National Institute for Health and Clinical Excellence

When to suspect Child Maltreatment
Stakeholder Comments

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Stakeholder Organisation:	**Association of Child Psychotherapists** 120 West Heath Road, London NW3 7TU Tel: 020 8458 1609 Fax: 020 8458 1482 www.acp.uk.net
Name of commentator:	Beverley Tydeman, Chair, Association of Child Psychotherapists

Order number	Document Indicate if you are referring to the **Full** version **NICE** version or the **Appendices**	Section Number Indicate **number** or **'general'** if your comment relates to the whole document	Page Number Indicate **number** or **'general'** if your comment relates to the whole document	Comments **Please insert each new comment in a new row.** **Please do not paste other tables into this table, as your comments could get lost – type directly into this table.**
1	Short	General	General	The ACP welcomes this guidance to support and orient healthcare professionals in the challenging area of child maltreatment. As indicated in our general and specific comments below, the ACP believes that this guideline can play a significant and much-needed role in drawing attention to possible deterrents to recognising and responding to concerns about child maltreatment and the challenges faced by healthcare professionals whose work focuses on engaging difficult or hard to reach parents and carers.
2	Short	General	General	In addition to our specific responses under the headings below, we wish to make three general points: 1. The experience of child and adolescent psychotherapists indicates that health professionals value guidance about the specific needs of babies, children and adolescents to help guide them as to what to look for and when to intervene. **a) Babies and pre-school children** The vulnerability of **babies** and young children to emotional as well as physical neglect and abuse needs to be highlighted. It may be particularly difficult for healthcare professionals to recognise and respond to maltreatment of babies and young infant. Belief remains widespread that babies are not affected by emotional neglect or abuse or, for example, by witnessing domestic violence, despite robust and extensive evidence from developmental, neurological and attachment research that, on the contrary, children are most vulnerable to the effects of emotional neglect and abuse in their first year of life. Healthcare professionals should be aware that **pre-**

				school aged children are at greater risk of undetected maltreatment because they are not necessarily seen on a daily basis by people beyond their immediate families. Nearly 50% of serious injuries or fatalities as a result of maltreatment are to infants under one year of age. With this age group, professionals should be particularly proactive in communicating their concerns to colleagues within and outside the service; especially when it is not clear who is living/staying in the family home. **b) Older adolescents** Healthcare professionals should also be aware of the needs of **older adolescent children** who may be very difficult to help. These emerged powerfully in Analysing Child Deaths and Serious Injury through abuse and neglect: What can we learn? A biennial analysis of serious case reviews 2003 – 2005 (DCSF, January 2008). Many 'hard to help' young people from the age of 11 have long histories of involvement with children's social care and other specialist agencies. Over time, 'professional fatigue' can set in, leading agencies to run out of helping strategies and become reluctant to continue to follow up suspicions of maltreatment. As a result, the needs of this age group are often 'neglected', repeating patterns of earlier neglect in the family. 2. Child and adolescent psychotherapists' experience is that the emotional, psychological, and psychosocial features of maltreatment need clear highlighting for healthcare professionals. Healthcare professionals should be aware of general trends in the incidence of maltreatment. As well as looking for indicators in the individual child, health professionals should be aware of the need for the child to be looked at within the context of the family and family relationships. 3. Healthcare professionals should also be aware of chronic and cumulative features of maltreatment in addition to acute features (see also comment 5 on Section 1.2.1).
3	Short	**Communic-ating with and about the child or young person.**	6	Healthcare professionals should be aware that psychological factors may powerfully deter children from disclosing maltreatment, or impede professionals from recognising and responding to maltreatment (see also comment 10 on section 1.2.7 - point 1 Deterrents in the child and point 3 Deterrents in the health professional).
4	Short	1.2.1	8	In addition to these indicators, healthcare professionals should suspect child maltreatment when they are concerned about a child and parents or carers refuse permission for them to see the child face-to-face or talk to them alone; or when parents are so hostile that professionals feel intimidated in carrying out their professional roles (see also comment 10 on section 1.2.7 - point 3 and comment 19 on section 1.7).
5	Short	1.2.1	8	Healthcare professionals should also be aware of chronic or cumulative presentations of maltreatment. For example they should be as alert to the possibility of maltreatment in a child who repeatedly presents at hospital with less serious injuries as in one that presents in acute crisis.
6	Short	1.2.1	8	Health care professionals should be aware of chronic developmental problems stemming from maltreatment.

7	Short	1.2.1	8	Further assessment should be sought when it is not clear whether a child's physical or emotional symptoms are caused by organic illness or neurological disorder, or by maltreatment, or are co-morbid.
8	Short	1.2.1	8	Healthcare professionals should consider maltreatment when several factors known to be co-morbid with maltreatment of children are present, such as: • Known parental substance misuse • Known mental health difficulties in parent(s) • Incomplete history or many changes of address (may indicate historical maltreatment) • Evidence, whether in the past or present, of injury to the caregiver: children in families where there is known or suspected domestic violence are more likely to be victims of violence themselves • Highly conflicting or unusually disturbing responses to observations or expressions of concern about a child.
9	Short	1.2.1	8	Healthcare professionals should be aware that pre-school aged children are at greater risk of undetected maltreatment because they are not necessarily seen on a daily basis by people beyond their immediate families. With this age group, professionals should be particularly proactive in communicating their concerns to colleagues within and outside the service (see also comment 2 general – point 1).
10	Short	1.2.7	9	This guidance on possible deterrents to recognising and responding to concerns about child maltreatment is of paramount importance. In addition to those listed, we suggest the specific indications listed below: **1. Deterrents in the child** Healthcare professionals need to be aware of the powerful loyalties that children and young people often feel towards their parents or carers, even when they are abusive or neglectful. A particularly strong or intense attachment between a child and their parent(s) or carer(s) should not in itself be assumed to be one that is in the child's best interests or promotes the child's healthy development. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that children may be frightened or confused by parents or carers who have mental health or personality difficulties. **2. Deterrents in the parent/carer** Healthcare professionals should be alert to the possibility of maltreatment when a parent or carer refuses them permission to see a child face-to-face or talk to a child alone. Concern should also be raised when curiosity or worry about a child's behaviour, appearance or emotional or physical presentation is met with a level of hostility that makes the professional feel intimidated in carrying out their role. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that they themselves feel frightened or confused by parents

				or carers who have mental health or personality difficulties. Healthcare professionals and their managers should be aware that some parents or carers with mental health or personality difficulties may be helped by support from family or friends, parenting support, training, or their own therapy, while others are not able to make use of help, or are not able to do so 'within the child's timescales'. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that parents or carers may be so needy and vulnerable in themselves that they cannot have adequate insight into features of maltreatment in their care of their children. Healthcare professionals should be aware that in severe cases of child maltreatment, perpetrators are likely to be highly motivated to escape detection, and may be highly skilled in manipulating professionals, creating confusion, and evading professional concern, as well as the concern of friends, family and neighbours. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that parents or carers may be dangerous, or manipulative, or may have mental health difficulties that make contact with them unpredictable, frightening or confusing. **3. Deterrents in the healthcare professional** Fear of hostility from parents or more general anxieties about raising the prospect of abuse and/or interfering with the structure of a family can propel healthcare professionals into unwittingly overlooking clearly-presented features of child maltreatment. Other contributory factors may include powerful denial on the part of a parent/carer; a lack of support structures in which to raise concerns; action-oriented workplace cultures which discourage reflection and reflective practice. Healthcare professionals' concentration on a specific remit, for example, to engage 'hard to reach' parents or carers, may inadvertently lead them to lose sight of the needs of the children. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that childrens' need for protection may outweigh professional priorities to engage parents. See also: comment 3 and comment 19.
11	Short	1.2.8	9	Support for healthcare professionals and liaison/consultation with mental health services are crucial to maintain professionals' capacities to recognise and respond to signs of maltreatment. A culture of open questioning, reflection and sharing of anxiety can help to overcome psychological barriers to raising the prospect of child maltreatment.
12	Short	1.4.14	19	'Healthcare professionals should consider child maltreatment in any child with abnormal growth patterns for which there is no medical cause.' This could include the under- and over-feeding of babies – the latter being linked to childhood obesity.

13	Short	1.6	22-26	The ACP welcomes the focus in 1.6 on emotional indicators, in addition to the physical indicators listed at 1.3, 1.4 and 1.5. In addition to the emotional indicators detailed at 1.6, healthcare professionals should consider the possibility of maltreatment when a child persistently shows emotional flatness, listlessness, lack of interest in others or surroundings, indiscriminate attachment, marked neediness, hypervigilance, emotional dysregulation and/or childhood depression.
14	Short	1.6	22-26	**Babies**: Special attention should be paid to presentations of maltreatment in babies including failure to thrive/faltering growth, lifeless reactions, persistently avoiding eye contact or face to face interaction with parents or carers and a lack of responsiveness. Healthcare professionals should consider the possibility of neglect when babies' interactions with their parents or carers are persistently avoidant or bizarre and disturbing (see also comment 18 on section 1.7). Nearly 50% of serious injuries or fatalities as a result of maltreatment are to infants under one year of age (see also comment 2, point 1).
15	Short	1.6	22-26	Healthcare professionals should consider the possibility of maltreatment when children's interactions with peers, teachers or other adults involve coercive controlling, pronounced aggression or emotional dysregulation.
16	Short	1.6	22-26	In addition to "marked changes" (1.6.1) in behaviour or emotional state, healthcare professionals should as alert to the possibility of chronic, cumulative maltreatment in a baby or child with chronic emotional or behavioural difficulties (as per comment 2 - point 3 and comment 5).
17	Short	1.6.11	25	Secondary day or night time wetting in the absence of medical causes could be understood as a communication of distress or a response to loss instead of or as well as a possible indication of maltreatment.
18	Short	1.7	26	We welcome the thorough attention that has been paid to the psychological aspects of emotional abuse in this section and the recognition that healthcare professionals should be aware of the emotional quality and context of parent-child interactions. In addition to the bullet points raised at 1.7.1, healthcare professionals should consider the possibility of emotional abuse when: • babies' or children's interactions with their parents or carers are persistently avoidant or bizarre and disturbing (as per comment 14 on section 1.6); • a baby or young infant persistently avoids interaction or eye contact with parents or carers, freezes or dissociates, has persistent rigid muscle tone, or is lifeless or listless in the presence of parents but shows extreme indiscriminate, excited responses to strangers. We feel that the fourth bullet point at 1.7.1, 'using the child for the fulfilment of the parents' needs, for example, children being used in marital disputes',

				needs further clarification. Children are often caught up in marital breakdown in complex ways when parental communication breaks down. In our view, it could be considered emotional abuse when, during marital conflict, a child is used by one parent against the other.
19	Short	1.7	26	Healthcare professionals should also be aware of the parents' style of interaction with professionals, which may provide pointers to the child's experience of the parents and may indicate difficulties in the parent that result in maltreatment. Professionals should be on the alert when they experience unusually extreme emotional reactions, for example strong feelings of discomfort or high levels of anxiety (as per comments 3, 4 and 10).
20	Short	1.7.2	27	As well as being alert to the possibility of emotional neglect, healthcare professionals should also be aware of the possibility of maternal depression in a parent who is emotionally unavailable and/or unresponsive.

Please add extra rows as needed

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Closing date: 5pm 10 February 2008

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