

## Section 5 Safety and Well-Being

### Unintentional Injury

Supporting healthy child development includes encouraging children's natural curiosity and emerging skills. As children explore their environment and try new skills they often do not recognize hazards in their environment or other factors that may compromise their safety and well-being. They also do not have the ability or autonomy to remove dangerous conditions from their environment. The child's caregiver and professionals who care for him need to keep the child safe. Keeping a child safe may be as simple as supervising him on the playground or providing information on safe infant sleep to parents. It can also include involving child protection services when those, whose role it is to protect the child, fail to provide that protection, putting the child's safety and well-being at risk.

Supporting children's safety and well-being is done in a number of ways:

- ◆ Preventing unintentional injury
- ◆ Preventing or recognizing maltreatment
- ◆ Reporting maltreatment



### Preventing Injury

Unintentional injury is the most common cause of death in children over the age of one. Most deaths are the result of motor vehicle accidents, but death from fire, drowning, choking, suffocation and poisoning also occur (Farchi et al., 2006; Grenier & Leduc, 2008). Unintentional injuries also lead to bumps and bruises, burns, scalds, broken bones, head injuries and more.

- ◆ It is more common for injuries to happen when
  - Adults are
    - Distracted
    - Very busy
    - Temporarily absent
    - Involved in situations that cause some confusion or unplanned changes in routine
  - Children are
    - Hungry
    - Tired
    - Distracted
    - Excited
    - Away from their regular routine

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- ◆ Injury prevention should therefore be done in a systematic approach that should include:
  - Providing a safe environment
  - Supervising children
  - Having appropriate policies and guidelines in place
  - Having safety rules for children
  - Communicating with the family

### Safe Environment



The spaces where children live, play and learn need to be designed with the child in mind. Children need space to be physically active, and to be quiet. Watching for hazards, keeping children contained in one area, having surfaces, furniture, play equipment and toys in good working order are also important. The space should also be appropriate for the developmental stage of the child. This can be a challenge with siblings of different ages, or in a small, home-based child care setting with children of different ages. Children outgrow equipment such as infant swings or stationary activity centres very quickly. Always follow the weight and height guidelines and instructions for use. The same rules apply to cribs, cradles, playpens and bassinets. It is also important to check the Health Canada website ([www.hc-sc.gc.ca](http://www.hc-sc.gc.ca)) regularly for consumer product safety and any recalls (Grenier and Leduc, 2008).

- ◆ A safe environment includes:
  - The physical environment
  - Products used
  - Storage and handling of equipment, food and drink
  - Knowledge of each child's developmental stage, ability and temperament
- ◆ To make the physical environment safe consider

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- The space
- The play surface
- The furniture or equipment in the space

Professionals need to put themselves at a child's level and assess their environment for any conditions that can be hazardous. Professionals also need to advocate for that same vigilance at home and provide resources for parents make a safer home environment.

### Supervision

Even the safest space does not reduce the need for adequate adult supervision. Adults must always remain vigilant and anticipate the child's needs, actions and level of development. Active supervision means that the adult stays close, especially when the child is exploring new equipment, play structures or trying new skills. The adult should scan the environment for any potential hazards and remove them, if possible, and make sure the children are not creating risks to their own safety or the safety of other children.



### Policies and Procedures

Early learning and child care settings have strict regulations around safety. Policies and guidelines set out by the licensing authority, the Day Nurseries Act, the Canadian Childcare Federation, or other organizations, provide consistency for all staff and children. Most settings will have preventive policies and procedures that each professional should know and follow. You can also promote or develop policies and procedures that will ensure children's safety in your setting.

### Safety Rules

As soon as children respond to their name and become more mobile, they can be taught some basic safety rules. Grenier and Leduc (2008) list the key ingredients of good safety rules in *Well-Beings: A Guide to Health in Childcare*.

- ◆ "A good safety rule ...
  - Is simple, clear and age-appropriate
  - Is consistent

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- Is reasonable
- Is reinforced
- Is shared with all caregivers
- Is positive
- Is not scary
- Has consequences” (p. 65)

### Communicating with the family

Children spend much of their time at home and in the care and presence of their family. Communicating with the family and providing the child’s primary caregiver with good resources on safety is therefore imperative.

- ◆ Caregivers need safety information on safe practices such as:
  - Infant sleep environment
  - Vehicle and traffic
  - Water
  - Sun
  - Equipment and toys
  - Household and environmental products
  - Food and drink



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### Safety Practices

The following practices have been found to increase children's safety:

#### Safety Practices to Prevent:

- ◆ Falls/ Cuts
  - ◆ Infant or child is not left unattended on above ground surfaces (e.g., change tables, climbers)
  - ◆ Safety gates are installed and used at stairs inside home or on decks
  - ◆ Infant walker/baby exerciser or similar equipment on wheels is not used
  - ◆ Baby jumpers have been properly secured to a door frame and are used only under supervision
  - ◆ Child is always supervised near or on balcony, staircase, or playground
  - ◆ Protective rail is used on beds for children
  - ◆ The top level of a bunk bed is only used with children 6 years of age or older
  - ◆ Child plays on playgrounds with impact-absorbing materials to soften falls
  - ◆ Child wears a safety helmet during bike riding, rollerblading, skateboarding or similar activities
  - ◆ Safety devices are installed on windows, patio and balcony doors
  - ◆ Sharp instruments (e.g., scissors, knives) are not within child's reach
- ◆ Motor Vehicle or Traffic Accidents
  - ◆ Car seats and booster seats are installed properly and used properly according to age, height and weight of the child
  - ◆ Child plays in safe areas away from parked cars or road
  - ◆ Child is taught how to "stop, look and listen"
- ◆ Drowning
  - ◆ Swimming pools or hot tubs are fenced in and can only be accessed through a locked gate
  - ◆ A supervising adult is within arms length of the child while near any water that is deeper than 5 cm (2 inches) (e.g., pools, bathtubs, ponds)
  - ◆ Baby bath seats or rings are not used

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### Safety Practices to Prevent:

- |  |  |
|--|--|
| Burning/Scalding                       | <ul style="list-style-type: none"> <li>◆ Home water temperature is set to 49 degree Celsius or less</li> <li>◆ Bath water is tested before putting child in bathtub (should be 49 degrees Celsius or less)</li> <li>◆ Cold water faucets are turned on before hot water faucets when washing hands</li> <li>◆ Hot liquids and foods are kept away from a child especially while carrying the child</li> <li>◆ Pot handles are turned towards centre of stove; hot soup is one of the leading causes of childhood scalding injury in the United States (WHO, 2008)</li> <li>◆ Smoke and carbon dioxide alarms are used throughout the house or apartment</li> <li>◆ Fire extinguisher is present in the kitchen and caregivers know how to use it</li> <li>◆ Barrier is used around fireplace or wood burning stove</li> <li>◆ Matches or lighters and other flammable substances are not within a child's reach</li> </ul> |
| Sunburns                               | <ul style="list-style-type: none"> <li>◆ Protective clothing such as wide brimmed hats are used when children are outdoors</li> <li>◆ Playing in the sun is avoided during peak sun hours (10am - 2pm)</li> <li>◆ Sunscreen is applied to children over 6 months 30 minutes before such exposure and reapplied every 2 - 3 hours</li> <li>◆ Spaces where children play are designed with structures providing shade</li> </ul>   |
| Suffocation/ Choking/<br>Strangulation | <ul style="list-style-type: none"> <li>◆ Small objects such as food (e.g., hard candy, nuts, popcorn, grapes, hotdog pieces), beads, coins, small parts of toys, are kept away from infants or toddlers under 3 years of age</li> <li>◆ Cribs are placed away from windows, blinds, curtain cords, straps, lamps, electrical plugs, and extension cords</li> <li>◆ Child is not wearing pacifier, jewelry, cord, string or skipping rope around neck</li> <li>◆ Child does not play on playground equipment wearing scarves or clothing with cords or drawstrings</li> </ul>   |
| Poisoning/ Electrocutation             | <ul style="list-style-type: none"> <li>◆ Child-resistant caps/package are used on medications and household poisons and kept out of reach</li> <li>◆ Cupboards containing poisonous items such as household cleaning products, medications, pesticides are locked with childproof locks</li> <li>◆ Toxic or poisonous plants are not within child's reach or not kept in or around the home until the child understands the danger</li> <li>◆ Electrical outlets are covered with plastic safety covers</li> </ul>   |

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Safety Practices to Prevent:	
<p>Sudden Infant Death Syndrome (SIDS)/ Sudden Unexpected Death in Infancy (SUDI)</p> <p>(applies to infants from birth to 12 months)</p>	<ul style="list-style-type: none"> <li>◆ Infant is placed on his back for night time sleep and all naps</li> <li>◆ Infant is placed in a crib with only a tightly fitted sheet and light blanket or sleep sac</li> <li>◆ Infant is not placed to sleep on waterbeds, futons, couches, loveseats, chairs, car seats, makeshift beds or adult beds</li> <li>◆ Infant sleeps in the parents' room for the first 6 months</li> <li>◆ Infant is not overheated</li> <li>◆ Bumper pads, duvets, pillows, heavy blankets and soft toys are not used in the crib</li> <li>◆ Infant is put to sleep in a smoke free environment</li> <li>◆ Infant does not share a sleep surface with others</li> </ul>
<p>Crib and Equipment Safety</p>	<ul style="list-style-type: none"> <li>◆ Cribs made before September 1986 are not used because they do not meet current Canadian safety regulations</li> <li>◆ The crib is not modified</li> <li>◆ Children younger than two years of age sleep in a crib</li> <li>◆ Equipment is used according to manufacturer's instructions</li> <li>◆ Equipment is used according to age limitations</li> <li>◆ Equipment is checked for recalls</li> </ul>
<p>Environmental Toxins and Pollutants</p>	<ul style="list-style-type: none"> <li>◆ Home is free from second-hand and third-hand smoke (toxic chemicals released by smoking that are trapped in hair, skin, fabric, carpet, furniture, and toys)</li> <li>◆ Child uses good quality toys without lead</li> <li>◆ Lead-free paint is used in the home</li> <li>◆ Home is kept clean (dust in older homes may contain lead) and free from allergens and moulds</li> <li>◆ Mercury thermometer is not used</li> <li>◆ Breastmilk, formula or food is not heated in plastic bottles or containers containing Bisphenol A</li> <li>◆ Cold tap water is used for drinking water or to reconstitute drinks including formula (hot tap water contains more lead)</li> <li>◆ In homes older than 1990, water is run for 2 minutes every morning before using it to make formula, other drinks or baby food</li> <li>◆ Vinyl toys are not used for young children (chemicals can be absorbed through chewing and sucking)</li> <li>◆ Children's art materials (e.g., markers, paints) are made of non-toxic materials</li> </ul>

**Section 5 Safety and Well-Being****Safety Practices to Prevent:****Environmental Toxins and Pollutants**

- ◆ Outdoor footwear is removed inside (e.g., metals, pesticides, and animal droppings can be tracked into the home on outdoor footwear)
- ◆ Children's playground equipment or picnic tables are made from cedar, redwood or metal, not pressure treated wood (may contain arsenic)
- ◆ Children are kept away from paints, glues, new carpets and similar things that may give off chemical gases
- ◆ Pesticides or harsh cleaning chemicals are not used near children
- ◆ Children are kept indoors on days when the air quality is poor
- ◆ Additional information can also be obtained at:
- ◆ <http://www.toronto.ca/health/hphe/children.htm> [http://beststart.org/resources/env\\_action/pdf/AppB\\_auditform.pdf](http://beststart.org/resources/env_action/pdf/AppB_auditform.pdf)

(Bridgman-Acker, 2009; Canadian Paediatric Society, 2004; Grenier & Leduc, 2008; Health Canada, 2008; Hunt & Hauck, 2006; Nansel et al., 2008; Safe Kids Canada, no date; Schnitzer, 2006; WHO, 2008)

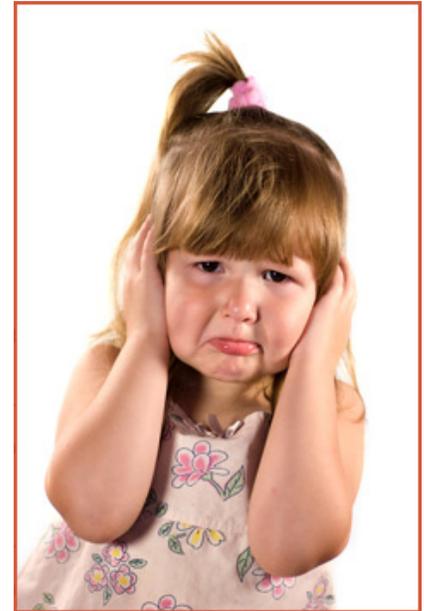
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### Definition

#### Child Maltreatment

Child maltreatment is a complex and pervasive issue which impacts children globally. The harmful effects of child maltreatment are evident through its various forms - child abuse and neglect, children witnessing violence or coercive treatment, and unintentional injuries related to child maltreatment (Schnitzer & Ewigman, 2008). The serious emotional, psychological, or physical harm that a child experiences as a result of child maltreatment can negatively impact a child's future life trajectory. The scars of child maltreatment can last a lifetime.

Abuse occurs when an adult intentionally inflicts harm upon a child. Sadly, parents are responsible for more than 80% of all abusive acts, with relatives accounting for another 7% (Berk & Roberts, 2009). Although neglect is often included under the child abuse umbrella, it differs from other forms of abuse. Abuse includes the presence of harmful acts upon children (e.g., injury, rape), whereas neglect is the absence of an expected set of conditions in which children thrive (English et al., 2005).



Any cases of abuse are unacceptable. Many cases go unreported, indicating that the actual rates of child abuse are in fact much higher than estimated (Berk & Roberts, 2009; Lambie, 2005). It is estimated that 100 Canadian children die each year as a result of abuse (Berk & Roberts, 2009). In addition, most forms of abuse are interrelated, so children who experience one form of abuse will likely experience other types of abuse (Berk & Roberts, 2009). As a result, many of the same indicators of neglect and abuse in children are found across the four main categories of abuse. Rates of abuse by gender indicate that boys and girls suffer from similar amounts of physical abuse, while girls suffer sexual abuse four times more often than boys (Lambie, 2005). Considering that young children often have difficulty disclosing abuse (Brilleslijper-Kater et al., 2004), it is critical that professionals know the signs of child maltreatment and consult their local child protection agency, when abuse and/or neglect are suspected.

### How are Neglect and Abuse Defined?

Different types of abuse, including exposure to abuse in the home are described by Cunningham and Baker (2007). For this section the following indicators have been used to define neglect and abuse:

- ◆ **Neglect** is the most commonly reported form of abuse (Berk & Roberts, 2009), but has received the least amount of attention (English et al., 2005; Lewin & Herron, 2007). It is often grouped into subtypes:

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- Failure to provide for a child's basic needs (e.g., food, clothing, shelter, education, medical care, supervision/safety);
  - Abandonment;
  - Failure to provide for the child's emotional well-being;
  - Failure to seek treatment or follow a recommended intervention can also be a form of neglect.
- ◆ **Emotional Abuse** includes acts that could cause serious mental or behavioural disorders, including social isolation, repeated unreasonable demands, ridicule, humiliation, intimidation, or terrorizing. Exposure to domestic violence has sometimes been included as a separate category (Trocmé et al., 2003), although it is generally considered to be a form of emotional abuse.
  - ◆ **Physical Abuse** is classified as assaults, such as kicking, biting, shaking, punching, beating, throwing, choking, burning or stabbing, that inflict physical injury.
  - ◆ **Sexual Abuse** is classified as fondling, intercourse, digital or object penetration, sex talk, exhibitionism, commercial exploitation through prostitution or production of pornography, and other forms of sexual exploitation, and unnatural sexual practices. (Berk & Roberts, 2009; Department of Justice Canada, 2005; English et al., 2005; Lambie, 2005; Trocmé et al., 2005)

### Consequences of Child Maltreatment

The short- and long-term consequences of child maltreatment vary considerably, with childhood death as the most serious outcome. Child maltreatment can also affect all areas of a child's development. Although not exhaustive, the following list provides some of the outcomes of child maltreatment:

- ◆ Permanent disability
- ◆ Brain damage
- ◆ Delays in development
- ◆ Behavioural problems; aggression; psychiatric problems; post-traumatic stress symptoms; increased risk of suicide
- ◆ Poor academic achievement; learning disorders; attention problems
- ◆ Difficulties with social relationships
- ◆ Reproductive health problems; sexually transmitted diseases including HIV/AIDS
- ◆ Anxiety, depression; low self-esteem

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- ◆ Anger, hostility, general mistrust of adults
- ◆ Failure to thrive
- ◆ Low birth weight
- ◆ Substance use
- ◆ Teen pregnancy
- ◆ Sexual revictimization
- ◆ Criminal behaviour including violent crime
- ◆ School truancy



(Cicchetti & Toth, 2006; Shonk & Cicchetti, 2001, Wolfe et al., 2001 as cited in Berk & Roberts, 2009; Dubowitz et al., 2005; English et al., 2005; Fusco & Fantuzzo, 2009; McGowan et al., 2009; Prevent Child Abuse America, 2003; Sechrist, 2000 as cited in Lambie, 2005)

### Recognition

Maltreatment has not only far reaching and devastating effects, it also results in a generational cycle of abuse, violence and neglect. Preventing maltreatment is a critical intervention that can stop the cycle of abuse and hurt. Known risk factors, related to child maltreatment, need to be addressed in order to succeed in prevention efforts.

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### Risk Factors

The following table identifies the range of risk factors that can contribute to child maltreatment, including family, community, and cultural factors.

Risk Factors Related to Child Maltreatment	
Parents/caregivers	Psychological disturbance; cognitive impairment; physical or mental health issues; alcohol and drug use; history of maltreatment as a child; belief in harsh, physical discipline; desire to satisfy unmet emotional needs through the child; unreasonable expectations for child behaviour; young age (most under 30); low educational level
Child	Premature or very sick baby; difficult temperament; inattentiveness and overactivity; developmental problems
Family	Low income; poverty; homelessness; marital instability; social isolation/lack of social supports; domestic violence; frequent moves; large families with closely spaced children; overcrowded living conditions; disorganized household; lack of steady employment; other signs of high life stress; criminal activity
Community	High rates of violence and social isolation; few parks, child care centres, preschool programs, recreation centres, religious or cultural centres to serve as family supports
Culture	Approval of physical force and violence as ways to solve problems

(Lambie, 2005; Trocmé et al., 2005; Wekerle & Wolfe, 2003; Whipple, 2006, as cited in Berk & Roberts, 2009)

- ◆ Professionals have an important opportunity to intervene and stop the cycle of maltreatment. They can:
  - Ensure children, adolescents and adults receive appropriate treatments for physical and mental illness
  - Identify and address developmental concerns early
  - Encourage individuals, families and communities to develop strong social support networks
  - Ensure education re positive parenting and discipline is universally available
  - Ensure literacy programs for adults are available
  - Lobby for and support poverty reduction initiatives
  - Promote treatment and cessation programs for substance use
  - Promote and refer to culturally appropriate family support programs

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### Neglect

#### Possible Indicators of Neglect

##### PHYSICAL INDICATORS IN CHILDREN

- ◆ Poor hygiene; unkempt; dirty or unbathed state; body odour; early childhood tooth decay; dirty clothes
- ◆ Unattended physical problems or medical needs; lack of routine medical and/or dental care
- ◆ Temporary abandonment by caregiver (e.g., alone in a car seat)
- ◆ Consistent lack of supervision
- ◆ Consistent hunger; distended stomach
- ◆ Inadequate clothing; inappropriate clothing for the weather
- ◆ Chronic diaper rash; infected sores or unattended skin disorders
- ◆ Infants or young children may display abnormal growth patterns; stunted growth; thin limbs or weight loss; sunken cheeks; dehydration; paleness; lethargy; poor appetite; unresponsiveness to stimulation
- ◆ Delays in development (e.g., motor, language, social skills); not meeting developmental milestones; failure to thrive; clumsiness

##### BEHAVIOURAL INDICATORS IN CHILDREN

- ◆ Poor social skills and peer relations
- ◆ Falls asleep frequently outside of naptime; regularly appears fatigued
- ◆ Frequently absent from program(s)
- ◆ Beggars or steals food; forages and hoards food; frequently “forgets” a lunch
- ◆ Self-destructive behaviour
- ◆ Delinquent behaviour
- ◆ Attention problems
- ◆ Negative view of self and others
- ◆ Little or indiscriminate crying
- ◆ Craves an enormous amount of attention or shows an inordinate amount of affection
- ◆ Anxiety, depression
- ◆ Listless
- ◆ Withdrawn; difficulty interpreting the emotions of others
- ◆ Lack of persistence, perseverance and enthusiasm
- ◆ Demonstrates lack of attachment to caregiver; may demonstrate indiscriminate attachment to other adults
- ◆ Little fear of strangers

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### BEHAVIOURAL INDICATORS IN CHILDREN

- ◆ Independence and self-care beyond the norm; has a lot of responsibility at home; left to care for other children; assumes parental role
- ◆ Unimaginative play
- ◆ Discloses neglect

### BEHAVIOURS OBSERVED IN AN ADULT WHO NEGLECT CHILDREN OR CONDITIONS IN THEIR HOMES

- ◆ Fails to provide for the child's basic needs (e.g., food, shelter, education, clothing)
- ◆ Fails to ensure that the child receives medical treatment for illness or injury, or basic health care
- ◆ Excessive use of punishment
- ◆ May indicate that the child was the result of an unwanted pregnancy; may indicate that the child continues to be unwanted
- ◆ Frequent negativity about the child; highly critical
- ◆ May have unrealistic expectations of the child
- ◆ Caregiver puts own needs first
- ◆ Family history of neglect and poor parenting
- ◆ Overwhelmed with own personal problems and needs; may indicate that the child is hard to care for/hard to feed; describes the child as demanding
- ◆ Maintains a chaotic home life, with little evidence of regular routines (e.g., consistently brings the child to care very early, picks up the child very late)
- ◆ Has little involvement in the child's life: appears apathetic toward child's daily events; fails to keep appointments regarding the child; fails to use services offered; unresponsive when approached with concerns
- ◆ May show ignoring or rejecting behaviour towards the child
- ◆ Substance use while parenting; substance use during pregnancy
- ◆ May experience domestic violence
- ◆ May have acute mental health needs
- ◆ May lack support network
- ◆ Lack of provision for child's safety; unsafe environment; evidence of human or animal excrement; little food available
- ◆ Fails to provide adequate supervision: may be frequently unaware of, or has no concern for the child's whereabouts; leaves the child alone, unattended, in a dangerous place, or in the care of others who are unsuitable or who cannot look after the child safely

(Children's Aid Society of Ottawa, 2005; English et al., 2005; Grenier & Leduc, 2008; Lambie, 2005; Lewin & Herron, 2007; Powell, 2003; Rimer & Prager, 1998; Scannapieco & Connell-Carrick, 2005; Stocker & Dehner, 2001; Trocmé et al., 2005)

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### Emotional Abuse

#### Possible Indicators of Emotional Abuse

Although neither conclusive nor exhaustive, the presence of one or more of the following indicators should alert professionals to the possibility of emotional abuse. However, these indicators should not be taken out of context, nor used individually to make unfounded generalizations. Pay close attention to the duration, consistency, and pervasiveness of each indicator. If unsure about whether or not certain behaviours constitute emotional abuse, consult with child protection staff.

#### PHYSICAL INDICATORS IN CHILDREN

- ♦ The child does not develop as expected; speech disorders; delays in physical or emotional development
- ♦ Frequent complaints of nausea, headaches, or stomach aches without any obvious reason
- ♦ Asthma, or severe allergies
- ♦ Child fails to thrive
- ♦ Wetting or soiling that is non-medical in origin
- ♦ Immature or overly mature behaviour
- ♦ May have “unusual” appearance (e.g., bizarre haircuts, dress, decorations)
- ♦ Dressed differently from other children in the family

#### BEHAVIOURAL INDICATORS IN CHILDREN

- ♦ Extremely passive or undemanding; extreme withdrawal; anxiety; sadness; ADD/ADHD; stress
- ♦ Extreme attention-seeking behaviours; extremely demanding, aggressive, angry
- ♦ Low self-esteem; severe depression; self-destructive behaviours (e.g., suicide threats or attempts, substance abuse); antisocial or destructive behaviour
- ♦ Regressive behaviours and/or habit disorders (e.g., toileting problems, thumb-sucking, rocking, biting, head-banging)
- ♦ Sleep disturbances
- ♦ Overly compliant; too well mannered; too neat or clean
- ♦ Overly self-critical; high self-expectations that result in frustration and failure, or avoidance of activities for fear of failure
- ♦ Unrealistic goals to gain adult approval
- ♦ Fearful of returning home or being left alone
- ♦ Lack of self-confidence
- ♦ Poor academic performance
- ♦ Irregular attendance at school or program

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### BEHAVIOURAL INDICATORS IN CHILDREN

- ◆ Displays extreme inhibition in play
- ◆ Runs away from home
- ◆ Has a lot of adult responsibility
- ◆ Poor peer relationships; lack of emotional connection with others
- ◆ Cruel to animals
- ◆ Discloses abuse

### BEHAVIOURS OBSERVED IN ADULTS WHO ABUSE CHILDREN

- ◆ Consistently degrades, criticizes, insults, ridicules, intimidates, humiliates or belittles the child, verbalizes negative feelings about the child to the child and others
- ◆ Compares the child to someone who is disliked or hated
- ◆ Terrorizes the child (e.g., threatens the child with physical harm or death, threatens someone or something the child loves; forces the child to watch physical harm being inflicted on a loved one)
- ◆ Isolates the child; does not allow the child to have contact with others, both inside and outside the family (e.g., locks the child in a closet or room)
- ◆ Consistently rejects or ignores the child; actively refuses to help the child or acknowledge the child's requests, needs or interests
- ◆ Blames the child for problems, difficulties, disappointments
- ◆ Displays violent behaviours; constant yelling; swearing
- ◆ May be inflexible and harsh; exhibits inconsistent behaviour
- ◆ Treats and/or describes the child as different from other children and siblings (e.g., does not provide food, clothing and care for child as well as for the other children in the family)
- ◆ Corrupts the child, teaches or reinforces criminal behaviour; provides antisocial role modeling; exploits the child for own gain
- ◆ Withholds physical and verbal affection from the child; withholds love, support, and guidance
- ◆ Makes excessive demands of the child; has unrealistic child expectations
- ◆ Exposes the child to sexualized/violent media (e.g., DVDs, TV)
- ◆ Communicates to the child that he is worthless, that his needs don't count, and that no one likes or loves him
- ◆ Substance use

(Case, 2007; Children's Aid Society of Ottawa, 2005; Christensen, 1999; Lambie, 2005; McKibbin & Walton, 2008; Muscari, 2004; Palmatier, 1997; Powell, 2003; Reardon & Noblet, 2008; Rimer & Prager, 1998; Trocmé et al., 2005)

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### Possible Exposure to Domestic Violence and Other Forms of Abuse

In recent years, the number of cases of exposure to domestic violence has risen dramatically in Canada (Trocmé et al., 2005). Although domestic violence may result from angry and violent outbursts, ultimately, it is “about control, not anger” (Nies & McEwen, 2001, p. 604). When domestic violence occurs in the home, the well-being and development of children are often negatively impacted. Children who have been exposed to domestic violence suffer from significantly more social, emotional, and cognitive problems in comparison to their peers (Fusco & Fantuzzo, 2009). In some cases, studies have shown that “almost 75% of all children exposed to domestic violence were also involved in the violence” (Fusco & Fantuzzo, 2009, p. 254). As a result of exposure to domestic violence, boys who are exposed to abuse of their mothers are more likely to abuse their partner as adults, while girls who grow up in that type of environment are more likely to accept abusive relationships as adults (Grenier & Leduc, 2008).

Children’s exposure to abuse in the home should always be taken seriously. Children may be affected differently, but children who live with conflict and abuse are actively involved by assessing their own roles, worrying about consequences, engaging in problem-solving and attempting to protect themselves, siblings or the caregiver (Cunningham & Baker, 2007).

Children who have witnessed abuse and coercive treatment in the home often display the same types of physical and behavioural indicators as children who are emotionally abused (see Possible Indicators of Emotional Abuse table). Furthermore, children can suffer from serious unintended injuries during violent episodes in the home, either in an effort to protect a family member or when objects have been thrown. Some children also experience post-traumatic stress symptoms as a result of witnessing family violence (Fusco & Fantuzzo, 2009).

Adults who engage in domestic violence also share the same types of behaviours as adults who emotionally abuse children (see Possible Indicators of Emotional Abuse table). This may include: engagement in ridicule, intimidation, humiliation, degradation, insults, verbal criticism, blame; violent behaviours; threats; terrorization of family members; isolation of family members; jealousy and possessiveness (Jenkins & Davidson, 2001); control of partner’s activities (Reyes, Rudman, & Hewitt, 2002), etc. In addition, risk factors that have been related to higher rates of domestic violence include poverty, substance use, and single female-headed households (Fusco & Fantuzzo, 2009).

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The victim of domestic violence is often the child's primary female caregiver, usually his mother. Victims often feel powerless to change their abuser's emotionally, physically, or financially controlling behaviours. Professionals can help victims, by recognizing the abuse, and offering an opportunity for disclosure and interventions. Professionals need to watch for a variety of behavioural indicators that victims may display. These may include:

- Injuries that do not appear accidental
  - Explanations for injury that are vague or do not match the injury
  - Embarrassment, shame, attempts to hide injuries
  - Reserved, quiet, or frightened demeanor in abuser's presence
  - Tense, jittery, no eye contact, defers to partner in answering questions
  - Complaints of "bad nerves", sleep or appetite disturbances
  - Mention of partner's temper; talks about avoiding troubles
  - Misses appointments; does not follow up on medications or plans
  - History of repeated injuries
  - History of visits to emergency rooms, mental health clinics
  - History of depression, anxiety, suicide attempts
  - Multiple injuries in various stages of healing
  - Apparent fearfulness, edginess, increased startle response
  - Isolated with little access to money, resources, friends, family, job, transportation
  - Alcohol or drug use
- (Jenkins & Davidson, 2001; Reyes, Rudman, & Hewitt, 2002)

## Section 5 Safety and Well-Being

### Physical Abuse

#### Possible Indicators of Physical Abuse

Although neither conclusive nor exhaustive, the presence of one or more of the following indicators should alert professionals to the possibility of physical abuse. However, these indicators should not be taken out of context nor used individually to make unfounded generalizations. Pay close attention to the duration, consistency, and pervasiveness of each indicator. If unsure about whether or not certain behaviours constitute physical abuse, consult with child protection staff.

#### PHYSICAL INDICATORS IN CHILDREN

- ◆ Presence of several, recurring injuries over time; unexplained injuries that are in various stages of healing
- ◆ Fractures, dislocations, multiple fractures all at once or over time; pain in the limbs, especially with movement; tenderness
- ◆ Distorted facial appearance with swelling, bleeding, bruising
- ◆ Limping or other abnormal use of limbs, without a reasonable explanation (e.g., lacks full range of movement in limb)
- ◆ Fractures of the ribs: painful breathing; difficulty raising arms
- ◆ Signs of possible head injuries (skull fractures included): swelling and pain; nausea or vomiting; patches of hair missing; irritability; lethargy; seizures; limpness; difficulty breathing; persistent crying; dizziness; unequal pupil size; bleeding from scalp wounds or nose
- ◆ Fractures in children younger than 12 months of age have been linked to abuse 40% - 56% of the time
- ◆ Facial injuries in infants and preschool children
- ◆ Cuts, scrapes, and welts inconsistent with normal play (e.g., bruises on cheeks; neck; back of arms and thighs); injuries inconsistent with the child's age and developmental phase
- ◆ Frequent hospital visits
- ◆ Unexplained injuries on questionable sites (e.g., on stomach, buttocks, ears, back of head, upper back, pubic area); bruises on children younger than 9 months of age are considered suspicious
- ◆ Bruising patterns, clustered bruising, or welts (e.g., from a wooden spoon, hand/finger print marks, belt)
- ◆ Burns from a cigarette; patterned burns (e.g., iron, electric burner); burns suggesting that something was used to restrain a child (e.g., rope burns on the wrists, ankles, neck); scalds
- ◆ Human bite marks
- ◆ Evidence of recent female genital mutilation (e.g., difficulty voiding, chronic infections, "waddling")
- ◆ Internal injuries
- ◆ Fractured or missing front teeth

## Section 5 Safety and Well-Being

### BEHAVIOURAL INDICATORS IN CHILDREN

- ◆ The story of what happened is inconsistent with the injury; refuses or is afraid to talk about injuries; denies injury; cannot recall or describe how injuries occurred
- ◆ Disruptive; destructive; nervous or hyperactive; violent towards others
- ◆ Exhibit depression or anxiety
- ◆ May show extremes in behaviour: extremely aggressive or passive, unhappy or withdrawn; extremely compliant/eager to please or extremely noncompliant
- ◆ Tries to hurt himself (e.g., self-mutilation)
- ◆ Expresses little or no emotion when hurt
- ◆ Wary or afraid of adults generally, or of a particular gender or individual
- ◆ Does not want to be touched; may cringe or flinch with physical contact
- ◆ May display over-vigilance, a frozen watchfulness, or vacant stare
- ◆ Academic or behavioural problems
- ◆ Afraid to go home; runs away from home
- ◆ Is frequently absent with no explanation, or shows signs of healing injury on return
- ◆ Tries to take care of the caregiver
- ◆ May be dressed inappropriately to cover injuries
- ◆ Poor peer relationships
- ◆ Evidence of developmental lags, especially in language and motor skills

### BEHAVIOURS OBSERVED IN ADULTS WHO ABUSE CHILDREN

- ◆ May provide inconsistent explanations as to how the child was injured
- ◆ May delay seeking medical attention for injuries or illnesses
- ◆ Gives harsh, impulsive or unusual punishments
- ◆ Shows lack of self-control with low frustration tolerance; extreme anger; impatience
- ◆ Socially isolated; little support or parenting relief
- ◆ May have little knowledge of child development and/or have unrealistic expectations of the child
- ◆ May often express having difficulties coping with the child or makes disparaging remarks; describes child as different, bad, or the cause of own difficulties
- ◆ May demonstrate little or no genuine affection, physically or emotionally for the child
- ◆ May state that the child is accident-prone or clumsy
- ◆ May appear unconcerned, indifferent, or hostile to child and injury

(Children's Aid Society of Ottawa, 2005; Grenier & Leduc, 2008; Lambie, 2005; Powell, 2003; Rimer & Prager, 1998; Trocmé et al., 2005; Ziegler, Sammut, & Piper, 2005)

## Section 5 Safety and Well-Being

### Shaken Baby Syndrome

- ◆ Another form of abuse that is caused by physical trauma to a child is shaken baby syndrome (SBS), now also called Abusive Head Trauma (AHT). This terminology includes a broader range of injuries such as:
  - Shaking
  - Blunt impact
  - A combination of blunt impact and shaking (Christian & Block, 2009)
- ◆ Shaken baby syndrome is the result of violent shaking of an infant or small child (Reynolds, 2008), while AHT includes shaking and injuries caused by hitting the child hard or with an instrument, or causing him to hit his head. Continuous infant crying is often the trigger for the shaking. With an infant's larger head and weaker neck muscles, even five seconds of vigorous shaking can cause injury. However, due to the lack of external signs of injury (Mraz, 2009), abusive head trauma is often difficult to diagnose. AHT occurs most frequently in infants younger than six months of age, although it has been recorded in children up to five years of age (Reynolds, 2008; Smith, 2003). Sadly, approximately one-third of children who are victims of AHT will die (WHO, 2002), and less than a third of infants who survive will develop normally (Reynolds, 2008). Other outcomes of AHT can include:
  - Permanent visual impairment
  - Seizures
  - Permanent brain damage
  - Developmental delays
  - Learning disabilities
  - Severe motor dysfunction
  - Paralysis
  - Epilepsy

Men carry out this type of abuse twice as often as women (Reynolds, 2008). As in any form of suspected child abuse, further investigation and consultation with child protection agencies may be necessary.

In the following table, a list of indicators of AHT is provided. If several of these indicators are noted, immediate attention by a primary health care provider or emergency doctor is required.

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### Indicators of Abusive Head Trauma (Shaken Baby Syndrome)

- ◆ History of poor feeding
- ◆ Vomiting
- ◆ Lethargy or irritability
- ◆ Hypothermia
- ◆ Failure to thrive
- ◆ Increased sleeping and difficulty arousing
- ◆ Inability to lift head
- ◆ Inability to suck, swallow, smile or vocalize
- ◆ Seizures
- ◆ Difficulty breathing
- ◆ Retinal bleeding - occurs in 50 - 100% of cases
- ◆ Bulging eyes
- ◆ Blue skin
- ◆ Mild anemia
- ◆ Inability of eyes to focus or to track objects
- ◆ Skeletal injury - old and new fractures are often found
- ◆ Massive intracranial bleeding - most common cause of death in shaken infants
- ◆ Bulging fontanelle (soft spot)
- ◆ Coma
- ◆ Bradycardia (slow heart rate)
- ◆ Complete cardiovascular collapse
- ◆ Sometimes bruising in shape of hand imprints on infant's trunk or extremities

(Reynolds, 2008; Smith, 2003)

## Sexual Abuse

### Children's Sexual Behaviour in Context

To accurately identify childhood sexual abuse, it is helpful to first understand developmentally appropriate sexual behaviours in young children. Surprisingly, there is little research that has been conducted on children's normal sexual development and experience (Schoentjes, Deboutte, & Friedrich, 1999). Furthermore, what little research is available, is also dated (Volbert, 2001). It is challenging to pinpoint normal sexual development, considering that a number of factors can influence a child's sexual behaviour. These include:

- ◆ Age of child
- ◆ Maternal level of education
- ◆ Family nudity
- ◆ Family attitudes toward sexuality (Schoentjes, Deboutte, & Friedrich, 1999)
- ◆ Culture (Volbert, 2001).

In the following table, developmentally appropriate sexual behaviours that have been documented in young children are outlined.

## Section 5 Safety and Well-Being

### Developmentally Appropriate Sexual Behaviours in Children Younger Than 6 Years of Age

- ♦ Asks questions about sexuality
- ♦ Plays doctor games
- ♦ Touches mother's breast
- ♦ Likes to be nude
- ♦ Likes to walk in underclothes
- ♦ Has erections
- ♦ Touches own genitals; masturbates
- ♦ Is aware of genital differences between sexes
- ♦ able to label genitalia; often uses nontechnical terms to describe
- ♦ Scratches anal and/or crotch area
- ♦ Looks at people when they are nude
- ♦ Cuddles
- ♦ Children aged 2 - 7 years typically do not associate genitalia with any sexual function - only with pregnancy/birth
- ♦ Curious about how babies are born
- ♦ Sits with crotch or underwear exposed
- ♦ May undress in public
- ♦ Kisses adults not in the family
- ♦ Kisses other children not in the family
- ♦ Purposely displays genitalia to peers (typically up to age 4)
- ♦ Fascinated by excretion; curiosity about bathroom behaviours
- ♦ By age 4, shows an increased need for privacy, especially in the bathroom

(Brilleslijper-Keter, Friedrich, & Corwin, 2004; Brittain, 2005; Schoentjes, Deboutte, & Friedrich, 1999; Stoudemire, 1998; Volbert, 2001)

## Section 5 Safety and Well-Being

### Possible Indicators of Sexual Abuse

Although neither conclusive nor exhaustive, the presence of one or more of the following indicators should alert professionals to the possibility of sexual abuse. However, these indicators should not be taken out of context nor used individually to make unfounded generalizations. Pay close attention to the duration, consistency, and pervasiveness of each indicator. If unsure about whether or not certain behaviours constitute sexual abuse, consult with child protection staff.

(Berk & Roberts, 2009; Brilleslijper-Kater et al., 2004; Brittain, 2005; Brown, Brack, & Mullis, 2008; Children's Aid Society of Ottawa, 2005; Department of Justice Canada, 2005; Felman & Nikitas, 1995; Glicksen, 2006)

#### PHYSICAL INDICATORS IN CHILDREN

- ◆ Unusual or excessive itching or pain in the throat, genital, or anal area
- ◆ Vaginal discharge; genital odour
- ◆ Torn, bloody, or stained (e.g., signs of semen) underclothing
- ◆ Pain on urination, elimination, sitting down, walking or swallowing
- ◆ Blood in urine or stool
- ◆ Injury to the breasts, genital or anal areas: redness; bruising; lacerations; tears; swelling; bleeding; infection
- ◆ Poor personal hygiene or excessive bathing
- ◆ Abdominal pain
- ◆ Constipation
- ◆ Sexually transmitted disease
- ◆ Frequent urinary tract or yeast infections
- ◆ Foreign objects in vagina or rectum

#### BEHAVIOURAL INDICATORS IN CHILDREN

- ◆ Displays sexual behaviour and knowledge that is beyond the child's age and stage of development
- ◆ Detailed and sophisticated understanding of sexual behaviour; age-inappropriate explicit drawings, descriptions
- ◆ Age-inappropriate sexual behaviour with dolls, toys, self, pets or others; provocative behaviour with adults; intrusive sexual behaviour with same-age children; expresses sexual aggression towards younger children; compulsive sexualized talk; excessive masturbation
- ◆ Atypical play behaviours (e.g., repeated reenactments of the trauma, aggressive play, sexualized play)
- ◆ Frequently asks to go to the bathroom; recurring physical complaints with no physical basis
- ◆ Nightmares, night terrors, and sleep disturbances

## Section 5 Safety and Well-Being

### BEHAVIOURAL INDICATORS IN CHILDREN

- ◆ Loss of appetite; sudden change in weight (either gain or loss)
- ◆ Clinging or very demanding of affection or attention; fear of abandonment if caregiver leaves momentarily
- ◆ Reluctance, fear or refusal to go to a parent, relative, friend for no apparent reason; mistrust of others; fearfulness
- ◆ Hyperactive or anxious; preoccupied; excessive worry about siblings; excessive crying
- ◆ Low self-esteem; depression; withdrawal; strong feelings of shame or guilt
- ◆ Sudden change in behaviour (e.g., outgoing child becomes withdrawn) or progress
- ◆ Regressive behaviour (e.g., bed-wetting, thumb-sucking, speech loss)
- ◆ Resists being undressed, or when undressing, shows apprehension or fear
- ◆ Afraid to go home; runs away
- ◆ Poor relationships with peers; social isolation
- ◆ Aggressive behaviour; self-injurious behaviours
- ◆ Lags in development
- ◆ Puts mouth on other child/adult sex parts; puts tongue in mouth when kissing
- ◆ Puts objects in vagina or rectum
- ◆ Repeatedly plays with or smears feces; purposely urinates in inappropriate places (e.g., on furniture)
- ◆ Touches animal sex parts
- ◆ Discloses sexual abuse

### BEHAVIOURS OR CONDITIONS OBSERVED IN ADULTS WHO ABUSE CHILDREN

- ◆ Relationship with the child may be inappropriate, sexualized or spousal in nature
- ◆ States that the child is sexual or provocative
- ◆ Shows physical contact or affection for the child that appears sexual in nature
- ◆ Permits or encourages the child to engage in sexual behaviour
- ◆ Is frequently alone with the child and is socially isolated
- ◆ May be jealous of the child's relationships with peers or adults
- ◆ Discourages or disallows child to have unsupervised contact with peers
- ◆ May use substances to lower inhibitions against sexually abusive behaviour
- ◆ May have an addiction to drugs, alcohol, or other substances
- ◆ Treats one child significantly differently to other children in the family
- ◆ May be unusually overprotective, over-invested in the child (e.g., clings to the child for comfort)
- ◆ Abuser is usually a male who is familiar to the child (e.g., father, step-father, boyfriend)
- ◆ May use internet or mobile phones to expose children to pornography

## Section 5 Safety and Well-Being

Lambie, 2005; Paradise, 2002; Powell, 2003; Reece, 2000; Rimer & Prager, 1998; Scannapieco & Connell-Carrick, 2005; Schoentjes, Deboutte, & Friedrich, 1999; Trocmé et al., 2005; WHO, 2002)

### Reporting and Supporting

#### Reporting Maltreatment

As professionals working directly with young children and families, situations may arise in which child abuse and/or neglect are suspected. According to the Child and Family Services Act (1990), any professional who works with children and who has reasonable grounds to suspect that a child has suffered harm or is at risk of harm, must report their suspicions immediately to a child protection agency. According to the UN Convention on the Rights of the Child (1989), a child is defined as any human being under the age of 18 years.

To support children's well-being, professionals have a legal and ethical obligation to consult with or report any suspicions of maltreatment to a Children's Aid Society. This includes indicators of neglect, sexual abuse, physical abuse, and emotional abuse, including a child's exposure to domestic violence (MCYS, 2005). In situations where the signs of abuse may not be straightforward, or where certain cultural practices conflict with Canadian law (e.g., female genital mutilation), consultation with a local child protection agency is recommended. Emergency services are available 24 hours/day, seven days a week at all child protection organizations.

The ongoing duty to report is also an important consideration for professionals. Even if a report has already been made to a child protection agency regarding a particular child, another report must be filed if additional reasonable grounds for concern arise.

Reporting Child Abuse and Neglect: It's Your Duty

#### Supporting Children Who Have Been or May be Maltreated

Professionals can support maltreated children in a number of ways. By closely monitoring a child's ongoing progress, and overall health and well-being, professionals can often detect any unusual changes in the child's behaviour or development. A home visiting program such as Healthy Babies Healthy Children can provide this ongoing monitoring and may be available for at risk families with children up to the age of six years. When serious concerns arise, professionals can help with referrals to the appropriate services or supports.

For children who have already suffered the damaging effects of maltreatment, professional therapy such as play therapy or therapeutic day care may be required (WHO, 2002). Rimer and Prager (1998) note that maltreated children benefit from stable, supportive, and nurturing environments with predictable adults. In order to support the healing process, they

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also suggest that a maltreated child may need help to develop:

- ◆ Positive self-image and self-esteem
- ◆ Trust
- ◆ Ability to identify and express emotions
- ◆ Communication skills
- ◆ Skills to identifying and solve problem situations
- ◆ Conflict resolution skills
- ◆ Overcoming developmental lags

### Supporting Adults Who Maltreat or Who Are at Risk of Maltreating Children

It is important for all professionals who work with children and families to have some form of training to help them identify the signs of abuse in children and families. This training can also provide them with the tools to effectively teach about the prevention of maltreatment (Brown, Brack, & Mullis 2008). There are a number of support programs and services available to caregivers or other adults who maltreat or who may be at risk of maltreating children. Some of these options may include:

- ◆ Long-term therapy
- ◆ Parent support groups or networks (e.g., Parents Anonymous)
- ◆ Parent education programs - often provided in centres; can enhance caregivers' parenting skills, understanding of child development, and positive discipline strategies
- ◆ New parent support programs (includes information about prenatal care, effective discipline strategies, addressing children's developmental needs, stress management techniques)
- ◆ Home visitation programs - caregivers are visited in their homes, and support, information and appropriate community referrals are provided to prevent child maltreatment
- ◆ Therapeutic day programs for adults abused as children
- ◆ Abuse prevention training programs (e.g., sexual abuse prevention programs)
- ◆ Social programs to support families
- ◆ Financial planning and occupational skills training
- ◆ Media campaigns to raise awareness of caregivers
- ◆ Interventions with multiple components (e.g., child care, parenting skills training, family support) (Berk & Roberts, 2009; Lambie, 2005; Mikton & Butchart, 2009; WHO, 2002)