

Technical Report

WHO GUIDELINES FOR THE HEALTH SECTOR RESPONSE TO CHILD MALTREATMENT

This technical report includes the recommendations for the *WHO Guidelines for the Health Sector Response to Child Maltreatment* that were approved by the WHO Guideline Review Committee on 28 August 2019.

The recommendations will be integrated with the recommendations of *Responding to children and adolescents who have been sexually abused: WHO Clinical Guidelines (2017)* into a clinical handbook.

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Acronyms and abbreviations

CBT	Cognitive behavioural therapy
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CRE	WHO Office of Compliance, Risk Management and Ethics
ERG	External Review Group
GDG	Guideline Development Group
GRADE	Grading of Recommendations, Assessment, Development and Evaluation
IPT	Interpersonal psychotherapy
IPV	Intimate partner violence
LGBTI	Lesbian, gay, bisexual, transgender and intersex
mhGAP	WHO Mental Health Gap Action Programme
PCIT	Parent-Child Interaction Therapy
PICO	Population, intervention, comparator, outcome
PTSD	Post-traumatic stress disorder
TF-CBT	Trauma-Focused Cognitive Behavioural Therapy
WHO	World Health Organization

Glossary

Adolescent: Any person aged between 10 and 19 years, in accordance with United Nations/ World Health Organization definition (1). The definition of an adolescent overlaps with that of a child, below. “Young adolescents” are defined as those aged between 10 and 14 years and “older adolescents” as those aged between 15 and 19 years.

Child: Any person under the age of 18 years, in accordance with the United Nations Convention on the Rights of the Child (2). The definition of a child overlaps with that of an adolescent. These guidelines use the terms “child” or “children and adolescent(s)” throughout, but include adolescents only up to the age of 18 years.

Child maltreatment: The abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results 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. Child maltreatment includes neglect, physical, sexual and emotional abuse, and fabricated or induced illness.

Case-finding or clinical enquiry: In the context of child maltreatment, this refers to the identification of children and adolescents experiencing violence who present to health-care settings, through use of questions based on the presenting conditions, the history and, where appropriate, examination of the patient. These terms are used as distinct from “screening” or “routine enquiry”.

Cognitive behavioural therapy (CBT) with a trauma focus: Cognitive-behavioural interventions with a focus on trauma respond to the idea that people exposed to traumatic event(s) and who have symptoms of posttraumatic stress disorder have unhelpful thoughts and beliefs related to the event and its consequences. These thoughts and beliefs result in unhelpful avoidance of reminders of the event(s) and maintain a sense of current threat. CBT usually involves exposure treatment (e.g. through imagined or in vivo situations) and/or direct challenging of unhelpful thoughts and beliefs related to the trauma. The term “CBT with a trauma focus” is often used synonymously with the term “trauma-focused cognitive behavioural therapy” (TF-CBT) (3, 4). However, in the literature on PTSD, the term “trauma-focused cognitive behavioural therapy” has a narrower definition for a specific and widely disseminated multi-component CBT protocol for children and adolescents and their families, developed by Cohen and colleagues (5). In these guidelines, the term “cognitive behavioural therapy with a trauma focus” is used to include a broad range of cognitive behavioural interventions that address trauma, including Cohen and colleagues’ TF-CBT (5) and any type of prolonged exposure treatment.

Consent to clinical care: Informed consent is the voluntary agreement of an individual, who is legally able to give consent for participating in clinical care. The legal age of consent for obtaining clinical care varies across countries and by type of treatment and care. Health-care decision-making requires individuals to exercise their right to independent decision-making. Consent to clinical care means that the health care providers seek permission before offering any clinical care. Informed consent means that the individual understands the purpose, benefits, risks, and other options of any tests or treatment that are offered. To be able to provide informed consent, the individual must be provided sufficient information (and in language that is appropriate) about all available options and their benefits and consequences, in order to make choices; given an explanation of what will happen to them; informed about their right to refuse any part of the care; and told about what information will be shared and with whom and limits to confidentiality. The individual must also have the capacity to know and understand the nature of care being offered and its benefits and consequences. Parents or legal guardians are typically responsible for giving informed

consent until their child or adolescent is legally able to give consent for obtaining relevant clinical care. However, in situations where it is in the best interests of the child or adolescent, informed consent should be sought from that child or adolescent. Assent¹ from the child or adolescent should always be sought regardless of whether consent has been obtained from the parents or legal guardians.

Multi-Systemic Therapy (MST): MST was originally designed for juvenile offenders and is an intensive family- and community-based treatment program that focuses on addressing all environmental systems that impact children/adolescents. MST posits that a child's behaviour problems are multi-determined and linked with characteristics of the individual child and their family, peer group, school, and community contexts. As such, MST interventions aim to comprehensively assess for and address the multi-determined factors impacting child behaviour by building on child/family strengths in a highly individualized manner. MST is generally home-based to mediate barriers children/families face in accessing services.

Parent-Child Interaction Therapy (PCIT): PCIT was originally developed to improve parenting skills and parent-child interactions among families struggling with their children's (aged 3-7) behavioural problems (e.g., oppositional defiant disorder). PCIT has two sequential phases known as child-directed interaction and parent-directed interaction. Each phase teaches parents communication skills that foster positive parent-child relationships. PCIT skills are taught via didactic presentations to parents and direct coaching of parents while they are interacting with their children. Coaching of parents often involves PCIT therapists' observing from a room with a one-way mirror into the playroom and communicating with parents as they play with the child using a "bug-in-the-ear" system, but the coaching can also be done in other ways.

SafeCare: SafeCare is a manualized, home-based structured behavioural skills training model that addresses parent/child interactions, home safety, and child health. SafeCare can be a freestanding intervention or used as a component in another home-based parenting intervention.

Screening (universal screening): Large-scale assessment of whole population groups, whereby no selection of population groups is made.² Screening involves administering a standard set of criteria to evaluate for potential child maltreatment in all presenting children (or a subset of children).

¹ Assent, according to the American Academy of Pediatrics should include at least the following elements: 1) Helping the patient achieve a developmentally appropriate awareness of the nature of his or her condition. 2) Telling the patient what he or she can expect with tests and treatments. 3) Making a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding (including whether there is an appropriate pressure to accept testing or therapy). 4) Soliciting and expression of the patient's willingness to accept the proposed care.

² The criteria are listed in JMG Wilson, Jungner G. Principles and Practice of Screening for Disease (italics). Geneva, World Health Organization, 1968. (http://whqlibdoc.who.int/php/WHO_PHP_34.pdf). The UK screening criteria are listed on <http://www.screening.nhs.uk/criteria#fileid9287>

Executive summary

These guidelines will be aimed at workers in the health sector who may encounter and respond to cases of suspected and known child maltreatment. They will provide guidance primarily for front-line health workers.

Rationale

The health sector is often the first point of contact for children exposed to maltreatment. In many instances, however, child maltreatment is not recognized, or health care providers are not trained in responding to child maltreatment. Only a small proportion of children that are exposed to child maltreatment and that are in need of health services, do receive them.

No international guidelines exist for the health sector response to child maltreatment. Several member states and WHO partners, such as the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), have urged WHO to develop such guidelines. The 2016 World Health Assembly adopted a Global plan of action to strengthen the role of the health system to address interpersonal violence, in particular against women and children (27.1). This global plan of action explicitly calls for the development of guidelines for the health sector response to child maltreatment.

In recent years, the evidence on what works in responding to child maltreatment has emerged rapidly. Today, the evidence-base is sufficiently established to develop guidelines on the topic.

Objectives

The aim of these guideline is to provide evidence-based recommendations for health care providers to provide appropriate clinical care for children and adolescents who have experienced maltreatment, in order to mitigate the negative health consequences and to improve their well-being.

The guidance is intended primarily for front-line health workers but also to specialists and policy makers to provide safe and appropriate, immediate and long-term clinical care and to apply ethical, human-rights-based and trauma-informed good practices in the provision of clinical care to victims of child maltreatment.

The guidelines will cover the identification of, initial response to, and interventions for children who have been exposed to child maltreatment and the prevention of recurrence of child maltreatment. The sections on identification and prevention of recurrence will cover all forms of child maltreatment, namely physical, sexual, and psychological abuse and neglect. The sections on initial response and interventions for child maltreatment will not cover sexual abuse, as these aspects have been covered by the WHO Guidelines “Responding to children and adolescents who have been sexually abused” (<http://bit.ly/2gwi3fP>). Other related WHO guidelines include

- *The Guidelines for the management of conditions specifically related to stress*, which include recommendations addressing acute traumatic stress symptoms, insomnia, enuresis, dissociative disorders, hyperventilation and posttraumatic stress disorder after a potentially traumatic recent event (146);
- The *mhGAP Intervention Guide* for mental, neurological and substance use disorders in non-specialized health settings which addresses general principles of care for people seeking mental health care, as well as interventions for a number of mental health conditions that can arise as a consequences of child maltreatment and can

- be risk factors for perpetrating child maltreatment again, including depression, self-harm and suicide, and alcohol and substance abuse (37);
- The *mhGAP module Assessment and Management of Conditions Specifically Related to Stress* which includes guidance on the assessment and management of, and interventions for, including advanced psychological interventions, conditions specifically related to stress;
- *Responding to intimate partner violence and sexual violence against women* WHO clinical and policy guidelines which also address violence but against adult women mainly and include identification and care for survivors of intimate partner violence and clinical care for survivors of sexual assault (66),

The following themes are covered in the guidelines.

- **Guiding principles derived from ethical principles and human rights standards**
Guiding principles are derived from obligations to protect, prevent, and respond to all forms of violence against children and adolescents derived from international human rights standards and instruments.
- **Initial identification of suspected child maltreatment:** This section includes recommendations on the best strategies to identify child maltreatment and a list of alerting symptoms for child maltreatment that can be identified in routine health encounters.
- **Detailed assessment, examination, documentation and reporting:** This section focuses on seeking informed consent and assent for examination and clinical care (Best practice statement, good clinical practices for conducting a physical examination in supposed cases of child maltreatment in order to minimize harms, reporting and the documentation of the medical history findings and forensic examination findings).
- **Interacting with caregivers:** This section focuses on communication with caregivers in suspected cases of child maltreatment.
- **Safety and risk assessment:** This section outlines best practices in assessing the safety of children and developing a safety plan for children.
- **Psychosocial support and mental health:** This section contains information about effective psychosocial interventions for children and recommendations concerning pharmacological interventions for children.
- **Treatment of perpetrators to prevent recurrence:** The section highlights the current state of research of psychosocial and pharmacological interventions for perpetrators to prevent recurrence.
- **Uptake of services:** The section focuses on best practices to facilitate uptake of health services related to child maltreatment.

For each section the available evidence and consideration that went into the development of the recommendations are provided. Detailed information on the studies that informed the recommendations, systematic review reports, Evidence-to-Decision Tables and GRADE tables are provided in web annexes.

Summary of guiding principles

Based on the United Nations Convention on the Rights of the Child (CRC)³ and other human rights standards, the following overarching principles need to be observed when providing care to children and adolescents who have, or may have, been exposed to maltreatment including emotional, physical and sexual abuse and neglect.

- Attention to the best interests of children and adolescents by promoting and protecting safety; providing sensitive care; and protecting and promoting privacy and confidentiality.
- Addressing the evolving capacities of children and adolescents by providing information that is appropriate to age; seeking informed consent and assent as appropriate⁴; respecting their autonomy and wishes; and offering choices in the course of their medical care.
- Promote and protect non-discrimination in the provision of care, irrespective of their sex, race, ethnicity, religion, sexual orientation, gender identity, ability and disability, or socioeconomic status.
- Ensuring the participation of children or adolescents in decisions that have implications for their lives, by soliciting their opinions and taking those into account, and involving them in the design and delivery of care.
- Demonstrating respect towards caregivers to support their engagement in the provision of care – when safe and appropriate - including interventions that promote nurturing and responsive childcare.

Summary of recommendations (R) and good practice statements (GP)

Recommendations and good practice statements			
A. INITIAL IDENTIFICATION			
		Quality of evidence	Strength of Recommendation
R 1 existing	Health care providers should be alert to the clinical features associated with child maltreatment and associated risk factors and assess for child maltreatment without putting the child at increased risk.	Very low	Conditional
R 2 new	Health care providers should not use a universal screening approach (e.g. a standard instrument, set of criteria, or questions asked of all children in health care encounters) to identify possible child maltreatment.	Low	Conditional
R 3 Adapted from existing	Health care providers should consider exposure to child maltreatment when assessing children with conditions that may be caused or complicated by maltreatment (see Boxes 1-6: Examples of clinical conditions associated with maltreatment and alerting features), in order to improve diagnosis/identification and subsequent care, without putting the child at increased risk.	Very low	Strong

³ Convention on the Rights of the Child. New York: United Nations; 1989 (<http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf>).

⁴ The child's preferences are paramount and should be put first.

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R4 Adapted from existing	Written information on child maltreatment should be available in health-care settings in the form of posters, and pamphlets or leaflets (<i>with appropriate warnings about taking them home in case that could compromise safety</i>).	Very low	Conditional
GP 1	<p>Health-care providers should seek explanations for any injuries or symptoms that may be caused by physical, sexual, emotional abuse or neglect from both the parent or the carer, and the child or adolescent in an open and non-judgemental manner (see Boxes 1- 6: Examples of clinical conditions associated with maltreatment and alerting features).</p> <p>Health care providers should</p> <ul style="list-style-type: none"> • Be alert for an implausible, inadequate or inconsistent explanation for any of the alerting features (see Box 1). All of them <u>can</u> be a sign for child maltreatment – however none of them provides sufficient proof for the occurrence of child maltreatment. • Consider child maltreatment when maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis. • Suspect child maltreatment when there is a serious level of concern about the possibility of child maltreatment. • Exclude maltreatment when a suitable explanation is found for alerting features. 		
B. MEDICAL HISTORY, PHYSICAL EXAMINATION AND DOCUMENTATION OF FINDINGS			
GP 2	<p>Before starting to obtain the medical history or forensic interview, any urgent medical and/or safety needs must be addressed.</p> <p>In line with the principle of “do no harm”, when the medical history is being obtained and, if needed, a forensic interview is being conducted, health-care providers should seek to minimize additional trauma and distress for children and adolescents.</p> <p>This includes the following:</p> <ul style="list-style-type: none"> • maximizing the child’s or adolescent’s control and participation in decision-making and not forcing them to speak or answer questions; • allowing them to choose who is present in the room whenever possible, and when ensuring that they are also interviewed separately from their caregivers, offering to have another person present as support; • minimizing the need to repeatedly tell their history, as it can be re-traumatizing. • building trust and rapport by asking about neutral topics first; • clearly explaining the interview process, including confidentiality and when the health worker might need to share specific information about the child or adolescent and with whom; • expressing interest in what the child is saying (verbally and non-verbally), affirming the child or adolescent for making the disclosure, and communicating to the child or adolescent that they are believed and not at fault; • using language and terminology that is appropriate to age, developmental stage and that is non-stigmatizing; • allowing the child or adolescent to answer questions and describe what happened to them in a manner of their choice, including, for example, by writing, drawing or illustrating with models; • involving a trained translator or interpreter if necessary, and not relying on caregivers for communication; making available trained interviewers and 		

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	<p>interpreters of both sexes, in case the child or adolescent expresses a preference;</p> <ul style="list-style-type: none"> • asking clear, open-ended questions without repetition; in some settings, while there may be requirements to document some information for reporting the maltreatment, it is important not to insist that the child or adolescent answers or discloses information that may cause them trauma or compromise their safety; • ensuring that - if forensic interviews are to be conducted - health facilities provide specialized training and structured interview protocols to interviewers, who are experienced in working with children; if a child or adolescent cannot be referred to appropriate services, weigh costs and benefits of forensic interview and whether it is justified given the circumstances. Information about the perpetrator should be gathered by trained investigators for legal purposes; • conducting a comprehensive assessment of their physical and emotional health, in order to facilitate appropriate decisions for conducting examinations and investigations, assessing injuries and providing treatment and/or referrals; • conducting the interview in a room that is safe, private, quiet, and child-friendly. Resources should be allocated to furnish the space with child and adolescent-friendly materials and comfortable seating.
<p>GP 3</p>	<p>Health care providers should seek informed consent for all decisions and actions to be taken as appropriate to the child’s or adolescent’s age and evolving capacity and the legal age of consent for obtaining clinical care.</p> <p>Where the child or adolescent is below the legal age of consent, it may still be in the child’s or adolescent’s best interests to seek informed consent.</p> <p>Moreover, in accordance with evolving capacities, children and adolescents have the right to access confidential counselling or advice and information without the consent of their parents or legal guardians.</p> <p>In situations where it is assessed to be in the best interests of the adolescents who are in need of care, and based on their preferences, health-care providers may consider whether to involve the parents or legal guardians.</p> <p>Seeking informed consent always includes:</p> <ul style="list-style-type: none"> • explaining the consent process, including confidentiality, to the child or adolescent and caregiver, and inform them of any mandatory reporting requirements, if applicable; • documenting consent with signature or fingerprint.
<p>GP 4</p>	<p>In conducting physical examinations and, where needed, forensic investigations, health-care providers should seek to minimize additional harms including trauma, fear and distress, and respect the autonomy and wishes of children or adolescents.</p> <p>This includes:</p> <ul style="list-style-type: none"> • maximizing efforts to have the child or adolescent undergo only one examination in order to minimize trauma; • communicating directly with the child or adolescent as much as possible • offering information about the implications of positive or negative findings of the physical examination and forensic investigations; • demonstrating trustworthiness by following through on anything told to the child or adolescent or caregiver and providing emotional support; • minimizing delays while conducting the examination in accordance with the child’s or adolescent’s wishes (for example, not rushing them); • during the examination, explaining what will be done, prior to each step; • offering choice in the sex of the examiner, where possible;

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	<ul style="list-style-type: none"> • as is standard practice, making sure that there is another adult present during the examination; • using age-appropriate visual aids and terms to explain the examination procedures; • using examination instruments and positions that minimize physical discomfort and/or psychological distress; • clearly explaining what to expect after the exam and providing instructions for follow-up • collecting forensic evidence in a way that is based on the account of the abuse and on what evidence can be collected, stored and analysed; it should be done with informed consent and assent from the child or adolescent and non-offending caregivers (see GP 3). <p>Health facilities should</p> <ul style="list-style-type: none"> • provide adequate training and on-going support enabling staff to adequately care for children and adolescents who have been maltreated; • ensure access to safe, private, and properly resourced locations for exams. <p>Actions that are medically unnecessary or are likely to increase harm or distress for the child or adolescent and, hence, are not to be undertaken, are as follows:</p> <ul style="list-style-type: none"> • carrying out the so called “virginity test” (also known as the “two-finger test” or per- vaginal exam). It has no scientific validity (i.e. does not provide evidence of whether or not a sexual assault took place), increases distress and harms to those examined and is a violation of their human rights; • speculums or anosopes and digital or bimanual examinations of the vagina or rectum of a pre-pubertal child are not routinely required, unless medically indicated; if a speculum examination is needed, sedation or general anaesthesia should be considered.
GP 5	<p>Health-care providers should accurately and completely document findings of the medical history, physical examination and forensic tests, and any other relevant information, for the purposes of appropriate follow-up and supporting children and adolescents in accessing police and legal services, while at the same time protecting confidentiality and minimizing distress for children or adolescents and their caregivers. This includes the following:</p> <ul style="list-style-type: none"> • using a structured format for recording the findings; • recording verbatim statements of the child or adolescent and the non-offending caregivers, when applicable, for accurate and complete documentation; • noting down discrepancies between the child’s or adolescent’s and the caregivers’ account, if any, without interpretation; • recording a detailed and accurate description of the symptoms and injuries; • where no physical evidence is found, noting that absence of physical evidence does not mean that abuse did not occur; • documenting the child’s or adolescent’s emotional state, while noting that no particular state is indicative of abuse; • seeking informed consent and assent, as appropriate, (see GP 3) for taking any photographs and/or videos, after explaining how they will be used; • handling all collected information confidentially (for example, sharing information only after obtaining permission from the child or adolescent and caregiver and only on a need-to-know basis, in order to provide care; storing the information securely preferably in a password protected file or else in a

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	<p>locked cupboard with access to the key restricted and recorded; anonymizing identifying information; and not disclosing any identifying information about a specific case to those who do not need to know, and especially not to the media);</p> <ul style="list-style-type: none"> • ensuring that documentation would be adequate for the pursuit of justice, even if the child (or caregiver) does not want to pursue prosecution of the perpetrator; • being aware of national laws and guidelines regarding reporting, and document the information that might be reported; • sharing reports with the child or adolescent in appropriate ways.
C. SAFETY AND RISK ASSESSMENT	
GP 6	<p>Promoting and protecting the physical and emotional safety of the child or adolescent must be the primary consideration throughout the course of care. This means that, with the participation from the child and adolescent (and their non-offending caregivers, as appropriate,) health-care providers need to consider all potential harms and take actions that will minimize the negative consequences for the child or adolescent, including the likelihood of the maltreatment continuing. Assessing safety and developing a safety plan for children and non-offending caregivers includes:</p> <ul style="list-style-type: none"> • assessing the child or adolescent’s physical and emotional safety needs; • involving the child and caregivers in safety planning, where safe to do so, prioritizing the physical and emotional wellbeing of the child or adolescent; • considering the risk of recurrence of child maltreatment taking into account whether the perpetrator of sexual or physical abuse has access to the child; whether caregivers are able to protect the child, and whether the child feels safe to return home; • considering that different types of violence, and especially child maltreatment and intimate partner violence, often co-occur in the same household and that spouses, siblings and other members of the household might also be at risk of violence; • involving other relevant agencies, in consultation with the child or adolescent, if the child’s safety is at risk. Information including contact details of relevant agencies should be made available to health care providers. In some settings no legal mechanism may be available to separate children from perpetrators of maltreatment in their current living arrangements or removing the child or adolescent may expose them to an even less safe environment. In such situations careful and frequent follow-up by health workers will be particularly important. • always following up on all referrals; • making a plan for follow-up contact with the child and/or caregivers, including what will happen if the child cannot be reached. <p>If assessment instruments are used to determine risk:</p> <ul style="list-style-type: none"> • be aware of the many factors that influence the risk of recurrence that may not be accounted for by assessment instruments; • treat instruments as a tool to enhance or expand clinical judgement, not as a substitute for clinical judgement.
D. INTERACTING WITH CAREGIVERS	
GP 7	<p>The interaction with caregivers when child maltreatment is suspected is complicated by the fact that the caregiver might be the perpetrator or may have allowed the maltreatment or felt powerless to stop it or may also be victim of</p>

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	<p>violence in the home. Good interaction will influence outcomes for and safety of the child or adolescent. When interacting with caregivers when child maltreatment is suspected, health care providers should therefore:</p> <ul style="list-style-type: none"> • consider that the caregiver might be the perpetrator or, in the case of a non-offending caregiver may have allowed the maltreatment to continue or felt powerless to stop it, and being aware of potential safety concerns for the child; • consider that the caregiver might also be affected by violence in the home; • recognize and address urgent health and safety needs of caregivers; • consider that caregivers may feel significant stress, and that past and current trauma may be affecting the caregiver’s emotional state and behaviour; • establish a rapport with caregivers and encourage their active engagement and participation in the provision of care, whenever safe and appropriate; • treat caregivers with respect, without being confrontational; • avoid blaming or stigmatizing caregivers and identify what they are doing well; • take care not to allow relationships with other family members to interfere with the ability to consider maltreatment; • ensure that the caregivers understand the potential health consequences of the abuse or neglect, the significance and possible side-effects of any interventions, and options and rights in consenting to or refusing treatment for the child or adolescent as well as the limitations of confidentiality and obligations to report. • carefully consider what information can be shared with whom in order to avoid placing the child or non-offending caregiver at risk of further harm.
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E. PSYCHOLOGICAL AND MENTAL HEALTH INTERVENTIONS

		Quality of evidence	Strength of Recommendation
R 5 Existing	Psychological debriefing should not be used in an attempt to reduce the risk of post-traumatic stress, anxiety or depressive symptoms.	Very low	Strong
R 6 Adapted from existing	Cognitive behavioural therapy (CBT) including with a trauma focus may be offered for children and adolescents who have been exposed to maltreatment and are diagnosed with PTSD.	Very low	Conditional
R 7 Adapted from existing	Evidence-based psychological interventions, such as cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT), may be offered to children and adolescents who have been exposed to maltreatment and are experiencing emotional disorders, and caregiver-skills training to their non-offending caregivers.	Low	Conditional
R 8 Adapted from existing	Evidence-based psychological interventions, such as CBT, may be offered to children and adolescents who have been exposed to maltreatment and are experiencing behavioural disorders.	Low	Conditional
R 9 New	Caregiver interventions that promote nurturing caregiver-child relationships, including through improved communication skills and direct coaching of parents while they are interacting with their children, may be considered.	Very low	Conditional

Recommendations and good practice statements			
R10 Adapted from existing	Pharmacological interventions should not be considered in children and adolescents exposed to child maltreatment with anxiety disorders, depressive episodes/disorders or behavioural disorders in non-specialist settings.	Low	Conditional
F. ETHICAL PRINCIPLES AND HUMAN RIGHTS STANDARDS FOR REPORTING CHILD OR ADOLESCENT			
GP 8	<p>Whether healthcare providers have to comply with a legal or policy requirement or are guided by an ethical duty to report known or suspected child or adolescent maltreatment, they should balance the need to take into account the best interests of that child or adolescent and their evolving capacity to make autonomous decisions. These actions include the following:</p> <ul style="list-style-type: none"> • being aware of any legal requirements to report known or suspected child or adolescent maltreatment; • assessing the implications of reporting for the health and safety of that child or adolescent and taking steps to promote their safety; there may be situations in which it may not be in the best interests of the child to report; • at the same time, recognizing and resisting psychological barriers to reporting, such as assumptions made about caregivers based on their demeanour or appearance, as well as close relationships between the health worker and caregivers; • treating all forms of maltreatment as significant while assessing the severity for guiding actions; the safety of the child or adolescent is paramount; • seeking advice from colleagues, supervisors, and/ or external experts when unsure about how to manage child or adolescent maltreatment; • documenting the reporting and maintaining confidentiality of the documented information with extra precautions where the perpetrator is a caregiver who could access the child's or adolescent's file; <p>Health managers and policy-makers should:</p> <ul style="list-style-type: none"> • be aware of any legal requirements to report known or suspected child or adolescent maltreatment. In situations where there are no functioning legal or child welfare/protection systems to act on a report, or where the perpetrator is part of the formal system, the usefulness of mandatory reporting may be reduced. In such situations, health managers may need to balance the need to comply with reporting requirements with considerations of and steps for mitigating potential harms of reporting; • institute clear and systematic protocols taking into account available services, national laws and regulations for managing suspected child or adolescent abuse and neglect; • facilitate health-care providers to receive training, support and supervision on the guiding principles for reporting, and whether, when, to whom and how to report as well as access to child maltreatment experts; • recognize that reporting occurs within a systemic response involving multiple actors and formal and informal systems, and form close collaborations with other agencies or institutions, including the child protection and police services, in order to coordinate an appropriate response. 		

Recommendations and good practice statements			
G. TREATMENT OF PERPETRATORS			
		Quality of evidence	Strength of Recommendation
R11 New	Treatment of perpetrators to prevent recurrence No recommendation can be made because evidence on the effectiveness (or harms) of psychosocial and/or pharmacological intervention for the reduction of recurrence of child maltreatment was not identified.	NA	NA
IMPLEMENTATION CONSIDERATIONS			
A. FACILITATING TIMELY UPTAKE OF SERVICES			
GP 9	<p>Health-care providers, including those working in communities, should facilitate the timely uptake of services by children and adolescents who have experienced maltreatment and are in need of services. This includes:</p> <ul style="list-style-type: none"> • raising public awareness of the signs, symptoms and health consequences of maltreatment, and the need to seek timely care; • collaborating with schools to inform and link children and adolescents to services; • making available comprehensive and integrated care that reduces the need for visiting several places for different aspects of services; • publicizing the availability of services, once services are established and available, through concerted efforts including community-based and media campaigns and outreach activities. Special efforts should be made to reach out to minority, indigenous or marginalized communities who may have less access and who need culturally tailored care; • working with communities, children and adolescents and their families to address the stigma of abuse and of seeking mental health care; and to improve the acceptability of services and trust in health-care providers; • advocating with policy-makers and management to reduce policy-level and practical barriers to accessing care (for example, requiring police reports as a condition for providing medical care and psychological support, or cost-related issues); • strengthening referrals within and between health services and other sector services (for example, police, child protection and legal services) ensuring services are provided in a timely manner (avoiding long gaps between health services and services provided by child protection services etc.); • demonstrating kindness and compassion, consistency, sensitivity, and professionalism and offering practical support to protect the child or adolescent; • building trusting, long-term relationships with families. <p>Health workers should NOT overlook or excuse child maltreatment, such as harsh physical discipline because it is normative in a given setting, but be aware of potential personal bias and be alert and sensitive to culture-specific perceptions of maltreatment.</p> <p>Health facilities should:</p> <ul style="list-style-type: none"> • make waiting rooms and services welcoming and child- and adolescent friendly while showing discreteness, e.g. avoiding labelling such as “child maltreatment room”; 		

Recommendations and good practice statements

- ensure privacy particularly in the emergency room during history taking and examination;
- make information about abuse and neglect, including information on accessing services, easily available in written form in waiting rooms and other areas; set up a child and adolescent helpline and direct counselling and information services to children and adolescents;
- collaborate with the community to develop services that are culturally appropriate, locally accessible and welcoming.

B. CREATING A SUPPORTIVE AND ENABLING SERVICE-DELIVERY ENVIRONMENT FOR HEALTH-CARE PROVIDERS

GP 10	<p>Health managers and policy-makers should create an enabling service-delivery environment and support health-care providers in carrying out their tasks and responsibilities related to caring for children and adolescents who have been exposed to maltreatment. This includes:</p> <ul style="list-style-type: none"> • making available and prioritizing the provision of high-quality care in health-care settings for children and adolescents who have been exposed to maltreatment; • facilitating on-going training, supervision and mentoring: <ul style="list-style-type: none"> ○ emphasis needs to be on general assessment, child- or adolescent-centred first-line support and medical history/interviewing as minimum requirements in low-resource settings; ○ all health-care providers who see children or adolescents need to have skills or competencies in assessing, examining and managing maltreatment in a gender-sensitive and child- or adolescent-friendly manner, and in documentation, including how to interpret examination findings; the exact cadre of health-care providers to be trained will vary depending on the context; ○ training needs to include skills on communication and interaction with families and children and adolescents that are suspected to have been maltreated in order to ensure health provider safety and best outcomes for the child or adolescent (see Good practice statement 7); ○ training needs to address attitudes of health-care providers, including those perpetuating gender inequality, stigmatizing adolescents based on their sexual orientation or gender identity, or blaming the child or adolescent in situations of maltreatment. It also needs to address health-care providers' reluctance to be involved in the care and management of children or adolescents who have been exposed to maltreatment; ○ training needs to address the nature of health-care provider obligations to report child or adolescent maltreatment; ○ ideally, multidisciplinary teams can be trained together, with a clear delineation of roles, responsibilities and expectations; ○ for training to be sustainable, it needs to be integrated into pre-service and in-service curricula for medical, nursing, midwifery and other health providers' education and involve the relevant professional bodies. • addressing needs for adequate staffing, with attention to retention of trained staff, along with adequate infrastructure, supplies and financial resources, including budgets, in order to support provision of services in a timely manner; • supporting health-care providers who provide care for children and adolescents who have been abused or neglected and who are called upon to give evidence in court. It is important to also provide a working environment to prevent
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Recommendations and good practice statements

burnout and support coping with burnout and vicarious trauma. This can be done by making available specialists on physical, sexual and emotional abuse and neglect and medical evaluation, for advice and to reduce professional isolation. In some settings, this kind of professional support has been facilitated online or through peer support, or a helpline for professionals and mobile health (mHealth) approaches;

- enabling health care provider to share and discuss the care plan and care decisions with colleagues and supervisors;
- taking seriously and providing protection and support in response to staff concerns regarding threats of physical violence, retribution, and/or legal action by families suspected of child maltreatment
- strengthening referrals and linkages with other allied services can facilitate a multi-disciplinary and multisectoral approach and improve access to comprehensive care;
- developing protocols or clinical care pathways which can be useful tools or job aids for health-care providers in systematically guiding care provision;
- conducting monitoring and evaluation of care provision, including by providing tools for collection of age-disaggregated data and assessing quality of care from the clients' perspectives, including children & adolescents.

1. Background

A. The magnitude of child and adolescent maltreatment

Maltreatment of children and adolescents is a major global public health problem with hundreds of millions of children and adolescents being affected, a violation of human rights, and has many health consequences in the short and long term. Estimates indicate that nearly a quarter of adults (22.6%) worldwide suffered physical abuse as a child, 36.3% experienced emotional abuse and 16.3% experienced physical neglect, with no significant differences between boys and girls; while the lifetime prevalence rate of childhood sexual abuse indicates more marked differences with a prevalence among girls at around 20% and among boys at around 8% (6).

National surveys of violence against children conducted in Africa reveal rates that are higher than these. Findings from the Violence Against Children Surveys conducted in Kenya, the Republic of Tanzania, Swaziland and Zimbabwe, for instance, indicate that about one in three girls experienced sexual abuse during their childhood. For boys, the reported prevalence of childhood sexual abuse ranged from 9% in Zimbabwe to 18% in Kenya. The reported prevalence of childhood physical abuse was between 53% and 76% in Kenya, the Republic of Tanzania, and Zimbabwe, with somewhat higher rates of childhood physical abuse experienced by boys than girls. The reported prevalence of childhood physical abuse of girls in Swaziland was 22%. The reported prevalence of emotional abuse during childhood for the four countries was between 24% and 38%, with similar rates indicated by boys and girls (7).

A recent systematic review of 38 high-quality studies from 96 countries on past-year prevalence of violence against children found that a minimum of 50% or more of children in Asia, Africa, and Northern America experienced past-year violence, and

that globally over half of all children—1 billion children, ages 2–17 years—experienced such violence (8).

Children with disabilities are a sub-group at particular risk of child maltreatment. A meta-analysis of international studies showed that they were 3.7 times more likely to be victims of any type of violence, 3.6 times more likely to be victims of physical abuse and 2.9 times more likely to be victims of sexual abuse. Children with mental or intellectual disabilities are 3.1, 4.6, and 4.3 times more like to victims of physical violence, sexual violence, and emotional abuse respectively (9).

Globally every year, there are some 41000 homicide deaths of children under 15 years of age. This number underestimates the true extent of the problem, as a significant proportion of deaths due to child maltreatment are incorrectly attributed to falls, burns, drowning and other causes (10).

B. Health consequences of child and adolescent maltreatment

Child maltreatment has serious and often lifelong consequences including for mental and physical health, reproductive health, academic performance, and social functioning (11) (12) (13) (14) (15) (16). Victims of child maltreatment are at higher risk of depression, anxiety, post-traumatic stress disorder and suicidal behaviour throughout their lives (17) (18) (15) (19). Exposure to child maltreatment is strongly associated with high-risk behaviours such as alcohol and drug abuse and smoking, key risk factors for leading causes of death such as cardiovascular disease, cancer, liver disease, and other non-communicable diseases (11) (12). Child maltreatment can affect cognitive and academic performance starting early in childhood and extending into adulthood (16). Child maltreatment can lead, later in adolescence and adulthood, to behavioural and social problems such as violence against peers, delinquency and crime, high-risk sexual behaviour, and increased risk of subsequent re-victimization, and, once a parent, perpetration of child maltreatment (20)(21)(22) (23) (24) (16).

Child maltreatment thus places a heavy strain on health and criminal justice systems and social and welfare services (25). The cost of child maltreatment has been estimated to be US\$ 206 billion in the East Asia and Pacific region, or 1.9% of the region's Gross Domestic Product (GDP) (26), and 3.59 trillion globally, or 4.21% of the world's GDP (27).

C. Use of health services by children and adolescents who have experienced maltreatment

Health care providers often encounter suspected cases of child maltreatment, treat injuries due to child maltreatment, and provide the mental health care to victims of child maltreatment. They are thus in a unique position to address the health and psychosocial needs of children who have experienced maltreatment. Children and adolescents who have experienced maltreatment may come to the attention of a health-care provider through a variety of ways. They may have a routine physical examination or present at emergency departments or general practice for related or

unrelated medical events, or other illness or complaint. Alternatively, they may be brought in by a caregiver, or by someone from an official institution, for a medical evaluation or for the purpose of an investigation.

D. Objectives of and rationale for these guidelines

The aim of these guidelines is to provide evidence-based recommendations for health care providers for quality clinical care for children and adolescents who have, or may have, been experiencing maltreatment, in order to mitigate the negative health consequences and improve their well-being. It responds to an important public health and human rights concern, addresses the gaps in the health response to maltreatment of children and adolescents, and aims to contribute to improved child and adolescent health and mental health.

Specific objectives

The objectives are

1. To provide guidance primarily for front-line health workers but also to specialists and policy makers to provide safe and appropriate, immediate and long-term clinical care and to apply ethical, human-rights-based and trauma-informed good practices in the provision of clinical care.
2. To provide guidance on the identification of, initial response to, and interventions for children and adolescents who have been exposed to maltreatment and on the prevention of recurrence of maltreatment. The guidance on identification and prevention of recurrence of maltreatment will cover all forms of maltreatment, namely physical, sexual, and emotional abuse and neglect. The guidance on initial response and interventions for child maltreatment will not cover sexual abuse, as WHO clinical guidelines on Responding to children and adolescents who have been sexually abused have been published in 2017 and can be accessed here: <http://www.who.int/reproductivehealth/publications/violence/clinical-response-csa/en/>

Why these guidelines were developed

Health care providers often are the first point of contact for children that became victims of child maltreatment. They treat injuries due to child maltreatment and provide the mental health care to victims of child maltreatment. They are thus in a unique position to identify and address the health and psychosocial needs of children who have experienced maltreatment. No international guidelines exist for the health sector response to child maltreatment. Several member states and WHO partners, such as the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), have urged WHO to develop such guidelines. While 20 years ago evidence would have been too scarce to develop such guidelines, considerable evidence has emerged in recent years. The political priority of child maltreatment has been rapidly increasing both within and outside of WHO. In September 2015, the UN General Assembly adopted the Sustainable Development Agenda, which includes a target (16.2) that reads “End abuse, exploitation, trafficking and all forms of violence against

and torture of children”. The 2016 World Health Assembly adopted a Global plan of action to strengthen the role of the health system to address interpersonal violence, in particular against women and children (27.1). This global plan of action explicitly calls for the development of guidelines for the health sector response to child maltreatment. During the course of 2016, the Global Partnership to End violence against children was launched to facilitate and coordinate the response to target 16.2. WHO is co-chairing the partnership and the health sector response to child maltreatment figures prominently in all these initiatives.

E. Target audience

The guidelines are primarily developed for use by frontline health service providers. They include, for instance, nurses, midwives and physicians in primary care settings, teaching hospitals, NGO-led health services, health services organized by faith-based organizations, private clinics, immunization stations, well-baby clinics, school health services, outpatient clinics, and emergency medical departments, general practitioners/family doctors, and psychiatrists and psychologists, where they exist. They also include paraprofessionals, such as nurse assistants and ambulance drivers, who are likely to encounter suspected child maltreatment. The guidelines are intended for health professionals in high-income, low- and middle-income countries including in protracted emergencies or emergency settings, where basic child protection services exist.

F. Scope of the guidelines

The scope of these guidelines includes the following:

- **Population:** all children, including adolescents, between the ages of 0 and 18 years who have, or may have, been maltreated. The guidelines take into account disproportionate vulnerability of children and adolescents who may face discrimination.
Beneficiaries of these recommendations will be children who have been victims of physical, emotional and sexual abuse and neglect who are in contact with health services. These recommendations will also affect non-offending parents and other caregivers of these children in two ways: first, their children will benefit from improved care and, second, some of the recommendations will address response to and treatment of the non-perpetrating parent. The last group affected by these recommendations will be offending parents and caregivers.
- **Interventions:** all relevant interventions for the provision of quality clinical care, including mental health care and immediate/short-term and long-term care. It also covers good practices to minimize harms and trauma in the process of medical history taking, physical examination and documentation, and ethical and safety considerations for reporting to the appropriate authorities. It flags implementation considerations related to the uptake of services, training of health-care providers and creating a supportive or enabling environment to

facilitate provision of care. All of these are framed by ethical and human-rights-based guiding principles.

Recommendations related to responding to sexual abuse of children or adolescents were part of a complementary guidelines published by WHO in 2017 and will be fully integrated in the subsequent publication of these guidelines.

- Outcomes: primary outcomes are related to improved child and adolescent health and well-being, including prevention of long-term disability and improved functioning. Secondary outcomes are related to the uptake of services by children and adolescents who have been exposed to maltreatment and to the well-being of non-offending caregivers.

The scope of these guidelines excludes the following:

- Populations: children and adolescents who have been subjected to female genital mutilation (see WHO Guidelines on the management of health complications from female genital mutilation⁵); human trafficking; and reproductive coercion (e.g. tampering with contraception), commercial sexual exploitation, trafficking and forced marriage.
- Interventions: non-clinical interventions – for example, pertaining to provision of allied care and services for children and adolescents subjected to maltreatment outside of health services (e.g. child protection, legal or social services). These guidelines do not include policy recommendations related to service-delivery models or training approaches.

The general principles that precede the recommendations have been adapted from the existing WHO guidelines *Responding to children and adolescents who have been sexually abused* (WHO, 2017). They are based on human-rights standards and go beyond clinical care. These principles cover aspects of communicating with children suspected to have suffered abuse, of providing safety and of dealing with caregivers, who might be perpetrators of abuse or victims themselves. These principles are equally relevant for all forms of child maltreatment.

The guidelines further include recommendations from the WHO guidelines *Responding to children and adolescents who have been sexually abused* (WHO, 2017). These recommendations have been adapted in consultation with the Guideline Development Group to cover aspects that are specific to physical abuse, emotional abuse and neglect, where needed. Further details are highlighted in each of the recommendations.

Wherever the evidence was insufficient to derive recommendations for children that have been exposed to a particular type of abuse e.g. physical abuse and that are

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https://apps.who.int/iris/bitstream/handle/10665/206437/9789241549646_eng.pdf?sequence=1

diagnosed with a particular mental disorder e.g. depression, the Guideline Development Group decided to draw from mhGAP Guidelines for children.

The recommendations of this report, which cover the health sector response to physical violence, emotional violence and neglect will be integrated with the recommendations of the WHO Guidelines *Responding to children and adolescents who have been sexually abused* into one forthcoming clinical handbook.

2. Methods

These guidelines were developed according to requirements specified in the WHO handbook for guidelines development, second edition (28). The process involved: (i) identification of critical research questions and outcomes; (ii) retrieval of evidence, including commissioning of systematic reviews; (iii) synthesis of the evidence; (iv) quality assessment including by a Guidelines Development Group (GDG); and (v) formulation of recommendations with the GDG and input from peer-reviewers.

A. Guideline contributors

The guidelines development process was guided by three main groups (see Annex 1 for names and designation):

- a) Steering Group comprising a core group of WHO staff members from relevant departments. A methodologist advised the Steering Group in reviewing the protocols and the grading of recommendations, assessment, development and evaluation (GRADE) tables (29) produced by the systematic review teams;
- b) the GDG, comprising external (non-WHO) international stakeholders, including content experts, clinical experts and researchers in the field of child maltreatment, who advised on the scope of the guidelines and assisted in formulating the recommendations.
- c) an External Review Group (ERG) of relevant international stakeholders who peer-reviewed the final document for clarity and accuracy, and advised on contextual issues and implications for implementation.

B. Declaration of interests by external contributors

All GDG members and other external contributors were required to complete a standard WHO declaration-of-interest form before engaging in the guidelines development process, including participating in the guidelines meetings. The WHO steering group reviewed all the declaration-of-interest forms and assessed any conflict of interest, before inviting experts to participate in the development of the guidelines in accordance with the WHO guidelines for declaration of interest (30) and the requirements of the WHO Office of Compliance, Risk Management and Ethics (CRE). In addition, in accordance with the regulations for transparency, short biographies of all the GDG members were posted on the WHO website for 2 weeks before inviting them to participate. None of the meeting participants declared a conflict of interest that was considered sufficiently significant to pose any risk to the guidelines

development process or to reduce its credibility (28). Observers participated in the second GDG meeting when evidence was presented, and recommendations were developed. They provided inputs upon request but were not involved in developing the recommendations. A summary of the declaration-of-interest statements and how conflicts of interest were managed is included in Web Annex 1 . No significant conflicts of interest were identified by the WHO Steering Group that required additional review by the WHO CRE.

C. Identification of priority research questions and outcomes – scoping exercise

During its first meeting in February 2016, the GDG identified the following: population, intervention, comparator, outcome (PICO) questions that need to be addressed:

1. For children (0 to <18) involved in health care encounters (P), does universal screening/routine inquiry (I) result in more children who have been exposed to child maltreatment being accurately identified (O) compared to clinical inquiry/case finding (C)?
2. For children (0 to <18) who have been exposed to child maltreatment (P), does method A for universal screening/routine inquiry (O), compared to method B or no method for universal screening/routine inquiry result in better child well-being and welfare outcomes (O)?
3. For children (0 to <18 years) exposed to child maltreatment and who are at risk of experiencing mental health difficulties (P), does psychosocial intervention A, compared to psychosocial intervention B or no psychosocial intervention (C), result in better child well-being outcomes (O)?
4. For children (0 to <18 years) exposed to child maltreatment and who are at risk of experiencing mental health difficulties (P), does pharmacological intervention A, compared to pharmacological intervention B or no pharmacological intervention or pharmacological intervention B (C), result in better child well-being outcomes (O)?
5. For perpetrators of CM (P), does psychosocial intervention A, compared to psychosocial intervention B or no psychosocial intervention (C), result in a reduction of recurrence of CM (O)?
6. For perpetrators of CM (P), does pharmacological intervention A (I), compared to pharmacological intervention B or no pharmacological intervention (C), result in a reduction of recurrence of CM (O)?

In addition, a series of good practice questions were identified that were considered important to be included in these guidelines including questions that concern ethical, human rights and equity issues, but which do not lend themselves to being formulated in terms of PICO questions and for which it is not feasible to produce evidence from experimental designs.

D. Evidence retrieval

A systematic and comprehensive retrieval of evidence was conducted to identify published studies concerning the PICO questions prioritized through the scoping

exercise. Systematic reviews were identified for three of the PICO questions agreed by the GDG for which new recommendations had to be developed. However, these were older than 2 years prior to the development of these guidelines. Hence, an update of previous systematic reviews was undertaken. The systematic reviews were commissioned to external groups (see [Annex 1](#) for names). Protocols were prepared for each systematic review, including the updates of previous ones. The protocols included the PICO question and the criteria for identification of studies, including search strategies (with support from the WHO librarian), methods for assessing the risk of bias and a plan for data analysis. The Steering Group and the guidelines methodologist reviewed and endorsed the protocols. To identify relevant studies, systematic searches of several electronic databases were conducted, including PubMed, Ovid, Medline, CINAHL (EBSCOhost), Web of Science, SCOPUS, African Index Medicus, LILACS, PsycINFO (EBSCOhost), POPLINE, WHOLIS via LILACS, ERIC (EBSCOhost), NYAM Library, ClinicalTrials.gov and African Journals Online. The search strategies employed to identify the studies, and the specific criteria for inclusion and exclusion of studies, were reported using the preferred reporting items for systematic reviews and meta-analyses (PRISMA) guidelines and flow diagram (31). These are described in the full reports of the individual systematic reviews. For the questions related to the guiding principles and good practices, additional literature reviews were conducted using similar databases to those mentioned above. The full reports of the systematic reviews and the literature reviews for the good practices, including their search strategies, are available as [Web Annexes](#).

E. Quality assessment, synthesis and grading of the evidence

The systematic reviewers performed quality assessments of the body of evidence using, where appropriate, the GRADE methodology (29). Following this approach, the quality of evidence for each outcome was rated as “high”, “moderate”, “low” or “very low”, based on the following set of pre-established criteria: (i) risk of bias, based on the limitations in the study design and execution; (ii) inconsistency of the results; (iii) indirectness; (iv) imprecision; and (v) publication bias (28).

Information to determine risk of bias was extracted from the primary methodology paper for each study and any other related published papers. For each study, one review team member completed the initial ratings which were then verified by a second person; disagreements were resolved through discussion and/or third party consultation when consensus could not be reached. To assign a high or low risk of bias rating for a particular domain team members looked for explicit statements or other clear indications that the relevant methodological procedures were or were not followed. In the absence of such details, a rating of “unclear” was assigned to the applicable risk of bias domains. Individual studies were assessed applying the Cochrane Review manager Risk of Bias tool. This rating tool covers six domains: sequence generation; allocation concealment; blinding of participants, personnel and outcome assessors; incomplete outcome reporting; selective outcome reporting; and other risk of bias.

The strength of evidence is labelled as “indirect evidence”, when no direct evidence was identified for the population of interest or outcome, or there are no studies

directly comparing the intervention and comparator. However, these studies, which were mainly observational studies were also subject to quality assessments based on risk of bias assessment. Therefore, the decision for making the recommendation was derived from indirect comparisons of the intervention and comparator, or the data were extrapolated from other appropriate populations or based on intermediate outcomes. GRADE evidence profile tables (or “summary of findings”) were developed for each priority PICO question for which evidence was available. The GRADE tables include quality assessments based on the above-mentioned criteria for rating each outcome as high, moderate, low or very low. GRADE tables are available as [Web Annexes](#).

F. Formulation of recommendations

Prior to the second GDG meeting (December 2017), the Steering Group formulated an initial draft statement for each priority question, which served as a basis for discussion. During the meeting, the evidence summaries, GRADE tables and draft statements were presented to the GDG. The GDG systematically reviewed and discussed (i) the evidence (contained in GRADE tables – Web Annexes); and (ii) each draft statement, using an established set of criteria (see Box 1) elaborated in evidence-to-decision tables (see [Web Annexes](#)).

Box 1. Factors considered in formulating the recommendations

Values and preferences of children and adolescents who have been maltreated, and of health-care providers
Balance between benefits and harms
Priority of the addressed health problem
Quality of the available evidence
Resource implications
Equity and human rights issues
Acceptability of the proposed intervention
Feasibility of the proposed intervention

Each recommendation contained in these guidelines encompasses a direction (in favour or against) and a rating of the degree of strength (see [Annex 2](#) for the implications of the rating). The following categories were used to establish the rating of the strength of a recommendation (28):

- *strong recommendation* means there is confidence that the desirable effects of adherence to a recommendation outweigh the undesirable effects;
- *conditional recommendation* means that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, but there is not full confidence of that conclusion.

At the meeting of the GDG in December 2017, the final recommendations for or against an intervention and its strength were decided by consensus. For each recommendation, based on iterative discussions, consensus was reached when there

was agreement. No major disagreements occurred that had to be resolved or put to vote.

G. Document preparation and peer-review

Following the second GDG meeting (December 2017), the WHO Steering Group drafted the guidelines containing all the recommendations (new and existing), good practice statements and guiding principles. The full draft of the guidelines was sent electronically to all the GDG members for review, and thereafter to the ERG for peer-review. Peer-reviewers from different WHO regions with expertise in paediatric research or clinical practice, or representing organizations providing services to children and adolescents affected by maltreatment, were selected after reviewing their declarations of interest (see [Annex 1](#) for names). The inputs from the ERG was limited to correcting factual errors, improving language clarity and providing contextual information.

1. Guiding principles derived from ethical principles and human rights standards

Clinical care for children and adolescents who have been exposed to physical, sexual, emotional abuse or neglect should be guided by obligations to protect, prevent and respond to all forms of violence against children and adolescents. These obligations are specified in international human rights standards (for a listing of the relevant instruments, see [Annex 3](#)). Several human rights instruments that many governments have ratified, including the Convention on the Rights of the Child (CRC) (32), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (33) recognize the rights of children and adolescents, as well as the responsibilities of the duty bearers in protecting and promoting these rights. These human rights standards specify the responsibilities of duty bearers (i.e. health-care providers and health-care institutions) to take all appropriate measures to protect the child or adolescent from all forms of violence and abuse. They confer rights to protection,⁶ privacy,⁷ participation⁸ and health,⁹ including access to care and information for children and adolescents. Health-care providers need to be aware of these standards and how they translate in relevant national laws and apply them as guiding principles in providing care to children and adolescents who have been maltreated. The overarching guiding principles derived from the key international human rights standards are listed below.

A. The principle of best interests of the child or adolescent

In practice, this requires that duty bearers take the actions listed below:

- **Protect and promote safety:** promoting and protecting the physical and emotional safety of the child or adolescent must be the primary consideration throughout

⁶ CRC, Articles 19 and 34

⁷ CEDAW Committee, General recommendation no. 24

⁸ CRC, Article 12.

⁹ CRC, Articles 24 and 39.

the course of care. This means that, with the participation from the child and adolescent and their non-offending caregivers, as appropriate depending on the age and the wishes of the child, health-care providers need to consider all potential harms and take or choose actions that will minimize the negative consequences on the child or adolescent, including the likelihood of the maltreatment continuing.

- **Provide sensitive care:** children and adolescents who disclose maltreatment including abuse need to be listened to attentively, without interpreting or judging their account, even when it might differ from that of the accompanying caregivers. Children and adolescents should be offered an empathetic and non-judgemental response that reassures them that they are not to blame for the maltreatment including abuse and that they have acted appropriately in disclosing it.
- **Protect and promote privacy and confidentiality:** protecting privacy during care and confidential handling of all collected information is of particular importance to promoting the safety of the child or adolescent. This means that during consultation and examination, only those who need to be present in the room (also to prioritize the safety and the wellbeing of the child or adolescent) should be allowed. For safety reasons, children and adolescents should be interviewed on their own, separately from the caregiver. Information collected from interviews and examination should be shared on a need-to-know basis and only after obtaining informed consent and assent from the child or adolescent and/or caregivers, as appropriate. Where there are limits to confidentiality, including any obligations to report incidents, these should be explained to children/adolescents and their caregivers at the beginning of care provision. Collected information should be stored securely (e.g. protected by key or password).

B. The principle of evolving capacities of the child or adolescent

The capacity¹⁰ of children and adolescents to understand information about the nature of the clinical care they will receive and its benefits and consequences, and to make voluntary and informed choices or decisions, evolves with their age and developmental stage. The evolving capacities of the child or adolescent will have a bearing on their independent decision-making on health issues. Health-care institutions need to have policies that support the ability of children and adolescents to make decisions on their medical care in accordance with this principle.¹¹ In practice, health-care providers and health-care institutions should consider the actions in the following list:

- **Provide information that is appropriate to age and developmental stage** as well as to other considerations (e.g. sex, race, ethnicity, religion, sexual orientation, gender identity, disability and socioeconomic status). This requires tailoring the information that is offered and how it is delivered (e.g. in choice of words or language, use of visual aids) to the child's or adolescent's age and developmental stage, including their cognitive, behavioural and emotional maturity to understand the information.

¹⁰ Refers to their cognitive, behavioural and emotional maturity and ability.

¹¹ CRC Committee, General comment no. 15, para 21.

- **Seek informed consent and assent as appropriate** to the child’s or adolescent’s age and evolving capacity and the legal age of consent for obtaining clinical care for all decisions and actions to be taken. Where the child or adolescent is below the legal age of consent, it may still be in their best interests to seek informed consent. For example, in some situations, adolescents may be deterred from seeking care where consent is required from their parents or legal guardians. Recognizing this, in some settings, older adolescents are able to provide informed consent in lieu of, or in addition to, their parents or legal guardians. Moreover, the Committee for the Rights of the Child (CRC) recognizes that, in accordance with evolving capacities, children have the right to access confidential counselling or advice and information without the consent of their parents or legal guardians.¹² In situations where it is assessed to be in the best interests of the adolescents who are in need of care, and based on their preferences, health-care providers may consider whether to involve the parents or legal guardians.
- **Respect the autonomy** and wishes of children or adolescents (e.g. not forcing them to give information or be examined) while balancing this with the need to protect their best interests (e.g. protect and promote their safety). In situations where a child’s or adolescent’s wishes cannot be prioritized, the reasons should be explained to the child or adolescent before further steps are taken.
- **Offer choices** in the course of the medical care.

C. The principle of non-discrimination

This principle requires that all children and adolescents should be offered quality care, irrespective of their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status. Health-care providers need to recognize and take into account gender and other social inequalities that can disproportionately increase vulnerabilities to maltreatment and pose barriers in access to services for some groups over others. Therefore, attention should be paid to the specific needs of groups in special or vulnerable situations – for example, adolescent girls from poor communities, children or adolescents with disabilities, adolescents who are part of the lesbian, gay, bisexual, transgender or intersex (LGBTI) communities, or adolescents that are part of ethnic minorities and indigenous groups.

D. The principle of participation

Children and adolescents have a right to participate¹³ in decisions that have implications for their lives, in accordance with their evolving capacities. In practice this means they should be asked what they think and have their opinions respected and taken into account when decisions are being made in relation to clinical care being offered to them. Moreover, young people generally want to be consulted and engaged and to meaningfully participate in the design and delivery of health services that affect them (34).

Interventions with children exposed to abuse and neglect includes assisting the improvement of the child-caregiver relationship (when safe and appropriate!) to

¹² CRC Committee, General comment no. 20, para 39.

¹³ CRC, Article 12, General comment no. 15, para 21 and General comment no. 20, para 39.

restore a sense of safety and trust and providing caregivers with positive parenting, coping, and life-skills essential for healthy family functioning. Thus, engaging caregivers' participation in intervention is critical to the child's healing from the trauma of maltreatment and promoting the child's healthy development and resilience. Being respectful towards caregivers and communicating with empathy, recognizing how their difficult current and past adversities and circumstances may affect their parenting, is essential to building trust and supporting their engagement in the provision of care for their children (35).

4. Recommendations and good practice statements

This section presents recommendations and good practice statements drawing on both the new content developed as part of the guideline development process, as well as existing WHO recommendations and good practice statements that are applicable for the provision of clinical care to children and adolescents who have been victims of neglect, physical, sexual, and/or emotional abuse. Evidence summaries and evidence-to-recommendation justifications are presented only for those recommendations and good practice statements that are new or updated and were developed for consideration by the GDG for these guidelines. For existing WHO recommendations or statements, the reader is directed to the source or the original WHO guidelines for those details. The original rating for quality of evidence and strength of recommendation from the source WHO guidelines are maintained for existing recommendations. Accompanying remarks for existing recommendations are also based on the original source WHO guidelines. However, where relevant, specific remarks have been added. This section has been structured in the order of the flow in which clinical care needs to be offered to children or adolescents who have been maltreated. The guiding principles related to human rights, equity and gender equality are integrated either into the wording of the recommendation or good practice statement and/or reflected in the accompanying remarks.

A. INITIAL IDENTIFICATION

Detecting physical, sexual and/or emotional abuse or neglect is an important aspect of efforts to protect children and adolescents from further maltreatment, as well as for determining which children are in need of interventions to reduce associated harm.

Several strategies and tools are available to assist healthcare providers in identifying children exposed to maltreatment. The two main approaches are screening and case finding: Screening involves administering a standard set of criteria to evaluate for potential child maltreatment in all presenting children (or a subset of children). It is often framed as a way to helping busy healthcare providers recognize the presence of child maltreatment. Case finding, alternatively, requires that providers are alert to the indicators of child maltreatment and, instead of standardized tools or questions, case finding entails providers asking about the child and their potential maltreatment exposure in a way that is tailored to the unique circumstances of the child.

An update to the systematic review by Bailhache et al. (36) was conducted to evaluate strategies and tools for identifying children who have suffered from one or more types of maltreatment and to consider the findings in relation to recommendations

published in the World Health Organization's (WHO) Mental Health Gap Action Programme (mhGAP) update (37).

The update addressed the PICO questions:

a) *"For children (0 to <18) involved in health care encounters (P), does universal screening/routine inquiry (I) result in more children who have been exposed to child maltreatment being accurately identified (O) compared to clinical inquiry/case finding (C)?" and*

b) *"For children (0 to <18) who have been exposed to child maltreatment (P), does method A for universal screening/routine inquiry (O), compared to method B or no method for universal screening/routine inquiry result in better child well-being and welfare outcomes (O)?"*.

Evidence summary

In addition to the 13 studies (38)(39)(40)(41)(42)(43)(44)((45)46)(47)(48)(49)(50). evaluated in the Bailhache et al. review (36), the systematic review identified twelve studies that were mostly from high-income settings (51)(52)(53)(54)(55)(56)(57)(58)(59)(60). Only two studies were from middle-income settings. (61)(62)

Tools and strategies evaluated aimed at identifying a range of types of maltreatment, including one or more types of maltreatment (4 studies), sexual abuse (4 studies), emotional abuse (1 study), child medical abuse (aka Munchausen syndrome by proxy) (1 study), physical abuse (5 studies), and abusive head trauma (10 studies).

While several identification strategies were identified that could be modified into more traditional screening tools, five studies evaluated two screening tools: SPUTOVAMO and Escape. Only one of these studies (63) avoided serious verification bias; the others evaluated only a very small proportion (<3%) of children classified as "not maltreated" by the screening tool with the reference standard, which limits the confidence in the accuracy outcomes by introducing risk of verification bias.

Using a prevalence range of 2% to 10% (which is reported as a common range for emergency room settings where most of the five screening studies took place), the Sittig et al. (63) study suggests that the SPUTAVAMO checklist identifies children exposed to physical abuse with a sensitivity of 100% and specificity of 87% and children exposed to neglect with a sensitivity and specificity of 83% and 87% respectively. Numbers of children falsely identified as being maltreated by this tool range from 12,150 to 13,230 per 100,000 for physical abuse and from 11,970 to 13,034 per 100,000 for neglect; numbers of children missed by this tool are 0 for physical abuse and range from 334 to 1670 per 100,000 for neglect. No evidence was found on how the use of these specific diagnostic tools impact child safety or well-being.

(See [Web Annexes](#) 2a, 2b and 2c for the full report, and evidence-to decision and GRADE table).

From evidence to recommendation

Ideally, screening or case-finding studies would be evaluated in randomized trials in order to assess the impact of identification strategies on long-term outcomes. However, all included studies were cross-sectional diagnostic accuracy studies (five case-control and 20 cohort studies). All individual studies were further downgraded due to very serious risk of bias (to "low quality") and some studies were further

downgraded for imprecision (to “very low quality”). Thus, evidence has to be considered low or very low certainty for accuracy outcomes (for which all studies measured). Due to the lack of direct data for long-term outcomes (e.g. mental health), the evidence is downgraded further for indirectness. The available evidence does not support a recommendation for universal screening. Many children would be falsely identified as being maltreated during universal screening using one of the studied tools and depending on jurisdiction, these children and their families may be subjected to a potentially distressing report, investigation, and child protection response.

In light of these findings, the GDG does not recommend changing the recommendation included in the WHO mhGAP, which suggests that clinicians use a case-finding approach to identify children exposed to maltreatment. Furthermore, the GDG recommends against using a universal screening approach.

R 1: Recommendation 1 (existing) (64) (65)

RECOMMENDATION 1	Quality of evidence	Strength of Recommendation
Health care providers should be alert to the clinical features associated with child maltreatment and associated risk factors and assess for child maltreatment without putting the child at increased risk.	Very low	Conditional

Justification

There is recognition in the child health literature of the importance of determining effective methods for health care providers to identify children at risk of- or currently experiencing - abuse or neglect. There is some uncertainty about the values and preferences, but generally it is agreed that it is important for health care providers to detect child maltreatment to mitigate negative health and social consequences of child maltreatment and to contribute to the prevention of the recurrence of abuse.

Remarks

Inquiry into child maltreatment should occur in the context of case finding and diagnostic assessment by clinicians competent to do so, and should be followed by interventions, referral and/or follow up, where appropriate. Inquiry and following actions should take into account the availability of interventions, such as caregiver skills training, and services. The strategies, including reporting and follow-up of the assessment should be culturally sensitive and should not allow violation of children’s basic human rights according to internationally endorsed principles. The opportunity to refer a child once identified varies depending on the setting, as well as the availability of resources. The evidence profile can be accessed here: http://www.who.int/mental_health/mhgap/evidence/resource/child_q15.pdf?ua=1

R 2: Recommendation 2 (new)

RECOMMENDATION 2	Quality of evidence	Strength of Recommendation
Health care providers should not use a universal screening approach (e.g. a standard instrument, set of criteria, or questions asked of all children in health care encounters) to identify possible of child maltreatment.	Low	Conditional

Justification

There is insufficient evidence to recommend screening for child maltreatment because 1) a number of the tools studied in the review are not suitable for screening, 2) most of the included studies evaluating screening tools suffer from serious verification bias, which decreases confidence in their accuracy values, and 3) the one study evaluating a screening tool that does not suffer from verification bias (63) still has a high number of children who are falsely identified and the tool is not sufficiently accurate in identifying children suffering from all types of maltreatment. None of the studies have evaluated the performance of measures in predicting referrals and health outcomes. Adverse effects of assessments were not evaluated in the studies; however, potential harms include consequences of false negatives (i.e., children identified wrongly as not abused) and of false positives (i.e., children identified wrongly as abused and/or parents identified wrongly as abusers); correct identification without any referral for services and/or lack of effective services; and possible increased risk of harm associated with a perpetrator becoming aware of the identification of maltreatment.

Additional possible adverse effects include psychological distress and increased family conflict and harm associated with a lack of skills in child maltreatment assessment among healthcare providers that can compromise a child's safety following a disclosure of maltreatment. Disclosures may also lead to risk for other siblings and a non-offending parent.

Given the potential harm of identifying false positives it was considered whether the strength of recommendations should be strong. However, given that the quality of evidence is low and considerable research gaps exist, the GDG decided for a conditional recommendation.

Remarks

It is essential for healthcare providers to be aware of the clinical features that should prompt consideration of one or more types of child maltreatment (neglect, physical, sexual and emotional abuse, and fabricated or induced illness).

It is recognised that the assessment of child maltreatment requires a competent health care provider to ask the appropriate questions and to respond safely.

Any intervention must be guided by the principal to “do no harm”, ensuring the balance between benefits and harms, and prioritizing the safety of children and adolescents as the uppermost concern.

Inquiry into child maltreatment should occur in the context of case finding and diagnostic assessment by clinicians competent to do so and should be followed by interventions, referral and/or follow up, where appropriate. Inquiry and following actions should take into account the availability of interventions, such as caregiver skills training, and other services.

Providers need to be aware of and knowledgeable about resources available to which children or adolescents and/or caregivers can be referred.

The strategies, including reporting and follow-up of the assessment should be culturally sensitive and not allow violation of children’s basic human rights according to internationally endorsed principles.

Subgroup considerations

Children or adolescents who have physical or mental disabilities, chronic illnesses or are orphans are at an increased risk of maltreatment. Health-care providers should pay particular attention to their multiple needs.

Equity considerations

The use of any of the studied tools as an assessment tool (as opposed to for screening all children) is also not recommended given their inaccuracy. In addition, their use as diagnostic tools would likely have a disproportionately higher negative effect on children from lower socioeconomic groups because health care providers may suspect maltreatment and apply diagnostic tools more frequently in vulnerable groups identifying disproportionately more false positives.

R 3: Recommendation 3 (adapted from existing) (66)

RECOMMENDATION 3	Quality of evidence	Strength of Recommendation
Health care providers should consider exposure to child maltreatment when assessing children with conditions that may be caused or complicated by maltreatment (see Box 1-6: Examples of clinical conditions associated with maltreatment and alerting features), in order to improve diagnosis/identification and subsequent care, without putting the child at increased risk.	Very low	Strong

Justification

The recommendation is adapted from existing WHO guidelines “Responding to intimate partner violence and sexual violence against women: WHO Clinical and

Policy Guidelines”(66). The GDG agreed that similar considerations apply in the identification of individuals exposed to intimate partner violence and children exposed to maltreatment. Both types of violence are rarely disclosed. For both, victims of intimate partner violence and victims of child maltreatment frontline health workers are often the first point of encounter with any official service. Given that only a fraction of children exposed to maltreatment that are in need of services are identified, health services should make considerable effort in training frontline health workers in the identification and management of child maltreatment. There is the assumption that assessment of child maltreatment by health care providers can lead to referrals (e.g., to child protection agencies) that will ensure cessation of the maltreatment and additional referrals for treatment related to the child maltreatment exposure.

There is high value on identifying children at risk or experiencing abuse or neglect since once child maltreatment is detected, there is the possibility of providing education, social services, parent skills training, child protection measures and treatment to address physical and psychological harms caused to the child.

Remarks

Health care providers need to consider that child maltreatment is often perpetrated by caregivers and the offending caregiver might be present. It is therefore important that health care providers are trained in communicating with caregivers in suspected cases of child maltreatment (see GP 7).

Implementation considerations

Given the complexity of accurately identifying children exposed to maltreatment and the potential negative effect of identifying children falsely as being exposed to maltreatment, health care providers must be trained on the correct way to ask and on how to respond to children and caregivers who disclose violence. Providers need to be aware and knowledgeable about resources available to refer children and adolescents to when asking about violence and neglect.

R 4: Recommendation 4 (adapted from existing) (66)

RECOMMENDATION 4	Quality of evidence	Strength of Recommendation
Written information on child maltreatment should be available in health-care settings in the form of posters, and pamphlets or leaflets (<i>with appropriate warnings about taking them home in case that could compromise safety</i>).	Very low	Conditional

Justification

The recommendation is adapted from existing WHO guidelines “Responding to intimate partner violence and sexual violence against women: WHO Clinical and Policy Guidelines”(66). Child maltreatment is rarely disclosed, and victims of child maltreatment are often not aware of existing services. In many contexts child maltreatment is associated with stigma. Therefore, health care providers should make

efforts in providing information about child maltreatment through alternative communication channels.

Remarks

Written information should contain warnings that it might compromise safety, if a perpetrator finds the information at home. Information materials can be designed in a way that it is not obvious at first sight that they contain information about child maltreatment.

Implementation considerations

Written information can be displayed in waiting rooms, integrated in health promotion events or in washrooms, where they can be assessed in privacy. They should contain information about child maltreatment, address the stigma often associated with child maltreatment and explain what services do exist for those affected by maltreatment and their caregivers. Written information can also be targeted at perpetrators of child maltreatment and provide concise information about positive discipline.

GP1: GOOD PRACTICES STATEMENT 1

Health-care providers should seek explanations for any injuries or symptoms that may be caused by physical, sexual, emotional abuse or neglect from both the parent and the carer, and the child or young person in an open and non-judgemental manner (see Box 1: Examples of clinical conditions associated with maltreatment and alerting features).

Health care providers should

- **Be alert** for an implausible, inadequate or inconsistent explanation for any of the alerting features (see Box 1). All of them can be a sign for child maltreatment however none of them provides sufficient proof for the occurrence of child maltreatment.
- **Consider** child maltreatment when maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis.
- **Suspect** child maltreatment when there is a serious level of concern about the possibility of child maltreatment.
- **Exclude** maltreatment when a suitable explanation is found for alerting features.

Boxes 1-6: Examples of clinical conditions associated with maltreatment

Box 1: Alerting features – Physical abuse

ALERTING FEATURES

Physical abuse

Bruises, lacerations, abrasions or scars

- Multiple bruises or injuries to the skin
- Bruises in a child who is not independently mobile
- Bruises in the shape of an implement used e.g. hand, stick
- Multiple bruises of a similar shape and size
- Bruises on any non-bony part of the body including the cheeks, trunk, eyes, ears and buttocks (*accidental bruises are generally over bony areas on the front of the body e.g. shins, knees*)

Bites

- A human bite mark that is thought unlikely to have been caused by a young child

Burns and scalds

- If the child is not independently mobile or
- Burn anywhere that would not be expected to come into contact with a hot object in an accident (e.g. the buttocks, trunk, upper arms)
- Burns in the shape of an implement (e.g. cigarette, iron) or
- Scalds that indicate forced immersion, e.g.
 - To buttocks, perineum and lower limbs
 - To limbs in a glove or stocking distribution
 - To limbs with symmetrical distribution
 - With sharply delineated borders

Fractures

- If a non-mobile infant has one or more fractures in the absence of a medical condition that predisposes to fragile bones (for example, osteogenesis imperfecta, osteopenia of prematurity)
- If x-ray have been undertaken
 - Occult fractures (fractures identified on X-rays that were not clinically evident) e.g. rib fractures in infants
 - Fractures of different ages, showing different stages of healing

Neurological injury, head injury (intra cranial identified on CT scan or MRI)

- An intracranial injury in the absence of confirmed major accidental trauma or known medical cause.
- If the child is aged under 3 years and there are also:
 - Retinal haemorrhages or
 - Rib or long bone fractures or
 - Other associated inflicted injuries
 - There are multiple subdural haemorrhages with or without subarachnoid haemorrhage with or without hypoxic ischaemic damage (damage due to lack of blood and oxygen supply) to the brain.

Box 2: Alerting features – Other possible clinical presentations

ALERTING FEATURES

Other possible clinical presentations

Apparent life-threatening event (ALTE):

- Combination of apnea (central or obstructive), colour change (cyanotic, pallid, erythematous or plethoric) change in muscle tone (usually diminished), and choking or gagging)

Poisoning

- With prescribed and non-prescribed drugs or household substance (e.g. bleach)

Non-fatal submersion injury

- Near drowning

Fabricated or induced illness (FII)

- Unusual attendance at medical services
- Reported symptoms and signs only appear or reappear and reported when the parent or carer is present
- An inexplicably poor response to prescribed medication or other treatment
- New symptoms are reported as soon as previous ones have resolved
- There is a history of events that is biologically unlikely (e.g. infants with a history of very large blood losses who do not become unwell or anaemic)
- Despite a definitive clinical opinion being reached, multiple opinions from other healthcare agencies are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms
- The child's normal daily activities (for example, school attendance) are being compromised, or the child is using aids to daily living (for example wheelchairs) more than would be expected for any medical condition that the child has.

Box 3: Alerting features – Sexual abuse

ALERTING FEATURES

Sexual abuse

Ano-genital signs and symptoms

- A genital, anal or perianal injury (e.g. bruising, laceration, swelling or abrasion)
- A persistent or recurrent genital or anal symptom (for example, bleeding, dysuria or discharge) that is associated with behavioural or emotional change and that has no medical explanation.
- Foreign bodies in the vagina or anus. (Foreign bodies in the vagina may be indicated by offensive vaginal discharge).

Sexually transmitted infections

- Including symptoms in the mouths or rarely in infected joints (gonorrhoeal septic arthritis).
- Pregnancy in a child or young teen
Sexualised behaviour

Box 4: Alerting features – Emotional abuse

- ALERTING FEATURES**
- Emotional abuse**
- Adverse parent child interactions
 - Negativity or hostility towards the child.
 - Rejection or scapegoating of the child.
 - Developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining.
 - Exposure to frightening or traumatic experiences.
 - Using the child for the fulfilment of the adult's needs (e.g. in marital disputes).
 - Failure to promote the child's appropriate socialisation (e.g. involving children in unlawful activities, isolation, not providing stimulation or education).
 - Parents or carers punish a child for wetting or soiling despite professional advice that the symptom is involuntary
 - Emotional unavailability and unresponsiveness from the parent or carer towards a child or young person and in particular towards an infant.
 - If a parent or carer refuses to allow a child to speak to a healthcare worker on their own when it is necessary for the assessment of the child.

Box 5: Alerting features – Any form of maltreatment may be associated with

- ALERTING FEATURES**
- Emotional, behavioural, interpersonal and social functioning**
- Any form of maltreatment may be associated with**
- Marked change in behaviour or emotional state
 - Recurrent nightmares containing similar themes
 - Extreme distress
 - Markedly oppositional behaviour
 - Withdrawal of communication
 - Withdrawn
- Some of these features may also be seen in a wide range of adolescents for other reasons, including use of drugs.

Box 6: Alerting features – Neglect

- ALERTING FEATURES**
- Neglect**
- Basic needs are not provided (e.g. food, appropriate clothing)
 - Faltering growth because of lack of provision of an adequate or appropriate diet
 - Persistent infestations, such as scabies or head lice.

- Inappropriately explained poor school attendance
- Access to appropriate medical care or treatment not ensured (e.g. failure to immunise)
- Failure to administer recommended treatment or medication
- Malnutrition
- Persistently poor hygiene
- Inappropriate supervision
- Cold injuries
- Abandoned children
- Unsafe living environment
- Lack of supervision; may present as repeated accidental injury

Assessing and planning for child safety when neglect is suspected may be complex. Neglect is less “clear cut” than other forms of maltreatment (72); what constitutes neglect is not clearly defined, particularly for adolescents (85). In responding to neglect, health workers should consider that material poverty may produce conditions that are hard to distinguish from neglect. Health workers should evaluate how caregivers are meeting the child’s needs for food, clothing and shelter, compared to other caregivers in similar circumstances (72).

B. MEDICAL HISTORY, PHYSICAL EXAMINATION AND DOCUMENTATION OF FINDINGS

GP 2: GOOD PRACTICE STATEMENT 2

Before starting to obtain the medical history or forensic interview, any urgent medical and/or safety needs must be addressed.

In line with the principle of “do no harm”, when the medical history is being obtained and, if needed, a forensic interview is being conducted, health care providers should seek to minimize additional trauma and distress for children and adolescents.

This includes the following:

- maximizing the child’s or adolescent’s control and participation in decision-making and not forcing them to speak or answer questions;
- allowing them to choose who is present in the room whenever possible, and when ensuring that they are also interviewed separately from their caregivers, offering to have another person present as support;
- minimizing the need to repeatedly tell their history, as it can be re-traumatizing.
- building trust and rapport by asking about neutral topics first;
- clearly explaining the interview process, including confidentiality and when the health worker might need to share specific information about the child or adolescent and with whom;
- expressing interest in what the child is saying (verbally and non-verbally), affirming the child or adolescent for making the disclosure, and communicating to the child or adolescent that they are believed and not at fault;
- using language and terminology that is appropriate to age, developmental stage and that is non-stigmatizing;

GP 2: GOOD PRACTICE STATEMENT 2

- allowing the child or adolescent to answer questions and describe what happened to them in a manner of their choice, including, for example, by writing, drawing or illustrating with models;
- involving a trained translator or interpreter if necessary, and not relying on caregivers for communication; making available trained interviewers and interpreters of both sexes, in case the child or adolescent expresses a preference;
- asking clear, open-ended questions without repetition; in some settings, while there may be requirements to document some information for reporting the maltreatment, it is important not to insist that the child or adolescent answers or discloses information that may cause them trauma or compromise their safety;
- ensuring that - if forensic interviews are to be conducted - health facilities provide specialized training and structured interview protocols to interviewers, who are experienced in working with children; if a child or adolescent cannot be referred to appropriate services, weigh costs and benefits of forensic interview and whether it is justified given the circumstances. Information about the perpetrator should be gathered by trained investigators for legal purposes;
- conducting a comprehensive assessment of their physical and emotional health, in order to facilitate appropriate decisions for conducting examinations and investigations, assessing injuries and providing treatment and/or referrals;
- conducting the interview in a room that is safe, private, quiet, and child-friendly. Resources should be allocated to furnish the space with child and adolescent-friendly materials and comfortable seating.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question *“What are child and adolescent-friendly, gender-sensitive and trauma-informed principles and practices to obtain medical history and conduct forensic interviewing?”*.

Six pre-identified guidance documents provided comprehensive information that informed the good practice statement (67)(68)(69)(70)(71)(72)(73). This information was supplemented by studies identified by the literature review (74). The WHO Clinical Guidelines for Responding to Children and Adolescents Who Have Been Sexually Abused include a good practice statement on the same topic that has been integrated in the statement above.

The common themes that emerged from these studies were: building rapport; using a supportive and non-judgemental approach; asking clear and open-ended questions while avoiding repetition; using appropriate terms and language; training interpreters if they are used; giving children or adolescents a choice in how to answer the questions during the interview; and providing a child- and adolescent- friendly environment. In addition to these themes, special considerations are required for disabled children, who are more likely to experience all forms of abuse and neglect. For disabled children, signs of abuse or neglect may be “masked” by characteristics of their disability. They may also have many caretakers, which can increase the chance of maltreatment. Children with visual or hearing impairment, learning disabilities, or other disabilities may also pose particular communication challenges.

If appropriate legal and social services for referral are lacking or insufficient, it may not be appropriate to conduct a forensic interview (80).
(See [Web annex](#) for the full report).

GP 3: GOOD PRACTICE STATEMENT 3

Health care providers should seek informed consent for all decisions and actions to be taken as appropriate to the child's or adolescent's age and evolving capacity and the legal age of consent for obtaining clinical care.

Where the child or adolescent is below the legal age of consent, it may still be in the child's and adolescents' best interests to seek informed assent.

Moreover, in accordance with evolving capacities, children and adolescents have the right to access confidential counselling or advice and information without the consent of their parents or legal guardians.

In situations where it is assessed to be in the best interests of the adolescents who are in need of care, and based on their preferences, health-care providers may consider whether to involve the parents or legal guardians.

Seeking informed consent always includes:

- explaining the consent process, including confidentiality, to the child or adolescent and caregiver, as appropriate, and inform them of any mandatory reporting requirements, if applicable;
- documenting consent with signature or fingerprint.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question *“What are best practices for seeking informed consent and assent taking into account the cognitive maturity of the child?”*.

Three pre-identified guidance documents and two expert guidance articles (one from the UK and one from South Africa) identified via the literature reviews informed the best practices identified for question two (71)(72)(67)(75)(76). No primary research articles were found that addressed this question.

Remarks

The question of when a child or adolescent is able to give informed consent is complex and subjective and, in many settings, it ultimately relies on health worker judgment. In some situations, older children or adolescents may be deterred from seeking care where consent is required from their parents or legal guardians. In the context of child maltreatment this becomes of particular importance. It has been argued that children are often more competent to give consent than assumed, and that the onus should be on the health worker to prove that the child is not competent rather than on the child to prove competence (75).

For a child who is deemed not fully capable to give consent, the health worker should attempt to maximize the child's inclusion in the decision-making process through seeking the child's assent (75). Assent empowers children to the extent of their

capabilities and includes gaining the willingness of the child to accept care without deception or coercion (75).

In many situations the parent or legal guardian of an adolescent, who is able to provide informed consent might him- or herself be exposed to maltreatment. In such situations it can help to involve the parent or guardian in further treatment and safety planning.

Subgroup considerations

Hearing-disabled children and adolescents and children and adolescents with cognitive disabilities will likely require additional considerations to ensure effective communication and comprehension during the consent process.

GP 4: GOOD PRACTICE STATEMENT 4

In conducting physical examinations and, where needed, forensic investigations, health-care providers should seek to minimize additional harms including trauma, fear and distress, and respect the autonomy and wishes of children or adolescents. This includes:

- maximizing efforts to have the child or adolescent undergo only one examination in order to minimize trauma;
- communicating directly with the child or adolescent as much as possible
- offering information about the implications of positive or negative findings of the physical examination and forensic investigations;
- demonstrating trustworthiness by following through on anything told to the child or adolescent or caregiver and providing emotional support;
- minimizing delays while conducting the examination in accordance with the child's or adolescent's wishes (for example, not rushing them);
- during the examination, explaining what will be done, prior to each step;
- offering choice in the sex of the examiner, whenever possible;
- as is standard practice, making sure that there is another adult present during the examination;
- using age-appropriate visual aids and terms to explain the examination procedures;
- using examination instruments and positions that minimize physical discomfort and/or psychological distress;
- clearly explaining what to expect after the exam and providing instructions for follow-up
- collecting forensic evidence in a way that is based on the account of the abuse and on what evidence can be collected, stored and analysed; it should be done with informed consent and assent from the child or adolescent and non-offending caregivers, as appropriate (see GP 3).

Health facilities should

- provide adequate training and on-going support enabling staff to adequately care for children and adolescents who have been maltreated;
- ensure access to safe, private, and properly resourced locations for exams.

GP 4: GOOD PRACTICE STATEMENT 4

Actions that are medically unnecessary or are likely to increase harm or distress for the child or adolescent and, hence, are not to be undertaken, are as follows:

- carrying out the so called “virginity test” (also known as the “two-finger test” or per-vaginal exam). It has no scientific validity (i.e. does not provide evidence of whether or not a sexual assault took place), increases distress and harms to those examined and is a violation of their human rights;
- speculums or anosscopes and digital or bimanual examinations of the vagina or rectum of a pre-pubertal child are not routinely required, unless medically indicated; if a speculum examination is needed, sedation or general anaesthesia should be considered and discussed with the child or adolescent.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question “*What are good clinical practices for conducting a physical examination and forensic investigation in supposed of child maltreatment in order to minimize harms/trauma to the child or adolescent who has or may have been exposed to physical abuse or neglect?*”.

Seven of the pre-identified guidance documents informed the good practice statement (71) (72) (70) (68) (67) (69) (78). Two additional expert guidance articles were identified via the literature review that provided perspectives from India and Korea (74)(77). The WHO Clinical Guidelines for Responding to Children and Adolescents Who Have Been Sexually Abused also describe best practices that align closely with those mentioned above (78).

Subgroup considerations

Communicating with disabled children may involve additional challenges and every effort should be made to communicate with them directly even if an interpreter is used, such as through smiling at and communicating non-verbally with a deaf child (72).

Feasibility considerations

Additionally, although well-resourced “one-stop” centres with well-trained staff have been established in some low-income settings, the vast majority of health facilities may lack the means to ensure staff receives such training or to ensure the availability of optimal exam locations (79).

Documentation of medical history findings and forensic examination findings

GP 5: GOOD PRACTICE STATEMENT 5

Health-care providers should accurately and completely document findings of the medical history, physical examination and forensic tests, and any other relevant information, for the purposes of appropriate follow-up and supporting children and adolescents in accessing police and legal services, while at the same time protecting confidentiality and minimizing distress for children or adolescents and their caregivers. This includes the following:

- using a structured format for recording the findings;

GP 5: GOOD PRACTICE STATEMENT 5

- recording verbatim statements of the child or adolescent and the non-offending caregivers, when applicable, for accurate and complete documentation;
- noting down discrepancies between the child's or adolescent's and the caregivers' account, if any, without interpretation;
- recording a detailed and accurate description of the symptoms and injuries;
- where no physical evidence is found, noting that absence of physical evidence does not mean that abuse did not occur;
- documenting the child's or adolescent's emotional state, while noting that no particular state is indicative of abuse;
- seeking informed consent (see also GP 3), as appropriate, for taking any photographs and/or videos, after explaining how they will be used;
- handling all collected information confidentially (for example, sharing information only after obtaining permission from the child or adolescent and caregiver and only on a need-to-know basis, in order to provide care; storing the information securely preferably in a password protected file or else in a locked cupboard with access to the key restricted and recorded; anonymizing identifying information; and not disclosing any identifying information about a specific case to those who do not need to know, and especially not to the media);
- gathering documentation that would be adequate for the pursuit of justice, even if the child (or caregiver) does not want to pursue prosecution of the perpetrator;
- being aware of national laws and guidelines regarding reporting, and document the information that might be reported;
- sharing reports with the child or adolescent in appropriate ways.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question *“What are the good practices for documentation of the medical history, physical and forensic examination findings?”*.

Seven of the pre-identified guidance documents informed the best practices for this question (67)(68)(69)(70)(71)(72)(80). One expert guidance article from India (74) and one primary research article from the United States (81) also provided information relevant to this question.

Feasibility considerations

Policies governing response to child maltreatment differ across countries and can generally be classified as either a child and family welfare approach or a child safety approach (82). Depending upon the approach taken, laws and protocols regarding documentation will differ substantially.

C. SAFETY AND RISK ASSESSMENT

GP 6: GOOD PRACTICE STATEMENT 6

Promoting and protecting the physical and emotional safety of the child or adolescent must be the primary consideration throughout the course of care. This means that, with the participation from the child and adolescent (and their non-offending caregivers, as appropriate), health-care providers need to consider all potential harms

GP 6: GOOD PRACTICE STATEMENT 6

and take actions that will minimize the negative consequences for the child or adolescent, including the likelihood of the maltreatment continuing.

Assessing safety and developing a safety plan for children and non-offending caregivers includes:

- assessing the child or adolescent’s physical and emotional safety needs;
- involving the child and caregivers in safety planning, where safe to do so, prioritizing the physical and emotional wellbeing of the child or adolescent;
- considering the risk of recurrence of child maltreatment taking into account whether the perpetrator has access to the child; whether caregivers are able to protect the child, and whether the child feels safe to return home;
- considering that different types of violence, and especially intimate partner violence, often co-occur in the same household and that spouses, siblings and other members of the household might also be at risk of violence;
- **involving other relevant agencies, in consultation with the child or adolescent, if the child’s safety is at risk. Information including contact details of relevant agencies should be made available to health care providers. In some settings no legal mechanism may be available to separate children from perpetrators of maltreatment in their current living arrangements or removing the child or adolescent may expose them to an even less safe environment. In such situations careful and frequent follow-up by health workers will be particularly important.**
- **always following up on all referrals;**
- making a plan for follow-up contact with the child and/or caregivers, including what will happen if the child cannot be reached.

If assessment instruments are used to determine risk:

- be aware of the many factors that influence the risk of recurrence that may not be accounted for by assessment instruments;
- treat instruments as a tool to enhance or expand clinical judgement, not as a substitute for clinical judgement.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question “*What are best practices in assessing the safety of and developing a safety plan for children and their non-offending caregivers when child maltreatment is suspected?*”.

Eight articles were identified via a literature review that informed the good practice statement in addition to information from six of the pre-identified guidance documents. (70)(71)(72)(69)(85)(83). Almost all research was carried out in high-income settings, Oman (84), UK (85), Hong Kong (86), Japan (87), US (88.1)(88.2), and the UK (89); only one study was from a middle-income setting, namely India (74).

In addition, a systematic review of the literature was conducted to answer the question: “*What instruments to assess the risk of recurrence of child maltreatment do exist and what considerations for their use by frontline health workers should be made?*”.

Three pre-identified guidance documents (70)(71) (72) and two articles identified via the literature review (one an expert guidance article and one a literature review) informed the development of the list of instruments and considerations for their use (83)(90). No low and middle-income country (LMIC) literature was found. Additionally, no instruments were identified which specifically assess risk of recurrence of child maltreatment. A number of instruments were identified which assess future risk of various forms of child abuse and neglect, and so could be used to assess risk of recurrence of child maltreatment. Of all types of maltreatment, neglect and emotional abuse are the most likely to recur or persist, and the following risk factors have been identified for recurring or persistent child abuse and neglect (72). These risk factors could be used as criteria for assessing recurrence of maltreatment

- The parent or carer does not engage with services;
- There has been more than one previous episode of abuse or neglect;
- The parent or carer has a mental health or substance misuse problem;
- There is chronic parental stress;
- The parent or carer experienced abuse or neglect as a child.

Feasibility considerations

Safety planning involves difficult decisions and requires distinguishing between a “child in need” and a “child in need of protection”, meaning that not every child in need is in need of an intervention or protection. Conversely, health workers may fail to recognize the need for protection (91). Health workers must also evaluate the presence and severity of different types of maltreatment, including being alert to the presence of other types of neglect or abuse beyond the ones initially recognized.

Whereas inter-agency cooperation in safety planning is always advised when possible, the exact protocol for safety planning and protection of maltreated children and adolescents will vary according to the approach taken by national and/or regional child maltreatment response systems (92). It will also vary according to the social, legal, and police services available, and the quality of those services. In many low-resource settings such services may not be sufficient for an effective response (79)(93). In some settings there may be no legal mechanism for removing children from their family, even if deemed unsafe for them to remain in their current living arrangements; in such situations careful follow-up by health workers may be particularly important (94). In some instances this might include hospitalization for very short periods of time.

The child or adolescent (and caregiver(s), if appropriate), should be involved in safety planning as much as possible, and health workers must use their judgment to decide when a child is developmentally able to participate (see GP 3 and guiding principles).

Subgroup considerations

Disabled children have special needs are at greater risk of recurrent or persistent abuse and neglect, and a specialist with expertise regarding the child’s impairment should be involved in safety planning if at all possible.

D. INTERACTING WITH CAREGIVERS

Intervention with children exposed to abuse and neglect includes repairing the child-caregiver relationship (when safe and appropriate) to restore a sense of safety and

trust and providing caregivers with positive parenting, coping, and life-skills essential for healthy family functioning. Thus, engaging caregivers' participation in intervention is critical to the child's healing from the trauma of maltreatment and promoting the child's healthy development and resilience. Being respectful towards caregivers and communicating with empathy, recognizing how their difficult current and past adversities and circumstances affect their parenting, is essential to building trust and supporting their engagement in the provision of care for their children. (35)

GP 7: GOOD PRACTICE STATEMENT 7

The interaction with caregivers when child maltreatment is suspected is complicated by the fact that the caregiver might be the perpetrator or may have allowed the abuse or felt powerless to stop it or may also be victim of violence in the home. Good interaction will in any case influence outcomes for and safety of the child or adolescent. When interacting with caregivers when child maltreatment is suspected health care providers should therefore:

- consider that the caregiver might be the perpetrator or, in the case of a non-offending caregiver may have allowed the maltreatment to continue or felt powerless to stop it, and being aware of potential safety concerns for the child;
- consider that the caregiver might also be affected by violence in the home;
- recognize and address urgent health and safety needs of caregivers;
- consider that caregivers may feel significant stress, and that past and current trauma may be affecting the caregiver's emotional state and behaviour;
- establish a rapport with caregivers and encourage their active engagement and participation in the provision of care, whenever safe and appropriate;
- treat caregivers with respect, without being confrontational;
- avoid blaming or stigmatizing caregivers and identify what they are doing well;
- take care not to allow relationships with other family members to interfere with the ability to consider maltreatment;
- ensure that the caregivers understand the potential health consequences of the abuse or neglect, the significance and possible side-effects of any interventions, and options and rights in consenting to or refusing treatment for the child or adolescent as well as the limitations of confidentiality and obligations to report.
- carefully consider what information can be shared with whom in order to avoid placing the child or non-offending caregiver at risk of further harm.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question: *“What are best practices for interacting with caregivers when child maltreatment is suspected, taking into account that caregivers might be perpetrators of abuse or might be aware of the abuse?”*.

Three pre-identified guidance documents and six articles identified via literature review informed the good practice statement. Of the article from the literature review, two were expert guidance articles from India (74) and Korea (77). The other four were primary research articles from Jordan (1), Brazil (1), Hong Kong (1), and the UK (1).

Feasibility considerations

In small and tightly knit communities, confidentiality may be quite difficult to achieve. Disclosure of child maltreatment may be of particular concern to caregivers and children or adolescents due to potential stigma. Health workers should recognize that even when professional standards of confidentiality are met, caregivers may feel that discussion of abuse or neglect is a “public event”(72).

E. PSYCHOLOGICAL AND MENTAL HEALTH INTERVENTIONS

Children and adolescents exposed to child maltreatment are at increased risk for mental health problems. These include internalizing conditions (such as depression, anxiety and post-traumatic stress disorder (PTSD)), externalizing conditions (such as antisocial behaviour and substance abuse) and suicidal behaviour. There is also increased risk of developmental problems (e.g. low academic achievement) and relationship problems (e.g. getting along with their peers)(95) (96) (97) (98) (99).

Evidence summary

A systematic review was conducted to answer the following PICO questions:

- For children (0 to <18 years) exposed to CM and who are at risk of experiencing mental health difficulties (P), does psychosocial intervention A, compared to psychosocial intervention B or no psychosocial intervention (C), result in better child well-being outcomes (O)?
- For children (0 to <18 years) exposed to CM and who are at risk of experiencing mental health difficulties (P), does pharmacological intervention A, compared to pharmacological intervention B or no pharmacological intervention or pharmacological intervention B (C), result in better child well-being outcomes (O)?

Due to the fact that a previous WHO GDG group had already evaluated the effectiveness of psychosocial interventions for children exposed to sexual abuse, only interventions that address children’s exposures to physical abuse, emotional abuse, and neglect were reviewed. Thirty-six articles representing 29 randomized controlled trials were included. The relevant studies are listed in the full report; see Webannex 4.

A variety of psychosocial interventions and their effects on depression, PTSD, caregiver-child interactions, internalizing symptoms, child subjective well-being, anxiety and externalizing symptoms were reviewed.¹⁴

These included:

1) Counselling/therapy interventions, 2) parenting interventions delivered in a) a clinic or community setting or b) a home setting (often referred to as home visiting interventions) and 3) child-focused skill development interventions.

No studies on pharmacological interventions were found.

1) Counselling/therapy interventions. There is little evidence for the effectiveness of counselling/therapy interventions for children exposed to maltreatment.

¹⁴ Note that these categories are not always mutually excluding and some overlap may exist.

There is very low certainty that pre-schooler-parent psychotherapy (PPT) may enable an increase in positive parent-child interaction for children exposed to maltreatment (physical abuse, neglect, emotional abuse). There are mixed results regarding counselling/therapy interventions for children exposed to physical abuse and neglect, in that interventions a) seem to reduce some mental health symptoms but not others or b) do not reduce mental health symptoms at all. There is very low certainty that individual parent and child CBT may enable small benefits in recurrence rates and may enable small reductions in internalizing and externalizing symptoms.

2a) Parenting interventions, clinic or community setting. There is very limited evidence of the effectiveness of parenting interventions delivered in a clinic- or community setting, with the exception of Parent-Child Interaction Therapy (PCIT) for physical abuse and neglect. For PCIT, there is moderate certainty evidence that it enables small benefits in reducing internalizing and externalizing symptoms at post-treatment, and low certainty evidence that it results in small reductions in recurrence rates and small to large increases in positive parent-child interaction.

2b) Parenting interventions, home-based. For parenting interventions delivered in a home setting, there is moderate certainty evidence that SafeCare¹⁵ enables small reductions in recurrence rates for preschool children exposed to maltreatment, and very low certainty evidence that multisystemic therapy may enable small reductions in recurrence for children (ages 10-17) exposed to physical abuse. Other than this, evidence for the effectiveness of parenting interventions delivered in a home setting for children exposed to maltreatment is limited and conflicting, especially showing limited benefits to mental health symptoms.

3) Child-focused skill development. There is very low certainty evidence that child-focused skill development interventions may enable reductions in internalizing and externalizing symptoms and behaviour problems at post-treatment.

Most of the evidence was graded low certainty, due to serious risk of bias and very serious concerns for impression. Only one large trial (SafeCare) and some aspects of PCIT¹⁶ were rated as moderate certainty evidence.

The GDG decided to downgrade the overall quality of evidence to very low given that the applicability and feasibility in LMIC settings is not known and the evidence indirect.

¹⁵ SafeCare is a manualized, home-based structured behavioural skills training model that addressed parent/child interactions, home safety, and child health. SafeCare can be a freestanding intervention or used as a component in another home-based parenting intervention.

¹⁶ PCIT was originally developed to improve parenting skills and parent-child interactions among families struggling with their children's (aged 3-7) behavioural problems (e.g. oppositional defiant disorder). PCIT has two sequential phases known as child-directed interaction and parent-directed interaction. Each phase teaches parents communication skills that foster positive parent-child relationships. PCIT skills are taught via didactic presentations to parents and direct coaching of parents while they are interacting with their children. Coaching of parents involves PCIT therapists' observing from a room with a one-way mirror into the playroom, and communicating with parents as they play with the child often using a "bug-in-the-ear" system.

(See WebAnnexes 4, 4a and 4b for the full report, and evidence-to decision and GRADE table).

Overall remarks for mental health recommendations:

The safety of the child or adolescent must always be the primary concern in all assessments and referrals for treatment. Providers of psychological interventions should be aware of the potential risks for children or adolescents and include on-going assessment of whether maltreatment is continuing or recurring as part of their overall treatment.

When safe and appropriate to do so, all sensible efforts should be made to involve the caregivers in interventions that promote safe, stable and nurturing relationships with their children. Health-care providers should assess the safety implications of the treatment/care they provide and take actions to minimize the risk of harms.

A holistic approach to the child or adolescent should be taken in promoting safety and wellbeing at the school and home and the community at large rather than a narrow focus on therapy given that maltreatment is an exposure rather than a condition or disorder.

The choice of psychological intervention and how it is implemented should be based on the type of emotional and/or behavioural problem(s) and the age and developmental stage of the child or adolescent. The content should be culturally sensitive and should not allow violation of the child or adolescent's basic human rights according to internationally endorsed principles.

Limited evidence suggests that the interventions may be acceptable to healthcare providers, but young people receiving the intervention may be concerned with stigma. It also suggests that in different cultural contexts there may be reluctance on the part of caregivers to allow their children to receive interventions; and to change culturally accepted parenting skills.

Health care providers can play an important role in addressing stigma and therefore removing barriers to access mental health services. The main sources of stigma in mental health care are negative attitudes and behaviours, lack of skills, the believe that nothing can be done about a condition. Skills-based interventions, and intensive social contact interventions for health care providers have shown promise in reducing stigma associated with mental disorders (145).

Minimum requirements for delivering psychological interventions include the need for thorough training and on-going supportive supervision of personnel, particularly for non-specialized providers.

Where a trained provider is not immediately available, children and adolescents should be referred to such provider after the assessment.

No economic evaluations of counseling/therapy interventions provided for children who have experienced physical abuse, neglect, or emotional abuse were found. The Global Mental Health initiative estimates that essential mental health services can be provided at an additional cost of US\$ 2 per person per year in low-income countries and US\$ 3-4 in lower middle-income countries.

R 5: Recommendation 5 (*existing, updated for remarks*) (100)

For exposure to a recent traumatic event that produces stress-related symptoms, WHO does not recommend psychological debriefing.¹⁷ This is also applicable to children and adolescents who have been exposed to maltreatment.

RECOMMENDATION 5	Quality of evidence	Strength of Recommendation
Psychological debriefing should not be used in an attempt to reduce the risk of post-traumatic stress, anxiety or depressive symptoms.	Very low	Strong

Justification

There is low quality evidence suggesting there is unlikely to be a clinically important difference between psychological debriefing and no intervention on preventing PTSD symptoms 1-4 months post intervention (100). Similarly, there is very low quality evidence suggesting there is unlikely to be a clinically important difference between psychological debriefing and no intervention on preventing depression symptoms 1-4 months post intervention (100). There is very low quality evidence for a small effect favouring control over psychological debriefing on preventing PTSD symptoms and depression symptoms at follow-up (+ 6 months) (100).

Despite the lack of effects in preventing mental health problems there is some evidence that recipients of psychological debriefing value the intervention (Adler et al, 2008).

Despite the case for not using it, it likely has to be substituted for another intervention (such as psychological first aid) since survivors seek help and services are motivated to grant it .

The evidence profile is available here:

https://www.who.int/mental_health/mhgap/evidence/resource/other_complaints_q5.pdf).

Remarks

Not all individuals with mental health problems need or wish to undergo therapeutic interventions. Informed consent and assent should be obtained of the child and the non-offending caregiver, as appropriate.

¹⁷ This involves a single debriefing session after exposure to the traumatic event, either individually or in a group, to help to process the trauma by recollecting the event and sharing their emotions with a counsellor or therapist in a structured way.

Psychosocial support should be provided to promote well-being and functioning, involving psycho-education, support for managing and coping with stress, and promoting daily functioning as they recover from their traumatic experience over time.

For detailed guidance on how to do this, see the section in the mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0 (2016) (101).¹⁸

R 6: Recommendation 6 (*adapted from existing*)

RECOMMENDATION 6	Quality of evidence	Strength of Recommendation
Cognitive behavioural therapy (CBT) including with a trauma focus may be offered for children and adolescents who have been exposed to maltreatment and are diagnosed with PTSD.	Very low	Conditional

Justification

- While there is evidence that CBT interventions with a trauma focus can be beneficial for children and adolescents who have been exposed to sexual abuse and have symptoms of PTSD, which is reflected in the Recommendation 11 WHO clinical guidelines “Responding to children and adolescents who have been sexually abused”, only three studies compared therapeutic interventions for children that have been exposed to the other forms of child maltreatment, physical abuse, emotional abuse and neglect. In addition to the evidence from the three studies, which favour CBT-based interventions, the recommendation from the abovementioned guidelines and the general mhGAP recommendations for children with PTSD were taken into account for the recommendation.
- For children and adolescents who have been sexually abused and are experiencing symptoms of PTSD, the WHO recommendation is: “Cognitive behavioural therapy (CBT) with a trauma focus should be considered for children and adolescents who have been sexually abused and are experiencing symptoms of PTSD.”(Recommendation 11 WHO clinical guidelines “Responding to children and adolescents who have been sexually abused”).
- The wording of the recommendation was adapted to “CBT including with a trauma focus” to reflect that CBT should also be considered, even if staff trained in trauma-informed approaches is not available.
- There is evidence that children with PTSD irrespective of what caused PTSD benefit from individual or group cognitive-behavioural therapy (CBT) with a trauma focus or eye movement desensitization and reprocessing (EMDR). The GDG felt however that in the context of child maltreatment therapeutic interventions that are administered in a group setting might not be appropriate for children that suffered maltreatment.

¹⁸ Sections on essential care and practice, page 12 and psychosocial interventions for child and adolescent mental disorders, pages 87–89.

- Considering benefits vs harms, the GDG agreed that benefits clearly outweigh potential harms of therapeutic interventions, which mainly concern costs of accessing treatment, the time spent during the intervention. The psychosocial intervention can have secondary positive effects on the general wellbeing of the child or adolescent that suffered maltreatment, his or her parents.

Remarks

- Not all individuals with mental health problems need or wish to undergo therapeutic interventions. Informed consent and assent should be obtained of the child and the non-offending caregiver, as appropriate.
- The safety of the child or adolescent who has been abused is to be prioritized. Those providing psychosocial interventions should be aware of the potential risks for children or adolescents. Health care providers should assess the safety implications of the care they provide, taking into account that the offending caregiver might be present or still has access to the child and take actions to minimize the risk of harms.
- The therapeutic intervention should not be applied on the basis of exposure to child maltreatment only. Children and adolescents should have an assessment by someone who is qualified to assess whether they have PTSD or symptoms of PTSD.

R 7: Recommendation 7 (adapted from existing) (101)

RECOMMENDATION 7	Quality of evidence	Strength of Recommendation
Evidence-based psychological interventions, such as cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT), may be offered to children and adolescents who have been exposed to maltreatment and are experiencing emotional disorders, and caregiver-skills training to their non-offending caregivers.	Low	Conditional

Justification

- Overall only 25 RCTs worldwide evaluated the impact of psychosocial interventions on children exposed to child maltreatment. Only 5 studies focused on clinic-based therapeutic interventions and their impact on emotional disorders and/or internalizing symptoms. We do have very low certainty that individual parent and child cognitive behavioural therapy may enable small benefits in recurrence rates and may enable small reductions in internalizing and externalizing symptoms. For parent-child interaction therapy (PCIT), we have moderate certainty evidence that it enables small benefits to internalizing and externalizing symptoms at post-treatment, and low certainty evidence that it enables small reductions in recurrence rates and small to large increases in positive parent-child interaction. The latter is described in [Recommendation 9](#).

- In addition to the research summarized here, there is a large body of research for children and adolescents experiencing emotional disorders, irrespective of exposure to child maltreatment, which the GDG felt important to consider. The recommendation is adapted from the existing recommendations of the WHO Clinical Guidelines “Responding to children and adolescents who have been sexually abused” which reads: “Psychological interventions, such as CBT, may be offered to children and adolescents with emotional disorders, and caregiver skills training to their non-offending caregivers.” and a WHO recommendation in mhGAP (updated 2015) that reads: “Psychological interventions, such as cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) for children and adolescents with emotional disorders, and caregiver skills training focused on their caregivers, may be offered for the treatment of emotional disorders.

Remarks

- Not all individuals with mental health problems need or wish to undergo therapeutic interventions. Informed consent and assent should be obtained of the child and the non-offending caregiver, as appropriate.
- The choice of psychological or behavioural intervention and how it is implemented should be based on the type of emotional disorder respectively, and on the age and developmental stage of the child or adolescent.
- To assess other mental disorders including risk of suicide, self-harm, depression, alcohol and drug-use problems and their management, follow the mhGAP intervention guide for mental neurological and substance use disorders in non-specialized health settings (102).
- If it is safe and appropriate to do so, it might be considered to extend caregiver skills training to all caregivers to prevent recurrence of abuse.

R 8: Recommendation 8 *(adapted from existing)*

RECOMMENDATION 8	Quality of evidence	Strength of Recommendation
Evidence-based psychological interventions, such as CBT, may be offered to children and adolescents who have been exposed to maltreatment and are experiencing behavioural disorders.	Low	Conditional

Justification

- For children exposed to physical abuse and neglect, we have very low certainty that individual parent and child cognitive behavioural therapy may enable small benefits in recurrence rates and may enable small reductions in externalizing symptoms and behavioural disorders.
- Overall only 12 studies measured the effect of psychological interventions for children that suffered maltreatment and are experiencing behavioural disorders. Some of these studies have very low numbers of participants.
- The GDG considered that it would not be justified to draw the recommendation only based on this limited number of studies, and therefore suggested to take into account the existing much broader literature on evidence-based interventions for children that are experiencing behavioural disorders, irrespective of whether they have been exposed to child maltreatment or not and the literature.

- Therefore, the existing recommendation is adapted from the existing recommendation in mhGAP (updated 2015) which reads: “Behavioural interventions for children and adolescents, and caregiver skills training, may be offered for the treatment of behavioural disorders. As the involvement of caregivers in the cases of child maltreatment is often a point of concern, the suggestion to involve caregivers has been omitted from this recommendation. It is dealt with in the section focusing on the involvement of caregivers.
- The above recommendation integrates well with the recommendation in the WHO Clinical Guidelines “Responding to children and adolescents who have been sexually abused” which reads: Psychological interventions, such as CBT, may be offered to children and adolescents with behavioural disorders, and caregiver skills training to their non-offending caregivers.”
- Considering benefits vs harms, the GDG agreed that benefits clearly outweigh potential harms of therapeutic interventions, which mainly concern costs of accessing treatment, the time spent during the intervention. The psychosocial intervention can have secondary positive effects on the general wellbeing of the child or adolescent that suffered maltreatment.

Remarks

- Behavioural disorders refer to a set of conditions that are characterized by hyperkinetic activity and/or persistent and repetitive instances of dissocial, aggressive or defiant conduct.
- The choice of psychological interventions should be based on the mental disorder not on the exposure to child maltreatment.

Equity and human rights considerations for psychological and mental health interventions

Access to psychological interventions may be challenging in LMICs and rural areas where there is limited availability of skilled healthcare providers or trained specialists; where physical access to facilities is limited; where costs are prohibitive; and for families who may have to take time off from work to attend or take their children to sessions. Access may similarly be limited for Indigenous groups, children or adolescents with disabilities and other minority groups. They are less likely to seek services and may face additional barriers. Therefore, extra effort may be needed to reach out and improve access for all of these groups.

R 9: Recommendation 9 (new)

RECOMMENDATION 9	Quality of evidence	Strength of Recommendation
Caregiver interventions that promote nurturing caregiver-child relationships, including through improved communication skills and direct coaching of parents while they are interacting with their children, may be considered.	Very low	Conditional

Justification

- There is limited evidence in the effectiveness of parenting interventions delivered in a clinic- or community setting for the improvement of child wellbeing, with the exception of parent-child interaction therapy (PCIT) for physical abuse and neglect. For parenting interventions delivered in a home setting, we have moderate certainty evidence that SafeCare enables small reductions in recurrence rates for preschool children exposed to maltreatment.
- There is a separate body of research on parenting interventions for the primary prevention of child maltreatment, which is not within the scope of this guidelines but well-documented in other WHO evidence summaries (WHO 2017).
- For parent-child interaction therapy, there is moderate certainty evidence that it results in small benefits in internalizing and externalizing symptoms at post-treatment, and low certainty evidence that it leads to small reductions in recurrence rates and small to large increases in positive parent-child interaction.
- Using health care settings to promote positive parenting interventions can have additional positive effects on child health and development, cognitive and emotional development of children. While the benefits are clear, based on our current knowledge, there are no known harms of this intervention.

Remarks

- PCIT is a behavioural intervention originally developed to improve parenting skills and parent-child interactions among families struggling with their children's (aged 3–7) behaviour problems (e.g. oppositional defiant disorder). PCIT teaches parents communication skills that foster positive parent-child interactions which, in turn, promotes more positive parent-child relationships. PCIT skills are taught via didactic presentations to parents and direct coaching of parents while they are interacting with their children. Coaching of parents typically involves PCIT therapists' observing from a room with a one-way mirror into the playroom and communicating with parents as they play with the child using a "bug-in-the-ear" system, which may make implementation in many setting challenging.
- While it might not be feasible in many settings to implement PCIT due to a lack of technical equipment, the GDG felt it was important to use healthcare encounters to promote nurturing relationships between the caregiver and the child.

Subgroup considerations

The choice of psychological intervention should be based on the age and developmental stage of the child or adolescent. For very young children, especially children birth to three years, relationship-based intervention (when safe and appropriate) that focuses on strengthening the caregivers' capacity for providing predictably nurturing and responsive care to promote a healthy child-caregiver attachment relationship is critical. Relational approaches that support parents' insight into their neglecting or abusive behaviour, focus on improving the parent-child relationship as the vehicle for restoring the very young child's sense of safety and basic trust. This, in turn, lays a strong foundation for healthy development, learning, and behaviour and positive outcomes across the life course.

Access may similarly be limited for Indigenous groups, children or adolescents with disabilities and other minority groups. Therefore, extra effort may be needed to reach out and improve access for these groups.

Implementation considerations

Those providing psychological interventions should be aware of the potential risks for children or adolescents and include on-going assessment of whether maltreatment is continuing or recurring as part of their overall treatment.

Minimum requirements for delivering the intervention include the need for thorough training and on-going supportive supervision of personnel, particularly for non-specialized providers.

Where a trained provider is not available, children and adolescents should be referred.

Feasibility considerations

No feasibility information is available about interventions that use observation and direct coaching of parents while they are interacting with their child as the evidence comes from high-income settings. Access to these particular interventions may be challenging in LMICs and rural areas where there is limited availability of skilled healthcare providers or trained specialists; where physical access to facilities is limited; where costs are prohibitive; and for families who may have to take time off from work to attend or take their children to sessions.

Parenting interventions are widely implemented and well accepted in many cultural settings. Although in some settings cultural punishment still is an accepted social norm, parents through the course of a parenting intervention become aware of the positive effects of positive discipline approaches. Parenting interventions have successfully been applied with lay workers in low resource settings (e.g. the suite of parenting programmes named “Parenting for lifelong health” <https://bit.ly/2WYLETh>).

R 10: Recommendation 10 (existing) (65) (64)

RECOMMENDATION 10	Quality of evidence	Strength of Recommendation
Pharmacological interventions should not be considered in children and adolescents exposed to child maltreatment with anxiety disorders, depressive episodes/disorders or behavioural disorders in non-specialist settings.	Low	Conditional

Remarks

For more information and recommendations about pharmacological interventions for children and adolescents with mental disorders please refer to the mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0 2016. Geneva: World Health Organization; 2016

https://www.who.int/mental_health/mhgap/evidence/resource/child_q12.pdf?ua=1
(pharmacological interventions for children with emotional disorder) and
https://www.who.int/mental_health/mhgap/evidence/resource/child_q8.pdf?ua=1
(pharmacological interventions for children with behavioural and conduct disorder).

Relevant recommendations are summarized below:

- Pharmacological interventions (such as methylphenidate, lithium, carbamazepine and risperidone) should not be offered by non-specialized health care providers to treat Disruptive Behaviour Disorders (DBD), Conduct Disorder (CD), Oppositional Defiant Disorder (ODD) and comorbid Attention-Deficit Hyperactivity Disorder (ADHD). For these conditions, the patients should be referred to specialist before prescribing any medicines.
Strength of recommendation: STRONG
Quality of evidence: LOW
- Antidepressants (Tricyclic antidepressants (TCA), Selective serotonin reuptake inhibitors (SSRI)) should not be used for the treatment of children under 12 years of age with depressive episode/disorder in non-specialist settings.
Strength of recommendation: STRONG
Quality of evidence: LOW
- Pharmacological interventions should not be considered in children and adolescents with anxiety disorders in non-specialist settings.
Strength of recommendation: CONDITIONAL
Quality of evidence: LOW

Evidence summary

No studies on pharmacological interventions were found. However, there is evidence from high-income settings of the overuse of medication in children and adolescents who have been maltreated and especially those living in foster care (103).

F. ETHICAL PRINCIPLES AND HUMAN RIGHTS STANDARDS FOR REPORTING CHILD OR ADOLESCENT MALTREATMENT

GP 8: GOOD PRACTICE STATEMENT 8

Whether healthcare providers have to comply with a legal or policy requirement, or are guided by an ethical duty to report known or suspected child or adolescent maltreatment, they should balance the need to take into account the best interests of that child or adolescent and their evolving capacity to make autonomous decisions. These actions include the following:

- being aware of any legal requirements to report known or suspected child or adolescent maltreatment;

GP 8: GOOD PRACTICE STATEMENT 8

- assessing the implications of reporting for the health and safety of that child or adolescent and taking steps to promote their safety; there may be situations in which it may not be in the best interests of the child to report;
- at the same time, recognizing and resisting psychological barriers to reporting, such as assumptions made about caregivers based on their demeanour or appearance, as well as close relationships between the health worker and caregivers;
- treating all forms of maltreatment as significant while assessing the severity for guiding actions; the safety of the child or adolescent is paramount;
- seeking advice from colleagues, supervisors, and/ or external experts when unsure about how to manage child or adolescent maltreatment;
- documenting the reporting and maintaining confidentiality of the documented information with extra precautions where the perpetrator is a caregiver who could access the child's or adolescent's file;

Health managers and policy-makers should:

- be aware of any legal requirements to report known or suspected of child or adolescent maltreatment. In situations where there are no functioning legal or child welfare/protection systems to act on a report, or where the perpetrator is part of the formal system, the usefulness of mandatory reporting may be reduced (207). In such situations, health managers may need to balance the need to comply with reporting requirements with considerations of and steps for mitigating potential harms of reporting;
- institute clear and systematic protocols taking into account available services, national laws and regulations for management of suspected child or adolescent abuse and neglect;
- facilitate opportunities for healthcare providers to receive training, support and supervision on the guiding principles for reporting, and whether, when, to whom and how to report as well as access to child maltreatment experts;
- recognize that reporting occurs within a systemic response involving multiple actors and formal and informal systems, and form close collaborations with other agencies or institutions, including the child protection and police services, in order to coordinate an appropriate response.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question: *“What are best practices for ensuring appropriate reporting or referral (in accordance with local laws and policies) of child maltreatment once it is suspected or identified?”*.

The literature search identified 18 relevant primary research articles from the following countries: Saudi Arabia (104), Kuwait (105), Turkey (106), Jordan (107), Brazil (108)(109)(110) (111) India (112), US (113)(114)(115)(116), UK (117) (118), Sweden (119), Vietnam (120), and the Netherlands (121).

Good practice statements included in the WHO Clinical Guidelines for Responding to Children and Adolescents Who Have Been Sexually Abused align closely.

Feasibility considerations

Due to the fact that child maltreatment is rarely integrated into pre-service training of health care providers health care providers in many settings are not aware about the role they have to play in recognizing and providing support to victims of child maltreatment. They often believe that reporting and referring victims of child maltreatment to other services or institutions is their sole role. In such setting awareness about the important role that health care providers can have on mitigating the negative consequences of child maltreatment should be increased.

In some cases, health workers may have to use their judgment regarding the mandate to report, if there is a possibility that such reporting would place the child at further risk. Such might include fragile health or legal systems that cannot prioritize the child's safety, and in which sharing information about a child might place the child at risk of stigma or harm (71).

Health workers experience considerable apprehension that they might make the wrong decision, which could result in negative consequences (such as an investigation) for a family that has not experienced maltreatment or fail to protect a child who is experiencing maltreatment. In many contexts, health workers deeply mistrust child protective services, and thus in some actively avoid referral. Child protective services are widely viewed as being slow and inefficient, offering poor communication and feedback to health workers (which causes health workers to lack confidence that past referrals were effective), and either under-reacting to suspicions of maltreatment (thus leaving children vulnerable and at risk) or over-reacting to suspicions of maltreatment (thus causing a family undue distress through an overly-intrusive investigation) (109)(110)(114)(116)(117). Working with other sectors to improve services and creating mutual trust and confidence between health workers and child protective services seems to be critical to improved child and adolescent health outcomes.

Fig. 1. Pathways of care for child or adolescent who have been exposed to maltreatment

1. Assess the child's urgent physical and emotional safety needs.
2. Consider that different types of violence often co-occur in the same household and that siblings and other members of the household might also be at risk of violence (intimate partner violence).
3. Consider the risk of recurrence of child maltreatment taking into account: whether the perpetrator has access to the child; whether caregivers are able to protect the child; whether the child feels safe to return home.
4. Involve the child and caregivers in safety planning, where safe to do so, prioritizing the physical and emotional wellbeing of the child.
5. Involve other relevant agencies as appropriate.
6. Make a plan for follow-up contact with the child and/or caregivers, including what will happen if the child cannot be reached.

G. TREATMENT OF PERPETRATORS

Interventions that address maltreatment recurrence

Recurrence refers to the second, third, or subsequent time that a child or adolescent has been found to be a victim of maltreatment after it has occurred previously. A child or adolescent may experience one form of maltreatment (e.g., neglect) at one point in their life and another form of maltreatment (e.g., sexual abuse) at a later point in their life (called 'sequential cross-type maltreatment'); they may also experience multiple forms of maltreatment simultaneously (cross-type maltreatment or co-occurring maltreatment), although this may not be apparent upon initial investigation (hidden cross-type maltreatment).

Evidence summary

A systematic review was conducted to answer the following PICO questions:

- For perpetrators of CM (P), does psychosocial intervention A, compared to psychosocial intervention B or no psychosocial intervention (C), result in a reduction of recurrence of CM (O)?
- For perpetrators of CM (P), does pharmacological intervention A (I), compared to pharmacological intervention B or no pharmacological intervention (C), result in a reduction of recurrence of CM (O)?

A total of 12 studies were analysed: seven addressed caregivers and five non-caregivers.

Interventions targeting caregivers

Of the seven randomized controlled trials addressing interventions for caregivers one addressed counselling/therapy interventions (individual child or parent CBT and family therapy) (122), two evaluated parenting interventions provided in clinic or community settings (123) (124), two addressed parent-child interaction therapy), and four evaluated in-home parenting interventions, namely SafeCare¹⁹ (125), home visits by public health nurses (126), multisystemic therapy²⁰ (127) and Project Support (128).

All studies took place in high-income countries, namely Canada or the United States of America.

¹⁹ SafeCare is a home-based structured behavioural skills training model that addresses parent/child interactions, home safety, and child health. SafeCare can be a freestanding intervention or used as a component in another home-based parenting intervention.

²⁰ Multi-systemic Therapy (MST): MST was originally designed for juvenile offenders and is an intensive family- and community-based treatment program that focuses on addressing all environmental systems that impact children/adolescents. MST posits that a child's behaviour problems are multidetermined and linked with characteristics of the individual child and their family, peer group, school, and community contexts. As such, MST interventions aim to comprehensively assess for and address the multidetermined factors impacting child behaviour by building on child/family strengths in a highly individualized manner. MST is generally home-based to mediate barriers children/families face in accessing services.

Most studies assessed re-reports of maltreatment, although some looked at re-reports and substantiated reports (recurrence) but did not distinguish between the two in their findings. The time period examined ranged from post-intervention (approximately 12 months) to just over 2 years. While all interventions showed a reduction in re-report rates, re-report rates were much more substantial in some interventions compared to others. For example, at a mean of a two-year follow-up, there is very low certainty that PCIT enabled 295 less re-reports per 1000 compared to a standard community-based parenting group.

Interventions targeting non-caregivers

All of the included studies for non-caregivers addressed sexual offenses. One study addressed multisystemic therapy for adolescent juvenile sexual offenders, with a mean age of 14 years (129). The other four studies addressed adult men who had committed sexual offenses; one addressed CBT (130), one group psychotherapy (131), one assertion therapy compared to the Medroxyprogesterone (132), and one a) imaginal desensitization, b) Medroxyprogesterone, and c) imaginal desensitization plus Medroxyprogesterone (133). All studies took place in high-income countries, namely the U.S., Canada and Australia. Studies addressed recurrence rates through assessments of arrests or involvement with court. (See Webannexes 5, 5a and 5b for the full report, and evidence-to decision and GRADE table).

R 11: Recommendation 11

No recommendation can be made because sufficient evidence on the effectiveness (or harms) of psychosocial and/or pharmacological intervention for the reduction of recurrence of child maltreatment was not identified.

Remarks

There is very low certainty in most of the evidence, due to serious or very serious concerns for risk of bias and very serious concerns for imprecision. Particularly interventions targeting adult non-caregivers charged with sexual offenses show little or no benefit with the evidence being of very low certainty. As some of the interventions might cause considerable harm, no recommendation can be made at this stage.

The SafeCare trial which is targeted at caregivers that perpetrate violence was rated as moderate certainty evidence and showed some benefit. While the GDG was concerned about the transferability to other settings because the evidence exclusively comes from a high-income setting, it acknowledges the potential benefits for other countries, including low and middle-income settings. [Recommendation 9](#) provides guidance on how to guide parents in interacting with their children.

Interventions targeting perpetrators, in particular non-caregivers tend to be resource-intensive and not feasible to implement in many settings.

Subgroup considerations

While more studies addressing adolescents or young people who maltreat children are needed to improve the certainty in the evidence for this population, the MST

intervention, an intensive programme that emphasize the ecology of youth, shows promise in reducing recurrence in adolescents who have committed sexual crimes.

Implementation considerations

These guidelines focus on recommendations and good practices for clinical aspects of care provision aimed at health-care providers. The scope did not include policy recommendations. However, some implementation considerations that enable health-care providers to deliver appropriate clinical care are included here. Two areas that were flagged by the GDG as being particularly important are:

H. FACILITATING UPTAKE OF SERVICES

GP 9: GOOD PRACTICE STATEMENT 9

Health-care providers, including those working in communities, should facilitate the timely uptake of services by children and adolescents who have experienced maltreatment and are in need of services. This includes:

- demonstrating kindness and compassion, consistency, sensitivity, and professionalism and offering practical support to protect the child or adolescent;
- building trusting, long-term relationships with families;
- making available comprehensive and integrated care that reduces the need for visiting several places for different aspects of services;
- raising public awareness of the signs, symptoms and health consequences of maltreatment, and the need to seek timely care;
- collaborating with schools to inform and link children and adolescents to services;
- publicizing the availability of services, once services are established and available, through concerted efforts including community-based and media campaigns and outreach activities. Special efforts should be made to reach out to minority, indigenous or marginalized communities who may have less access and who need culturally tailored care;
- working with communities, children and adolescents and their families to address the stigma of abuse and of seeking mental health care; and to improve the acceptability of services and trust in health-care providers;
- advocating with policy-makers and management to reduce policy-level and practical barriers to accessing care (for example, requiring police reports as a condition for providing medical care and psychological support, or cost-related issues);
- strengthening referrals within and between health services and other sector services (for example, police, child protection and legal services) ensuring services are provided in a timely manner (avoiding long gaps between health services and services provided by child protection services etc.);

Health workers should NOT overlook or excuse child maltreatment, such as harsh physical discipline because it is normative in a given setting but be aware of potential personal bias and be alert and sensitive to culture-specific perceptions of maltreatment.

Health facilities should:

GP 9: GOOD PRACTICE STATEMENT 9

- make waiting rooms and services welcoming and child- and adolescent-friendly while showing discretion, e.g. avoiding labelling such as “child maltreatment room”;
- ensure privacy particularly in the emergency room during history taking and examination;
- make information about abuse and neglect, including information on accessing services, easily available in written form in waiting rooms and other areas; set up a child and adolescent helpline and direct counselling and information services to children and adolescents;
- collaborate with the community to develop services that are culturally appropriate, locally accessible and welcoming.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question: “*How can uptake of services for child maltreatment be facilitated?*”. Four of the pre-identified guidance documents and ten articles identified via the literature review informed the good practice statement. Relevant articles identified through the literature review included expert guidance articles regarding child maltreatment response in Hong Kong and Kenya, and primary research articles from the following countries: Saudi Arabia (1), Israel (1), Uganda (1), Palestine (1), Latvia (1), India (1), the UK (1), and the US (1). The *WHO Clinical Guidelines Responding to Children and Adolescents Who Have Been Sexually Abused* also describe good practices that align closely. *Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services* (147) provides further guidance on how to address barriers that adolescents in particular face in obtaining the health services they need.

Feasibility considerations

A critical point regarding facilitating uptake of services is that many factors must be addressed at the level of the health facility, rather than by individual health workers. Health workers can model professionalism and build trusting relationships with patients and their families, which may facilitate disclosure of neglect or abuse. However, many barriers to care—particularly for minority, vulnerable, and marginalized populations—must be addressed through institutional action and inter-agency cooperation. For example, providing services to disabled children may require the support of specialists, such as interpreters for deaf children. In low-resource settings, however, such services may not exist, and the costs involved with providing child-friendly spaces, community outreach, on-going training, and access to experts may be prohibitive.

In many cultures, violence against children (including physical discipline) is widespread and seen as acceptable. This may prevent victims and caregivers, as well as providers, from recognizing child maltreatment. Additionally, in some settings, the treatment of children by their caregivers may be seen as a family matter that outsiders, including medical providers, should not interfere with (134)(135)(136).

I. CREATING A SUPPORTIVE AND ENABLING SERVICE-DELIVERY ENVIRONMENT FOR HEALTH-CARE PROVIDERS

GP 10: GOOD PRACTICE STATEMENT 10

Health managers and policy-makers should create an enabling service-delivery environment and support health-care providers in carrying out their tasks and responsibilities related to caring for children and adolescents who have been maltreated. This includes:

- making available and prioritizing the provision of high-quality care in health-care settings for children and adolescents who have been maltreated;
- facilitating on-going training, supervision and mentoring:
 - emphasis needs to be on general assessment, child- or adolescent-centred first-line support and medical history/interviewing as minimum requirements in low-resource settings;
 - skills or competencies in assessing, examining and managing maltreatment in a gender-sensitive and child- or adolescent-friendly manner, and in documentation, including how to interpret examination findings, need to be provided to all health-care providers who see children or adolescents; the exact cadre of health-care providers to be trained will vary depending on the context;
 - training needs to include skills on communication and interaction with families and children and adolescents that are suspected to have been maltreated in order to ensure health provider safety and best outcomes for the child or adolescent (see [Good practice statement 7](#));
 - training needs to address attitudes of health-care providers, including those perpetuating gender inequality, stigmatizing adolescents based on their sexual orientation or gender identity, or blaming the child or adolescent in situations of maltreatment. It also needs to address health-care providers' reluctance to be involved in the care and management of children or adolescents who have been exposed to maltreatment;
 - training needs to address the nature of health-care provider obligations to report child or adolescent maltreatment;
 - ideally, multidisciplinary teams can be trained together, with a clear delineation of roles, responsibilities and expectations;
 - for training to be sustainable, it needs to be integrated into pre-service and in-service curricula for medical, nursing, midwifery and other health providers' education and involve the relevant professional bodies.
- addressing needs for adequate staffing, with attention to retention of trained staff, along with adequate infrastructure, supplies and financial resources, including budgets, in order to support provision of services in a timely manner;
- supporting health-care providers who provide care for children and adolescents who have been abused or neglected and who are called upon to give evidence in court. It is important to also provide a working environment to prevent burnout and support coping with burnout and vicarious trauma. This can be done by making available specialists on physical, sexual, emotional abuse and neglect and medical evaluation, for advice and to reduce professional isolation. In some settings, this kind of professional support has been facilitated online or through peer support, or a helpline for professionals and mobile health (mHealth) approaches;

GP 10: GOOD PRACTICE STATEMENT 10

- enabling healthcare provider to share and discuss the care plan and care decisions with colleagues and supervisors;
- taking seriously and providing protection and support in response to staff concerns regarding threats of physical violence, retribution, and/or legal action by families suspected of child maltreatment
- strengthening referrals and linkages with other allied services can facilitate a multi-disciplinary and multisectoral approach and improve access to comprehensive care;
- developing protocols or clinical care pathways which can be useful tools or job aids for health-care providers in systematically guiding care provision;
- monitoring and conducting evaluations of care provision, including by providing tools for collection of age-disaggregated data.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question: “*What are best practices for ensuring the safety of health workers who are dealing with suspected child maltreatment?*”.

Five of the pre-identified guidance documents (71)(69)(70)(68)(72) informed the good practice statement in addition to six primary research articles identified via the literature review. These six primary research articles include studies from Brazil (137)(138), Latvia (139), the US (140), and the UK (141)(142).

This is to be seen in the broader context of creating a supporting and enabling service-delivery environment for the health care provider.

Feasibility Considerations

In many settings, health workers may be well known by and live in the same community as the families with whom they work. This can exacerbate health worker concerns about reprisal if they report a suspected case of child maltreatment (143).

6. Research implications

Important knowledge gaps were identified in the process of developing these guidelines that need to be addressed through research. However, the following does not represent a comprehensive assessment of research gaps. All the new recommendations developed for these guidelines are based on evidence that has been labelled “very low” or “low” quality, indicating the need for further research. In some areas direct evidence from evaluated interventions was unavailable. Hence, indirect evidence in the form of descriptive studies or case reports had to be used. Most of the evidence is from a handful of high-income countries, with LMICs being underrepresented.

For each area considered in these guidelines, additional topics requiring further research are presented under following headings.

A. Initial identification

- Given that the systematic reviews could not identify sufficient evidence on how specific diagnostic tools impact child safety or well-being and the identified

screening tools still cannot identify 100% of maltreated children and many children will be falsely identified as being maltreated by these tools more research is needed on if and how child maltreatment identification strategies improve child well-being or reduce recurrence.

B. Medical history, physical examination and documentation of findings

- Identify approaches or practices that promote child- or adolescent-centred and sensitive interviewing, examination and documentation techniques based on the rights of the child, ensuring participation and taking into account their evolving capacities.

C. Safety and risk assessment

- There is no evidence that the use of tools enhances the assessment of risk of recurrence of maltreatment. Existing studies considered accuracy and more research is required looking at feasibility of the use of tool. In general, the GDG was concerned about the indiscriminate use of tools for the assessment of risk for recurrence of maltreatment and requested a further systematic review based on a PICO question.

D. Interacting with caregivers

- Research on strategies for engagement of maltreating caregivers that enhance participation in the child's provision of care and interventions is needed. Attention to subgroups (types of maltreatment, child age, caregiver demographics including cultural and social contextual variations) is needed to elucidate effective strategies for distinct populations or groups by type of maltreatment.
- Interventions that support and empower non-offending caregivers to provide a healing and safe home environment require further research.

E. Psychological and mental health interventions

- The effectiveness of psychosocial interventions for children and adolescents exposed to maltreatment needs to be further evaluated. While a number of different interventions have been tested in single trials, future trials are needed to determine if the results can be replicated. At least as important as trials of novel interventions is further evaluation of existing, promising interventions.
- Evidence on interventions for children exposed to neglect is particularly weak and evidence specific to children exposed to emotional abuse is entirely absent. Greater attention to child developmental considerations is needed, with stratification to assess effectiveness within age subgroups. Future studies would benefit if they assess for multiple forms of maltreatment in their sample. For example, while children may be recruited for studies aimed at interventions to reduce impairment associated with physical abuse, they may also be experiencing emotional abuse (but the latter exposure is often not assessed). Accurate assessment of co-occurring forms of maltreatment would help to determine if the intervention is beneficial to one or co-occurring forms of maltreatment.

- Information on child subjective well-being and child suicidal behaviour was not found in the included studies; future research on these outcomes is needed.
- Harmful effects were not measured or reported in existing studies; future research to measure harms is needed.
- Research on interventions to prevent and mitigate the consequences of child maltreatment in children with disabilities, who are at higher risk of maltreatment compared to the general population, is lacking. More and higher quality research is required, particularly from low- and middle-income countries and on various forms of disability such as physical impairments, sensory impairments, and mental health conditions.
-

F. Ethical principles and human rights standards for reporting child or adolescent

- Research is required on the effectiveness, benefits and harms of mandatory reporting of child and adolescent maltreatment, as well as on benefits and harms of non-reporting.

G. Treatment of perpetrators

- Studies assessing maltreatment recurrence need to apply clear and uniform measures for referrals, re-reports, and recurrence rates. Uniformity of measures across studies would increase the ability to compare findings.
- Further studies addressing youth who maltreat children are needed to improve the certainty in the evidence for this population.

H. Implementation considerations

Facilitating timely uptake of services

- Conduct systems-level research on factors in the policy and infrastructure environment that support or undermine the uptake of services.
- Conduct evaluations of strategies, especially from LMICs and different community settings, to increase timely uptake of services. While the literature suggests that simply providing comprehensive care could increase uptake, research is required to explore this association.
- Conduct research to understand better who is accessing services, how are they learning about services and which communities are being left out.
- Evaluate different models of care and service delivery, to assess how they improve uptake and access.

Creating a supportive and enabling service-delivery environment for health-care providers

- Evaluate different training modalities and their effectiveness.
- Identify how innovations such as offering access to experts through online approaches can contribute to strengthening health-care-provider capacity.
- Assess how to promote the well-being of, and address burnout or vicarious trauma among health-care providers involved in this work.

- Assess how to strengthen provision of care in private as well as public-sector services.
- Identify how to strengthen intersectoral coordination by working together with other sectors (e.g. child welfare/protection, education) and improve options and outcomes for children and adolescents who are referred to other service
- Document and evaluate field-based practices of programme implementers that could offer valuable lessons learnt about implementation of services.
- In many countries the response to child maltreatment is not systematically integrated into health care provision. The impact of existing norms and values and preferences on the implementation of the recommendations outlined in these guidelines requires further research.

7. Dissemination, implementation, monitoring and evaluation

The dissemination and implementation of these guidelines will build on the work that has gone into disseminating and implementing the *WHO clinical guidelines: Responding to children and adolescents who have been sexually abused*. Both guidelines will be fully integrated into a practical handbook and incorporated into guidelines for primary care providers caring for children and adolescents.

A systematic and formal knowledge-to-action framework will be applied to the implementation of these guidelines, which involves the following steps:

- Introduction of the guidelines to national stakeholders through a participatory and consensus-driven process, which involves identifying whether existing national guidelines or protocols need to be updated or new guidelines need to be developed;
- Adaptation of the guidelines to context, based on inputs from national stakeholders so that it can meet the needs of the country and take into account available human and financial resources, the organization of the health system, national laws and policies, clinical guidance and cultural and social factors. It is important that the adaptation process and any changes made, including to those recommendations that are conditional, are explicit and conducted in a transparent manner;
- Use of updated or adapted national guidelines to train health-care providers in selected sites;
- Monitoring of whether the knowledge and skills of health-care providers has improved, and documenting lessons learnt, and barriers faced;
- On the basis of lessons learnt, identifying with national stakeholders how to further roll out the guidelines; it is important that such a process identifies and addresses barriers that need to be addressed for creating an enabling environment for health-care providers to deliver clinical care.

The aim of such a process is to promote a systematic approach to facilitate uptake and scale-up of guidelines, and to identify lessons learnt that can be applied in other settings. The monitoring and evaluation of the implementation process is a critical component of determining not only if health-care providers are improving their knowledge and skills, but also whether the healthcare system is delivering safe and appropriate, high-quality care to children and adolescents experiencing

maltreatment. Information can be gathered through periodic evaluations of service delivery, including by assessing how children and adolescents and caregivers experience the care they receive and whether there has been improved and timely uptake of services over time. As much as possible, indicators that are to be reported internationally (144) are to be based on existing agreed-upon indicators, and these include:

- The number of countries that have developed or updated their national guidelines or protocols or standard operating procedures for the health-system response to child and adolescent maltreatment, consistent with international child and human rights standards and WHO guidelines.
- The number of countries that provide comprehensive care for children and adolescents who have been exposed to maltreatment, consistent with WHO guidelines.

Updating the guidelines

These guidelines will be updated in 7–10 years or following the identification of new evidence that reflects the need for changing any recommendations. Where possible, the timing of the updates will also consider any opportunities to produce consolidated guidelines for children and adolescents. WHO welcomes suggestions regarding additional topics for inclusion in future guidelines. Please email these to: KieselbachB@who.int.

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Annex 2: Implications of the strength of the recommendation

Implications	Strong recommendation	Conditional recommendation
For clients	Most people in this situation would want the recommended course of action and only a small proportion would not.	Most people in this situation would want the recommended course of action, but many would not.
For clinicians	Most clients should receive the recommended course of action.	Different choices will be appropriate for different clients, who will require assistance in arriving at a decision consistent with their values and preferences.
For policy-makers	The recommendation can be adopted as a policy in most situations.	Policy-making will require substantial debate and involvement of many stakeholders.

Annex 3: International and regional human rights treaties and consensus documents containing safeguards that are relevant for child and adolescent maltreatment

International instruments

- Convention on the Rights of the Child, adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, entry into force 2 September 1990, in accordance with article 49. New York: United Nations; 1990 (A/44/49; <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>).
- United Nations Committee on the Rights of the Child. General comment no. 4, Adolescent health and development in the context of the Convention on the Rights of the Child. New York: United Nations; 2003 (CRC/GC/2003/4; <http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC4.pdf>).
- United Nations Committee on the Rights of the Child. General comment no. 12, The right of the child to be heard. New York: United Nations; 2009 (CRC/C/GC/12; <http://www.refworld.org/docid/4ae562c52.html>).
- United Nations Committee on the Rights of the Child. General comment no. 13, The right of the child to freedom from all forms of violence. New York: United Nations; 2011 (CRC/C/GC/13; <http://www.refworld.org/docid/4e6da4922.html>).
- United Nations Committee on the Rights of the Child. General comment no. 14, The right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1). New York: United Nations; 2013 (CRC/C/GC/14; <http://www.refworld.org/docid/51a84b5e4.html>).
- United Nations Committee on the Rights of the Child. General comment no. 15, The right of the child to the enjoyment of the highest attainable standard of health (art. 24). New York: United Nations; 2013 (CRC/C/GC/15; <http://www.refworld.org/docid/51ef9e134.html>).
- United Nations Committee on the Rights of the Child. General comment no. 20, The implementation of the rights of the child during adolescence (art. 39). New York: United Nations; 2016 (CRC/C/GC/20; <http://www.refworld.org/docid/589dad3d4.html>).
- Convention on the Elimination of all Forms of Discrimination against Women, adopted 18 December 1979, entry into force, 3 September 1981. New York: United Nations; 1980 (<http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>).

- United Nations Committee on the Elimination of Discrimination Against Women. General Recommendation no. 24. Women and Health (art. 12). New York: United Nations; 1999
(<http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24>)
- International Covenant on Civil and Political Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 23 March 1976, in accordance with Article 49. New York: United Nations; 1976 (A-14668; <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx>).
- International Covenant on Economic, Social and Cultural Rights, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976, in accordance with article 27. New York: United Nations; 1976 (<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>).

Regional instruments

- African Charter on the Rights and Welfare of the Child, adopted 11 July 1990, entry into force, 29 November 1999. Addis Ababa: Organization of African Unity; 1999 (CAB/ LEG/24.9/49; <http://www.refworld.org/docid/3ae6b38c18.html>).
- European Convention on the Exercise of Children's Rights, adopted 25 January 1996, entry into force 1 July 2000. Strasbourg: Council of Europe; 2000 (CETS 160; <https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168007cdaf>)
- Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence, adopted 11 May 2011, entry into force 1 August 2014. Strasbourg: Council of Europe; 2014 (CETS 210; <https://rm.coe.int/168008482e>).

Annex 4. List of supplementary materials in Web Annexes

The following documents are available as supplementary materials either as Web Annexes or upon request from @who.int. These include: (i) the full reports of all the systematic reviews and additional literature reviews containing the protocols, search strategies and results; (ii) evidence-to-decision tables; and (iii) GRADE tables, where relevant.

Web Annexes

	REVIEW	EVIDENCE-TO-DECISION TABLE	GRADE TABLE
Summary of declaration-of-interest statements	Web Annex 1	Not applicable	Not applicable
Identification	Web Annex 2	Web Annex 2a	Web Annex 2b
Good practice statements 1–10	Web Annex 3	Not applicable	Not applicable
Psychosocial interventions for children and adolescents	Web Annex 4	Web Annex 4a	Web Annex 4b
List of PICO questions and best practice questions	Web Annex 5	Not applicable	Not applicable

References

- (1) Health for the world's adolescents: a second chance in the second decade. Geneva: World Health Organization; 2014 (<http://apps.who.int/adolescent/second-decade/>, accessed 13 September 2017).
- (2) Convention on the Rights of the Child. New York: United Nations; 1989 (<http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf>, accessed 3 March 2018).
- (3) National Collaborating Centre for Mental Health. Post-traumatic stress disorder: the management of PTSD in adults and children in primary and secondary care. London: Royal College of Psychiatrists; 2005.
- (4) Bisson J, Andrew M. Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database Syst Rev.* 2005;(2):CD003388.
- (5) Cohen JA, Mannarino AP, Deblinger E. Child and parent trauma-focused CBT manual. Philadelphia: Drexel University, College of Medicine; 2001.
- (6) Stoltenborgh M, van Ijzendoorn MH, Euser EM, Bakermans-Kranenburg MJ. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child Maltreat.* 2011;16(2):79–101. doi:0.1177/1077559511403920.
- (7) US Centers for Disease Control and Prevention. Violence Against Children Surveys. Atlanta: US Centers for Disease Control and Prevention; Available from: <http://www.cdc.gov/violenceprevention/vacs/>
- (8) Hillis S, Mercy J, Amobi A, Kress H. Global Prevalence of Past-year Violence Against Children: A Systematic Review and Minimum Estimates. *Pediatrics.* 2016 Mar;137(3):e20154079. doi: 10.1542/peds.2015-4079.
- (9) Jones L, Bellis MA, Wood S, Hughes K, McCoy E, Eckley L, Bates G, Mikton C, Shakespeare T, Officer A. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *The Lancet* 2012 Sep 14;380(9845):899-907.
- (10) World Health Organization. Global Burden of Disease Estimates. Geneva: World Health Organization Available from: http://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html
- (11) Bellis MA, Hughes K, Leckenby N, Jones L, Baban A, Kachaeva M, et al. Adverse childhood experiences and associations with health-harming behaviours in young adults: surveys in eight eastern European countries. *Bull World Health Organ* 2014;92(9):641-655.
- (12) Danese A, Moffitt TE, Harrington H, Milne BJ, Polanczyk G, Pariante CM, et al. Adverse childhood experiences and adult risk factors for age-related disease: depression, inflammation, and clustering of metabolic risk markers. *Arch Pediatr Adolesc Med* 2009;163(12):1135-1143.

-
- (13) Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, 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. *Am J Prev Med* 1998;14:245-258.
- (14) Miller GE, Chen E, Parker KJ. Psychological stress in childhood and susceptibility to the chronic diseases of aging: moving toward a model of behavioral and biological mechanisms. *Psychol Bull* 2011;137(6):959.
- (15) Norman RE, Byambaa M, De R, Butchart A, Scott J, Vos T. The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS Med* 2012;9(11).
- (16) Widom CS. Longterm consequences of child maltreatment. In: Korbin JE, Krugman RD, editors. *Handbook of child maltreatment*: Springer 2014. p. 225-247.
- (17) Black MC. Intimate partner violence and adverse health consequences: implications for clinicians. *Am J Lifestyle Med* 2011;5(5):428-439.
- (18) Leeb RT, Lewis T, Zolotor AJ. A review of physical and mental health consequences of child abuse and neglect and implications for practice. *Am J Lifestyle Med* 2011;5(5):454-468.
- (19) Andrews G, Corry J, Slade T, Issakadis C, Swanston H. Child sexual abuse. In: Ezzati M, Lopez AD, Rodgers A, Murray CJL, editors. *Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors - Volume 2*. Geneva: World Health Organization; 2004. p. 1851-940.
- (20) Coid J, Petruckevitch A, Feder G, Chung W-S, Richardson J, Mooney S. Relation between childhood sexual and physical abuse and risk of revictimisation in women: a cross-sectional survey. *Lancet* 2001;358(9280):450-454.
- (21) Kim J, Cicchetti D. Longitudinal pathways linking child maltreatment, emotion regulation, peer relations, and psychopathology. *J Child Psychol Psychiatry* 2010;51(6):706-716.
- (22) Maker AH, Kemmelmeier M, Peterson C. Child sexual abuse, peer sexual abuse, and sexual assault in adulthood: A multi-risk model of revictimization. *J Trauma Stress* 2001;14(2):351-368.
- (23) Manly JT, Kim JE, Rogosch FA, Cicchetti D. Dimensions of child maltreatment and children's adjustment: Contributions of developmental timing and subtype. *Dev Psychopathol* 2001;13(04):759-782.
- (24) Widom CS, Czaja SJ, Dutton MA. Childhood victimization and lifetime revictimization. *Child Abuse Negl* 2008;32(8):785-796.
- (25) World Health Organization. *Manual for estimating the economic costs of injuries due to interpersonal and self-directed violence*. Geneva: World Health Organization 2008

-
- (26) Fang X, Fry DA, Brown DS, Mercy JA, Dunne MP, Butchart AR, et al. The burden of child maltreatment in the East Asia and Pacific region. *Child Abuse Negl* 2015; Online 7 March 2015.
- (27) Fearon J, Hoeffler A. Benefits and Costs of the Conflict and Violence Targets for the Post-2015 Development Agenda. Copenhagen: Copenhagen Consensus Center 2014.
- (27.1) WHO (2016). Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. Geneva: World Health Organization.
- (28) WHO handbook for guidelines development, 2nd ed. Geneva: World Health Organization; 2014 <http://apps.who.int/medicinedocs/documents/s22083en/s22083en.pdf> (accessed 5 March 2018).
- (29) GRADE working group (<http://www.gradeworkinggroup.org/> , accessed 5 March 2018).
- (30) World Health Organization. Declaration of interests for WHO experts – forms for submission (<http://www.who.int/about/declaration-of-interests/en/>, accessed 5 March 2018).
- (31) PRISMA: transparent reporting of systematic reviews and meta-analyses (<http://www.prisma-statement.org/PRISMAStatement/Default.aspx> accessed 5 March 2018).
- (32) Convention on the Rights of the Child. New York: United Nations; 1989 (<http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf>, accessed 18.02.2018).
- (33) Convention on the Elimination of All Forms of Discrimination Against Women. New York: United Nations; 1979 (<http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>, accessed 18.02.2018).
- (34) Moore L, Kirk S. A literature review of children’s and young people’s participation in decisions relating to health care. *J Clin Nurs*. 2010;19(15–16):2215–25. doi:10.1111/j.1365-2702.2009.03161.x.
- (35) National Scientific Council on the Developing Child. (2016). Applying the science of child development in child welfare systems. Retrieved from <http://developingchild.harvard.edu/resources/child-welfare-systems/>
- (36) Bailhache, M., Leroy, V., Pillet, P. & Salmi, L.-R. Is early detection of abused children possible?: a systematic review of the diagnostic accuracy of the identification of abused children. *BMC Pediatr*. **13**, 202 (2013).
- (37) mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0 2016. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/250239/1/9789241549790-eng.pdf>, accessed 3 March 2018). And http://www.who.int/mental_health/mhgap/evidence/resource/child_q15.pdf

-
- (38) Hettler, J. & Greenes, D. S. Can the Initial History Predict Whether a Child With a Head Injury Has Been Abused? *Pediatrics* **111**, 602–607 (2003).
- (39) Vinchon, M., Foort-Dhellemmes, S. de, Desurmont, M. & Delestret, I. Confessed abuse versus witnessed accidents in infants: comparison of clinical, radiological, and ophthalmological data in corroborated . *Childs Nerv. Syst.* **26**, 637–645 (2009).
- (40) Vinchon, M., Defoort-Dhellemmes, S., Desurmont, M. & Dhellemmes, P. Accidental and nonaccidental head injuries in infants: a prospective study. *J. Neurosurg. Pediatr.* **102**, 380–384 (2005).
- (41) Cheung, P. C. H. *et al.* Correlation of colposcopic anogenital findings and overall assessment of child sexual abuse: prospective study. *Hong Kong Med. J. Xianggang Yi Xue Za Zhi* **10**, 378–383 (2004).
- (42) Bernstein, D. P., Ahluvalia, T., Pogge, D. & Handelsman, L. Validity of the Childhood Trauma Questionnaire in an Adolescent Psychiatric Population. *J. Am. Acad. Child Adolesc. Psychiatry* **36**, 340–348 (1997).
- (43) Berenson, A. B. *et al.* Use of Hymenal Measurements in the Diagnosis of Previous Penetration. *Pediatrics* **109**, 228–235 (2002).
- (44) Drach, K. M., Wientzen, J. & Ricci, L. R. The diagnostic utility of sexual behavior problems in diagnosing sexual abuse in a forensic child abuse evaluation clinic. *Child Abuse Negl.* **25**, 489–503 (2001).
- (45) Greiner, M. V., Palusci, V. J., Keeshin, B. R., Kearns, S. C. & Sinal, S. H. A preliminary screening instrument for early detection of medical child abuse. *Hosp. Pediatr.* **3**, 39–44 (2013).
- (46) Wells RG, Vetter C & Laud P. Intracranial hemorrhage in children younger than 3 years: Prediction of intent. *Arch. Pediatr. Adolesc. Med.* **156**, 252–257 (2002).
- (47) Wells RG, Vetter C & Laud P. Intracranial hemorrhage in children younger than 3 years: Prediction of intent. *Arch. Pediatr. Adolesc. Med.* **156**, 252–257 (2002).
- (48) Chang, D. C., Knight, V. M., Ziegfeld, S., Haider, A. & Paidas, C. The multi-institutional validation of the new screening index for physical child abuse. *J. Pediatr. Surg.* **40**, 114–119 (2005).
- (49) Valvano, T. J., Binns, H. J., Flaherty, E. G. & Leonhardt, D. E. Does bruising help determine which fractures are caused by abuse? *Child Maltreat.* **14**, 376–381 (2009)
- (50) Pierce, M. C., Kaczor, K., Aldridge, S., O’Flynn, J. & Lorenz, D. J. Bruising Characteristics Discriminating Physical Child Abuse From Accidental Trauma. *Pediatrics* **125**, 67–74 (2010).
- (51) Schouten, M. C. *et al.* The Value of a Checklist for Child Abuse in Out-of-Hours Primary Care: To Screen or Not to Screen. *PLOS ONE* **12**, e0165641 (2017).

-
- (52) Louwers, E. C. F. M. *et al.* Accuracy of a screening instrument to identify potential child abuse in emergency departments. *Child Abuse Negl.* **38**, 1275–1281 (2014).
- (53) Cowley, L. E., Morris, C. B., Maguire, S. A., Farewell, D. M. & Kemp, A. M. Validation of a Prediction Tool for Abusive Head Trauma. *Pediatrics* **136**, 290–298 (2015).
- (54) Bousema, S. *et al.* Epidemiology and screening of intentional burns in children in a Dutch burn centre. *Burns J. Int. Soc. Burn Inj.* **42**, 1287–1294 (2016).
- (55) Cowley, L. E., Morris, C. B., Maguire, S. A., Farewell, D. M. & Kemp, A. M. Validation of a Prediction Tool for Abusive Head Trauma. *Pediatrics* **136**, 290–298 (2015).
- (56) Palifka, L. A., Frasier, L. D., Metzger, R. R. & Hedlund, G. L. Parenchymal Brain Laceration as a Predictor of Abusive Head Trauma. *AJNR Am. J. Neuroradiol.* **37**, 163–168 (2016).
- (57) Acker, S. N. *et al.* Head injury and unclear mechanism of injury: Initial hematocrit less than 30 is predictive of abusive head trauma in young children. *J. Pediatr. Surg.* **49**, 338–340 (2014).
- (58) Hymel, K. P. *et al.* Validation of a Clinical Prediction Rule for Pediatric Abusive Head Trauma. *Pediatrics* **134**, e1537–e1544 (2014).
- (59) Hymel, K. P. *et al.* Derivation of a clinical prediction rule for pediatric abusive head trauma. *Pediatr. Crit. Care Med. J. Soc. Crit. Care Med. World Fed. Pediatr. Intensive Crit. Care Soc.* **14**, 210–220 (2013).
- (60) Kim, P. T. *et al.* Consistent screening of admitted infants with head injuries reveals high rate of nonaccidental trauma. *J. Pediatr. Surg.* doi:10.1016/j.jpedsurg.2017.02.014
- (61) Fernandopulle, S., Fernando, D. Development and initial validation of a scale to measure emotional abuse among school children aged 13-15 years in Sri Lanka. *Child Abuse Negl.* **27**, 1087–1099 (2003).
- (62) Dinpanah, H., Pasha, A. A. & Sanji, M. Potential Child Abuse Screening in Emergency Department; a Diagnostic Accuracy Study. *Emergency* **5**, 8 (2016).
- (63) Sittig, J. S. *et al.* Value of systematic detection of physical child abuse at emergency rooms: a cross-sectional diagnostic accuracy study. *BMJ Open* **6**, e010788 (2016).
- (64) mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0 2016. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/250239/1/9789241549790-eng.pdf>, accessed 3 March 2018) and http://www.who.int/mental_health/mhgap/evidence/resource/child_q15.pdf
- (65) WHO mhGAP Guideline Update, Update of the Mental Health Gap Action Programme (mhGAP) Guideline for Mental, Neurological and Substance use Disorders May 2015 ISBN 978 92 4 154941 7, World Health Organization 2015 http://apps.who.int/iris/bitstream/10665/204132/1/9789241549417_eng.pdf?ua=1 accessed 07 March 2018

-
- (66) Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013
http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf.
accessed 03 March 2018).
- (67) World Health Organization (WHO) and United Nations Office on Drugs and Crime. (2015c). Strengthening the medico-legal response to sexual violence. Geneva, Switzerland.
- (68) World Health Organization (WHO) and United Nations Office on Drugs and Crime. (2015a). Background paper for medico-legal toolkit. Geneva, Switzerland.
- (69) World Health Organization (WHO). (2009). Expert meeting on health-sector responses to violence against women. Geneva, Switzerland.
- (70) Scott K, Broaddus E, Beckham S. (2017). A literature review on best practices and preferences for initial health system response to child and adolescent sexual abuse.
- (71) International Rescue Committee (IRC). (2012). Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings.
- (72) National Institute for Health and Care Excellent (NICE). (2017). Draft guideline on child abuse and neglect: recognising, assessing and responding to abuse and neglect of children and young people.
- (73) Jones, C., Stalker, K., Franklin, A., Fry, D., Cameron, A., and Taylor, J. (2017) Enablers of help - seeking for deaf and disabled children following abuse and barriers to protection: a qualitative study. *Child & Family Social Work*, 22: 762–771. doi: 10.1111/cfs.12293.
- (74) Aggarwal, K., Dalwai, S., Galagali, P., Mishra, D., Prasad, C., & Thadhani, A. (2010). Recommendations on recognition and response to child abuse and neglect in the Indian setting. *Indian Pediatrics*, 47(6), 493-504. doi:10.1007/s13312-010-0088-0
- (75) De Zulueta, P. (2010). Choosing for and with children: consent, assent and working with children in the primary care setting. *London Journal of Primary Care*, 3(1), 12–18.
- (76) van Bogaert DK, GA Ogunbanjo (2013) Ethics and medicine: revisiting the Children's Act and the implications for healthcare practitioners Download citation
<https://doi.org/10.1080/20786204.2013.10874312>
- (77) Lee, Korea, Diagnostic Evaluation of Physical Abuse in Children, 2008 – REF missing
- (78) World Health Organization, Responding to children and adolescents who have been sexually abused: WHO clinical guidelines ISBN 978-92-4-155014-7, 2017
- (79) Molyneux, E. M., Kennedy, N., Dano, A., & Mulambia, Y. (2013). Sexual abuse of children in low-income settings: Time for action. *Paediatrics and International Child Health*, 33(4), 239-246. doi:10.1179/2046905513Y.0000000087

-
- (80) World Health Organization (WHO) and United Nations Office on Drugs and Crime. (2015b). *Medico-legal Policy Note*. Geneva, Switzerland.
- (81) Draus, John M. A Multidisciplinary Child Protection Team Improves the Care of Nonaccidental Trauma Patients, *The American Surgeon*, Volume 83, Number 5, May 2017, pp. 477-481(5)
- (82) Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D., & MacMillan, H. L. (2009). Recognising and responding to child maltreatment. *The Lancet*, 373(9658), 167-180. doi:10.1016/S0140-6736(08)61707-9
- (83) D'andrade, A., Austin, M. J., & Benton, A. (2008). Risk and safety assessment in child welfare: Instrument comparisons. *Journal of evidence-based social work*, 5(1-2), 31-56.
- (84) Al-Saadoon, M., Al-Sharbati, M., El Nour, I., & Al-Said, B. (2012). Child maltreatment types and effects: Series of six from a University hospital in Oman. *Sultan Qaboos University Medical Journal*, 12(1), 648-653.
- (85) Davies, C., & Ward, H. (2012). *Safeguarding Children Across Services: Messages from research*. Retrieved from London and Philadelphia:
- (86) Chan Yuk Chung, Gladys L.T. Lam Chan, Syrine K.S. Lam Yeung & Li Shing Fu (2012) A Review on Multi-disciplinary Intervention by Child Protection Professionals in Child Sexual Abuse in Hong Kong, *Asia Pacific Journal of Social Work and Development*, 12:1, 97-111, DOI: 10.1080/21650993.2002.9755890
- (87) Kobayashi M. Infant abuse in Osaka: Health center activities from 1988 to 1999. *Pediatr Int*. 2001 Apr;43(2):197-201. PubMed PMID: 11285081.
- (88) Campbell KA, Bogen DL, Berger RP. The Other Children A Survey of Child Abuse Physicians on the Medical Evaluation of Children Living With a Physically Abused Child. *Arch Pediatr Adolesc Med*. 2006;160(12):1241–1246. doi:10.1001/archpedi.160.12.1241
- (89) Sidebotham P, Biu T, Goldsworthy L. Child protection procedures in emergency departments. *Emergency Medicine Journal : EMJ*. 2007;24(12):831-835. doi:10.1136/emj.2007.051011.
- (90) van der Put, C. E., Bouwmeester-Landweer, M. B., Landsmeer-Beker, E. A., Wit, J. M., Dekker, F. W., Kousemaker, N. P. J., & Baartman, H. E. (2017). Screening for potential child maltreatment in parents of a newborn baby: The predictive validity of an Instrument for early identification of Parents At Risk for child Abuse and Neglect (IPARAN). *Child Abuse & Neglect*, 70, 160-168.
- (91) Vincent S and Petch A (2012) *Audit and analysis of significant case reviews*. Edinburgh: The Scottish Government

(92) Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D., & MacMillan, H. L. (2009). Recognising and responding to child maltreatment. *The Lancet*, 373(9658), 167-180. doi:10.1016/S0140-6736(08)61707-9

(93) Child JC, Naker D, Horton J, Walakira EJ, Devries KM. Responding to abuse: Children's experiences of child protection in a central district, Uganda. *Child Abuse Negl.* 2014 Oct;38(10):1647-58. doi: 10.1016

(94) Naughton, A. M. et al. Emotional, behavioral, and developmental features indicative of neglect or emotional abuse in preschool children: a systematic review. *JAMA Pediatr.* 167, 769–775 (2013).

(95) Veenema, T. G., Thornton, C. P. & Corley, A. The public health crisis of child sexual abuse in low and middle income countries: an integrative review of the literature. *Int. J. Nurs. Stud.* 52, 864–881 (2015).

(96) Miller, G. E., Chen, E. & Parker, K. J. Psychological stress in childhood and susceptibility to the chronic diseases of aging: moving toward a model of behavioral and biological mechanisms. *Psychol. Bull.* 137, 959–997 (2011).

(97) McCrory, E., De Brito, S. A. & Viding, E. The link between child abuse and psychopathology: a review of neurobiological and genetic research. *J. R. Soc. Med.* **105**, 151–156 (2012).

(98) Norman, R. E. *et al.* The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLoS Med* **9**, e1001349 (2012).

(99) Naughton, A. M. *et al.* Emotional, behavioral, and developmental features indicative of neglect or emotional abuse in preschool children: a systematic review. *JAMA Pediatr.* **167**, 769–775 (2013).

(100) Guidelines for the management of conditions specifically related to stress. Geneva: World Health Organization; 2013
http://apps.who.int/iris/bitstream/10665/85119/1/9789241505406_eng.pdf?ua=1 , accessed 14 February 2018).

(101) mhGAP intervention guide for mental, neurological and substance use disorders in non- specialized health settings. Version 2.0 2016. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/250239/1/9789241549790-eng.pdf>, accessed 6 April 2018).

(102) mhGAP intervention guide for mental, neurological and substance use disorders in non- specialized health settings. Version 2.0 2016. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/250239/1/9789241549790-eng.pdf>, accessed 6 April 2018).

(103) Leckman-Westin E, Finnerty M, Scholle SH, Pritam R, Layman D, Kealey E, Byron S, Morden E, Bilder S, Neese-Todd S, Horwitz S, Hoagwood K, Crystal S. J Differences in

Medicaid Antipsychotic Medication Measures Among Children with SSI, Foster Care, and Income-Based Aid. *Manag Care Spec Pharm.* 2018 Mar;24(3):238-246. doi: 10.18553/jmcp.2018.24.3.238.

(104) Alnasser, Y., Albijadi, A., Abdullah, W., Aldabeeb, D., Alomair, A., Alsaddiqi, S., & Alsalloum, Y. (2017). Child maltreatment between knowledge, attitude and beliefs among Saudi pediatricians, pediatric residency trainees and medical students. *Annals of Medicine and Surgery*, 16, 7-13. doi:10.1016/j.amsu.2017.02.008

(105) Al-Moosa, A., Al-Shaiji, J., Al-Fadhli, A., Al-Bayed, K., & Adib, S. M. (2003). Pediatricians' knowledge, attitudes and experience regarding child maltreatment in Kuwait. *Child Abuse and Neglect*, 27(10), 1161-1178. doi:10.1016/j.chiabu.2003.09.009

(106) Orhon FS, Ulukol B, Bingoler B, Gulnar SB Attitudes of Turkish parents, pediatric residents, and medical students toward child disciplinary practices. *Child Abuse Negl.* 2006 Oct;30(10):1081-92.

(107) Abu-Moghli et al. 2005 Jordanian Nurses' Perception of their Role Regarding Child Maltreatment January 2005 *Dirasat. Medical and biological sciences* 32(Volume 32, No. 1 & 2):1-15

(108) Leite, 2006, Brazil Notificação de maus-tratos infantis: necessidade de educação médica continuada

(109) Leite, 2016 Brazil Coping with domestic violence against children and adolescents from the perspective of primary care nurses

(110) Bannwart, 2011 Brazil Dificuldades enfrentadas para identificar e notificar casos de maus-tratos contra crianças e/ou adolescentes sob a óptica de médicos pediatras

(111) Amaral, 2013, Brazil, Significado do cuidado às crianças vítimas de violência na ótica dos profissionais de saúde

(112) Deshpande, (2015), India Knowledge and attitude in regards to physical child abuse amongst medical and dental residents of central Gujarat: A cross-sectional survey

(113) Flaherty, 2008 US Telling their stories: Primary care practitioners' experience evaluating and reporting injuries caused by child abuse

(114)Flaherty & Sage 2005 US Barriers to physician identification and reporting of child abuse

(115) Jones, 2008 US Clinicians' description of factors influencing their reporting of suspected child abuse: Report of the child abuse reporting experience study research group

(116) Tiyyagura, 2015 US. Barriers and facilitators to detecting child abuse and neglect in general emergency departments

(117) Woodman, 2013 UK. Responses to concerns about child maltreatment: A qualitative study of GPs in England

-
- (118) Sidebotham, 2007UK, Child protection procedures in emergency departments
- (119) Svärd, 2017, Sweden, “Why don’t they Report?” Hospital Personnel Working with Children at Risk
- (120) Flemington, 2016 Vietnam, Building workforce capacity to detect and respond to child abuse and neglect cases: A training intervention for staff working in emergency settings in Vietnam
- (121) Konijnendijk, 2017, The Netherlands, In-house consultation to support professionals’ responses to child abuse and neglect: Determinants of professionals’ use and the association with guideline adherence
- (122) Kolko, D. J. Individual Cognitive Behavioral Treatment and Family Therapy for Physically Abused Children and their Offending Parents: A Comparison of Clinical Outcomes. *Child Maltreat.* 1, 322–342 (1996).
- (123) Chaffin, M., Funderburk, B., Bard, D., Valle, L. A. & Gurwitch, R. A combined motivation and parent-child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *J. Consult. Clin. Psychol.* **79**, 84–95 (2011).
- (124) Chaffin, M. *et al.* Parent-Child Interaction Therapy With Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports. *J. Consult. Clin. Psychol.* **72**, 500–510 (2004).
- (125) Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F. & Beasley, W. H. A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. *Pediatrics* **129**, 509–515 (2012).
- (126) MacMillan, H. L. *et al.* Effectiveness of home visitation by public-health nurses in prevention of the recurrence of child physical abuse and neglect: a randomised controlled trial. *The Lancet* **365**, 1786–1793 (2005).
- (127) Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R. & Mayhew, A. M. Multisystemic Therapy for Child Abuse and Neglect: a randomized effectiveness trial. *J. Fam. Psychol. JFP J. Div. Fam. Psychol. Am. Psychol. Assoc. Div.* **43** **24**, 497–507 (2010).
- (128) Jouriles, E. N. *et al.* Improving parenting in families referred for child maltreatment: a randomized controlled trial examining effects of Project Support. *J. Fam. Psychol. JFP J. Div. Fam. Psychol. Am. Psychol. Assoc. Div.* **43** **24**, 328–338 (2010).
- (129) Borduin, C. M., Schaeffer, C. M. & Heiblum, N. A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: effects on youth social ecology and criminal activity. *J. Consult. Clin. Psychol.* **77**, 26–37 (2009).
- (130) Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C. & Ommeren, A. van. Effects of a Relapse Prevention Program on Sexual Recidivism: Final Results From California’s Sex Offender Treatment and Evaluation Project (SOTEP). *Sex. Abuse J. Res. Treat.* **17**, 79–107 (2005).

MARQUES, J. K., DAY, D. M., NELSON, C. & WEST, M. A. Effects of Cognitive-Behavioral Treatment on Sex Offender Recidivism. *Crim. Justice Behav.* **21**, 28–54 (1994).

(131) Romero, J. J. & Williams, L. M. Group Psychotherapy and Intensive Probation Supervision with Sex Offenders. *Fed. Probat.* **47**, 36 (1983).

(132) Langevin, R. *et al.* The effect of assertiveness training, provera and sex of therapist in the treatment of genital exhibitionism. *J. Behav. Ther. Exp. Psychiatry* **10**, 275–282 (1979).

(133) McConaghy, N., Blaszczyński, A. & Kidson, W. Treatment of sex offenders with imaginal desensitization and/or medroxyprogesterone. *Acta Psychiatr. Scand.* **77**, 199–206 (1988).

(134) Al Eissa M, Almuneef M. Child abuse and neglect in Saudi Arabia: journey of recognition to implementation of national prevention strategies. *Child Abuse Negl.* 2010 Jan;34(1):28-33. doi: 10.1016

(135) Bridgewater G. Physical and sexual violence against children in Kenya within a cultural context. *Community Pract.* 2016 Feb;89(2):30-4.

(136) Halileh S, Abdullah A. Child abuse and neglect services in the occupied Palestinian territory. *East Mediterr Health J.* 2009 Nov-Dec;15(6):1504-12.

(137) Amaral LV, Gomes AM, Figueiredo SV, Gomes IL. [The meaning of care for child victims of violence from the perspective of health professionals]. [Article in Portuguese] *Rev Gaucha Enferm.* 2013 Dec;34(4):146-52.

(138) Bannwart, Dificuldades enfrentadas para identificar e notificar casos de maus-tratos contra crianças e/ou adolescentes sob a óptica de médicos pediatras [Article in Portuguese] 2011 Brazil

(139) Kalnins I Latvian community nurses practising in a time of turmoil: a thin line of defence for children at risk *Int Nurs Rev.* 2002 Jun;49(2):111-21.

(140) Lewington L, Unruh A, Ornstein A The experience of paediatric residents participating in a child protection rotation: A qualitative study *Paediatr Child Health.* 2013 Mar;18(3):e10-4.

(141) Sidebotham P, Biu T, Goldsworthy L. Child protection procedures in emergency departments. *Emerg Med J.* 2007 Dec;24(12):831-5.

(142) Rowse V. Support needs of children's nurses involved in child protection. *J Nurs Manag.* 2009 Sep;17(6):659-66. doi: 10.1111/j.1365-2834.2009.00987.x.

(143) Leite JT, Beserra MA, Scatena L, Silva LM, Ferriani Md. Coping with domestic violence against children and adolescents from the perspective of primary care nurses. *Rev Gaucha Enferm.* 2016 Jun;37(2):e55796. doi: 10.1590/1983-1447.2016.02.55796.

(144) Global plan of action to strengthen health systems, within a multisectoral response, to address interpersonal violence, in particular against women and girls and against children.

Geneva: World Health Organization; 2016

(<http://apps.who.int/iris/bitstream/10665/252276/1/9789241511537-eng.pdf?ua=1>, accessed 15 May 2018).

(145) Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare management forum*, 30(2), 111–116. doi:10.1177/0840470416679413

(146) World Health Organization (2013). WHO Guidelines for the management of conditions specifically related to stress. Geneva: WHO.

https://www.who.int/mental_health/emergencies/stress_guidelines/en/

(147) World Health Organization (2012). Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services.

https://apps.who.int/iris/bitstream/handle/10665/75217/9789241503594_eng.pdf?sequence=1