

6. Child abuse and domestic violence

Health status

Key point

- ▶ *A significant number of children in New Zealand are victims of maltreatment through physical, emotional or sexual abuse, neglect, peer abuse, and/or being caught up in domestic violence.*

- Between eight and 12 children die annually as a result of assault by their parents or caregivers (Kotch et al 1992). In 1994, a total of 13 children were classified as having died as a result of deliberately inflicted injuries, including child battering. Seven of these children were preschoolers (NZHIS 1998).
- In 1996/97, there were 3901 reported violent or abusive offences (including sexual offences) against children 16 years and under (data supplied by the Policy and Planning Group, New Zealand Police). These included sexual offences (48 percent), assault (29 percent) and child abuse (20 percent).
- There were 194 cases of intentional physical harm resulting in hospitalisation of children 0 to 14 years of age in 1995 (a rate of 23 per 100 000 children). Hospitalisation is more common in males and in Māori (Ministry of Health 1998).
- In the year ending June 1997, there were 23 246 notifications of suspected abuse or neglect made to the Children Young Persons and Their Families Service (CYPFS). Of these, 18 467 were accepted for investigation (Department of Social Welfare 1997).
- Both boys and girls are at risk of sexual abuse. A random survey of 3000 Otago women found that 31 percent of women had had unwanted sexual experiences before the age of 16 years (Anderson et al 1993).
- Various surveys have identified peer emotional and physical violence (including bullying) as a significant problem for New Zealand children and young people (Maxwell and Carroll-Lind 1996; Kearney 1993; Special Education Services 1994).
- Many children witness physical violence between their caregivers and some are physically caught up in this themselves (Robertson and Busch 1994; Maxwell 1994; National Collective of Independent Women's Refuges 1991).

Implications

Key point

- ▶ *Children who experience abuse are more prone than non-abused children to develop emotional, behavioural, social, and cognitive problems that will affect them during their childhood and later life.*

Child abuse has traditionally extended to physical, sexual, emotional maltreatment and neglect perpetrated by adults but children can also be abused by their peers (bullying and sexual molestation). Exposure to the violence perpetrated by their caregivers towards each other is also abusive for children.

Family violence (including child abuse) and other forms of violence affecting children are major social problems with negative short- and long-term impacts on the children and well recognised intergenerational patterns (Browne et al 1989; Tattum 1993; Jaffe et al 1991; Fergusson et al 1997; Fergusson and Lynskey 1997; Mullen et al 1993).

The short- and long-term outcomes of child abuse and neglect have been found to include physical aggression and antisocial behaviour, violent offending, re-abuse, social incompetence, suicide, and mental health problems (Fergusson and Lynskey 1997; Mrazek and Haggerty 1994). Sexually abused children may develop sexually inappropriate behaviour and a variety of emotional and behavioural problems. Various studies have found a positive correlation between reported abuse and greater than normal levels of psychopathology in adult life (Mullen et al 1993; Mrazek and Haggerty 1994). The consequences of abuse and neglect can be especially severe in the early stages of child development (Perry 1996; Mrazek and Haggerty 1994).

Children caught up in domestic violence have been found to experience disturbed patterns of cognitive, emotional and behavioural adjustment (Jaffe et al 1991).

Various studies have found that women subjected to highly intrusive sexual abuse as children are more likely than non-abused women to have low self-esteem and sexual problems, become pregnant before 19 years of age, harm themselves, and to experience a variety of psychiatric disorders (Romans et al 1995, 1997; Briggs and Joyce 1997; Bushnell et al 1992; Beauvais et al 1994).

Factors influencing health status

Key point

- ▶ *There are a range of social, economic and family factors, which may be interactive in nature, known to be associated with increased risk of a child being abused.*

While no single variable can adequately explain the origins of child maltreatment, and interactive effects between contributing factors will be present in every case, the following factors have been found to be associated with increased risk of child abuse (Mrazek and Haggerty 1994; Browne et al 1989):

- domestic violence between caregivers
- intergenerational history of family violence (including sexual abuse)
- social stresses including poverty
- unsatisfactory and unstable housing
- young parents
- social isolation
- single-parent family
- unwanted child
- attachment difficulties, including separations from child
- history of mental illness, drug or alcohol addiction in the caregiver
- child disabled.

Also:

- children between the ages of 0 and 4 are most at risk of physical assault by parents and caregivers (NZHIS 1998)
- a New Zealand health survey found that the girls were most at risk of sexual abuse between the ages of 8 and 12 years (Anderson et al 1993)
- a child previously abused is at increased risk of further abuse (Jellinek et al 1995).

Interventions

1 Educating children in skills to avoid becoming a victim or a perpetrator of abuse (for example, anti-bullying programmes and 'keeping ourselves safe' programmes)

Key point

- ▶ *Children learn from programmes that teach them how to keep themselves safe, but it is not clear whether they can carry new behaviour over to real life situations.*

Interventions aimed at assisting primary school aged children to identify inappropriate advances by an adult have been evaluated and RCTs have demonstrated that education programmes significantly increase knowledge about sexual abuse, enhance awareness of safety skills and modify children's behaviour in response to hypothetical vignettes. However, the appropriate response of a child in a research situation does not guarantee that the child will protect themselves in a real situation. No study has produced evidence that educating children about abduction and sexual abuse actually reduces the occurrence of sexual abuse (MacMillan et al 1994).

A nationwide Norwegian programme involving teachers, parents and provision of informational material to children and adults was able to reduce antisocial behaviour in the school environment (Olweus 1991 cited in Earls 1994). A range of anti-bullying programmes exist in New Zealand and other countries. This review has not identified assessments of the effectiveness of these programmes.

2 Educating the population at large, and parents in particular, to improve parenting practices, increase awareness of abuse, encourage notification to child protection services, and to change attitudes (for example, Police domestic violence campaigns, CYPFS 'Breaking the Cycle' campaign)

Measures to prevent child abuse are delivered at a societal, community or age group level and are concerned with changing attitudes, values and behaviour. This review has not identified any reviews evaluating the effectiveness of community-wide public education programmes aimed at changing attitudes or increasing reports of abuse to authorities.

CYPFS has used a 'social marketing' approach in an attempt to change abusive parenting behaviour. Part of the Service's 'Breaking the Cycle' campaign has involved a multimedia approach using television advertisements, radio and print advertising, as well as parenting

booklets underpinned by an 0800 freephone providing counselling, information and referral. Ongoing qualitative and quantitative research has been undertaken to determine the general public's awareness of child abuse and its attitudes to this mistreatment. Results from the research to date show that the campaign has increased awareness and self-reported behaviour change (Hall and Stannard 1997).

3 Intensive home visiting

Key points

- ▶ *A review of research has not unequivocally established intensive home visiting as an effective intervention in preventing child abuse but there are indications that at least in some cases it has an effect.*
- ▶ *While formal screening processes that identify families at risk of abusing children are not advocated, knowledge of risk factors is important in helping professional staff make decisions about appropriate interventions.*

In a review of research on home visiting, Olds and Kitzman (1993) conclude: 'It is particularly difficult to determine whether programs have prevented child abuse and neglect because there are no standardised measures of maltreatment and because definitions of maltreatment vary among studies ... In summary, none of the six trials that sought to use home visiting to prevent child abuse and neglect demonstrated overall decreases in maltreatment as evidenced by state CPS (child protection services) records. Three, however, did demonstrate differences for at least some study participants which are suggestive of benefits, either in decreasing abuse and neglect, improving parenting, or decreasing use of medical services often associated with abuse and neglect.'

A related issue is the identification of families to target for extra services. Can families be screened in order to identify whether they are at risk of abusing or neglecting children? MacMillan et al (1994) determine: 'There is insufficient evidence to justify use of screening approaches to predict child maltreatment in the general population. The main problem is the number of false positives which would arise.' Many families who would not abuse their children might be labelled and put under stress. The authors conclude: 'Nevertheless, knowledge of risk indicators for child maltreatment can assist clinicians in making decisions regarding the provision of preventive interventions to individuals and families in high-risk populations'.

4 Programmes aimed at protecting children from further abuse and lessening the effects of their trauma (care and protection systems and therapeutic interventions) (See Implications for Policy and Services below.)

Implications for policy and services

1 Socioeconomic disadvantage

Key point

- ▶ *Socioeconomic disadvantage is associated with increased risk of child abuse.*

Various studies have found socioeconomic stress a factor in at least some forms of child maltreatment (Browne et al 1989). Issues such as housing, poverty and unemployment are significant. Other studies have noted associations with criminality, alcohol and drug addiction, social isolation, and an intergenerational history of violence (Browne et al 1989). Socioeconomic disadvantage and child health is discussed more fully in the section on Factors Influencing Health Status, at the front of this report.)

2 Māori ethnicity

Key point

- ▶ *Hospitalisation data indicate that tamariki Māori are more at risk of experiencing physical abuse than other New Zealand children.*

The only data available in regard to Māori children relate to hospitalisation rates for injuries purposely afflicted by others. During 1988 and 1995, Māori children were hospitalised because of maltreatment at a greater rate than non-Māori children. (For a discussion on Māori children and child health see the section on Factors Influencing Health Status, at the front of this report.) The provision of culturally effective preventive interventions and treatment services must be a key component of any programmes designed to reduce child abuse and assist victims.

3 Family violence

Key point

- ▶ *Child abuse is more likely to occur in homes where partner violence exists (than in homes where it does not). A variety of initiatives exist which are aimed at reducing family violence.*

Studies indicate that child abuse is more likely to occur in homes already characterised by spousal abuse (McKay 1994, Jaffe et al 1991). In a 1990 study of children in women's refuges, 90 percent of children had witnessed abuse and 50 percent were themselves physically abused (National Collective of Independent Women's Refuges 1991). Children living in homes where family violence occurs are more likely than other children to have behavioural and emotional difficulties, including aggression, during their childhood and in their later life (Robertson and Busch 1994; Jaffe et al 1991). Various public awareness campaigns have drawn attention to family violence issues in New Zealand and a variety of protocols and initiatives have been developed. This review did not examine evidence for effectiveness of interventions aimed at reducing family violence.

However, health care workers in regular contact with families should be alert to the signs of domestic violence and know how to intervene to help prevent further violence. Guidelines on family violence practice protocols will be available, for health sector providers, later in 1998.

4 Physical punishment of children

Key point

- ▶ *Physical punishment is still a primary form of discipline of children in some New Zealand homes. Physical punishment can have negative consequences including physically injuring children.*

While most physical punishment does not injure children, physical abuse, when it occurs, often arises in the context of physical punishment (Kadushin and Martin 1981). Recent research links later maladjustment, including violence, with harsh physical punishment in childhood (Fergusson and Lynskey 1997). Another study links corporal punishment with increased antisocial behaviour in children (Straus et al 1997).

Compared to parents in the 1960s and 1970s, New Zealand parents may now be using less violent forms of physical punishment on their children, but the prevalence of smacking has reduced only slightly (Maxwell 1993). Physical punishment of children in schools and preschools has been illegal since 1990.

Legislative measures and public education in Sweden have been effective in changing attitudes about the use of physical punishment and in reducing its use (Statistics Sweden 1996).

5 Home visiting (See section on Key Interventions to Improve Health Gain for Children and Improve Family Functioning, at the front of this report.)

6 Child mortality reviews (See section on Key Interventions to Improve Health Gain for Children and Improve Family Functioning, at the front of this report.)

7 Secondary prevention

Key point

- ▶ *Ideal preventive work is primary, preventing child abuse before it occurs. However, in many cases, preventive work for healthcare workers begins with recognising the child who has already been abused. Appropriate measures must be taken to reduce the risk of further victimisation.*

Child abuse and neglect is often a continuing pattern of experience for a child (Jellinek et al 1995; Fryere and Miyoshi 1994). It is difficult to reduce the risk of further abuse, and even placement outside the family may not reduce it. Healthcare workers need to know how to recognise abuse when they see it and how to work with statutory agencies to try to ensure the future safety of the child (see Inter-agency Co-operation and Professional Education below).

In most situations, those who abuse children are family members. In some situations the need to prevent further abuse may lead to a decision to remove a child or young person from the family, whether temporarily or permanently. These decisions are made by statutory social workers within CYPFS and are difficult decisions to make. Children and young people who are removed from their families continue to need input from healthcare services.

In many cases, secondary prevention involves therapeutic programmes targeted at the family to reduce the risk of repeated abuse (see Therapeutic Services below).

8 Therapeutic services

Key point

- ▶ *Adequate family support and therapeutic services for abused children are a part of prevention because of their potential to protect the child from further abuse and reduce risk of the child developing into an abuser themselves.*

Children (and their families and caregivers) who have experienced maltreatment often require extensive emotional and social support and rehabilitation. Therapeutic services are of a secondary prevention nature because they reduce the risk of revictimisation and contribute to the rehabilitation of the child therefore reducing the risk of a child becoming violent later in their development. The most effective therapy is that introduced early to aid the child's recovery from the trauma they have experienced. In situations where the child has not been abused by a family member, the family plays a crucial part in the child's recovery and needs access to support services.

In New Zealand, sexual abuse victims (but not their families) can have treatment costs met by ACC. Some assistance for children who have been affected by domestic violence is available under the Domestic Violence Act 1995. Assistance for other children is dependent on the availability of child mental health services and community-based family support agencies. Shortcomings and deficiencies in mental health services for children and young people have been commented on in recent reports (Mason et al 1996; McGeorge 1995).

9 Inter-agency co-operation and professional education

Key point

- ▶ *Protecting children from abuse is an inter-agency and public responsibility. The effectiveness of New Zealand systems has not been formally evaluated.*

A wide range of educational, health and family support organisations provide services for children and families. An effective child protection system depends on the ability of staff in early childhood services, schools, child and family support services, and hospitals to recognise abuse and report suspicion of child abuse and neglect to child protection services. New Zealand does not have mandatory reporting but relies instead on raising awareness of abuse and encouraging the public to notify CYPFS when they suspect abuse.

Many countries have formal inter-agency child protection teams. In New Zealand, multidisciplinary advice is sought through Care and Protection Resource Panels (Children, Young Persons and Their Families Act 1989).

Agencies in New Zealand have been encouraged to develop policies and protocols aimed at assisting them to act responsibly in protecting children. The CYPFS published and distributed inter-agency guides and protocols (Children, Young Persons and Their Families Service 1997; Wood and Smith 1993).

The efficacy of the New Zealand care and protection system in improving short- and long-term outcomes for abused children has not been evaluated.

There have been numerous extensive investigations in New Zealand and overseas into the deaths of children who were known to various care and protection systems (Reder et al 1994; Children, Young Persons and Their Families Service 1997). These consider the professional practice of social workers and others who work with families before a child is killed violently and identify characteristics of the children and families involved. Reder et al identify a range of practice short-comings and inter-agency failings, including issues of inter-agency communication and co-operation and a range of personal responses which inhibit best practice. The education of all health professionals is an important part of prevention and responsibility for ensuring this happens lies within the health sector.

10 Research

In the course of preparing this child health programme review and other related child health documents, the limitations on availability of up-to-date and culturally inclusive data has become very clear. Better statistics on the incidence and prevalence of child abuse and other forms of violence affecting children are needed as is research into effective interventions relevant to New Zealand.

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