

**CHILD PROTECTION
AND
CHILD ABUSE MANUAL
A Protocol for Nurses**

Revised 2003

**Manitoba Family Services
and Housing**



Quick Reference for Suspected Child Abuse

- **A suspicion that a child may be in need of protection requires a report to a child and family services agency or the police. Individuals are not required nor should they attempt to diagnose or investigate potential abuse cases.**
- **The immediate safety of the child is the paramount concern. If either a child and family services agency or the police cannot be reached in a timely fashion, evaluation at a medical facility should be considered.**
- **An immediate medical examination is indicated only in cases where acute injuries or symptoms are present. Where there is a history of chronic abuse, a child and family service agency and/or police investigation is necessary to determine the need for medical consultation and most importantly the need for protection of the alleged victims and other potential victims.**
- **If you are unsure of an appropriate course of action, it might be helpful to consult by telephone with a local child and family services agency and/or the police. The Children's Hospital Child Protection Centre or if outside office hours, the Children's Hospital Emergency Room are also available for consultation.**

Local Child and Family Services _____

Local Police Detachment _____

Local Medical Facility _____

Children's Hospital, Child Protection Centre 787-2811

Children's Hospital Emergency Room 787-2306

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INTRODUCTION

Child abuse includes the physical, emotional, neglectful, and sexual maltreatment of children. The reasons for child abuse are complex. By their very nature children need supervision, care and management. Unfortunately many parents and caregivers are not adequately prepared and/or supported for this important role. As a result, maladaptive parenting or caregiving may occur as some form of physical, emotional, and/or neglectful behaviours with children.

The effects of all forms of child abuse can be devastating and long lasting. Its identification, treatment and prevention require an interdisciplinary approach and close collaboration of all those who work with children and their families including those in health care, child and family services, law enforcement, education and the court system.

The legal definitions of ‘abuse’ can be found in The Revised Manitoba Guidelines on Identifying and Reporting a Child in Need of Protection (Including Child Abuse), hereafter referred to as the Guidelines. The Guidelines have been developed to assist professionals and lay persons in carrying out their responsibilities under *The Child and Family Services Act* of Manitoba, hereafter referred to as the *Act*. The Guidelines explain the basic obligations under the *Act* to report a child in need of protection and the subsequent steps to be followed by the various disciplines involved.

Nurses, due to their access to children and their parents and/or caregivers at all stages of the family cycle, are in a unique position to intervene in all aspects of child abuse and particularly in its prevention as well as identification and intervention. The purpose of this handbook is to serve as a guide for nurses to further their understanding of the extent and nature of the issue of child abuse as well as related legal implications and professional responsibilities as detailed in the *Act* and the Guidelines.

This handbook has been jointly prepared in consultation with the Departments of Family Services and Housing, Health, Justice, and Education and Youth through the Provincial Advisory Committee on Child Abuse (PACCA). PACCA is a multi-disciplinary, multi-agency, cross-governmental body organized to consider policy issues related to child abuse and to make recommendations to the Executive Director of the Child Protection and Support Services Branch and as appropriate to other Ministries. This handbook has been endorsed by the College of Registered Nurses of Manitoba (CRNM). The important contributions of the authors of the previous versions of this document are gratefully acknowledged.

Although these protocols refer to current provincial and federal legislation, changes to such legislation will be made from time to time.

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I DEFINITIONS AND LEGAL RESPONSIBILITIES

Child Abuse

Child abuse is the active and/or passive (neglect) harming of a child by any person. Refer to the Guidelines for legal definitions of abuse. Child maltreatment can occur as a result of abusive acts or neglectful behaviours that are physical, emotional or sexual in nature, as illustrated in the table below:

	Abuse (Commission)	Neglect (Omission or failure to protect)
Physical	Deliberate application of force to any part of a child's body resulting in trauma or injury. This may involve a single event or an ongoing pattern of incidents. Most child physical abuse incidents are associated with acts of physical punishment.	Failure to provide adequate supervision, nutrition, medical attention, clothing, shelter and education to a child. May result in repeated accidents, delinquent behaviour, failure to thrive, and poor health.
Emotional	Attacks on a child's self-esteem (e.g., overly critical), verbal threats, enforced social isolation, ignoring, rejection, intimidation, corrupting, permissiveness, and making unreasonable demands. May result in poor self-esteem, and negatively affect the development of future positive and healthy interpersonal relationships.	Failure to meet the child's emotional needs for attachment (e.g., nurturing, cuddling, demonstrating affection and caring). May result in non-organic failure to thrive, depression, behavioural problems, somatic complaints, and withdrawal.
Sexual	When an adult or youth uses a child for sexual purposes, and may include such acts as fondling, intercourse, incest, sodomy, exhibitionism, and commercial exploitation.	Condoning inappropriate sexual activity by inaction, not responding to a child's disclosure of sexual abuse, or not reporting suspicion or knowledge of sexual abuse.

There are two forms of child abuse that have been identified relatively recently. **Shaken Baby Syndrome** most often involves infants less than one year and occurs when the infant or young child is shaken violently by a caregiver. The injuries that may result include torn blood vessels and damaged nerves around the brain which may result in brain dysfunction or death.

Munchausen Syndrome by Proxy is a rare form of child abuse and occurs when parents deliberately subject their children to unwarranted medical procedures including examinations, medications, even surgery. The parent may cause symptoms to occur by, for example, administering harmful substances with the intent of inducing a condition which will necessitate the attention of medical staff and the possible hospitalization of the child. Child abuse in any form may, in severe cases, result in the death of a child.

Child in Need of Protection

A child should be considered in need of protection whenever the child's life, health or emotional well-being is endangered by either acts of commission or omission. See the Guidelines for legal detail and discussion. In general, a child in need of protection is one who is (one or more of the following):

- Without adequate care or supervision;
- Under the care or supervision of someone whose conduct might endanger the life, health or emotional well-being of the child;
- Being abused or in danger of being abused;
- Beyond the control of the person responsible for the child's care and supervision;
- At risk of harm or injury due to issues related to the child or the person who is providing care or supervision to the child;
- Being subjected to aggression or sexual exploitation;
- Under 12 years and left unattended without reasonable provision made;
- At risk of an unlawful adoption or sale.

Legal Duty to Report a Child in Need of Protection

Any person who has information that leads him/her to reasonably believe that a child is or might be in need of protection has a legal obligation to report this information to an agency (e.g., child and family services agency) or the parent or guardian. This duty to report applies even when the information is obtained during a professional or confidential relationship such as the nurse-client relationship. Since the parents and guardians are the primary protectors of children, it may be sufficient to notify the parent or guardian to protect the child (e.g., taunting by class-mates). However, most referrals occur to a child and family services (CFS) agency, and if in doubt about reporting, it is advisable to check with a CFS agency. In particular a CFS agency should be notified when there is a reasonable belief that the parent or guardian is responsible for the child to be in need of protection or if the identity of the parent or guardian of the child in need of protection is not known. If a nurse is unsure whether or not a situation needs to be reported, the nurse can first consult with a CFS worker to discuss the situation prior to deciding to report.

After Reporting

The responsibility of the nurse is to report any situation of suspected or alleged abuse to a CFS agency or the police. The CFS agency and/or the police assume responsibility for the investigation of the situation. Each CFS Agency is expected to have a regional/agency child abuse committee charged with the responsibility of reviewing all cases of suspected/alleged child abuse within the agency's region. The regional/agency committees are multidisciplinary. Under the *Child and Family Services Act*, each committee must have representation from the CFS agency, the medical profession, education and the police. The committee can and often does include representation from the other relevant professions as well.

Protection of Informant

If someone reports to a CFS Agency or police in good faith and, after an investigation, abuse is not substantiated the reporting requirements of the *Act* protect the informant from legal action.

Failure to Report

Failure to report by any professional can have three serious consequences:

- 1) The child will not receive the protection required and/or may sustain further abuse.
- 2) The family situation is likely to continue to deteriorate, putting the child (and any siblings) at further risk.
- 3) If a professional fails to report abuse to a CFS agency, he/she can be charged and punished on summary conviction, which at present in Manitoba carries a \$2000.00 fine and/or six months in jail.

These legal requirements supercede all internal policies and procedures.

Abuse by Professionals

When there is reason to suspect that a colleague or another professional is abusive to a child, all of the above responsibilities apply.

How to Report

A report of suspected or alleged child abuse or neglect is made directly to an intake social worker at the local CFS agency. Some agencies have social workers who work specifically in the area of child abuse and reports are usually made to them. It is important that nurses know whom to contact at their local CFS agency both during and after hours.

Information Required

As much of the following information as possible should be provided to the social worker and/or police:

- Full name, age, and address of the child and parent/guardian(s)
- Name(s) and age(s) of other children in the family
- The type of suspected/alleged abuse
- Any available social history of the family
- The name and agency affiliation of the person reporting
- Dates and times of disclosure (if applicable)

Note: When a report is made, it is the responsibility of the CFS worker to contact the parent/guardian(s) of the child.

Documentation

Whether the nurse sees an abused child and his/her family in a hospital emergency department, a pediatric ward, or the community, clear and concise documentation of the situation is absolutely necessary. It is recommended that this documentation be done as soon as possible after a disclosure or witnessing of abuse. The following should be documented:

- A description of the child, including any physical abuse that may be noted (drawings may be useful to pinpoint the area, size, and colour of injuries)
- An accurate recording of the child's developmental stage
- Height and weight plotted on a growth chart
- The child's behaviour with and without his/her parent/guardian(s) and other visitors
- Specific dates and times of disclosure(s) - if applicable
- Visits and telephone calls by the parent/guardian(s)
- Consultation with other health professionals
- Name and agency of the social worker and/or police officer contacted

Points to Remember

Caution must be taken not to chart subjective feelings. In obtaining the necessary information a nurse must:

- Take a nursing history, remembering to allow the parent/guardian(s) to state, in their own words, what happened to the child. The child should **not** be present.
- Allow time for the parent/guardian(s) to describe the child's behaviour as they see it.
- Use open-ended questions.
- Document fully the child's history of what happened to him/her. If possible and appropriate, this interview should be done when the parent/guardian(s) is **not** present.
- Maintain a matter-of-fact non-judgemental attitude.
- Control one's own non-verbal behaviour, always appearing interested and empathic.

Nurses should follow-up all verbal reports made to a CFS agency and the police with a letter outlining the details of the referral. This ensures that an accurate, written account of the referral is on record. The nurse's supervisor should always be notified when a report is made.

Court Testimony

Nurses who have been involved in the identification or care of an abusive family are sometimes required to testify as a witness at a court hearing. Often cases come to court long after the incident occurred. Therefore, clear documentation at the time of the incident makes organizing and presenting evidence at a later date easier.

Points to Remember

- Notify your supervisor when you receive a subpoena.
- Contact the lawyer calling you to court to review what is expected of you.
- Take a resume of your education, qualifications, and experience.
- Personal notes may be produced in court for cross-examination - all notes should be clear, concise, and dated.
- When testifying in court, nurses should describe only direct observations - reporting what one has been told by someone else is considered “hearsay” and is not permitted.
- The Personal Health Information Act (PHIA) allows for the sharing of personal health information without consent of the individual in cases of child protection.
- Questions raising ethical issues (e.g., confidentiality) can be referred to the judge by the nurse at any time. The lawyer calling you to court should be aware of such issues beforehand.
- A nurse who testifies as an expert is free to express professional opinions and to refer to professional literature. Texts and articles may be taken into the witness box and referred to as required.

For further information on the legal process, see Section IV - Legal Processes.

II CHARACTERISTICS AND INDICATORS OF ABUSE

Characteristics of Abuse

The abused child is often one who is seen as different by his/her parent(s) or one who fails to respond in the expected manner.

Some characteristics that may predispose children to be at risk are:

- The child with a congenital abnormality, either physical or mental
- The premature infant or the ill newborn who is separated from his/her parent(s) during the neonatal period
- The colicky or irritable child
- The child who is rigid or non-cuddly
- The unwanted child
- The child who is not of the gender desired by the parent(s)
- The child with dubious paternity
- The foster, adopted, or stepchild
- The exceptional child, e.g., learning disabled, gifted or hyperactive

Other characteristics often seen in abusive families:

- A child trying to meet the parent's emotional needs.
- Parent with unrealistic expectations of a child.
- Parent who demeans, does not recognize, or ignores the child's physical and/or emotional needs.
- Parent who seems to abdicate the parenting role and has very few, if any, expectations of the child.
- Family history of abuse and/or neglect.
- Regular use of harsh physical punishment as a means of discipline.
- Delay by a parent in seeking medical attention.
- Discrepancies or inconsistencies in the history, or a history which is not compatible with the presenting problem.
- Vagueness about specific and important details.
- Parent who does not demonstrate interest in the child's condition or well-being or who fails to visit or enquire about the child following admission to hospital.
- Frequent disruptions in continuity of medical care:
 - a) changing physician and/or hospital.
 - b) inordinate frequency of emergency visits.
 - c) frequent relocation of the family.
 - d) disregard for essential follow-up care.

Indicators of Abuse

A Caution About the Use of Indicators: Since there are many types of abuse, abusers, and abused children, no single list of indicators applies to all of them. Therefore, one must exercise caution in the use of the following tables. As well, the tables are not all-encompassing, but present many of the common indicators. These indicators should be used as a guide, together with other diagnostic skills to determine the presence or absence of abuse. The presence of one of these indicators, or even several of them, does not necessarily mean that abuse has occurred. However, it may mean that the family does need some help. In addition, it is estimated that as many as 25% of children who have been abused have no significant behavioural changes.

In examining children with injuries and considering the possibility of maltreatment, it is important to take into account their age and developmental stage. For example, bruising on the shins of a six month old has quite a different meaning than the same bruising on a toddler.

Questions nurses might ask themselves when assessing children are:

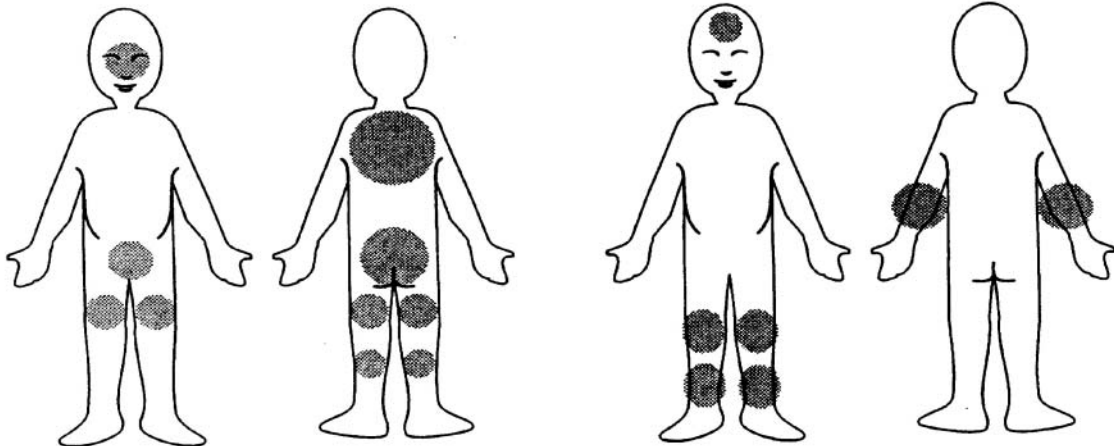
- “Is the child’s behaviour and development consistent with their age?”
- “Could the injury have happened as described?”
- “Does this seem reasonable?”

Nurses require knowledge and skills to recognize differences between accidental and suspicious injuries as well as normal conditions. For example, Mongolian spots can be mistaken for bruising, infected impetigo can resemble cigarette burns, and there can be medical reasons for some fractures and bruising. It is very important to avoid an accusatory attitude when examining children and making nursing assessments.

Location of Bruises and Abrasions

Suspicious Sites

Common Accidental Sites



Physical Abuse

Physical Indicators

Bruises, marks, welts, lacerations, or abrasions:

- on face, lips, mouth, gums, eyes
- on torso, back, buttocks, external genitalia, thighs
- in various stages of healing
- clustered, forming regular patterns
- reflecting shape of implement used to inflict, e.g., electrical cord, belt buckle
- on several different surfaces
- regularly appear after absence, weekend, or vacation
- bald patches on scalp

Burns:

- cigar/cigarette, especially on soles, palms, or buttocks
- immersion burns, e.g., sock-like, glove-like, doughnut-shaped on buttocks or genitalia
- patterned like electric burner, iron, etc.
- rope burns on arms, legs, neck, or torso
- infected burns, indicating delay in seeking treatment

Fractures/dislocations:

- to skull, nose, facial structure, posterior ribs, long bones, spinous processes, sternum, or scapulae
- in various stages of healing
- multiple or spiral fractures

Behavioural Indicators

- Reports injuries by others
- Lies very still while surveying surroundings
- Vacant or frozen stare
- Does not seek comfort when injured
- Fear of a particular person or place
- Indiscriminately seeks affection
- Does not appear apprehensive when approached by an examiner (age dependent)
- Wary of physical contact
- Apprehensive when other children cry
- Manipulative behaviour to get attention
- Behaviour extremes, e.g., aggressive, withdrawn
- Inappropriate or precocious maturity
- Expresses feeling deserving of punishment
- Capable of only superficial relationships
- Afraid to go home
- Poor self-concept/self-esteem
- Uncharacteristic changes in behaviour

- Constantly tries to please the parent/guardian
- Role-reversal: tries to care for parent, with particular emphasis on emotional care
- Isolated, few friends
- Unusual need to achieve
- Impaired capacity to enjoy life

Neglect

Physical Indicators

- Underweight, poor growth pattern, failure to thrive
- Abdominal distention
- Wasting of subcutaneous tissue
- Bald patches on the scalp
- Constant hunger, unkempt, inappropriate dress
- Consistent lack of supervision
- Poor hygiene:
 - persistent diaper rash
 - skin rashes
 - dirty hair and face
 - persistent body odour
- Unattended needs:
 - glasses
 - dental work
 - medical care, e.g., immunizations
- Abandonment

Behavioural Indicators

- Inactive babies, no vocalization
- “Silent watchers” - children with hyper-vigilant, expressionless facial appearance
- Indiscriminate seeking of affection
- Begging, stealing, hoarding food
- Extended stays at school (early arrival and/or late departure)
- Inconsistent attendance at school
- Constant fatigue, listlessness, or falling asleep in class
- Underachievement
- Obvious lack of energy when playing
- Pseudo-independence
- Assuming adult responsibilities and concerns (e.g., physical care for home and siblings)
- Child states there is no caregiver
- Alcohol or drug abuse
- Delinquency, e.g., thefts
- Few or superficial friendships

Sexual Abuse

Physical Indicators

- Bruises, bleeding, or lacerations of external genitalia, vaginal, or anal areas
- Torn, stained, or bloody underclothing
- Pain, swelling, or itching in genital area
- Difficulty in walking or sitting
- Pain on urination
- Vaginal/penile discharge
- Poor sphincter tone
- Repeated urinary tract infections
- Recurrent abdominal pain
- Sexually transmitted disease, especially in pre-teens
- Pregnancy

Behavioural Indicators

Reactions similar to those precipitated by any other severe stress including:

- Regressive behaviour in younger children, e.g., bed-wetting, thumb-sucking
- Sudden fears or phobias, e.g., of the dark or of a particular person, place, or situation
- Running away from home
- Abuse of drugs or alcohol
- Noticeable personality changes, e.g., depression, anger, hostility, aggression
- Change in school performance
- Suicidal thoughts or attempts
- Self-mutilation

Reactions more likely related to sexual abuse including:

- States he/she is being sexually assaulted
- Provocative drawings of sexual nature
- Age-inappropriate sexual play
- Compulsive masturbation
- Bizarre, sophisticated, or unusual sexual behaviour or knowledge
- Overtly seductive behaviour or aversion to intimacy with adults
- Promiscuity
- Withdrawal from peers
- Prostitution
- Confusion about sexual identity, norms, love, caregiving/receiving

Emotional Abuse

Physical Indicators

- Speech disorders
- Lags in physical development
- Failure to thrive
- Hyperactive/disruptive behaviour
- States no one cares about him/her or that he/she is no good and cannot succeed

- Extreme lack of confidence, withdrawn, depressed
- Inability to concentrate, continual procrastination
- Over-participation, e.g., involvement in too many activities
- “Has to win” attitude
- Fear of new situation and changes
- Becomes depressed at school holiday times
- Presence of psychosomatic complaints, e.g., headaches, nausea, abdominal pain

Behavioural Indicators

- Behaviour extremes: compliant, passive-aggressive, demanding
- Conduct/learning issues: antisocial, destructive
- Developmental lags: mental, emotional
- Habit disorder: sucking, biting, rocking
- Neurotic traits: sleep disorders, inhibition of play, unusual fearfulness
- Overly adaptive behaviour: inappropriately adult, inappropriately infant
- Psychoneurotic reactions: hysteria, obsession, compulsion, phobias, hypochondria
- Suicide, threatened or attempted

For further information see Appendix A: Statistics and Common Questions about Child Abuse

III PREVENTION AND THE ROLE OF THE NURSE

The major roles of the nursing profession in child maltreatment are in the areas of identification, reporting, early intervention and prevention:

Identification

Having the knowledge and skills to assess injuries, behaviours, and family functioning in order to recognize abusive situations.

Reporting

Having knowledge of one's legal responsibilities, understanding the reporting process, and carrying it out.

Early Intervention

Having knowledge and understanding of healthy child and family functioning, recognizing potentially stressful situations, knowing available resources, and having the skills to intervene in an appropriate manner.

Prevention

Using knowledge and understanding of healthy attachment patterns, expected growth and development needs, and positive non-physical disciplinary strategies to promote healthy parenting.

Prevention Strategies for Nurses

The goal of prevention is to provide care and to promote activities which are focussed on improving parenting skills. The following are examples of strategies nurses might use:

- Disseminate family life information at all stages of the life cycle. This should include information on the importance of creating a nurturing environment for children, normal growth and development, values, human sexuality, decision-making, problem-solving skills, family planning, having respect for one's body, and use of non-physical disciplinary strategies.
- Promote the development of family and community support systems throughout the child-bearing period, including early and regular prenatal care, adequate nutrition, attendance at pre-natal classes, parenting courses, involvement of extended family members, and respite care as appropriate.
- Promote and enhance development of at least one consistent and nurturing relationship for all children.
- Help parents improve their self-image and feeling of confidence in being able to care for their children.
- Communicate with other professionals at all stages of a child's life to allow for the utilization of resources to help prevent problems.

Nurses working in specialized areas of child maltreatment such as treatment, research, education and advocacy require specific advanced knowledge and skills for those settings. However, in order to practice effectively in any setting with children and families where child maltreatment is a concern, issues of knowledge, skills, and dealing with personal feelings need to be understood.

Knowledge

The nurse needs a sound knowledge of:

- normal child growth and development
- normal attachment theory
- healthy family functioning
- dynamics of child maltreatment
- characteristics of abusive parents and abused children
- characteristics of high risk parents/caregivers and children
- reactions of parents and children when confronted with the fact that abuse or neglect is being considered or confirmed
- positive (non-physical) disciplinary strategies that are age-appropriate

Skills

Assessment

- Physical assessment - expertise in normal childhood physical and cognitive development and the ability to consider whether injuries might be non-accidental.
- Social and emotional assessment - ability to assess the general social and emotional functioning of children and families.

Interviewing

The nurse needs the ability to talk with children and families in a manner that:

- is appropriate to the age and developmental stage.
- is respectful and projects a feeling of good will toward the person.
- establishes a sense of trust.
- provides honest interpretation and feedback.

Dealing with Personal Feelings

Nurses working with abused children and their families tend to experience feelings of rage, anger, horror, sadness, pity, empathy, fear, hopelessness, and helplessness. Sometimes, nurses are reminded of personal experiences, e.g., their own childhood, their present situation, their own parenting style. It is important to be aware of feelings, to label them, and to begin to deal with them. No feeling is wrong or bad, it simply occurs. Dealing with personal values and feelings about child maltreatment is important so that these feelings do not interfere in one's abilities to help abused children and their families.

IV LEGAL PROCESSES

The following processes apply in general although each case is specific to its circumstances and variations may occur.

1. The provincial requirements of *The Child and Family Services Act* set out specific procedures to be followed in the management of child abuse cases. The *Act* requires agency child abuse committees to review all suspected cases of child abuse.

Child abuse committees are composed of persons from many disciplines and include the agency child abuse co-ordinator, another agency staff member, a qualified medical practitioner, local law enforcement personnel, a representative from the local school division, plus any others who may have significant input (e.g. Elder, probation officer, nurse).

The Personal Health Information Act (PHIA) allows for the sharing of personal health information without the consent of the individual to facilitate a child protection investigation.

2. The *Act* requires the Director of Child and Family Services to maintain a Child Abuse Registry. Upon completion of a full abuse investigation, an agency, where there is a finding of abuse (and upon the review of the agency's abuse committee) will submit to the Director of Child and Family Services the names of abusers for entry in the Registry where:
 - (a) a person has been convicted of abusing the child;
 - (b) a court finds on the basis of abuse that a child is in need of protection; or
 - (c) where an agency's child abuse committee has reviewed the case and is of the opinion that the person abused the child and that the person's name should be entered on the Registry. The person's name and the circumstances of the abuse will be forwarded to the Director.

Under (c) the name(s) will not be forwarded to the Director for placement on the Registry until the following steps occur. Anyone being considered under part (c) for possible registration will be first provided with an opportunity to provide information to a child abuse committee. The information will be reviewed by the child abuse committee and considered when they formulate their opinions. If the child abuse committee is of the opinion under (c) that a person abused a child and that the person's name should be entered in the Registry that person is notified of the intent to register and the reasons why. The person can object to the entry by filing an objection with the Court of Queen's Bench of Manitoba within 60 days and a hearing will occur. The name is not forwarded to the Registry until the appeal period has passed or the court hearing has been concluded.

3. If child abuse cases are legally processed this may occur by two routes (which often occur simultaneously):
 - (a) Family Court and/or
 - (b) Criminal Court

The legislation that principally guides child protection services is to be found either in:

(c) *The Child and Family Services Act* (Manitoba)

(d) *The Criminal Code* (Canada)

4. It is important to note that where a child is defined to be in need of protection and a change in guardianship is required, an apprehension hearing will take place in Family Court. This type of hearing will take place regardless of whether a criminal hearing is scheduled to take place.
5. In order for an abuse case to be heard in Family Court, the Child and Family Services agencies will have investigated a report of abuse to a child. This means that, as well as interviewing the child and family, the agency will have sought information from pertinent collateral sources.
6. As a result of this investigation, the agency will determine whether or not it is necessary to remove the child from the home (apprehension). When apprehension of a child occurs, evidence must subsequently be presented in Family Court. The court hearing is necessary in order to facilitate an impartial inquiry regarding the child's need for protection and to allow the parents to present (with legal representation) their interpretation of the events of concern to the agency.
7. Generally, a Family Court hearing does not attempt to find a guilty party. It attempts to answer the question, "Is the child in need of protection?" If the judge finds the child to be in need of protection, he or she will grant the application (made by the agency) for an Order of Guardianship or Supervision of the child. With the exception of extreme cases of child abuse (for example, the child permanently disabled by the abusive injury or a previous history of abusive injuries) this Order of Guardianship (granted at a first hearing) would be a Temporary Order of Guardianship.
8. Permanent Orders of Guardianship of a child are rarely requested at a first hearing. It is hoped that during the period of temporary guardianship, the parents will be able (with help) to make the type of changes that would result in a non-abusive home environment. The Temporary Order of Guardianship also allows the child to receive, through substitute care, the nurturing and stimulation appropriate to his/her age and developmental stage, thus helping to ameliorate some of the deficits of the abusive home.
9. In addition to the Family Court hearing, a Criminal Court hearing may be scheduled for the same case. It is important to note that the criminal process varies considerably from that of Family Court. For a Criminal Court hearing to take place, charges must be laid against one or both parents (or other persons). The primary purpose in Criminal Court is to determine the guilt or innocence of the alleged offender(s), not the protection needs of the child. This does not mean that the Criminal Court disregards the needs of the child but that the focus is different from that of Family Court.

10. In those cases where an alleged offender is found guilty in the Criminal Court, sentencing will take place as it would for any other criminal offence. Therefore, a person found to be guilty of child abuse may be put on probation or given a jail sentence. Sentencing can occur in Criminal Court regardless of the decision made in Family Court. On the other hand, a guardianship order can be made in Family Court even if the alleged offender is found not guilty in Criminal Court. Therefore, the two processes can be viewed as separate in intention and focus, but both related to abuse allegations.
11. Manitoba, like other provinces, has developed guidelines for helping to determine which cases should be referred to Criminal Court. All sexual abuse cases are referred to the police (special unit) for investigation. The police, in consultation (where necessary) with the crown prosecutor, determine whether charges will be laid. If charges are laid, the case will be processed through the criminal system.
12. Physical abuse cases, where there are serious injuries that can be conclusively determined to be abusive in nature (by medical practitioner), are usually referred to the police for investigation. If charges are laid, the case will be processed through the criminal system in the same manner as sexual abuse cases.
13. In both types of abuse, the difficulty in criminal prosecution is related to the type of evidence that is admissible in Criminal Court. When abuse occurs to young children (particularly nonverbal children) and there are not witnesses to the abusive act, it is often difficult to proceed in Criminal Court unless there is corroboration such as medical evidence. Recent changes in the *Criminal Code* have reduced, but not completely eliminated, these difficulties.

APPENDIX A

Statistics and Common Questions about Child Abuse

1. How may children be abused or neglected in Canada?

The following are the highlights from Child Maltreatment in Canada: Canadian Incidence Study (CIS) of Reported Child Abuse and Neglect (Health Canada, 2001).

- In 1998, there were an estimated 21.52 investigations of child maltreatment per 1,000 children in Canada. Forty-five percent of these investigations were substantiated, 22% remained suspected, and 33% were found to be unsubstantiated.
- Child maltreatment investigations were divided into four primary categories: physical abuse (31% of all investigations), sexual abuse (10% of all investigations), neglect (40% of all investigations), and emotional maltreatment (19% of all investigations).
- Thirty-four percent of the physical abuse investigations were found to be substantiated. This compares with 38% for sexual abuse, 43% for neglect, and 54% for emotional maltreatment.
- Substantiated cases of physical abuse consisted of:
 - inappropriate punishment (69%)
 - Shaken Baby Syndrome (1%)
 - other forms of physical abuse (31%)
- Substantiated cases of sexual abuse consisted of:
 - touching and fondling of the genitals (68%)
 - attempted and completed intercourse (35%)
 - adult exposing genitals to a child (12%)
- Substantiated cases of neglect consisted of:
 - failure to supervise or protect leading to physical harm (48%)
 - physical neglect (19%)
 - permitting maladaptive/criminal behaviour (14%)
 - abandonment (12%)
 - educational neglect (11%)
- Substantiated cases of emotional maltreatment consisted of:
 - exposure to family violence (58%)
 - emotional abuse (34%)
 - emotional neglect (16%)

2. Are there more children being abused now than there were in the past?

Although we know of more child abuse now than we did in the past, most experts feel that we identify more child abuse now because physicians, nurses, social workers, teachers, and other professionals are better able to detect child abuse.

3. Does most abuse occur in low socio-economic families and in families not well-educated?

According to statistics there are more reports of child abuse and neglect in lower income families. This may be because these families are involved with public agencies, such as Welfare, and Public Health clinics and hospitals and are therefore more visible to the authorities. Child abuse is not, however, limited to the poor. Many professionals believe that the middle-class and rich are just as likely to abuse their children as are the poor. Other professionals believe that the poor actually do abuse more often because they have more of the kinds of problems which increase stress, contributing to child abuse.

4. Is the parent usually the person who physically abuses the child?

In many cases the abuser is related to the child, most commonly a parent or step-parent. In a few cases, someone unrelated to the child, such as a babysitter or the mother's boyfriend, is the abuser. In even fewer cases, the abuser is a brother or sister.

It depends on who spends the most time with the child. In abusive families where the mother is home all day, she is more likely to be the one who abuses. If the father is home all day, he may be the abuser. In some homes, one person, either the mother or father, abuses the child, but the other parent does not protect the child and allows the abuse to continue.

5. What are some of the factors that would influence a person's personality in a way that would make him or her more likely to physically abuse a child?

- A parent who was abused and neglected as a child.
- A parent who was not nurtured and/or rarely experienced positive parenting.
- A parent who regularly uses harsh physical punishment for behaviour management.
- A parent who was considered "different" in his/her family.
- A parent who relies on their child(ren) to meet their emotional needs.

The existence of any one of these factors does not necessarily mean that a parent will be an abuser, but together, these feelings and experiences are often present in many of the parents who abuse their children.

6. Do most parents intend or plan to physically abuse their children?

Usually parents who physically abuse their children love their children. They may not mean to hurt them, but may be angry about something else that happened during the day and/or regularly use harsh physical punishment in behaviour management.

7. Who usually sexually abuses children?

In most cases (approximately 90%) the sexual abuser is someone the child knows and trusts. Studies state that the majority of sexual abusers are male, although we know that some females also abuse children. Usually the abuser is a family member, a relative, a babysitter or a close family friend.

8. What are some of the factors that would influence a person's personality in a way that would make him or her more likely to sexually abuse a child?

- A person who was sexually abused as a child.
- A person who was physically abused or neglected as a child.
- A person who grew up in a home where other people were physically and/or sexually abused.
- A person who grew up in a home where there was no respect for individual privacy.
- A person who grew up in a home where they were prematurely exposed to eroticised relationships and behaviours.

The existence of any one of these factors does not necessarily mean that a person will be an abuser, but together, these experiences seem to have been part of the lives of people who do sexually abuse children.

9. Are parents who abuse their children mentally ill or criminals?

Most parents who abuse their children are unhappy, lonely people with many problems. They often lacked parental nurturing, appropriate guidance and were themselves abused as children. Experts feel that most parents can be helped; only a few abusive parents are mentally ill or criminal.

10. How old are most children who are abused?

In 2000, the Children's Hospital Child Protection Centre's statistics regarding children diagnosed as being physically or sexually abused indicated the following:

AGES	PHYSICAL ABUSE		SEXUAL ABUSE	
	Boys	Girls	Boys	Girls
0 - 2 years	9%	10%	1%	2%
2 - 6 years	16%	11%	8%	25%
6 - 12 years	23%	15%	4%	31%
over 12 years	2%	15%	1%	28%

APPENDIX B

Bibliography and Selected Resources

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Daigle, M. You are not the boss of me. Ontario: Outreach Child Abuse Prevention.

Freeman, L. It's my body. Seattle, WA: Parenting Press.

Freeman, L. Loving touches. Seattle, WA: Parenting Press.

Jessie. Please tell! A child's story about sexual abuse. Early Steps.

Kehoe, P. Something happened and I'm scared to tell. Seattle, WA: Parenting Press.

Otto, M. Never, no matter what.

Paris, S. Mommy and Daddy are fighting. Seattle: The Seal Press.

Porett, J. When I was little like you. Washington, DC: Child Welfare League of America

Satulla, J. It happens to boys too....Rape Crisis Centre of Berkshire County, Inc.

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Child Protection Centre. Never shake a baby! Child Protection Centre, Health Sciences Centre, Winnipeg, Manitoba.

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National Clearing House on Family Violence, Health Canada:
Sexual Abuse Counselling: A guide for parents and children
When Children Act Out Sexually: A guide for parents and teachers
When Boys Have Been Sexually Abused: A guide for young boys
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Sexual Abuse - What Happens When You Tell: A guide for children

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Kidsrights Video (1990). Shaking, Hitting, Spanking: What to Do Instead. (with accompanying booklet) 30 minutes.
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Websites

National Clearing House on Family Violence (Health Canada)
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