).

Figure 3.1   A logic model for planning a prevention programme

Goals		Resources		Activities		Outputs		Outcomes
The overall purpose of the programme	→	You need certain resources to be able to run your programme	→	IF you have access to those resources THEN you can accomplish your activities	→	IF you can accomplish these activities THEN you will have delivered the services you planned	→	IF you have delivered the services as planned, THEN there will be benefits for the target individuals and communities

This logic model is reproduced from the *Logic Model workbook*, published by the Innovation Network. The workbook can be downloaded from http://www.innonet.org/ (accessed 19 January 2006).

As each part of the logic model is drafted, it is useful to read through it and consider the "if-then" relationship. If it is not possible to connect each element of the logic model, one should identify where the gaps are and adjust the work. This may mean that some elements of the programme are revised to ensure that the programme goals can be achieved.

The development of a logic model also gives an opportunity to engage all the groups and individuals involved in a discussion about the programme. These could include programme staff, intervention recipients, partners, funders, board members, community representatives and volunteers. The perspectives these individuals provide can enhance the programme logic model while at the same time clarifying the different expectations for the programme.

The non-profit-making *Innovation Network* is a useful Internet-based resource that, by asking questions specific to each element of the logic model, guides one through the process of developing a model for a specific programme. The *Innovation Network* also has several other resources related to programme evaluation.[1]

Selecting outcomes and sources for outcome data

Once there is a match between the prevention objectives and organizational capacity, the next step is to choose the *outcomes* that the programme attempts to change. It would be ideal if all outcome evaluation studies could have, as their principal outcomes, objective measures of maltreatment such as the number and rate of:

- child deaths resulting from maltreatment;
- children receiving hospital emergency care for injuries from maltreatment;
- adults displaying health-risk behaviours and conditions associated with maltreatment;
- adults convicted of maltreating a child in the family.

In practice, however, only a few high-income countries have sufficiently well developed information systems to measure such outcomes. In addition, since child injuries and deaths from child maltreatment are relatively rare outcomes, it is difficult to detect significant changes in them with small-scale prevention trials. Those undertaking prevention should therefore consider selecting a number of other outcomes, as well as the objective measures listed above – such as changes in knowledge, attitudes, beliefs and practices (see Box 3.2).

Other outcomes should also be considered. This includes those outcomes related to risk and protective factors, and other health consequences linked to child maltreatment – such as depression, post-traumatic stress disorders, alcohol and substance misuse, eating disorders and risk-taking behaviours. Table 3.2 lists a selection of outcomes that

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[1]   Can be viewed at: <http://www.innonet.org> (accessed 19 January 2006).

Selecting multiple outcomes to evaluate a home visitation programme

A home visitation programme aimed at preventing child maltreatment may be assumed to work in at least four ways:

- by increasing parental knowledge, or altering expectations, about child development;
- by changing parental attitudes towards child-rearing;
- by modifying the interaction between parent and child;
- by increasing professional surveillance of the family – leading either to the earlier detection of a problem or preventing such a problem from taking place.

Although a change in maltreatment rates is the ultimate goal, accurately measuring such change is difficult for various reasons. These include the reluctance of people to report maltreatment and the wide variability in the responses by child protection agencies to such reports. Assessing changes in child maltreatment rates alone may therefore make a programme look less effective than it really is, with evaluators missing changes in intermediate outcomes – such as parent-child interactions – that are due to the programme. The choice of outcomes should thus include measures for all intermediate goals, as well as the ultimate goal, as shown in the following examples.

- **Parental knowledge and expectations of child development** could be measured using questionnaires for assessing knowledge of infant care, development and behaviour – for example, the Knowledge of Infant Development Inventory.
- **Parental child rearing attitudes** could be measured using scales for assessing attitudes to parenting and confidence in parenting ability – for example, the Parenting Sense of Competence Scale.
- **Interactions between parent and child** could be measured by scales assessing violent behaviour towards children – for example, the Parent-Child Conflict Tactics Scale.
- **The impact of increased surveillance on early detection and on the discouragement of maltreatment** could be measured by comparing reported maltreatment rates in families receiving the intervention with reported rates from control families not receiving the intervention.

could be considered when designing an outcome evaluation for a child maltreatment prevention programme. In choosing the outcomes for a particular programme, considerations that should be taken into account include:

- the *relevance* of the outcome for prevention;
- the *type* and *frequency* of the outcome;
- the *availability of data* on the outcome.

The relevance of the outcome for prevention

The logic model of prevention requires that the chosen outcomes should be valid indicators of *one or more* of the risk and protective factors, and *one or more* of the physical, psychological and social consequences. Unless the outcome indicators are highly specific to these factors, then evidence of a preventive effect may be missed.

The type and frequency of the outcome

Outcomes can be:

- **events** – such as deaths, injuries, acts of violent behaviour, episodes of illness, or visits to a doctor;
- **conditions** – such as depression, post-traumatic stress disorder, alcoholism:
- **individual attributes** – such as knowledge, attitudes, beliefs and practices.

Where outcomes are events and conditions, the frequency of their occurrence will influence the required size of the intervention population. The less frequent an outcome, the larger the size of the intervention population required in the outcome evaluation. The more frequent the outcome, the smaller the size of the required population.

Table 3.2 Examples of outcome evaluation indicators by ecological level

(See Appendix 2 for examples of validated tools for measuring these outcomes)

Time between intervention and measurement	Ecological level		
	Infant and child	Parent and family	Community and society
Short-term ⬇ **Long-term**	Infant and child development – including physical, verbal and intellectual Health – for example, visits for preventive care; immunization Externalizing and internalizing behaviours Hospital emergency department and other hospital admissions for intentional injuries Social competency Educational achievements, including school performance Encounters with criminal justice system – as victim or perpetrator Use of health services, for all reasons – including as hospital outpatient or inpatient, or visit to general practitioner Self-reported health-risk behaviours – such as harmful alcohol and drug use; multiple sexual partners; smoking; intimate partner violence Parental knowledge, attitudes and behaviour related to discipline	Parent-child attachment Competency as parent; attitudes about parenting Parental knowledge and expectations of infant and child development – including physical, emotional, cognitive and sexual developments Parental knowledge, attitudes and behaviour related to discipline Encounters related to child maltreatment with criminal justice system and child welfare services Contacts with community service agencies	Belief in the social acceptability of physical punishment for children Discharges from hospital of children under 5 years of age, having been admitted as a result of child maltreatment and assault Availability of community services to address consequences of child maltreatment Emergency room visits as a result of child maltreatment and assault in children under 5 years of age Adults in specified age ranges reporting adverse childhood experiences Homicides of children under 5 years of age[1] Deaths from child maltreatment in children under 5 years of age

[1] Ideally, homicide rates in children aged 5 to 9 years and 10 to 14 years should also be included as indicators. Homicide rates in children under 5 years of age, however, are likely to be the most sensitive indicator. This indicator should be measured when resources are not sufficient to measure and report on homicide rates in all three age groups.

Outcomes such as injuries and deaths resulting from maltreatment are rare and need large-scale outcome evaluation studies to detect whether they are significantly changed by the prevention programme. For instance, outcome evaluation studies of efforts to prevent homicides in children aged 0–14 years would need to be conducted over many years at the national level in smaller countries, and at least at the provincial and city level in larger ones.

Where the outcomes are individual attributes, smaller-scale studies are possible. Indeed, since most existing outcome evaluation studies have involved smaller studies, they have tended to focus on knowledge, attitudes, beliefs and practices.

Calculating the required size of the intervention population for a valid result from an outcome evaluation study needs specialist statistical expertise.

The availability of data on the outcome

Outcome data can be obtained by applying evaluation methods designed specifically for the outcome evaluation study and – where well-developed community-level violence and injury surveillance systems exist – directly from these information systems. Such systems are, however, absent in many places, so that it is only through the application of specifically designed instruments that outcome data can be obtained.

Where this is the case, the population-based epidemiological surveys described in Chapter 2 can be used to generate outcome data for exposure to violent behaviours and their consequences for larger-scale interventions and for interventions where the impact must be tracked and monitored over several years. For other outcomes such as knowledge, attitudes, practices and behaviours, data questionnaires need to be specifically developed, drawing wherever possible on well-tested examples from previous outcome evaluation studies (see Table 3.2 and Appendix 2 for examples).

Designing the delivery and evaluation of the intervention

After defining prevention objectives, outcome indicators and sources of outcome data, it is necessary to design the way in which the intervention will be delivered and evaluated. This involves specifying:

- the type of intervention;
- the scope of the intervention;
- who will carry out the intervention;
- the intervention recipients;
- how the process will be monitored and documented.

Type of intervention

It is first necessary to decide which of the many possible prevention strategies are designed to achieve the objectives set out and are consistent with the organizational capacity of the organization to deliver them. This decision should be made with reference to the existing epidemiological information and the evidence for effective, promising and unclear strategies as shown in Table 3.1. This will ensure that resources are used on the strategies that are most promising in achieving the objectives.

Having decided which strategies are appropriate, there are two broad approaches in designing the intervention and evaluation methods. The first is to attempt to reproduce an already tested intervention in one's own setting. The second is to design from the beginning an intervention based on what has been shown to be successful elsewhere, but at the same time reflecting the particular realities of the setting.

Reproducing a proven intervention

Reproducing an intervention that has proved effective in another setting requires detailed information on how that intervention was conducted. The ways in which the intervention and its monitoring and evaluation were carried out must all be copied as exactly as possible. If there are any deviations from the original programme it will be difficult to establish whether the degree of effectiveness found is due to the programme or to the new setting. Replication studies aim to find out whether a programme is effective in a different setting from where it was first shown to be effective.

Designing a new intervention

There are often marked differences in both resources and social and cultural norms between the place where an effective intervention was originally implemented and that where a new intervention is envisaged. As an example, in places where privacy is highly valued, there could be opposition towards home visitation programmes on the grounds that they are too intrusive. In such an instance, it would be necessary to find another way of reaching parents and their children – for instance, through training programmes for parents at clinics offering antenatal and postnatal services. In cases of this type, interventions should be designed with regard to the principles behind successful strategies that address the same or similar risk factors, and should be based on appropriate theoretical considerations.

The scope of the intervention

As noted in relation to the prevention strategies listed in Table 3.1, strategies may be designed to address all communities, families and individuals regardless of differences in risk, or to address only those identified as being at risk. For strategies such as home visitation, where the evidence shows they are most effective when targeting at-risk groups, this focus should be retained. For strategies where the evidence is unclear, the decision whether to target at-risk groups or the entire population should be based on the nature of the intervention, the intensity of activity and extent of resources it requires.

As a general rule, the impact of strategies demanding sustained, high levels of active intervention by professionals is more likely to be diluted by extending them to everyone than would be the case with strategies involving one-off or periodic interventions, such as legal reforms. Additionally, by their very nature, some interventions target the entire population – such as legal reforms, tax and pricing policies to regulate alcohol availability, and awareness campaigns addressing social and cultural norms.

Partners in the intervention

As already noted, it is important that prevention strategies and objectives should be properly matched with the mix of sectors, organizations and individuals involved in implementing the intervention. Deciding who to involve should be based on the risk factors to be addressed, the roles that different sectors can play in changing those risk factors, and the need to share information, research findings and outcome evaluation results.

To ensure that partners fulfil their obligations for the duration of the project, it is useful to draw up a formal contracts for their work.

The intervention recipients

Defining who will receive the intervention will be influenced by the prevention strategy chosen and whether the intervention will target everyone or only those at risk. If the decision is to target at-risk individuals and groups, then rigorous criteria and screening

procedures to identify those at risk must be developed. These procedures should be scrupulously applied to ensure that only those at a specified level of risk receive the intervention.

Regardless of whether everyone receives the intervention, or only those at risk, it is important that representatives of the targeted group be involved in deciding the design of the intervention and how it will be delivered. This will ensure that the intervention is acceptable to the group and does not risk being resisted. Involving members of the target group can also help to resolve the initial question of whether to reproduce an existing intervention developed in a different setting or to design a new intervention.

Identifying a control group

Most outcome evaluation studies include a comparison, or control group to measure whether those receiving the intervention benefited more than they would have done without the intervention. The problem is to construct this comparison group so that it is as similar to the group receiving the services as possible. If the two groups are very similar to begin with, and if the only way their experiences differed was in exposure to the intervention, then it is much easier to argue that it was the intervention that caused any observed changes. Usually, comparison groups are constructed in one of three ways:

- after the fact;
- at the beginning of the programme, through some type of matching process;
- by randomized assignment.

Some interventions, though, address entire populations – such as multimedia campaigns to raise awareness about child maltreatment. In such cases, an option is to compare the situation before the intervention with that after it. Here, the population prior to the intervention serves as its own control group.

Identifying a control group is a technically complex task that requires the input of a specialist in research design.

Monitoring the delivery process

Adequate monitoring and documentation of the process of implementing the intervention is essential to any outcome evaluation study. Precise records should be maintained, in chronological order, with a full description of the content, frequency and nature of all interactions between programme staff and those receiving the intervention. The records must also be kept up to date, so that deviations from the planned schedule can be quickly identified and corrected. This record will also be needed later for working on the findings of the outcome evaluation.

Obstacles to adequately monitoring and documenting the implementation process can include:

- a resistance by programme managers and staff because such work is seen as potentially threatening to their positions;
- reluctance by government and funding agencies to provide resources for monitoring and documentation because it is regarded as a non-essential "research" activity;

- a lack of human resources, with staff often already overburdened with programme duties.

Although these problems are common, they can be overcome. The integration of monitoring and documentation activities into the programme from its onset can ensure that

appropriate human and financial resources are allocated and reduce the later burden on staff. Partnerships between research or academic centres and programmes can provide technical assistance for good-quality monitoring and documentation. Finally, the involvement of programme staff in planning the exercise and dividing tasks can make the process less threatening to them. Sharing positive outcomes stemming from the evaluation process among staff members can also demonstrate to them the importance of monitoring and documentation.

Analysing the evaluation and disseminating the results

Evidence-based practice in the planning and implementation of child maltreatment prevention will result in better outcomes and help practitioners, programme planners and funding bodies as they deal with strategies and activities to prevent child maltreatment. A central objective of this guide, therefore, with its emphasis on conducting outcome evaluation studies, is to expand the scientific evidence base for prevention beyond its currently limited focus on a small number of intervention types in a few high-income countries.

The evidence base for interventions – in health care, social welfare, education and other areas – consists of systematic reviews of large numbers of single-outcome evaluation studies of interventions to prevent particular problems – such as child physical abuse by parents. Such evaluation studies will have been carried out by researchers working independently in different parts of the world. Systematic reviews use transparent procedures to search for, assess and bring together the all results of research on a particular topic. These procedures:

- are explicit, so that others can reproduce the review;
- are defined before carrying out the review;
- include clear criteria for inclusion and exclusion in the review;
- specify the study designs, populations, interventions and outcomes to be covered in the review.

New outcome evaluation studies of interventions are continually appearing, and systematic reviews of a particular problem or type of intervention are therefore regularly updated. The findings of these reviews are disseminated to those making decisions on what programmes to develop. The availability of systematic reviews greatly increases the ability to successfully argue for increased political and financial commitment to a strategy shown to be effective.

To be included in a systematic review, it is essential that the design, analysis and reporting of an outcome evaluation study should meet standard scientific criteria. These include specific requirements for the methodologies used for analysing the data, and a review of the findings by other scientists working in the field. Publication of the findings in a peer-reviewed scientific journal, while not essential, nonetheless makes the findings easier to identify and retrieve, and therefore more likely to be included in a systematic review. Analysing the findings and disseminating the results of outcome evaluation studies of prevention programmes for child maltreatment should therefore be undertaken with the explicit aim of producing reports of sufficient scientific rigour to be included in a systematic review. This aim, though, should not detract from also disseminating the results in an easily understandable way to many other interested audiences.

CHAPTER 4

Services for affected children and families

When an instance of child maltreatment becomes known, help must be given to the child and the family. Child maltreatment may come to light because of signs – such as particular injuries – displayed by the child; through a disclosure by the child, or a report from a witness of or participant in the abuse; or through the discovery of some evidence, such as a diary or videotape. The role of service providers is to provide care in order to minimize the consequences of the abuse or neglect that has occurred, and to determine what actions could prevent future maltreatment. Legal reforms, policies and programmes should all help service providers to carry out these tasks. Interventions to assist maltreated children should deal with the immediate well-being of the children as well as addressing the long-term health and social costs associated with maltreatment.

There is little evidence, as already stated, on the effectiveness of prevention strategies for child maltreatment, but there is even less evidence on the effectiveness of interventions for responding to cases of child maltreatment. With a few exceptions, it is therefore difficult to make recommendations on such interventions. All the same, formal support is vitally necessary for children who have been maltreated.

This chapter discusses some necessary elements of responses to known cases of child maltreatment. The emphasis is on delivering services in a way that allows the outcomes to be measured and thus contribute to the evidence base on the effectiveness of service provision. Given the large amount of human and financial resources currently invested in child protection systems, there is an urgent need for country-specific information about the effectiveness of the various interventions employed by these services.

4.1   Improving the evidence base

Good-quality health care and social services that respond to child maltreatment need to deliver their interventions appropriately. Where service protocols are based only on intuition, anecdotal information or political considerations, without taking into account scientific evidence, services may be not only be ineffective, but possibly even harmful. It is therefore important that interventions should be grounded in an appropriate theory and designed according to the best available scientific evidence.

It is also important that the outcomes of interventions be measured to see whether or not they achieve their intended effects. There is therefore a need for *intervention outcome studies* of health care, social and legal services responding to child maltreatment. The information given in Chapter 3 on outcome evaluations of prevention programmes applies equally to interventions with maltreated children and their families. As with prevention strategies, services should be developed so that:

- a logic model is used;
- the capacity of the organization, including its human resources, should correspond to the objectives of the service;
- appropriate outcome indicators should be identified.

Process evaluations measuring service delivery indicators are important for continuous quality improvement and to guide administration and planning, but evaluations of services for children and families must expand beyond process evaluation to evaluation of the short and long-term impact of the services on their clients.[1]

The United Kingdom's Department of Health suggests that effective services for children and families are the result of a combination of evidence-based practice and "finely balanced professional judgment".[2] According to the Department of Health, in order to achieve services and interventions based on evidence, practitioners should:

- critically use knowledge, obtained from research and practice, of the needs of children and families and the outcomes of services and interventions;
- systematically record and update information, distinguishing sources of information – such as from direct observation, from other agency records or from interviews with family members;
- learn from the users of services, including children and families;
- continuously evaluate whether an intervention is effective in responding to the needs of an individual child and family – and modify the intervention accordingly;
- rigorously evaluate information, processes and outcomes from interventions carried out by the practitioner.

Even in high-income countries with a developed infrastructure, child protection services fail many children. Complex and costly child protection systems should not be developed at the expense of investment in prevention. Instead, policies and programmes for child protection should be developed in tandem with those aimed at preventing child maltreatment. In addition, services for responding to cases of child maltreatment should be integrated wherever possible into existing health care and social services.

4.2 The response to child maltreatment: the key components
Detecting child maltreatment

Researchers and practitioners recognize that many cases of child maltreatment go undetected and that those children therefore do not receive formal help or protection. Given the extent of child maltreatment and its long-term health and social consequences, it is very likely that teachers, health care and social workers and other "frontline" professionals interact each year – without being aware of the fact – with many children and adults who are current or former victims of child maltreatment.

Early detection of child maltreatment and early intervention can help to minimize the likelihood of further violence and the long-term health and social consequences. Very young children are not able to report violence themselves, yet – among all children – they are at the greatest risk of severe injury, neurological harm and death. Increasing the capacity of frontline professionals to detect child maltreatment in children under five years of age is therefore critically important.

To achieve this end, frontline workers regularly in contact with children and families

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[1] Case events – such as adoption, placement in foster care, or changes of address – can be used as proxy outcome measures, but the their relationship to actual child outcomes should be considered carefully.

[2] *Framework for the assessment of children in need and their families*. London, United Kingdom Department of Health, 2000:16.

must be able to recognize the warning signs that indicate children and families who may need assistance, and they must be able to act on these signs. Creating this ability to detect early on and to intervene calls first for special training of professionals. This training should cover knowledge of:

- myths about child maltreatment;
- physical and behavioural signs of possible, probable and definite maltreatment – as well as signs that are not indicative of maltreatment;
- how to respond when possible maltreatment is indicated – including the use of protocols for involving supervisors, reporting cases and making referrals.

Many professionals are anxious about what might happen to themselves – as well as to the children and to families concerned – if they intervene in a possible case of maltreatment. These anxieties need to be addressed. Training for health care and social workers should also include information on the options for medical and psychosocial treatment for those affected by maltreatment.

In places where there are functioning primary health care systems, the regular interaction between parents and children, on the one hand, and health care workers, on the other, provides a valuable opportunity to detect and intervene in cases of child maltreat-

Figure 4.1 Example of a simple intervention to improve the detection of child abuse in emergency departments

Paediatric injury flow chart: Fix in the notes of all children under the age of 6 attending A&E with any injury
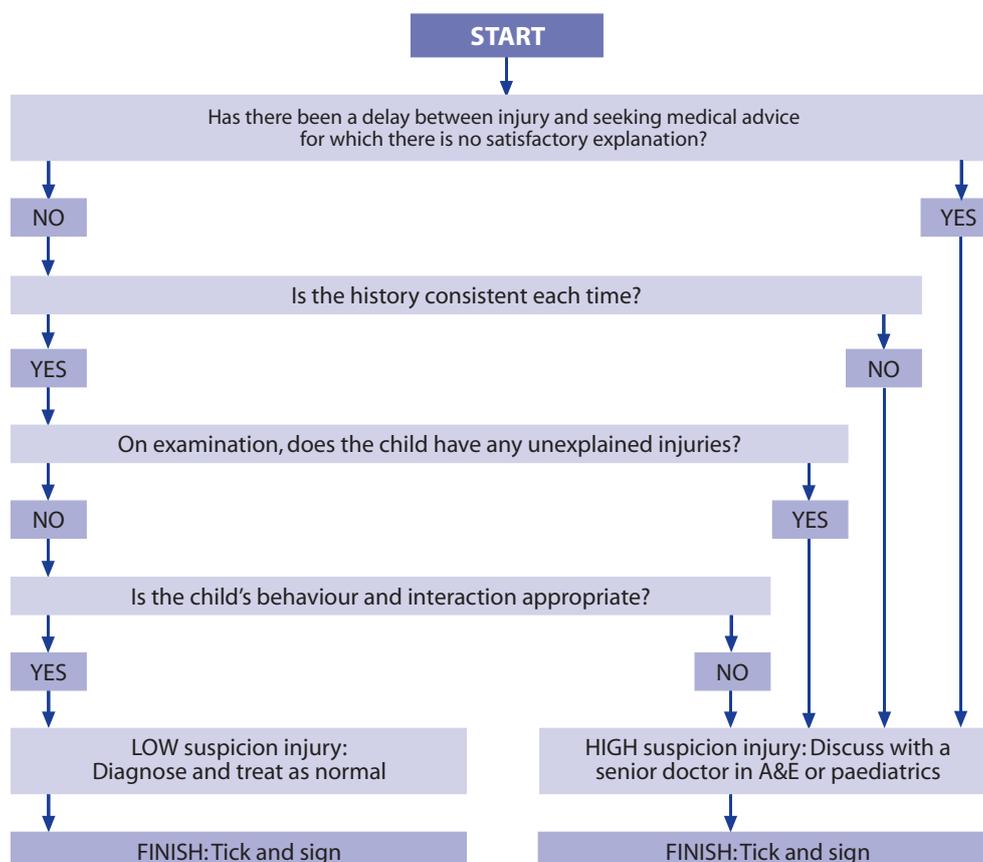
From: Benger JR, Pearce V. Simple intervention to improve detection of child abuse in emergency departments. *British Medical Journal*, 2002, 324:780.

ment. So do the interactions between families and health care workers in emergency departments. Although the health consequences of maltreatment can be of various types and are spread out over a life span, much work is being done on how health workers can use markers of injury, disease and behaviour to identify possible child maltreatment. The detection of child maltreatment with these indicators can be improved by training health workers – especially paediatricians and Emergency Department doctors and nurses – to use algorithms, flow-charts or checklists. Figure 4.1 gives an example of the type of algorithms that can help in this way. It is important that health workers should be aware of *all* the potential health consequences of child maltreatment – and not only the warning signs – so that they can assist maltreated children appropriately.

Procedures to improve the early detection of maltreatment – including the training of professionals – have not been rigorously evaluated and should not necessarily be considered as stand-alone solutions. Some types of child maltreatment – such as psychological violence and the less severe forms of physical and sexual violence – may be missed by professionals, as these types of maltreatment do not always leave clear markers on young victims.

There are also systemic obstacles to detecting child maltreatment that are difficult to overcome. One problem in providing more training for professionals is that they are already frequently over-stretched in their work. They may also be reluctant to become involved in a sensitive issue which they feel is a private matter for the family.

Perhaps the greatest problem is how to direct professionals to intervene where there are no functioning child welfare or protection services. Investment in the early detection of child maltreatment is only worthwhile if the detection will be followed up by action to help and protect the child.

Integrated health care and forensic assessment

Where suspicions of maltreatment arise, a physical and mental health assessment is necessary for the sake of the child's well-being. Where the case is likely will go to court, a forensic assessment is needed. In some legal systems, an inherent conflict exists between addressing the needs of a child and collecting evidence. This happens largely in legal systems that are oriented towards adults and do not take into account children's developmental and mental health needs. The child's needs, though, must come before those of the forensic investigation – something that all sectors involved should be clear on. If the child refuses a health examination and such an examination is not warranted by the child's condition, disclosure or symptoms, it is important not to force the child to submit to the physical examination or verbal interview, even if evidence may be lost in the process. To avoid further victimization of the child, the medical and forensic examinations and the forensic interview should be coordinated and conducted by professionals specially trained to work with child victims. Services should be harmonized in a way that minimizes the number of times a child is asked to relate what took place.

At a minimum, the health assessment should include:

- obtaining consent from both child and caregiver;
- a medical or health history, obtained from both the caregiver and child;
- a "top-to-toe" physical examination, including of the genito-anal area;
- the documentation and treatment of injuries;
- a mental health assessment;
- screening or treatment for sexually transmitted infections and HIV;
- the prevention of pregnancy, where this is appropriate.

BOX 4.1

Responding to children's disclosures

When child maltreatment is disclosed, either inadvertently or purposely, a crisis usually follows. Children do not know how the information will be received, or whether they will be believed, supported or blamed. Young children in particular may not understand the consequences of sharing information, and may be shocked or bewildered by the reaction of adults to the disclosures they make.

If a child discloses abuse or neglect, it is essential that the person to whom the disclosure is made should respond appropriately, to support the child. This will avoid undermining the subsequent investigation, which would put the child at further risk. It is common for children to give a small piece of information first to see how adults react and later to divulge more when they feel safe.

The following are suggestions on how to respond to children who disclose maltreatment.

- Treat the child with dignity and respect.

- Remain calm and do not express reactions such as shock, revulsion or moral indignation. The influence of the listener is less if he or she is in an emotional state, especially if the emotions expressed are different from those the child was expecting to receive.

- Avoid expressing disapproval of the alleged perpetrator, as this individual may be loved or cared for by the child even though abusive or neglect may have taken place.

- Listen attentively to a child who is disclosing maltreatment, and avoid filling in silences for the child. Allow the child to express thoughts in its own words, including the use of slang. Do not correct or challenge it – by saying, for example, "Are you sure it was your uncle?".

- Allow the child to express and report whatever emotions she or he feels, rather than making possibly inaccurate assumptions about what *should* be felt.

- Never force the child to show physical injuries, or to reveal feelings that the child is not prepared to share.

- Avoid words that may disturb or frighten the child – such as "rape", "incest" or "assault".

- Offer the child reassurance and support by using statements such as:
  — "You were very brave to talk about this."
  —"I am glad you are telling me about this."
  —"I am sorry that this has happened to you."
  —"You are not alone – this happens to other children too."
  —"I will do everything I can to help."

- Avoid comments about the actual incident, including those referring to the alleged perpetrator or the impact of the abuse, such as:
  —"How can you say such things about ...?"
  —"What a liar!"
  —"That horrible man has ruined your life."
  —"How could you let him do those things to you?"
  —"Why didn't you tell me this before?"

- Do not make any assumptions about the identity of the suspected perpetrator.

- Answer a child's questions as simply and honestly as possible. If, for instance, a child asks, "Will Daddy have to go to prison now?" a response might be, "I don't know. Other people decide that."

- Only make promises that can be kept. Do not agree, for instance, to keep what the child said a secret. Explain, in such a case, that some secrets must be shared in order to get help, or to keep people from being hurt. Tell the child the information will be shared only with people who are trying to give help and protection.

Where an allegation is to be investigated and a forensic assessment is therefore necessary, the health assessment should include a forensic examination conducted at the same time as the physical examination, for the purpose of collecting relevant forensic specimens. Forensic evidence should be collected and stored according to standard practices.[1]

Efforts should be made to collect the necessary forensic evidence for obtaining protection of the child and the desired outcome in criminal proceedings. The evidence to which the courts attach the greatest weight should be given the greatest priority. Cooperation and good communications between law enforcement agents, the judicial system, health care providers and forensic scientists is important when evidence is found, analysed, evaluated and interpreted.

In addition to the forensic examination, the forensic assessment includes interviews of the person reporting the abuse, the child or children suspected of having been abused, the alleged abuser and any other relevant individuals. These interviews are needed to determine the facts as they are understood by each of these parties, in order to establish whether the child has indeed been abused. Forensic interviewing of children is a specialized skill and, wherever possible, should be conducted by a trained and experienced professional. In some countries, forensic interviewing is the responsibility of the legal or social sector, and health workers are neither trained nor authorized to undertake it. Where possible, the forensic interview should be combined with the mental health assessment to minimize the number of interviews to which the child is subjected.

Children with serious mental health problems may be asked to talk to investigators in order to provide the necessary evidence to charge the abuser and to help protect the children. Both legal and health service providers must be aware of the needs of maltreated children, who may suffer from aspects of traumatic mental ill-health or other symptoms as a result of their maltreatment. The well-being of the child must be paramount and the child should not be subjected to undue pressure to give an account of suspected abuse. Besides being potentially harmful to the child, such an action could adversely affect the credibility of information obtained.

In some cases, mental health treatment for maltreated children may be necessary so that they can give more useful accounts – for legal purposes – of their experiences, especially where sexual abuse has taken place. At the same time, mental health workers need to recognize the dangers of failing to deal with suspected maltreatment out of fear of traumatizing the child and because of the risk that certain treatment approaches may interfere with the investigation. Mental health workers therefore need to adopt a neutral, factual and investigative attitude when obtaining a disclosure from a child on abuse – while at the same time being sensitive to the situation. Similarly, legal service providers and forensic evaluators should be able to recognize when a child's feelings and emotions threaten to undermine the child's well-being or prevent the child from making legally accurate and valid cognitive statements. Because of these competing interests, in cases of suspected abuse, especially those of sexual abuse, a conference between the different sectors involved may be necessary before intervening.

Psychosocial support

All forms of child maltreatment can have significant and lifelong adverse effects on the child's mental health and development. Psychosocial support is therefore critical for the child's recovery. The presence of a trusted, non-offending caregiver who takes

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[1] For an example of guidelines for collecting forensic evidence, see: *Guidelines for medico-legal care for victims of sexual violence*, Geneva, World Health Organization, 2004.

the child's situation seriously will provide the child with strong psychosocial support. Ideally, culturally-sensitive mental health assessment, support and treatment should be offered by qualified practitioners along with any medical treatment. In many communities, though, access to formal mental health care is not a reality. Where access to such care is limited, efforts should be made to link the child and the family to community-based support, which may be informal. Mental health support and treatment – whether formal or informal – need to include the child's caregivers or family and should be closely coordinated with any legal procedures and efforts to protect the child. In severe cases, therapy may need to take precedence over the legal process. This applies to cases of severe mental ill-health, suicidal or self-injuring behaviour, severe dissociation and post-traumatic stress disorder.

Mental health interventions that show the greatest empirical evidence for their effectiveness tend to employ behavioural and cognitive intervention techniques and to intervene with both the individual child and the family. Empirically-validated treatments also tend to be goal-directed and structured in their approach. They emphasize repetitive practice skills to manage emotional distress and behavioural disturbances. Important skills for children include:

- skills to identify, process and regulate emotions;
- anxiety management skills;
- skills to identify and alter inaccurate perceptions;
- problem-solving skills.

It is important for parents and other caregivers to teach behaviour management skills that reinforce positive behaviour – rather than punish negative behaviour. Cognitive behavioural interventions that are trauma-specific appear to be particularly effective at reducing victims' anxiety, depression, sexual concerns and symptoms of post-traumatic stress disorder.

Support services for families

A child's experience of maltreatment may cause great stress and disruption in the family. The child and other siblings may be afraid of what is going to happen or feel guilty about what has already occurred in the home. Other family members may also have been abused or neglected. Service providers must recognize the importance of particular interventions in helping the family cope, providing reassurance and supporting the rehabilitation of those affected. While it may be difficult for providers to give support to family members suspected of maltreating their children, helping the family will often help the child. There is therefore a need for specific support for the parents as well as the family as a whole.

Such support may be needed from the time of suspicion or disclosure of maltreatment onwards, through to the healing process. Support should be provided until all members of the family have been referred to the appropriate services according to their individual needs. Support services should be integrated across sectors, with effective communication and collaboration between the sectors – so that each sector is fully aware of its role and primary responsibilities and clashes between these roles are avoided.

The number of individual service providers in contact with the family should be limited to only those who are immediately involved in the care and case management of the child and family. This will help ensure continuity and consistency of care. It will also protect the forensic integrity of the case and the confidentiality of the family.

The exact point at which interventions for support are considered necessary will depend on:

- the age and developmental abilities of the child;
- the physical and mental health of the child and of the parent or parents;
- obstacles that the family considers affect their ability to cope and their treatment of the children;
- the material and social resources available to the child and family;
- the ability of the existing professional and informal systems to deal effectively with the situation.

Families will usually need help with referrals to appropriate services – including specialized treatment for the person responsible for the maltreatment. A formalized referral system is desirable here. This will define what support is appropriate and determine when to refer to more specialized resources, such as psychological trauma assessments or mental health interventions. The basic necessities of life – such as food, housing and transportation – should also be included when referrals are made, in addition to the provision of support specific to abuse. In some situations, a family or individual members may refuse help. In such cases, service providers should ensure that the family knows what services are available and how to access them. Whatever the attitude of the family, the first priority is the child's well-being and protection.

In addition to protection from further maltreatment, maltreated children and their families frequently need interventions to help them recover and become again productive members of society. This kind of rehabilitation intervention may involve range of sectors, requiring continuous or intermittent periods of service. Both children and perpetrators should be assessed for susceptibility and protective factors when a plan for such services is designed. Social and mental health rehabilitation interventions should take into account existing community structures and be specific to culture.

Rehabilitation services include:

- **health interventions** – such as ongoing medical care; mental health interventions; trauma therapy; and individual, group or family counselling;

- **social interventions** – such as respite care; assistance with everyday home tasks, including cleaning and preparing food; foster placement; and supervision by child protection services;

- **educational interventions** – such as special schooling or training;

- **legal interventions** – such as the prosecution of perpetrators; child protection; and measures to claim damages;

- **financial assistance** – such as victim compensation funds to help with the above interventions.

The better the above services can work together, the more likely it is that successful outcomes will be achieved. While, as always, good communications between sectors are of great importance, the bounds of confidentiality must also be borne in mind. For instance, from the point of view of a child's performance, it might be useful for a school to know that the child is under stress; at the same time, sharing such knowledge may be harmful for the child's well-being and status as a pupil. Children and families themselves may need to be cautioned against sharing too much information with others.

A network of direct service providers will bring together all accessible health, legal and social services providers that specialize in child maltreatment. To be effective, it should conduct case conferences with other service providers. Where appropriate, families and children might be invited to take part in these conferences – an action that may also ensure their cooperation. The network can share and make use of printed

and electronic reference materials, including information on the Internet about legal processes, prevention interventions and support services.

Follow-up

If the primary health care provider for the child and family is aware of the issue of maltreatment, then that person should be involved where there are further contacts with the child and family – such as with possible subsequent incidents of maltreatment.

The primary health care provider is needed to help with the traumatic effects of the abuse and of the intervention to deal with it on the well-being of both child and family. During future health visits, the primary health care provider should consider the level of family stress, since high stress levels might make it more difficult to care for a sick child. It may be that the family does not want the delicate issue of child maltreatment shared with their primary health care provider. In such cases, family members need to be reassured that informing the primary health care provider helps them to continue to have access to care.

Where care is delivered by a team made up of representatives from a range of agencies or sectors, it is essential to have a well-developed plan for following up, with the roles of each member of the team clearly defined. Service plans are most effective if each sector knows which areas it is responsible for and the time within which it is expected to act. Clearly identified plans for each individual affected by abuse or neglect and for the family as a unit should be documented, including ongoing issues to be followed up. Establishing links between service providers in each sector ensures that information is shared quickly and accurately, while at the same time respecting confidentiality. This is particularly important if further incidents of abuse or neglect arise that require notifying the authorities. Each child should have a case manager who can act consistently as a contact person for the family and coordinate the various services.

Services for adult victims of child maltreatment

Research with adults who have experienced maltreatment as a child confirm that although such maltreatment is fairly common, most instances go undisclosed and unreported. Health workers caring for adults may therefore be dealing with victims of child maltreatment without knowing it. As illustrated in Box 1.3, evidence is growing that there is a relationship between victimization in childhood and health-risk behaviours, illnesses and conditions in adulthood. It therefore follows that helping adult victims of child maltreatment address the trauma and its long-term effects is an important part of ensuring their overall health and well-being. Where resources are available, training and procedural interventions to help identify victims of child maltreatment should be integrated into adult health services. In this way, affected adults can be referred to the appropriate psychosocial support services.

Protecting the child

When child maltreatment is suspected or disclosed, action must be taken to protect the children at risk. Many countries have created child protection or child welfare systems with the powers to provide protection. The legal and policy structures and the contents of child protection services vary from country to country. Each approach has its strengths and weaknesses. No country, though, has completely effective child protection services. Protection services, therefore, need to be reformed or set up everywhere and the process has already begun in various countries. While it is beyond the scope of this guide to analyse in depth the relative merits and disadvantages of different systems,

this section presents some of the leading issues that should be considered with any kind of child protection system.

Some approaches to child protection are focused heavily on confrontation and punishment. In such systems, there is an obligation to investigate every single reported case using forensic methods to determine whether child maltreatment either has occurred or is likely to occur. These investigations are numerous and place a heavy demand on resources, and in many cases maltreatment is not proved. Careful thought should therefore be given before adopting an approach with an excessive emphasis on investigation, since with investigation absorbing so many resources, families may not be offered any services beyond the investigation itself.

Some communities with child protection services that have traditionally emphasized reporting and investigation have started to reform their system to offer other responses to children and families who have less immediate concerns about safety. Studies in the United States on such alternative responses have shown that, where they are adopted, families receive more services than in cases where investigation and case management are the only interventions. Research is urgently needed to identify effective approaches to child protection oriented around support, assistance and treatment, and to study how these approaches might best be implemented in both high-resource and low-resource settings.

In responding to reports of maltreatment a balance has to be struck between legally-driven safety and protection on the one hand, and support and treatment as part of a health and social support approach, on the other. Assistance without protection endangers the child's well-being and development and violates the Convention on the Rights of the Child. Protection and a focus on the law with insufficient follow-up, treatment and care can lead to severe and lifelong damage to a child's health and development. It is therefore vital that there should be close collaboration across a range of sectors and a joint approach to investigation and treatment of the child, the family and the perpetrator. The health, social and legal sectors each have important roles to play in this process. Agencies providing services to children and families should, as far as possible, share case information among themselves. Although regulations on privacy and confidentiality can make this difficult, a free flow of information between agencies can be critical in successfully protecting a child. Collaboration can often be improved by setting up a local committee with representatives from each agency providing services to families and children.

An intervention involving a range of sectors is only as good as its weakest element. It is therefore important to develop all sectors in equal measure. An evenly developed multisectoral approach using a low but balanced level of resources can produce much better results than an unevenly developed system with high standards and resources in a single sector and a comparatively low level of resources for the other sectors.

Reporting child maltreatment

In many places, when service providers – such as nurses, doctors, social workers and teachers – identify a suspected case of child maltreatment, they are required to report their suspicions to the child protection authorities. Countries have taken different approaches to the issue of reporting suspected child maltreatment. Some – including Australia, Canada, South Africa, and the United States – have chosen a system with mandatory reporting to authorities with responsibility for legal child protection. Others have opted for confidential reports to the health care system, without automatic legal repercussions. In some countries, professional standards and ethics make reporting the accepted norm. Many others have no system for reporting or responding to suspected

BOX 4.2

A multisectoral approach to comprehensive service provision: the Child Protection Unit of the Philippines General Hospital[1]

The Child Protection Unit of the Philippine General Hospital (CPU), founded in 1997, uses a multisectoral approach towards comprehensive medical and psychosocial services for maltreated children and their families. The aim is to prevent further maltreatment and to start the process of healing.

The CPU operates 24 hours a day, seven days a week. The largest group of patients are those referred from law enforcement agencies, followed by walk-in patients referred from other hospital units. The overwhelming majority are sexually abused children. In 2005, the CPU cared for 972 new cases of maltreated children, 81% of whom had been sexually abused.

From the first point of contact through a long follow-up, the CPU provides quality care using a multisectoral approach. The actions of the health, legal and social sectors are coordinated through CPU's case management system. The following are the stages in managing a typical case.

— When the patient arrives, the guardian is asked to give consent and is interviewed by the social worker and the doctor, while the child is briefed by the nurse in the playroom.

— A doctor conducts a forensic interview, which the social worker and police officer observe through a monitor. With older children who are prepared to file a complaint, the police officer conducts the interview with the social worker observing through the monitor.

— The doctor conducts a medical examination that includes an overall health assessment, the collection of forensic specimens, developmental screening and – where necessary – the provision of treatment.

— The doctor and social worker conduct a risk assessment for the child and family. A safety plan results, to be implemented by the social worker. Counselling is given by the social worker and the doctor.

— During a home visit, the social worker assesses the situation of the child and its family and conducts a second risk assessment, revising the safety plan accordingly.

— The child and caregivers are referred to mental health care as appropriate. A CPU psychologist or psychiatrist conducts a mental health assessment from which a treatment plan results. The CPU offers abuse-specific therapy for children – including individual, group and play therapy – therapy for parents, and therapy for the family.

— Case conferences involving various sectors are held on a regular basis, led by the CPU physician who first saw the patient and the social worker who conducted the home visit. CPU child psychiatrists are also involved and other agencies working with the family are invited to take part.

— Each child has a CPU case manager to coordinate all services received by the child and the family and to facilitate and monitor child safety placement, legal assistance and mental health care. Case managers work with the children and families for as long as is necessary.

The CPU also incorporates legal and police services. Its lawyers handle court cases and prepare children who are to testify. Additional legal services are provided by the Child Justice League. CPU doctors, social workers and psychiatrists provide evidence in court when summoned. Since 2004, an officer from the national police force has been detailed to the CPU, which has helped to file cases on-site.

The CPU also provides other social services, including:

— assistance for maltreated children of very poor families, in the form of grants to pay school fees, transport to and from school and school uniforms;

— livelihood assistance in the form of interest-free loans to needy families who wish to create small-scale businesses;

— parenting classes to help parents manage their expectations of their children and better understand their children's behaviour, and to adjust their methods of discipline accordingly.

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[1] More information can be obtained from the Child Protection Unit Network – from the web site at <http://www.cpu-net.org.ph> (accessed 28 June 2006), or from the director, Dr Bernadette Madrid, at <madridb@cpu-net.org.ph>.

or actual child maltreatment. Whatever the system, service providers in all the relevant sectors must know clearly what their responsibilities are and what protocols to follow. Reporting structures should always be matched with equally well-developed structures for protection, support and treatment for children and families.

When designing a reporting process, there should be agreement on which elements need legislation, which should be set as guidelines reflecting best practice, and which could be in the form of a professional code of practice. The capacity of the child protection and legal services and the likelihood of reports of maltreatment actually being followed up also needs to be considered. The following issues need to be specifically addressed.

- What is the aim of the reporting process, both in terms of potential legal consequences as well as its impact on the health and social support services?

- How should the aspects of the reporting process that deal with different sectors be integrated and how does the reporting process link with the health, social and legal sector responses?

- Who are the service providers for whom reporting laws apply, and how should these providers be informed of their responsibilities?

- If reporting is mandatory, how and when do mandated reporters inform clients of their duty to report suspected abuse?

- What are the criteria for reporting? In other words, what level of concern or suspicion needs to exist for a report to be made?

- Can there be consultation with the child protection authorities on whether or not a report should be made?

- What should the report contain – such as documentation of the indicators of abuse or neglect, the date and time of the report, to whom the report was made, and any recommendations?

- Should a service provider be obliged to make a report even if their supervisor disagrees with the report being made? If individuals are not free to report their suspicions, some cases of child maltreatment may go unreported.

- How should self-reporting by perpetrators be dealt with, since self-reporting is tantamount to a confession?

- How should anonymous reports be dealt with, as these will limit the ability to investigate the situation fully?

- What protection should be offered to the person reporting, as well as to others involved in the investigation, from reprisals by family members or the alleged perpetrator?

- If a report is made in good faith, but the investigation finds that child maltreatment has not taken place, what support can be offered to protect the reporter from any repercussions?

- When should the child and the family be informed that a report has been made, and how should this be done?

- What mechanisms should be set up for children to lodge confidential complaints?

There is growing consensus that countries with mandatory reporting laws should allow children and families greater access to confidential services where they can receive

support on a voluntary basis. Mandated reporting creates an adversarial relationship between families and child protection authorities – even sometimes to the extent that any expression of concern is interpreted as an allegation of wrongdoing rather than a request for assistance. The fear of reporting and its consequences can be a powerful deterrent for families who might otherwise access formal support. The usefulness of mandatory reporting is particularly questionable in situations where there is no functioning legal or child protection system to act on a report.

At the same time, there is extensive evidence that the public as well as professionals are reluctant to act on knowledge or suspicions of maltreatment. This raises concerns that, without reporting laws, children in need of protection will not be identified and systems will not be put in place to prevent further maltreatment. It is up to communities to decide whether, given their situation, they prefer interventions to protect children through mandatory reporting with adequate services for those who are reported – or whether a system of voluntary identification and therapeutic intervention would be better. Even with the latter system, though, if families cannot receive the interventions offered, formal reporting to the authorities may still be necessary in order to remove the child from harm. Whichever approach is chosen, it should be founded in a public health and social support context rather than being primarily punitive. Its effectiveness should be evaluated and any unintended consequences identified.

Integrated assessment of families at risk

When a family considered to be susceptible to maltreatment is referred to child protection authorities, an *integrated risk and needs assessment* may be required. Such an assessment evaluates the overall needs of the child and family in terms of protection, social support and physical and mental health, and enables consistent and correct decisions to be made about services and the schedule for their provision.

An assessment of the ability of the parents to provide for their children's safety and well-being is needed in families receiving targeted or specialized services. When one child is found to have been harmed, other children in the family may also be susceptible. The safety, health and development of each child should therefore be assessed. Such an assessment goes beyond the susceptibility and protective factors already identified, to an analysis in greater depth, and should include:

- an individual history of the parent or parents;

- an individual history of the child or children;

- a family history;

- the physical, social and mental health symptoms of the parent or parents;

- the physical, social and mental health symptoms of the child or children;

- developmental assessment of the child or children;

- the family dynamics, including the quality of attachment and interactions between parent and child;

- the parent's knowledge of and attitudes towards child development and child-rearing, and perceptions of the child's behaviour;

- the family's perception of the situation, including whether or not a parent believes and supports the child victim;

- the physical environment where the child lives or is cared for;

BOX 4.3

Collaborative and coordinated investigation

Where investigation is a main element of the child protection response, a team of investigators who are specially trained and experienced in responding to suspicions of child maltreatment may sometimes be set up. Child protection authorities and law enforcement agents, for instance, may conduct joint investigations in cases involving a protection element and a criminal justice element, or in cases where children have witnessed criminal acts of violence. All relevant service providers should be involved in determining the approach to take before starting the investigation. A collaborative and coordinated approach across sectors increases the likelihood of responding in time and providing appropriate services to the child and family. A joint investigation can be more efficient, but requires flexibility and cooperation.

A formal process where all the parties involved in the investigation meet to plan a joint investigation should include the following.

— A review of the available history of the child, the family and the alleged offender – including, for example, records from child protection, law enforcement and health authorities.

— An overview of the components of the investigation, including forensic interviews of the person who suspected maltreatment, the child, the alleged perpetrator and other relevant witnesses.

— A physical and mental health assessment of the child with forensic specimen collection, and the collection of forensic evidence from the scene of the incident and from the alleged perpetrator.

— A determination of the response time, based either on legal requirements or clinical recommendations, and a proposal for complying with mandated or recommended response times, which may vary depending on the circumstances.

— A decision on who will take the lead and under what circumstances.

— A decision on at what point information obtained in the course of the investigation is to be shared with parents – or whether any information should be kept confidential.

— Procedures for further investigations, in cases where the alleged perpetrator had access to other potential victims.

— A decision on how authorities will identify themselves to the reporting individual, reporting agency, the child and family, other witnesses and alleged perpetrator.

— A decision on any changes in procedures as a result of the type of maltreatment, or because of imminent safety or health issues. For example, it is usual for law enforcement agents to lead an investigative interview, but this could be changed, or may need to be postponed, if a child is seriously injured or particularly distressed emotionally.

— A schedule for the anticipated completion of the investigation. This may vary for the different systems – with, for example, a shorter time period to determine if a child is in need of protection than would be the case with a criminal investigation, which can remain open until all evidence is gathered. Investigations involving children, however, should be expedited to minimize the trauma and increase the likelihood of children remembering specific details.

— Consideration of the circumstances under which deadlines will be extended – such as cases in which immediate mental health needs to take priority over the legal process.

• the conditions for physical, social and mental health development;

• whether the circumstances under which the maltreatment took place have changed – and if so, how this affects the susceptibility of the child;

• the strengths of the family.

Intervening for the best interest of the child

Any assessment and intervention by a social service provider on behalf of a child, including the decision to remove a child from the home, must be determined by what is in the best interests of the child. Defining what is in the child's best interests involves:

- respect for the ethnic, religious, cultural and linguistic background of the family;

- consideration of the physical and developmental level of the child and the child's caregivers;

- consideration of the mental health status of the child and the caregivers;

- support for the integrity, stability and autonomy of families by dealing with them on a basis of mutual consent;

- respect for the importance to the child of continuity of care, upbringing and stability and of nurturing family relationships;

- a plan to reduce the future risk of maltreatment;

- the removal of obstacles to fulfilling the child's needs;

- consideration of the child's wishes and concerns, including those that relate to temporary care arrangements, physical and mental health care, education, and religious and cultural issues – given the child's level of understanding. The child's expressed wishes, though, should be considered taking into account the child's developmental stage and emotional health, as well as the nature of bonds between the child and other family members.

The least detrimental course of action for the child, and the least intrusive one for the family, should be employed, as long as the child's safety is assured. Many matters can be resolved without any legal intervention. The possible range of interventions includes the following measures, listed in increasing degrees of intrusiveness. Some of these measures can be used in combination.

- Assistance for a family that finds itself overwhelmed, but that could provide adequate parenting if certain support were given. Such support could include respite care in the form of an occasional babysitter, regular day care services, or periodic foster care.

- Practical help with daily household tasks, including managing domestic finances, or with training in work skills.

- Training in parenting.

- Therapeutic interventions, such as attendance at substance abuse programmes, treatment for mental illness, or marital counselling.

- Supervision of the home, with a child protection service provider visiting periodically to evaluate the progress of the child and family. This supervision may be voluntary on the part of the child's legal guardians or may be ordered by the state.

- The removal of the alleged perpetrator from the home, while the rest of the family is kept intact.

- The removal of the child from the home and placement in a relative's home, a foster home, or – as a last resort only – residential care. Conditions may be attached to the child's supervision order or temporary removal from the home. These conditions may include the attendance of parents at a substance abuse or an anger management programme, the provision for parents of mental health care, and periodic health checks for the child.

CHAPTER 5

Conclusions and recommendations

Child maltreatment is not a simple problem with easy solutions. Significant improvements in prevention, child protection and treatment, though, are not beyond reach. There is enough knowledge and experience on the subject for any country to begin addressing the problem. One of the greatest obstacles to effectively responding to child maltreatment has been the lack of information. This guide has discussed how strategies and programmes can be built on evidence and can also generate evidence, so that in the future it becomes easier to design evidence-based responses to child maltreatment.

Wherever researchers have studied child maltreatment by adults within the family, the phenomenon – influenced by factors operating at a number of levels – has been found to be alarmingly common. The greatest gains in addressing such a widespread and complex problem will come from employing the systematic approach described in the Introduction. This guide has focused on three major components of that approach:

- **information** for effective action;
- **prevention** of child maltreatment;
- **care services** for victims and families, including child protection.

To further the understanding of child maltreatment and responses to it, **information** systems should incorporate the surveillance of reported cases – generating facility-based information. Surveillance systems should be supplemented by:

- *population-based surveys*, to capture:
  — the prevalence of child maltreatment;
  — the association between past maltreatment and high-risk behaviour;
  — the association between past maltreatment, high-risk behaviour and current health status;
- *mechanisms for investigating* all known and suspected child deaths due to injuries.

Population-based surveys should be designed and implemented using tried and tested survey instruments and should meet epidemiological criteria for objectivity, validity, reliability and sample size. Information yielded by these measures should lead to more accurate estimates of child maltreatment in the population, trends in reporting maltreatment and the utilization of services. It will also provide the foundation for outcome evaluation.

A comprehensive strategy for the **prevention** of child maltreatment includes interventions at all levels of the ecological model. These address an array of risk factors – ranging from cultural norms conducive to child maltreatment to unwanted pregnancies. Support for families by means of home visits and training programmes for parents are the prevention strategies with the most evidence of effectiveness. They therefore provides a good starting point for preventing child maltreatment. Prevention

programmes should make a priority of working with subgroups of the population at the highest risk of maltreatment. This will ensure that scarce resources are sufficiently concentrated to sustain prevention activities at the required levels and for the time necessary to achieve a prevention effect, as indicated by scientific outcome studies of similar interventions.

Services providing care and support to maltreated children and their families should be strengthened and need a stronger evidence base than presently exists to show their effectiveness. Well-trained professionals who regularly work with children can be an invaluable asset in the detection of child maltreatment. Protocols for the provision of services will help to standardize care and improve its quality. Standards should be developed for:

- *health care for maltreated children*, including:
  — the documentation of injuries;
  — forensic assessment;
  — psychosocial support;
- *child protection services*, including:
  — coordinated case management;
  — court proceedings with child witnesses;
  — social service interventions with families;
  — alternative placements for children.

Several principles for implementation emerge from this guide, including the following.

- Policies, plans, programmes and services should be based on scientific evidence – from both local and global studies – about the magnitude, consequences, causes and preventability of child maltreatment and the effectiveness of various interventions. Where there is no evidence or the evidence is unclear, innovative work should be conducted, based on theory.

- Interventions should be designed and implemented in such a way that they can be evaluated for their effectiveness and monitored for progress in preventing child maltreatment.

- Wherever possible, child maltreatment surveillance, prevention programmes and care services for children and families should be integrated into existing services and systems.

- Interventions and information systems should define child maltreatment with reference to international norms, including the behavioural definitions used in well-tested survey instruments. For the operational classification of maltreatment cases identified in care service facilities, the relevant International Classification of Diseases codes should be used.

While an evidence-based, evidence-generating approach incorporating information for prevention and care services is necessary for a successful response to child maltreatment, it is not by itself sufficient. To build an effective, systematic response that will be sustainable and far-reaching, the core components must operate in unison as part of a single system. The work of the different sectors, groups and individuals involved must be woven together in a way that minimizes duplication of work and maximizes its effectiveness. The following principles can help ensure that a systematic response is designed and implemented effectively.

- A systematic response will function best when it is both multisectoral and coordinated using some formal mechanism, such as a national plan of action or national policy.

- The roles of the different sectors involved in preventing child maltreatment should be clearly specified according to the capacity of each sector to:
  — gather data and conduct research;
  — have an impact on one or more of the causes and risk factors underlying child maltreatment;
  — provide care services to children and families.

- A national coordinating committee, with representatives from all relevant sectors, can help facilitate the implementation of a systematic response. A lead agency, though, is also desirable for this purpose. This should be a body with the capacity to coordinate a complex undertaking, conducted simultaneously at a number of different levels.

- A systematic response must make clear which sectors and agencies are responsible for implementing and monitoring information systems on child maltreatment, for prevention strategies and for care services. It is not sufficient simply to identify the tasks of the various bodies.

- Responsibility for setting up, conducting and monitoring child maltreatment prevention programmes should be clearly assigned to central and local government departments with expertise in carrying out prevention work.

- Those designing plans, policies, programmes and services need to take into account the differential susceptibility of girls and boys to various forms of maltreatment. Particular attention should be given to the needs of especially susceptible and marginalized children – including children with disabilities, displaced and refugee children, children affected by HIV/AIDS and children from ethnic minorities.

- Proper resources, allocated in an appropriate way, are required for research on child maltreatment, for prevention programmes and for care activities. The individual and societal benefits of safeguarding children from abuse and neglect well justify the investment needed.

Significant gains will be made by adopting these principles for a coordinated, systematic approach to child maltreatment prevention. Rates of child maltreatment will fall and care for children and families who experience violence will improve. As an increasing number of agencies respond to child maltreatment adopting the methods and principles of this guide, the evidence base will expand. Scientifically sound information will be at hand to develop policies and programmes and to help resource allocation.

An evidence-*based* approach to child maltreatment is essential for the long-term success in preventing child maltreatment. At the present time, though, the evidence base is not sufficiently large or geographically widespread for decision-makers to have full confidence in their judgements. Increasing the number of child maltreatment responses conducted in an evidence-*generating* way is therefore vital to ensure that an evidence-based approach will be used in the future.

Adverse Childhood Experiences Study Questionnaires[1]

Family Health History: Women's

These questionnaires are reproduced verbatim from the versions applied in the California, U.S.A., Adverse Childhood Experiences Study, and certain items (e.g. demographic questions 1b, 3a, 3b, education questions 4, 11a, 11b) will always have to be amended to reflect local circumstances.

1. **What is your birthdate?**
Month .... Year ....

lb. **In what state were you born?**
State ....
☐ was born outside of the U.S

2. **What is your sex?**
☐ Male   ☐ Female

3a. **What is your race?**
☐ Asian   ☐ American Indian
☐ Black   ☐ White
☐ Other

3b. **Are you of Mexican, Latino , or Hispanic origin?**
☐ Yes   ☐ No

4. **Please check how far you've gone in school. (Choose one.)**
☐ Didn't go to high school
☐ Some high school
☐ High school graduate or GED
☐ Some college or technical school
☐ 4-year college graduate

5. **What is your <u>current</u> marital status? Are you now...**
☐ Married
☐ Not married but <u>living together</u> with a partner
☐ Widowed
☐ Separated
☐ Divorced
☐ Never married

6a. **How many times have you been married?**
☐ 1   ☐ 2   ☐ 3   ☐ 4 or more
☐ Never married

6b. **During what month and year were you first married?**
Month .... Year ....
☐ Never married

7a. **Which of the following best describes your current employment status?**
☐ Full-time (35 hours or more)
☐ Part-time (1–34 hours)
☐ Not employed outside the home

7b. **If you are currently employed outside the home, how many days of work did you miss in the past 30 days due to stress or feeling depressed?**
Number of days: ....

7c. **If you are currently employed outside the home, how many days of work did you miss in the past 30 days due to poor physical health?**
Number of days: ....

8. **For most of your childhood, did your family own their home?**
☐ Yes   ☐ No

9a. **During your childhood how many times did you move residences even in the same town?**
Number of times: ....

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[1] The questionnaires can be downloaded from the web site of the United States Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/nccdphp/ace/ (accessed 7 June 2006). They are not copyrighted and there are no fees for their use, though CDC and Kaiser Permanente (a non-profit-making health care delivery organization in the United States) request copies of any articles on research conducted using the questionnaires.

10. How old was your mother when you were born?

Age: ....

11a. How much education does/did your mother have? (Choose one)
- ☐ Didn't go to high school
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ Some college or technical school
- ☐ College graduate or higher

11b. How much education does/did your father have? (Choose one)
- ☐ Didn't go to high school
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ Some college or technical school
- ☐ College graduate or higher

12. Have you ever been pregnant?
- ☐ Yes   ☐ No

If NO, skip to item 16.

13a. Are you pregnant now?
- ☐ Yes   ☐ No   ☐ Don t know

13b. How many times have you been pregnant?

Number: ....

13c. How many of these pregnancies resulted in the birth of a child?

Number: ....

13d. How old were you the first time you became pregnant?

Age: ....

13e. The first time you became pregnant how old was the person who got you pregnant?

Age: ....

13f. During what month and year did your first pregnancy end?

Month .... Year ....

13g. How did your first pregnancy end?
- ☐ Live birth(s)
- ☐ Stillbirth/miscarriage
- ☐ Tubal or ectopic pregnancy
- ☐ Elective abortion
- ☐ Other

13h. When your first pregnancy began did you intend to get pregnant at that time in your life?
- ☐ Yes   ☐ No   ☐ Didn't care

14. Were you ever pregnant a 2nd time?
- ☐ Yes   ☐ No

If NO, skip to item 16.

15a. During what month and year did your second pregnancy end?

Month .... Year ....

15b. How did your second pregnancy end?
- ☐ Live birth(s)
- ☐ Stillbirth/miscarriage
- ☐ Tubal or ectopic pregnancy
- ☐ Elective abortion
- ☐ Other

15c. When your second pregnancy began did you intend to get pregnant at that time in your life?
- ☐ Yes   ☐ No   ☐ Didn't care

In order to get a more complete picture of the health of our patients, the next three questions are about voluntary sexual experiences only.

16. How old were you the first time you had sexual intercourse?

Age: ....
- ☐ Never had intercourse

17. With how many different partners have you ever had sexual intercourse?

Number of partners: ....

18. During the past year, with how many different partners have you had sexual intercourse?

Number of partners: ....

19a. Have you smoked at least 100 cigarettes in your entire life?
- ☐ Yes   ☐ No

19b. How old were you when you began to smoke cigarettes fairly regularly?

Age: ....

20c. Do you smoke cigarettes now?
- ☐ Yes   ☐ No

20d. If "Yes": on average, about how many cigarettes a day do you smoke?

Number of cigarettes: ....

If you used to smoke cigarettes but don't smoke now:

21a. About how many cigarettes a day did you smoke?

Number of cigarettes: ....

21b. **How old were you when you quit?**
Age: ....

During your first 18 years of life:

22a. **Did your father smoke?**
☐ Yes   ☐ No

22b. **Did your mother smoke?**
☐ Yes   ☐ No

23a. **During the past month, about how many days per week did you exercise for recreation or to keep in shape?**
☐ 0   ☐ 1   ☐ 2   ☐ 3
☐ 4   ☐ 5   ☐ 6   ☐ 7

23b. **During the past month, when you exercised for recreation or to keep in shape how long did you usually exercise (minutes)?**
☐ 0   ☐ 1–19   ☐ 20–29   ☐ 30–39
☐ 40–49   ☐ 50–59   ☐ 60 or more

24a. **What is the most you have ever weighed?**
Weight in pounds: ....

24b. **How old were you then?**
Age: ....

25a. **How old were you when you had your first drink of alcohol other than a few sips?**
Age: ....
☐ Never drank alcohol

During each of the following age intervals, what was your usual number of drinks of alcohol per week?

25b1. **Age 19–29**
☐ None   ☐ 13/week
☐ Less than 6/week   ☐ 14 or more/week
☐ 7–13/week

25b2. **Age 30–39**
☐ None   ☐ 13/week
☐ Less than 6/week   ☐ 14 or more/week
☐ 7–13/week

25b3. **Age 40–49**
☐ None   ☐ 13/week
☐ Less than 6/week   ☐ 14 or more/week
☐ 7–13/week

25b4. **Age 50 and older**
☐ None   ☐ 13/week
☐ Less than 6/week   ☐ 14 or more/week
☐ 7–13/week

25c. **During the past month, have you had any beer, wine, wine coolers cocktails or liquor?**
☐ Yes   ☐ No

25d. **During the past month, how many days per week did you drink any alcoholic beverages on average?**
☐ 0   ☐ 1   ☐ 2   ☐ 3
☐ 4   ☐ 5   ☐ 6   ☐ 7

25e. **On the days when you drank, about how many drinks per day did you have on average?**
☐ 1   ☐ 2   ☐ 3   ☐ 4 or more
☐ Didn't drink in past month

25f. **Considering all types of alcoholic beverages, how many times during the past month did you have 5 or more drinks on an occasion?**
Number of times: ....

25g. **During the past month, how many times have you driven when you had perhaps too much to drink?**
Number of times: ....

25h. **During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been drinking alcohol?**
Number of times: ....

26. **Have you ever had a problem with your use of alcohol?**
☐ Yes   ☐ No

27. **Have you ever considered yourself to be an alcoholic?**
☐ Yes   ☐ No

28a. **During your first 18 years of life did you live with anyone who was a problem drinker or alcoholic?**
☐ Yes   ☐ No

28b. **If "Yes": check all who were:**
☐ Father   ☐ Other relative
☐ Mother   ☐ Other non-relative
☐ Brothers   ☐ Sisters

29. **Have you ever been married to someone (or lived with someone as if you were married) who was a problem drinker or alcoholic?**
☐ Yes   ☐ No

30a. **Have you ever used street drugs?**
☐ Yes   ☐ No

30b. If "Yes": How old were you the first time you used them?
Age: ....

30c. About how many times have you used street drugs?
☐ 0 ☐ 1–2 ☐ 3–10 ☐ 11–25
☐ 26–99 ☐ 100+

30d. Have you ever had a problem with (your use of) street drugs?
☐ Yes ☐ No

30e. Have you ever considered yourself to be addicted to street drugs?
☐ Yes ☐ No

30f. Have you ever injected street drugs?
☐ Yes ☐ No

31. Have you ever been under the care of psychologist, psychiatrist, or therapist?
☐ Yes ☐ No

32a. Has a doctor, nurse, or other health professional ever asked you about family or household problems during your childhood?
☐ Yes ☐ No

32b. How many close friends or relatives would help you with your emotional problems or feelings if you needed it?
☐ None ☐ 1 ☐ 2 ☐ 3 or more

During your first 18 years of life:

33. Did you live with anyone who used street drugs?
☐ Yes ☐ No

34a. Were your parents ever separated or divorced.
☐ Yes ☐ No

34b. Did you ever live with a stepfather?
☐ Yes ☐ No

34c. Did you ever live with a stepmother?
☐ Yes ☐ No

35. Did you ever live in a foster home?
☐ Yes ☐ No

36a. Did you ever run away from home for more than one day?
☐ Yes ☐ No

36b. Did any of your brothers or sisters run away from home for more than one day?
☐ Yes ☐ No

37. Was anyone in your household depressed or mentally ill?
☐ Yes ☐ No

38. Did anyone in your household attempt to commit suicide?
☐ Yes ☐ No

39a. Did anyone in your household ever go to prison?
☐ Yes ☐ No

39b. Did anyone in your household ever commit a serious crime?
☐ Yes ☐ No

40a. Have you ever attempted to commit suicide?
☐ Yes ☐ No

40b. If "Yes": how old were you the first time you attempted suicide?
Age: ....

40c. If "Yes": how old were you the last time you attempted suicide?
Age: ....

40d. How many times have you attempted suicide?
Number of times: ....

40e. Did any suicide attempt ever result in an injury, poisoning or overdose that had to be treated by a doctor or nurse?
☐ Yes ☐ No

Sometimes physical blows occur between parents. While you were growing up in your first 18 years of life, how often did your father (or stepfather) or mother's boyfriend do any of these things to your mother (or stepmother)?

41a. Push, grab , slap or throw something at her?
☐ Never ☐ Often
☐ Once, twice ☐ Very often
☐ Sometimes

41b. Kick, bite, hit her with a fist, or hit her with something hard?
☐ Never ☐ Often
☐ Once, twice ☐ Very often
☐ Sometimes

41c. **Repeatedly hit her over at least a few minutes?**
☐ Never ☐ Often
☐ Once, twice ☐ Very often
☐ Sometimes

41d. **Threaten her with a knife or gun , or use a knife or gun to hurt her?**
☐ Never ☐ Often
☐ Once, twice ☐ Very often
☐ Sometimes

Some parents spank their children as a form of discipline. While you were growing up during the first 18 years of life:

42a. **How often were you spanked?**
☐ Never ☐ Many times in a year
☐ Once, twice ☐ Weekly or more
☐ A few times a year

42b. **How severely were you spanked?**
☐ Not hard ☐ Quite hard
☐ A little hard ☐ Very hard
☐ Medium

42c. **How old were you the last time you remember being spanked?**
Age: ....

While you were growing up, during your first 18 years of life, how true were each of the following statements:

43. **You didn't have enough to eat.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

44. **You knew there was someone to take care of you and protect you.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

45. **People in your family called you things like "lazy" or "ugly".**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

46. **Your parents were too drunk or high to take care of the family.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

47. **There was someone in your family who helped you feel important or special.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

48. **You had to wear dirty clothes.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

49. **You felt loved.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

50. **You thought your parents wished you had never been born.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

51. **People in your family looked out for each other.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

52. **You felt that someone in your family hated you.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

53. **People in your family said hurtful or insulting things to you.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

54. **People in your family felt close to each other.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

55. **You believe you were emotionally abused.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

56. **There was someone to take you to the doctor if you needed it.**
☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

57. **Your family was a source of strength and support.**

☐ Never true ☐ Often true
☐ Rarely true ☐ Very often true
☐ Sometimes true

Sometimes parents or other adults hurt children. While you were growing up, that is, during your first 18 years of life, how often did a parent, step-parent, or adult living in your home:

58a. **Swear at you, insult you, or put you down?**

☐ Never ☐ Often
☐ Once, twice ☐ Very often
☐ Sometimes

58b. **Threaten to hit you or throw something at you, but didn't do it?**

☐ Never ☐ Often
☐ Once, twice ☐ Very often
☐ Sometimes

58c. **Actually push, grab , shove, slap, or throw something at you?**

☐ Never ☐ Often
☐ Once, twice ☐ Very often
☐ Sometimes

58d. **Hit you so hard that you had marks or were injured?**

☐ Never ☐ Often
☐ Once, twice ☐ Very often
☐ Sometimes

58e. **Act in a way that made you afraid that you might be physically hurt?**

☐ Never ☐ Often
☐ Once, twice ☐ Very often
☐ Sometimes

Some people, while growing up in their first 18 years of life, had a sexual experience with an adult or someone at least five years older than themselves. These experiences may have involved a relative, family friend, or stranger. During the first 18 years of life, did an adult or older relative, family friend, or stranger ever:

	The first time this happened, how old were you?	The first time, did this happen against your wishes?	The last time this happened, how old were you?	About how many times did this happen to you?	How many different people did this to you?	What was the sex of the person(s) who did it?
59a. Touch or fondle your body in a sexual way? ☐ Yes ☐ No ☐ If "Yes" ▶	.... age	☐ Yes ☐ No	.... age	.... times	.... people	☐ Male ☐ Female ☐ Both
60a. Have you touch their body in a sexual way? ☐ Yes ☐ No ☐ If "Yes" ▶	.... age	☐ Yes ☐ No	.... age	.... times	.... people	☐ Male ☐ Female ☐ Both
61a. Attempt to have any type of sexual intercourse (oral, anal, or vaginal) with you? ☐ Yes ☐ No ☐ If "Yes" ▶	.... age	☐ Yes ☐ No	.... age	.... times	.... people	☐ Male ☐ Female ☐ Both
62a. Actually have any type of sexual intercourse (oral , anal, or vaginal) with you? ☐ Yes ☐ No ☐ If "Yes" ▶	.... age	☐ Yes ☐ No	.... age	.... times	.... people	☐ Male ☐ Female ☐ Both

Did any of these sexual experiences with an adult or person at least 5 years older than you involve:

63a. **A relative who lived in your home?**
☐ Yes ☐ No

63b. **A non-relative who lived in your home?**
☐ Yes ☐ No

63c. **A relative who didn't live in your home?**
☐ Yes ☐ No

63d. **A family friend or person whom you knew and who didn't live in your home?**
☐ Yes ☐ No

63e. **A stranger?**
☐ Yes ☐ No

63f. **Someone who was supposed to be taking care of you?**
☐ Yes ☐ No

63g. **Someone you trusted?**
☐ Yes ☐ No

Did any of these sexual experiences involve:

64a. **Trickery, verbal persuasion, or pressure to get you to participate?**
☐ Yes ☐ No

64b. **Being given alcohol or drugs?**
☐ Yes ☐ No

64c. **Threats to harm you if you didn't participate?**
☐ Yes ☐ No

64d. **Being physically forced or overpowered to make you participate?**
☐ Yes ☐ No

65a. **Have you ever told a doctor, nurse or other health professional about these sexual experiences?**
☐ Yes ☐ No

65b. **Has a therapist or counselor ever suggested to you that you were**
sexually abused as a child?
☐ Yes ☐ No

66. **Do you think that you were sexually abused as a child?**
☐ Yes ☐ No

Apart from other sexual experiences you have already told us about, while you were growing up during your first 18 years of life:

67a. **Did a boy or group of boys about your own age ever force you or threaten you with harm In order to have sexual contact?**
☐ Yes ☐ No

67b. **If "Yes": did the contact involve someone touching your sexual parts or trying to have intercourse with you (oral , anal or vaginal)?**
☐ Yes ☐ No

67c. **If "Yes": how many times did someone do this to you?**
☐ Once ☐ 6–10 times
☐ Twice ☐ More than 10 times
☐ 3–5 times

67d. **Did the contact involve a person actually having intercourse with you (oral, anal, or vaginal)?**
☐ Yes ☐ No

67e. **If "Yes": how many times did someone do this to you?**
☐ Once ☐ 6–10 times
☐ Twice ☐ More than 10 times
☐ 3–5 times

68a. **As an adult (age 19 or older), did anyone ever force or threaten you with harm in order to have sexual contact?**
☐ Yes ☐ No

68b. **If "Yes": did the contact involve someone touching your sexual parts or trying to have intercourse with you (oral, anal , or vaginal)?**
☐ Yes ☐ No

68c. **If "Yes": how many times did someone do this to you?**
☐ Once ☐ 6–10 times
☐ Twice ☐ More than 10 times
☐ 3–5 times

68d. **Did the contact involve someone actually having intercourse with you (oral , anal, or vaginal)?**
☐ Yes ☐ No

68e. **If "Yes": how many times did someone do this to you?**
☐ Once ☐ 6–10 times
☐ Twice ☐ More than 10 times
☐ 3–5 times

Family Health History: Men's

These questionnaires are reproduced verbatim from the versions applied in the California, U.S.A., Adverse Childhood Experiences Study, and certain items (e.g. demographic questions 1b, 3a, 3b, education questions 4, 11a, 11b) will always have to be amended to reflect local circumstances.

1. **What is your birthdate?**
Month .... Year ....

1b. **In what state were you born?**
State ....
☐ was born outside of the U.S

2. **What is your sex?**
☐ Male ☐ Female

3a. **What is your race?**
☐ Asian ☐ American Indian
☐ Black ☐ White
☐ Other

3b. **Are you of Mexican, Latino , or Hispanic origin?**
☐ Yes ☐ No

4. **Please check how far you've gone in school. (Choose one.)**
☐ Didn't go to high school
☐ Some high school
☐ High school graduate or GED
☐ Some college or technical school
☐ 4-year college graduate

5. **What is your current marital status? Are you now...**
☐ Married
☐ Not married but living together with a partner
☐ Widowed
☐ Separated
☐ Divorced
☐ Never married

6a. **How many times have you been married?**
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
☐ Never married

6b. **During what month and year were you first married?**
Month .... Year ....
☐ Never married

7a. **Which of the following best describes your current employment status?**
☐ Full-time (35 hours or more)
☐ Part-time (1–34 hours)
☐ Not employed outside the home

7b. **If you are currently employed outside the home, how many days of work did you miss in the past 30 days due to stress or feeling depressed?**
Number of days: ....

7c. **If you are currently employed outside the home, how many days of work did you miss in the past 30 days due to poor physical health?**
Number of days: ....

8. **For most of your childhood, did your family own their home?**
☐ Yes ☐ No

9a. **During your childhood how many times did you move residences even in the same town?**
Number of times: ....

9b. **How long have you lived at your current residence?**
☐ Less than 6 months
☐ Less than 1 year
☐ Less than 2 years
☐ 2 or more years

10. **How old was your mother when you were born?**
Age: ....

11a. **How much education does/did your mother have? (Choose one)**
☐ Didn't go to high school
☐ Some high school
☐ High school graduate or GED
☐ Some college or technical school
☐ College graduate or higher

llb. **How much education does/did your father have? (Choose one)**
☐ Didn't go to high school
☐ Some high school
☐ High school graduate or GED
☐ Some college or technical school
☐ College graduate or higher

12a. **Have you smoked at least 100 cigarettes in your entire life?**
☐ Yes ☐ No

12b. How old were you when you began to smoke cigarettes fairly regularly?
Age: ....

12c. Do you smoke cigarettes now?
☐ Yes　　☐ No

12d. If "Yes": on average, about how many cigarettes a day do you smoke?
Number of cigarettes: ....

If you used to smoke cigarettes but don't smoke now:

13a. About how many cigarettes a day did you smoke?
Number of cigarettes: ....

13b. How old were you when you quit?
Age: ....

During your first 18 years of life:

14a. Did your father smoke?
☐ Yes　　☐ No

14b. Did your mother smoke?
☐ Yes　　☐ No

15a. During the past month, about how many days per week did you exercise for recreation or to keep in shape?
☐ 0　　☐ 1　　☐ 2　　☐ 3
☐ 4　　☐ 5　　☐ 6　　☐ 7

15b. During the past month, when you exercised for recreation or to keep in shape how long did you usually exercise (minutes)?
☐ 0　　☐ 1–19　☐ 20–29　☐ 30–39
☐ 40–49　☐ 50–59　☐ 60 or more

16a. How old were you when you had your first drink of alcohol other than a few sips?
Age: ....
☐ Never drank alcohol

During each of the following age intervals, what was your usual number of drinks of alcohol per week?

16b1. Age 19–29
☐ None　　　　　☐ 7–13/week
☐ less than 6/week　☐ 14 or more/week

16b2. Age 30–39
☐ None　　　　　☐ 7–13/week
☐ less than 6/week　☐ 14 or more/week

16b3. Age 40–49
☐ None　　　　　☐ 7–13/week
☐ less than 6/week　☐ 14 or more/week

16b4. Age 50 and older
☐ None　　　　　☐ 7–13/week
☐ less than 6/week　☐ 14 or more/week

16c. During the past month, have you had any beer, wine, wine coolers, cocktails or liquor?
☐ Yes　　☐ No

16d. During the past month, how many days per week did you drink any alcoholic beverages on average?
☐ 0　　☐ 1　　☐ 2　　☐ 3
☐ 4　　☐ 5　　☐ 6　　☐ 7

16e. On the days when you drank, about how many drinks per day did you have on average?
☐ 1　　☐ 2　　☐ 3　　☐ 4 or more
☐ Didn't drink in past month

16f. Considering all types of alcoholic beverages, how many times during the past month did you have 5 or more drinks on an occasion?
Number of times: ....

16g. During the past month, how many times have you driven when you had perhaps too much to drink?
Number of times: ....

16h. During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been drinking alcohol?
Number of times: ....

17. Have you ever had a problem with your use of alcohol?
☐ Yes　　☐ No

18. Have you ever considered yourself to be an alcoholic?
☐ Yes　　☐ No

19a. During your first 18 years of life did you live with anyone who was a problem drinker or alcoholic?
☐ Yes　　☐ No

19b. If "Yes": check all who were:
☐ Father　　☐ Other relative
☐ Mother　　☐ Other non-relative
☐ Brothers　☐ Sisters

20. **Have you ever been married to someone (or lived with someone as if you were married) who was a problem drinker or alcoholic?**
☐ Yes ☐ No

21a. **Have you ever used street drugs?**
☐ Yes ☐ No

21b. **If "Yes": How old were you the first time you used them?**
Age: ....

21c. **About how many times have you used street drugs?**
☐ 0 ☐ 1–2 ☐ 3–10 ☐ 11–25
☐ 26–99 ☐ 100+

21d. **Have you ever had a problem with your use of street drugs?**
☐ Yes ☐ No

21e. **Have you ever considered yourself to be addicted to street drugs?**
☐ Yes ☐ No

21f. **Have you ever injected street drugs?**
☐ Yes ☐ No

22. **Have you ever been under the care of psychologist, psychiatrist, or therapist?**
☐ Yes ☐ No

23a. **Has a doctor, nurse, or other health professional ever asked you about family or household problems during your childhood?**
☐ Yes ☐ No

23b. **How many close friends or relatives would help you with your emotional problems or feelings if you needed it?**
☐ None ☐ 1 ☐ 2 ☐ 3 or more

While you were growing up, during your first 18 years of life:

24. **Did you live with anyone who used street drugs?**
☐ Yes ☐ No

25a. **Were your parents ever separated or divorced.**
☐ Yes ☐ No

25b. **Did you ever live with a stepfather?**
☐ Yes ☐ No

25c. **Did you ever live with a stepmother?**
☐ Yes ☐ No

26. **Did you ever live in a foster home?**
☐ Yes ☐ No

27a. **Did you ever run away from home for more than one day?**
☐ Yes ☐ No

27b. **Did any of your brothers or sisters run away from home for more than day?**
☐ Yes ☐ No

28. **Was anyone in your household depressed or mentally ill?**
☐ Yes ☐ No

29. **Did anyone in your household attempt to commit suicide?**
☐ Yes ☐ No

30a. **Did anyone in your household ever go to prison?**
☐ Yes ☐ No

30b. **Did anyone in your household ever commit a serious crime?**
☐ Yes ☐ No

31a. **What is the most you have ever weighed?**
Weight in pounds: ....

31b. **How old were you then?**
Age: ....

32a. **Have you ever attempted to commit suicide?**
☐ Yes ☐ No

32b. **If "Yes": how old were you the first time you attempted suicide?**
Age: ....

32c. **If "Yes": how old were you the last time you attempted suicide?**
Age: ....

32d. **How many times have you attempted suicide?**
Number of times: ....

32e. **Did any suicide attempt ever result in an injury, poisoning or overdose that had to be treated by a doctor or nurse?**
☐ Yes ☐ No

In order to get a more complete picture of the health of our patients, the next three questions are about voluntary sexual experiences only.

33a. **How old were you the first time you had sexual intercourse?**
Age: ....
☐ Never had intercourse

33b. **With how many different partners have you ever had sexual intercourse?**
Number of partners: ....

33c. **During the past year, with how many different partners have you had sexual intercourse?**
Number of partners: ....

34a. **Have you ever gotten someone pregnant?**
☐ Yes   ☐ No

34b. **If "Yes": how old were you the first time you got someone pregnant?**
Age: ....
☐ Never got someone pregnant

34c. **What was the age of the youngest woman you ever got pregnant?**
Age: ....
☐ Never got someone pregnant

34d. **How old were you then?**
Age: ....

Sometimes physical blows occur between parents. While you were growing up in your first 18 years of life, how often did your father (or stepfather) or mother's boyfriend do any of these things to your mother (or stepmother)?

35a. **Push, grab , slap or throw something at her?**
☐ Never   ☐ Often
☐ Once, twice   ☐ Very often
☐ Sometimes

35b. **Kick, bite, hit her with a fist, or hit her with something hard?**
☐ Never   ☐ Often
☐ Once, twice   ☐ Very often
☐ Sometimes

35c. **Repeatedly hit her over at least a few minutes?**
☐ Never   ☐ Often
☐ Once, twice   ☐ Very often
☐ Sometimes

35d. **Threaten her with a knife or gun , or use a knife or gun to hurt her?**
☐ Never   ☐ Often
☐ Once, twice   ☐ Very often
☐ Sometimes

Some parents spank their children as a form of discipline. While you were growing up during the first 18 years of life:

36a. **How often were you spanked?**
☐ Never   ☐ Many times in a year
☐ Once, twice   ☐ Weekly or more
☐ A few times a year

36b. **How severely were you spanked?**
☐ Not hard   ☐ Quite hard
☐ A little hard   ☐ Very hard
☐ Medium

36c. **How old were you the last time you remember being spanked?**
Age: ....

While you were growing up, during your first 18 years of life, how true were each of the following statements:

37. **You didn't have enough to eat.**
☐ Never true   ☐ Often true
☐ Rarely true   ☐ Very often true
☐ Sometimes true

38. **You knew there was someone to take care of you and protect you.**
☐ Never true   ☐ Often true
☐ Rarely true   ☐ Very often true
☐ Sometimes true

39. **People in your family called you things like " lazy" or "ugly".**
☐ Never true   ☐ Often true
☐ Rarely true   ☐ Very often true
☐ Sometimes true

40. **Your parents were too drunk or high to take care of the family.**
☐ Never true   ☐ Often true
☐ Rarely true   ☐ Very often true
☐ Sometimes true

41. **There was someone in your family who helped you feel important or special.**
☐ Never true   ☐ Often true
☐ Rarely true   ☐ Very often true
☐ Sometimes true

42. You had to wear dirty clothes.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

43. You felt loved.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

44. You thought your parents wished you had never been born.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

45. People in your family looked out for each other.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

46. You felt that someone in your family hated you.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

47. People in your family said hurtful or insulting things to you.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

48. People in your family felt close to each other.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

49. You believe you were emotionally abused.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

50. There was someone to take you to the doctor if you needed it.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

51. Your family was a source of strength and support.
- ☐ Never true
- ☐ Rarely true
- ☐ Sometimes true
- ☐ Often true
- ☐ Very often true

Sometimes parents or other adults hurt children. While you were growing up, that is, during your first 18 years of life, how often did a parent, stepparent, or adult living in your home:

52a. Swear at you, insult you, or put you down?
- ☐ Never
- ☐ Once, twice
- ☐ Sometimes
- ☐ Often
- ☐ Very often

52b. Threaten to hit you or throw something at you, but didn't do it?
- ☐ Never
- ☐ Once, twice
- ☐ Sometimes
- ☐ Often
- ☐ Very often

52c. Actually push, grab , shove, slap, or throw something at you?
- ☐ Never
- ☐ Once, twice
- ☐ Sometimes
- ☐ Often
- ☐ Very often

52d. Hit you so hard that you had marks or were injured?
- ☐ Never
- ☐ Once, twice
- ☐ Sometimes
- ☐ Often
- ☐ Very often

52e. Act in a way that made you afraid that you might be physically hurt?
- ☐ Never
- ☐ Once, twice
- ☐ Sometimes
- ☐ Often
- ☐ Very often

Some people, while growing up in their <u>first 18 years of life</u>, had a sexual experience with <u>an adult or someone at least five years older than themselves</u>. These experiences may have involved a relative, family friend, or stranger. During the <u>first 18 years of life</u>, did an adult or older relative, family friend, or stranger ever:

	The first time this happened, how old were you?	The first time, did this happen against your wishes?	The last time this happened, how old were you?	About how many times did this happen to you?	How many different people did this to you?	What was the sex of the person(s) who did it?
59a. Touch or fondle your body in a sexual way? ☐ Yes ☐ No ☐ If "Yes" ▶	.... age	☐ Yes ☐ No	.... age	.... times	.... people	☐ Male ☐ Female ☐ Both
60a. Have you touch their body in a sexual way? ☐ Yes ☐ No ☐ If "Yes" ▶	.... age	☐ Yes ☐ No	.... age	.... times	.... people	☐ Male ☐ Female ☐ Both
61a. Attempt to have any type of sexual intercourse (oral, anal, or vaginal) with you? ☐ Yes ☐ No ☐ If "Yes" ▶	.... age	☐ Yes ☐ No	.... age	.... times	.... people	☐ Male ☐ Female ☐ Both
62a. Actually have any type of sexual intercourse (oral , anal, or vaginal) with you? ☐ Yes ☐ No ☐ If "Yes" ▶	.... age	☐ Yes ☐ No	.... age	.... times	.... people	☐ Male ☐ Female ☐ Both

If you answered "No" to each of the last 4 questions (53a–56a) about sexual experiences with older persons, please skip to question 57a.

Did any of these sexual experiences with an adult or person at least 5 years older than you involve:

57a. A relative who lived in your home?
☐ Yes   ☐ No

573b. A non-relative who lived in your home?
☐ Yes   ☐ No

57c. A relative who didn't live in your home?
☐ Yes   ☐ No

57d. A family friend or person whom you knew and who didn't live in your home?
☐ Yes   ☐ No

57e. A stranger?
☐ Yes   ☐ No

57f. Someone who was supposed to be taking care of you?
☐ Yes   ☐ No

57g. Someone you trusted?
☐ Yes   ☐ No

Did any of these sexual experiences involve:

58a. Trickery, verbal persuasion, or pressure to get you to participate?
☐ Yes   ☐ No

58b. Being given alcohol or drugs?
☐ Yes   ☐ No

58c. Threats to harm you if you didn't participate?
☐ Yes   ☐ No

58d. Being physically forced or overpowered to make you participate?
☐ Yes   ☐ No

59a. Have you ever told a doctor, nurse or other health professional about these sexual experiences?
☐ Yes   ☐ No

59b. Has a therapist or counselor ever suggested to you that you were sexually abused as a child?
☐ Yes   ☐ No

60. Do you think that you were sexually abused as a child?
☐ Yes   ☐ No

Apart from other sexual experiences you have already told us about, while you were growing up during your first 18 years of life:

61a. **Did a boy or group of boys about your own age ever force you or threaten you with harm in order to have sexual contact?**
☐ Yes ☐ No

61b. **If "Yes": did the contact involve someone touching your sexual parts or trying to have intercourse with you (oral or anal)?**
☐ Yes ☐ No

61c. **If "Yes": how many times did someone do this to you?**
☐ Once ☐ 6–10 times
☐ Twice ☐ More than 10 times
☐ 3–5 times

61d. **Did the contact involve a person actually having intercourse with you (oral or anal)?**
☐ Yes ☐ No

61e. **If "Yes": how many times did someone do this to you?**
☐ Once ☐ 6–10 times
☐ Twice ☐ More than 10 times
☐ 3–5 times

62a. **As an adult (age 19 or older), did anyone ever force or threaten you with harm in order to have sexual contact?**
☐ Yes ☐ No

62b. **If "Yes": did the contact involve someone touching your sexual parts or trying to have intercourse with you (oral, anal, or vaginal)?**
☐ Yes ☐ No

62c. **If "Yes": how many times did someone do this to you?**
☐ Once ☐ 6–10 times
☐ Twice ☐ More than 10 times
☐ 3–5 times

62d. **Did the contact involve someone actually having intercourse with you (oral, anal, or vagina1)?**
☐ Yes ☐ No

62e. **If "Yes": how many times did someone do this to you?**
☐ Once ☐ 6–10 times
☐ Twice ☐ More than 10 times
☐ 3–5 times

Health Appraisal Questionnaire: Women's

Verbatim question	Coding and comments
Do you suffer from:	
Frequent stuffy or watery nose, sneezing	1=yes 2=no
An allergy to any medications	1=yes 2=no
Asthma or notice yourself wheezing	1=yes 2=no
Chronic bronchitis or emphysema	1=yes 2=no
A frequent cough for any reason	1=yes 2=no
Shortness of breath	1=yes 2=no
Have you ever:	
Coughed up blood (coughed not vomited)	1=yes 2=no
Been treated for tuberculosis or Coccidomycosis	1=yes 2=no
Had a positive tuberculosis test	1=yes 2=no
Been a smoker	1=yes 2=no
If now a smoker how many cigarettes a day	....
Had lung cancer	1=yes 2=no
Do you chew tobacco	1=yes 2=no
Have you ever had, or ever been told you have :	
High blood pressure	1=yes 2=no
To take blood pressure medicine	1=yes 2=no
A heart attack (coronary)	1=yes 2=no
To take medicine to lower your cholesterol	1=yes 2=no
Do you get :	
Pains or heavy pressure in your chest with exertion	1=yes 2=no
Do you use nitroglycerin	1=yes 2=no
Episodes of fast heart beats or skipped beats	1=yes 2=no
Other heart problems	1=yes 2=no
Nocturnal leg cramps	1=yes 2=no
Leg pains from rapid or uphill walking, stairs	1=yes 2=no

Verbatim question	Coding and comments
Do you have :	
Varicose veins	1=yes 2=no
Any skin problems	1=yes 2=no
Are you troubled by:	
Abdominal (stomach) pains	1=yes 2=no
Frequent indigestion or heartburn	1=yes 2=no
Constipation	1=yes 2=no
Frequent diarrhea, loose bowels	1=yes 2=no
Has there been a definite change:	
In the pattern or regularity of your bowel movements in the last year	1=yes 2=no
Are you a vegetarian	1=yes 2=no
Have you ever had, or been told you have:	
An ulcer	1=yes 2=no
Vomited blood	1=yes 2=no
Black tar-like bowel movements	1=yes 2=no
Gallstones, gallbladder problems	1=yes 2=no
Yellow jaundice, hepatitis, or any liver trouble	1=yes 2=no
Definite change in your weight in recent months	1=yes 2=no
Are you troubled by:	
Frequent headaches	1=yes 2=no
Attacks of dizziness	1=yes 2=no
Have you ever:	
Had seizures, convulsions, fits	1=yes 2=no
Fainted or lost consciousness for no obvious reason	1=yes 2=no
Temporarily lost control of a hand or foot (paralysis)	1=yes 2=no
Had a stroke or "small stroke"	1=yes 2=no
Been temporarily unable to speak	1=yes 2=no

Verbatim question	Coding and comments
Are you troubled by :	
Frequent back pain	1=yes 2=no
Pain or swelling in your joints	1=yes 2=no
Have you ever :	
Broken any bones	1=yes 2=no
Frequently worried about being ill	1=yes 2=no
Been troubled as a result of being more sensitive than most people	1=yes 2=no
Had special circumstances in which you find yourself panicked	1=yes 2=no
Had reason to fear your anger getting out of control	1=yes 2=no
Have you had, or do you have :	
Any problems with your urinary tract (kidney, bladder)	1=yes 2=no
Loss of control of your urine	1=yes 2=no
Pain or burning when you urinate	1=yes 2=no
Blood in your urine	1=yes 2=no
Trouble starting the flow of urine	1=yes 2=no
To get up repeatedly at night to urinate	1= yes 2= no
Vaginal bleeding between periods	1=yes 2=no
After menopause, any vaginal bleeding whatsoever	1=yes 2=no
A noticeable lump in your breast	1=yes 2=no
Do breast self-exams regularly	1=yes 2=no
Discharge from your nipples	1=yes 2=no
Have you ever been treated for or told you had :	
Any venereal disease	1=yes 2=no
Diabetes	1=yes 2=no
To take medicine for diabetes	1=yes 2=no
Thyroid disease	1=yes 2=no
Cancer	1=yes 2=no

Verbatim question	Coding and comments
Have you ever had or do you now have:	
Radiation therapy	1=yes 2=no
Trouble refusing requests or saying "No"	1=yes 2=no
Hallucinations (seen, smelled, or heard things that were not really there)	1=yes 2=no
Trouble falling asleep or staying asleep	1=yes 2=no
Tiredness, even after a good night's sleep	1=yes 2=no
Crying spells	1=yes 2=no
Depression or "feel down in the dumps"	1=yes 2=no
Much trouble with nervousness	1=yes 2=no
Do you:	
Sometimes drink more than is good for you	1=yes 2=no
Use street drugs	1=yes 2=no
Have you ever:	
Been raped, or sexually molested as a child	1=yes 2=no
Are you :	
Currently sexually active with a partner	1=yes 2=no
Satisfied with your sex life	1=yes 2=no
Concerned you are at risk for AIDS	1=yes 2=no
Please tell us:	
In the past year, about how many visits to a doctor have you made	....
How far have you gone in school	....
Are you married	1=yes 2=no
How many times have you been married	....
Are you now having serious or disturbing problems with your:	
Marriage	1=yes 2=no
Family	1=yes 2=no
Drug usage	1=yes 2=no
Job	1=yes 2=no
Financial matters	1=yes 2=no

Verbatim question	Coding and comments	Verbatim question	Coding and comments
Have you ever had coronary artery surgery	1=yes 2=no	Are there any unusual illnesses in your family you didn't list previously?	1=yes 2=no
Approximate year	Range : 1–96	Has a parent, brother, or sister developed coronary (heart) disease before age 60?	1=yes 2=no
Did you have a blood transfusion between 1978 and 1985	1=yes 2=no	Do you have an identical twin?	1=yes 2=no
Do you feel you need any immunizations	1=yes 2=no		
Are you retired	1=yes 2=no	Please fill in the circle that you think best describes your current state of health	1 = excellent 2= good 3= fair 4= poor
Have members of your family died before the age of 65?	1=yes 2=no	Do you regularly use seat belts in a car?	1=yes 2=no
Are there diseases which a number of family members have had?	1=yes 2=no	Please fill in the circle that best describes your stress level:	1= high 2= medium 3= low

Health Appraisal Questionnaire: Men's

Verbatim question	Coding and comments
Do you suffer from:	
An allergy to any medications	1=yes 2=no
Asthma or notice yourself wheezing	1=yes 2=no
Chronic bronchitis or emphysema	1=yes 2=no
A frequent cough for any reason	1=yes 2=no
Shortness of breath	1=yes 2=no
Have you ever:	
Coughed up blood (coughed not vomited)	1=yes 2=no
Been treated for tuberculosis or coccidomycosis	1=yes 2=no
Had a positive TB test	1=yes 2=no
Been a smoker	1=yes 2=no
If now a smoker how many cigarettes a day	....
Had lung cancer	1=yes 2=no
Do you chew tobacco	1=yes 2=no
Have you ever had, or ever been told you have :	
High blood pressure	1=yes 2=no
To take blood pressure medicine	1=yes 2=no
A heart attack (coronary)	1=yes 2=no
To take medicine to lower your cholesterol	1=yes 2=no
Do you get :	
Pains or heavy pressure in your chest with exertion	1=yes 2=no
Do you use nitroglycerin	1=yes 2=no
Episodes of fast heart beats or skipped beats	1=yes 2=no
Other heart problems	1=yes 2=no
Nocturnal leg cramps	1=yes 2=no
Leg pains from rapid or uphill walking, stairs	1=yes 2=no

Verbatim question	Coding and comments
Do you have :	
Varicose veins	1=yes 2=no
Any skin problems	1=yes 2=no
Are you troubled by:	
Abdominal (stomach) pains	1=yes 2=no
Frequent indigestion or heartburn	1=yes 2=no
Constipation	1=yes 2=no
Frequent diarrhea, loose bowels	1=yes 2=no
Has there been a definite change:	
In the pattern or regularity of your bowel movements in the last year	1=yes 2=no
Are you a vegetarian	1=yes 2=no
Have you ever had, or been told you have:	
An ulcer	1=yes 2=no
Vomited blood	1=yes 2=no
Black tar-like bowel movements	1=yes 2=no
Gallstones, gallbladder problems	1=yes 2=no
Yellow jaundice, hepatitis, or any liver trouble	1=yes 2=no
Definite change in your weight in recent months	1=yes 2=no
Are you troubled by:	
Frequent headaches	1=yes 2=no
Attacks of dizziness	1=yes 2=no
Have you ever	
Had seizures, convulsions, fits	1=yes 2=no
Fainted or lost consciousness for no obvious reason	1=yes 2=no
Temporarily lost control of a hand or foot (paralysis)	1=yes 2=no
Had a stroke or "small stroke"	1=yes 2=no
Been temporarily unable to speak	1=yes 2=no

Verbatim question	Coding and comments
Are you troubled by :	
Frequent back pain	1=yes 2=no
Pain or swelling in your joints	1=yes 2=no
Have you ever :	
Broken any bones	1=yes 2=no
Frequently worried about being ill	1=yes 2=no
Been troubled as a result of being more sensitive than most people	1=yes 2=no
Had special circumstances in which you find yourself panicked	1=yes 2=no
Had reason to fear your anger getting out of control	1=yes 2=no
Have you had, or do you have :	
Any problems with your urinary tract (kidney, bladder)	1=yes 2=no
Loss of control of your urine	1=yes 2=no
Pain or burning when you urinate	1=yes 2=no
Blood in your urine	1=yes 2=no
Trouble starting the flow of urine	1=yes 2=no
To get up repeatedly at night to urinate	1= yes 2= no
Discharge from your nipples	1=yes 2=no
Have you ever been treated for or told you had :	
Any venereal disease	1=yes 2=no
Diabetes	1=yes 2=no
To take medicine for diabetes	1=yes 2=no
Thyroid disease	1=yes 2=no
Cancer	1=yes 2=no

Verbatim question	Coding and comments
Have you ever had or do you now have:	
Radiation therapy	1=yes 2=no
Trouble refusing requests or saying "No"	1=yes 2=no
Hallucinations (seen, smelled, or heard things that were not really there)	1=yes 2=no
Trouble falling asleep or staying asleep	1=yes 2=no
Tiredness, even after a good night's sleep	1=yes 2=no
Crying spells	1=yes 2=no
Depression or "feel down in the dumps"	1=yes 2=no
Much trouble with nervousness	1=yes 2=no
Do you:	
Sometimes drink more than is good for you	1=yes 2=no
Use street drugs	1=yes 2=no
Have you ever:	
Been raped, or sexually molested as a child	1=yes 2=no
Are you :	
Currently sexually active with a partner	1=yes 2=no
Satisfied with your sex life	1=yes 2=no
Concerned you are at risk for AIDS	1=yes 2=no
Please tell us:	
In the past year, about how many visits to a doctor have you made	....
How far have you gone in school	....
Are you married	1=yes 2=no
How many times have you been married	....
Are you now having serious or disturbing problems with your:	
Marriage	1=yes 2=no
Family	1=yes 2=no
Drug usage	1=yes 2=no
Job	1=yes 2=no
Financial matters	1=yes 2=no

Verbatim question	Coding and comments
Have you ever had coronary artery surgery	1=yes 2=no
Approximate year	Range : 1-96
Did you have a blood transfusion between 1978 and 1985	1=yes 2=no
Do you feel you need any immunizations	1=yes 2=no
Are you retired	1=yes 2=no
Have members of your family died before the age of 65?	1=yes 2=no
Are there diseases which a number of family members have had?	1=yes 2=no

Verbatim question	Coding and comments
Are there any unusual illnesses in your family you didn't list previously?	1=yes 2=no
Has a parent, brother, or sister developed coronary (heart) disease before age 60?	1=yes 2=no
Do you have an identical twin?	1=yes 2=no
Please fill in the circle that you think best describes your current state of health	1 = excellent 2= good 3= fair 4= poor
Do you regularly use seat belts in a car?	1=yes 2=no
Please fill in the circle that best describes your stress level:	1= high 2= medium 3= low

APPENDIX 2

Examples of validated measurement tools for outcome evaluation (see Table 3.2)

Infant and child outcomes

Infant and child development
Bayley Scales of Infant Development (BSID and BSID-II)[1]
Developmental Profile II (DPII)[2]
Kaufman Assessment Battery for Children (K-ABC)[3]
Stanford-Binet Intelligence Scale, 4th Edition[4]

Child's externalizing and internalizing behaviours
Child Behavior Checklist (CBCL)[5, 6]

Social competency
Developmental Checklist[7]
Scott and Hogan Adaptive Social Behavior Inventory (ASBI)[8]

Educational achievements (including school performance)
Child Classroom Adaptation Index (CCAI)[9]
Cooperative Preschool Inventory (CPI)[10]

Self-reported health risk behaviours (such as harmful alcohol and drug use, multiple sexual partners, smoking, intimate partner violence)
Adverse Childhood Experiences (ACE) Study Questionnaire (see Appendix 1)

Parent's disciplinary knowledge, attitudes and behaviours
Conflict Tactics Scale (CTS2)[11]
Adult-Adolescent Parenting Inventory (AAPI)[12]

[1] Bayley, N. *Bayley Scales of Infant Development*. San Antonio, TX, The Psychological Corporation, 1969 and 1993.
[2] Alpern G, Boll T, Shearer M. *Developmental Profile II*. Los Angeles, CA, Western Psychological Services, 1986.
[3] Kaufman AS, Kaufman NL. *Kaufman Assessment Battery for Children*. Circle Pines, MN, American Guidance Service, 1983.
[4] Thorndike RL, Hagen EP, Sattler JM. *Stanford-Binet Intelligence Scale*. 4th ed. Itasca, IL, Riverside Publishing Company, 1986.
[5] Achenbach TM, Edelbrock C. *Manual for the Child Behavior Checklist and Revised Behavior Checklist and Revised Behavior Profile*. Burlington, VT, University of Vermont, Department of Psychiatry, 1983.
[6] Achenbach TM. *Child Behavior Checklist for ages 2–3*. Burlington, VT, University of Vermont, 1988.
[7] St Pierre RG et al. *National impact evaluation of the Comprehensive Child Development Program, final report*. Cambridge, MA, Abt Associates, 1997:5.7, 5.12.
[8] Scott KG, Hogan A. *The Adaptive Social Behavior Inventory*. New York, NY, Harcourt Brace Jovanovich, 1987.
[9] Halpern R, Baker AJL, Piotrkowski CS. *The Child Classroom Adaptation Index*. New York, NY, National Council of Jewish Women, 1993.
[10] Caldwell BM. *Cooperative Preschool Inventory*. Princeton, NJ, Educational Testing Service, 1974.
[11] Straus MA et al. *The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data*. Durham, NH, Family Research Laboratory, University of New Hampshire, 1995.
[12] Bavolek S. *Research and validation report of the Adult-Adolescent Parenting Inventory (AAPI)*. Eau Claire, WI, Family Development Resources, 1989.

Parent and family outcomes

Parent-child attachment
> The Attachment Q-Set (Version 3.0)[1]

Sense of parenting competency, attitudes about parenting
> Parenting Sense of Competence Scale (PSOC)[2]
> Parenting Stress Index (PSI), including Sense of Competence Subscale[3]

Parent knowledge and expectations of infant and child development (physical, emotional, cognitive, sexual)
> Knowledge of Infant Development Inventory (KIDI)[4]
> Nursing Child Assessment Satellite Training (NCAST) Teaching Scale[5,6]

Parent's disciplinary knowledge, attitudes and behaviours
> Conflict Tactics Scale (CTS2)[7]
> Adult-Adolescent Parenting Inventory (AAPI)[1]

[1] Waters E. Caregiving, cultural, and cognitive perspectives on Secure-Base Behavior and working models: new growing points of Attachment Theory and research. *Monographs of the Society for Research in Child Development*, 1995, 60:234–246.
[2] Gibaud-Wallston J, Wandersman LP. The Parenting Sense of Competence Scale (PSOC). In: Touliatos J, Perlmutter B, Straus M, eds. *Handbook of family measurement techniques.* Thousand Oaks, CA, Sage, 2001:166–167.
[3] Abidin RR. *Parenting Stress Index: manual.* Charlottesville, VA, Pediatric Psychology, 1986.
[4] MacPhee D. *Knowledge of Infant Development Inventory.* Chapel Hill, University of North Carolina, 1981. [Unpublished document; available on request from David L MacPhee, Human Development and Family Studies, Colorado State University, Fort Collins, CO 80523, USA.]
[5] Barnard K. *NCAST Scale.* Seattle, WA, University of Washington, School of Nursing, 1989.
[6] *NCAST caregiver–parent interaction teaching manual.* Seattle, WA, Nursing Child Assessment Satellite Training Program, University of Washington, School of Nursing, 1994.
[7] Bavolek S. *Research and validation report of the Adult-Adolescent Parenting Inventory (AAPI).* Eau Claire, WI, Family Development Resources, 1989.

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