World Health Organization
REGIONAL OFFICE FOR Europe

European report on preventing child maltreatment

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Edited by:

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ABSTRACT

Child maltreatment is a leading cause of health inequality, with the socioeconomically disadvantaged more at risk. It worsens inequity and perpetuates social injustice because of its far-reaching health and development consequences. In spite of child maltreatment being a priority in most countries in the WHO European Region, few have devoted adequate resources and attention to its prevention. This report outlines the high burden of child maltreatment, its causes and consequences and the cost–effectiveness of prevention programmes. It makes compelling arguments for increased investment in prevention and for mainstreaming prevention objectives into other areas of health and social policy, reflecting the whole-of-society approach promoted by Health 2020 and the need for increased intersectoral working and coordination. The report offers policy-makers a preventive approach based on strong evidence and shared experience to support them in responding to increased demands from the public to tackle child maltreatment. Prevention programmes that stop maltreatment from occurring in the first place and reduce children's exposure to adversity have wide-ranging public health and societal benefits.

Keywords
Child abuse – prevention and control
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CONTENTS

ACRONYMS

ACE	adverse childhood experiences
ADHD	attention deficit hyperactivity disorder
BECAN	The Balkan Epidemiological Study of Child Abuse and Neglect
CBT	cognitive behavioural therapy
CI(s)	confidence interval(s)
CIS	Commonwealth of Independent States
EU	European Union
GDP	gross domestic product
HIC	high-income countries
ICAST	International Society of Child Abuse and Neglect child abuse and neglect screening tools
ISO	International Organization for Standardization
LMIC	low- and middle-income countries
MICS	multiple indicator cluster survey
NCD	noncommunicable diseases
NSPCC	National Society for the Prevention of Cruelty to Children [United Kingdom]
NZFH	National Centre on Early Prevention [Germany]
NFP	nurse–family partnership
OR	odds ratio
SEEK	Safe environment for every kid [programme] [United States]
STEEP™	Steps Towards Effective Enjoyable Parenting [Germany]
VIPP	Video-feedback intervention to promote positive parenting
VIPP–SD	Video-feedback intervention to promote positive parenting – sensitive discipline [component]

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FOREWORD

Reducing child maltreatment is a mainstay of the actions required to reduce inequity in Europe and achieve the goals of Health 2020. Child abuse and neglect are a product of social, cultural, economic and biological factors and occur in all societies and countries in the WHO European Region. They are a leading cause of health inequality and social injustice, with the socioeconomically disadvantaged more at risk. Estimates suggest that at least 18 million children in the Region will suffer from maltreatment during their childhood. Most child abuse and neglect occurs in the community and may not come to the attention of child protection agencies. They are nevertheless grave public health and societal problems with far-reaching consequences for the mental, physical and reproductive health of children and for societal development. Maltreated children are at increased risk of becoming victims or perpetrators of violence in later life and may have poorer educational attainment and employment prospects. Maltreatment is also closely linked to other adverse childhood experiences. The consequences of such adversity may affect people throughout the life-course, with high societal costs.

Child maltreatment has long been regarded as a criminal justice and social issue and has only recently been seen in a public health perspective. This report supports the view that child maltreatment is not inevitable and that it is preventable. It endorses a public health approach and argues that prevention is more cost–effective than dealing with the consequences. Evidence indicates that organized responses by society can prevent child maltreatment. Experience accumulated in countries across the Region and worldwide shows that sustained and systematic approaches can address the underlying causes of violence and make children's lives safer. Among these are programmes to promote positive parenting and provide welfare support to families at risk.

The report documents these evidence-informed approaches, which take a broad interdisciplinary approach that cuts across sectors. Health systems have a key role not only in providing high-quality services for children who experience violence, but also in detecting and supporting families at risk. The health sector is also best placed to advocate for preventive approaches within an evaluative framework.

Member States need to join the global effort to reduce a leading health and social problem and to create safer and more just societies for children in the Region. The prevention of maltreatment in children can only be achieved by mainstreaming responses into other areas of health and social policy. Investing in nurturing relationships would reduce the cycles of violence, improve social cohesion and represent a worthwhile investment. We at the WHO Regional Office for Europe hope that this report will provide policy-makers, practitioners and activists with the facts they need to integrate the agenda for preventing child maltreatment into health and other sectors.

Zsuzsanna Jakab

WHO Regional Director for Europe

EXECUTIVE SUMMARY

Child maltreatment – the physical, sexual, mental abuse and/or neglect of children younger than 18 years – exists in every society. It is common in the WHO European Region and globally, often occurring with other negative experiences, such as having a carer with a mental illness, drug or alcohol problem or who is in prison, or witnessing intimate partner (domestic) violence, or living through parental separation.

While severe child maltreatment may come to the attention of child protection agencies, more hidden forms that progress over many years also exist. Concerns that traditional responses focusing on protecting children from harm are failing to stem the tide of child maltreatment in Europe are increasing, with calls for a greater focus on prevention. This report for policy-makers, practitioners and activists from across government sectors and nongovernmental organizations argues that much child maltreatment can be prevented through a public health approach.

Why is preventing child maltreatment a priority in the WHO European Region?

Child maltreatment leads to the premature death of 852 children under 15 years in the European Region every year. Not all deaths from maltreatment are properly recorded and this figure is likely to be an underestimate.

Data show inequalities in the Region with higher death rates in the east, though trends seem to be declining overall. Deaths, however, are only the tip of the iceberg: much abuse may not come to the attention of child protection services.

National policies and practices on maltreatment vary between countries, making it difficult to take a regional view. Vital registration and official statistics need to be improved to provide a better picture of the scale of the problem at country level. Multidisciplinary approaches to cases, with teams using reliable and valid investigative methods, and periodic surveys to detect hidden maltreatment in the community would contribute greatly to this.

Analyses of community surveys from Europe and around the world have confirmed the extent of abuse in the community. They show a prevalence rate of 9.6% for sexual abuse (13.4% in girls and 5.7% in boys), 22.9% for physical and 29.1% for mental, with no real gender differences. Few studies have been done on neglect, but analyses of worldwide research shows that prevalence is also high – 16.3% for physical neglect and 18.4% for emotional.

Applying these figures to the population of children in Europe suggests that 18 million children suffer from sexual abuse, 44 million from physical abuse and 55 million from mental abuse. More studies in European countries, undertaken periodically using the same methods, are needed to better understand not only the scale of the problem, but also the risk factors and long-term outcomes.

Most maltreatment in the community is relatively mild, although it may persist for long periods. This type of abuse warrants parental supportive interventions by welfare and family support services, rather than investigation by child protection agencies.

What are the consequences and costs of child maltreatment?

Maltreatment may cause stress that affects children's brain development, especially in the early years but also into adolescence. This can lead to cognitive impairment and the development of health-risk behaviours, harming mental and physical health.

The evidence for development of mental ill health, such as depression, anxiety, eating disorders, behaviour problems, suicide attempts, self-harm and illicit drug use, is strong and indisputable. Post-traumatic stress disorder has been reported in as many as a quarter of abused children. Child maltreatment may be responsible for almost a quarter of the burden of mental disorders, especially in association with other adverse or negative experiences in childhood.

There is also a strong association with risky sexual behaviour and sexually transmitted infections, and emerging evidence for the development of obesity and other noncommunicable diseases. It affects schooling, leading to lower educational attainment and poorer employment prospects. The transmission of violence between generations, with violent behaviours passing from grandparents to parents to children – a phenomenon known as the "cycle of violence" – and the tendency for

abuse victims to continue to suffer and inflict violence as they move through life are also long-term consequences of maltreatment in childhood.

Emerging evidence suggests the economic and social costs are very high with heavy health care, social welfare, justice and lost productivity costs, perhaps running into tens of billions of euros: that is on a par with expenditure on noncommunicable diseases.

The extent of maltreatment, its far-reaching health and social consequences and high economic costs emphasize the importance of its prevention. There is an urgent need not only for services to lessen its consequences, but also for better preventive services.

Inequalities in the Region

Death rates are higher in children under 5 years and in boys, who account for 61%.

Child maltreatment is a leading cause of health inequality and social injustice, with poorer and disadvantaged populations being more at risk. Homicide rates in children below 15 years are more than twice as high in low- and middle-income countries in the Region than in high-income countries: 7 out of 10 child homicide deaths occur in these states.

Differences also exist within countries. Child death rates are several times higher in disadvantaged populations than wealthier communities. This is also true for hospital admissions, with children from deprived neighbourhoods more likely to be admitted for assaults. Deprivation exposes children to more risk factors for abuse: these can grow over time, increasing the likelihood of violence and neglect.

Child maltreatment is higher in countries in eastern Europe and in those with high levels of inequality and where there are few social safeguards to buffer families from economic stress. The number of under-threes in institutional social or health care is also higher in these countries. These children may be at increased risk.

Maltreatment makes inequality worse because of its health and social impacts: it also affects social development. The recent economic crisis has led to high levels of unemployment and cutbacks in public health and welfare services. Reports show parents under increasing stress, with depression, anxiety and suicidal-thinking levels rising. These are all risk factors for child abuse and neglect and may jeopardize the gains countries have made in child well-being.

What are the risk and protective factors for child maltreatment?

Biological, social, cultural, economic and environmental factors interact to influence child maltreatment. Most individual-level factors relate to parents and other adults, rather than children, but children with behaviour problems, conduct disorders and disabilities can be at increased risk.

Young, single and poor parents with low education levels may be more likely to maltreat their children. Parents' mental ill health is strongly associated, as is alcohol and drug abuse in the family, parenting stress and poor parenting practice. Intimate partner (domestic) violence, family conflict and poor family solidarity are also linked to child maltreatment.

Maltreatment tends to be more common in families in deprived communities. These areas can lack "social capital" – the institutions, relationships and norms that shape a society's social interaction – and may have many alcohol outlets. Social and cultural acceptability of physical punishment of children, levels of inequality, economic stress and legislation can all affect rates of child maltreatment.

Factors that protect against maltreatment include strong relationships between parents and children, parents having a good understanding of child development, parents' ability to face and respond to challenges (resilience), strong social support and children's emotional and social competence. More research is needed to develop programmes that promote these "protective factors".

What can be done to prevent child maltreatment?

Society has a moral and legal obligation to protect children. Much attention has been paid to detecting abuse and protecting children from further harm, but this report argues that it is high time to focus on ***prevention***. Prevention programmes need to be put in place and a public health, evidence-based approach adopted to meet the challenge.

Child maltreatment and its devastating impacts on young people's lives can be prevented. Prevention initiatives have been implemented in Europe, but only some have been tested for effectiveness. Most research comes from the

United States and focuses on risk factors. The evidence base now needs to be developed in Europe.

Existing studies provide a wealth of information on the types of interventions that show promise in preventing child maltreatment and its associated risks. Programmes that intervene early with at-risk families, providing parenting support throughout the first few years of children's lives, are strongly supported by scientific evidence. They can improve parenting, reduce stress and improve child outcomes; some have also been effective in preventing maltreatment.

Parenting programmes implemented and evaluated in European settings have shown success in addressing risk factors (although their impact on maltreatment has not yet been examined) and can generate significant cost savings. Experience from countries from the Region and worldwide shows that sustained and systematic approaches can address the underlying causes of violence and make children's lives safer.

Less research has looked at the effectiveness of universal approaches in preventing child maltreatment, even though "universalist" measures such as mass media campaigns, social norms programmes and measures to alleviate poverty are widespread across Europe. Developing a better understanding of their impacts should be a priority in creating community- and society-based initiatives. Further research is also needed on how best to promote resilience in children who have been abused.

The way forward in the European Region

This report highlights the great public health and social problem child maltreatment presents. Child abuse and neglect has long been regarded as a criminal justice and social issue, but is now also recognized as a public health concern.

The report supports the view that child maltreatment is not inevitable: it is preventable. It promotes a public health approach which argues that prevention is more cost–effective than dealing with the consequences. Organized responses by society can prevent child maltreatment and the report collates the rich evidence and experience from the Region and elsewhere.

Surveys show that the public and policy-makers are increasingly concerned about this problem. Child maltreatment affects future health, educational and social prospects, so will perpetuate the cycle of disadvantage and social injustice. Reducing it is among the mainstay of actions required to reduce inequity in Europe and achieve the goals of the new European policy framework for health and well-being, Health 2020. This calls for investment in programmes for the prevention of maltreatment and other adverse experiences in childhood, adopting a "whole-of-society" and multisectoral approach led and coordinated by the health sector.

The report proposes a set of actions for Member States, international agencies, nongovernmental organizations, researchers, practitioners and other stakeholders, reflecting European Region and other international policy initiatives.

1. Develop national policy for prevention based on multisectoral action

Health ministries need to take a leadership role in ensuring that national policies and plans for preventing child maltreatment are developed. A national response should be multidisciplinary, involving sectors such as education, social welfare, justice and stakeholders representing local authorities, practitioners and nongovernmental organizations. Monitoring and evaluation should be embedded to assess progress towards objectives. Child maltreatment prevention needs to be mainstreamed into other areas of health and social policy.

2. Take action with evidence-based prevention

Prevention programmes that have been shown to be cost–effective should be implemented. Key approaches include reducing risk factors by providing parenting support through home-visitation and parenting programmes. More "upstream" activities focusing on deprivation, social and gender inequalities, social attitudes towards violence, beliefs in corporal punishment and access to alcohol are worthwhile investments in the long term. These universal population-level approaches require intersectoral action and coordination for successful implementation.

3. Strengthen health systems' response for prevention and rehabilitation

Health systems should provide high-quality detection, recording, treatment, support and rehabilitation services in coordination with other sectors. Health workers can act as advocates for prevention, going beyond their traditional role of gathering, recording and presenting forensic evidence for child protection cases. Primary care teams, school health services and paediatricians are uniquely placed to assess and support children and families at risk and to refer for parenting support. Access to

multidisciplinary support across sectors is essential to successfully mounting a preventive or protective response.

4. Build capacity and exchange good practice

Child maltreatment prevention needs to be mainstreamed into the curricula of health and other professionals. Exchange of best practice can be promoted through existing networks of, for example, focal persons, practitioners (including paediatricians, general practitioners, nurses, teachers, social workers, police personnel and lawyers), researchers and nongovernmental organizations.

5. Improve data collection for monitoring and evaluation

Prevention policies at local, national and regional levels need to be monitored and evaluated. Data on deaths, illness, social and economic factors, risk factors, outcomes and costs are incomplete or unreliable in many countries. There is an urgent need for reliable and valid data that can be exchanged across sectors. Community surveys using international standardized tools should be conducted regularly to identify trends in prevalence, risks and outcomes.

6. Define priorities for research

There is a need for more evidence from European countries and the testing, adaptation and transferral into European social and cultural contexts of programmes that are effective in other parts of the world. More research is needed to identify risk and protective factors and to evaluate preventive programmes. There is also a need for studies to identify types of abuse that require a swift and legalistic response and those that are better served by family-oriented welfare support.

7. Raise awareness and target investment in best buys

Good evidence exists for the cost–effectiveness of interventions for preventing child maltreatment: this can be used to advocate for preventive approaches. Broader government policy using a "whole-of-society" approach is needed to develop nurturing and safer environments for children in families, communities and societies. The benefits of such policies far outweigh the costs and bring advantages to all sectors and society as a whole. Social marketing, mass media and education programmes should be used to raise awareness of the effects of child maltreatment and to promote positive parenting and nonviolent behaviour.

8. Address equity in child maltreatment in the Region

Equity needs to be incorporated at all levels of government policy to achieve greater social justice for children. The health sector should use the Health 2020 framework to fulfil its obligation to advocate across government for just action for children, promoting equity for children's health in all government policies and raising awareness of child maltreatment as a consequence of economic and social activity. The health sector should ensure that prevention is universally incorporated within primary care and child health services, focusing particularly on the socially disadvantaged. Families at risk need to be supported through targeted primary care and community-based welfare support programmes.

Conclusions

Child maltreatment is a serious public health and societal problem in the European Region. It has far-reaching consequences for children's mental, reproductive and physical health and societal development.

The full scale of the problem is coming to light. Conservative estimates suggest that it affects 18 million children and that tens of millions more will suffer from negative consequences that will affect them throughout their lives. Child maltreatment is a leading cause of health inequality, with the socioeconomically disadvantaged more at risk; it worsens inequity and perpetuates social injustice. It is a priority in most countries in the Region, but few have devoted adequate resources and attention to its prevention.

This report outlines the high burden of child maltreatment, its causes and consequences and the cost–effectiveness of prevention programmes. It makes a compelling argument for increased investment in prevention and for mainstreaming prevention objectives into other areas of health and social policy. This complements the "whole-of-society" approach promoted by Health 2020 and requires increased intersectoral working and coordination.

The report offers policy-makers a preventive approach based on strong evidence and shared experience to support them in responding to increased demands from the public to tackle child maltreatment. Prevention programmes that stop it from occurring in the first place and reduce children's exposure have wide-ranging public health and societal benefits. Child maltreatment in unacceptable – this report challenges policy-makers and practitioners to invest in prevention.

CHAPTER 1
OVERVIEW: CHILD MALTREATMENT IN THE WHO EUROPEAN REGION

1.1 General introduction

Child maltreatment is prevalent in every society. It is usually a hidden form of violence and may go undetected by carers and professionals for many years, with serious and far-reaching consequences. Few countries have reliable detection and surveillance systems, but even when they do, reports suggest that 90% of child maltreatment goes unnoticed *(1–3)*. Evidence from population surveys has shown its true extent, with prevalence in the WHO European Region and globally unacceptably high.

The *World report on violence and health (3)* defines child maltreatment as all forms of physical and/or emotional or sexual abuse, deprivation and neglect of children or commercial or other exploitation resulting in harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. The report highlights the unrecognized but large extent of the problem and proposes prevention through a public health approach. The United Nations Secretary-General's study on violence against children has brought renewed policy attention *(4,5)*, but concern about childhood violence and the need for prevention is increasing among Member States of the Region *(6–8)*.

Children may be exposed to more than one type of maltreatment simultaneously, or it may happen over time in infancy, childhood and/or adolescence *(9)*. It can be a chronic recurring condition serious enough to be noticed by families, professionals and bystanders and to merit intervention from child protection agencies. A pattern of relentlessness in the maltreatment is more likely to be associated with adverse health outcomes for the child, such as increased tendency to mental ill health, alcohol abuse and violence starting in adolescence but persisting into later life.

The problem affects every country and community in Europe, but with inequalities in distribution. Rates of fatal child maltreatment are more than twice as high in low- and middle-income countries (LMIC) *(10)*. Differences also exist within countries, with fatality in children of less-well-off parents being several fold higher than in those from wealthier parts of society *(11)*.

Child maltreatment is linked to variations in socioeconomic means. Violence against children may perpetuate more inequalities, leading not only to physical and mental illness, but also affecting educational attainment and future employment and earning potential *(2,5,12)*. Societal costs are high, not least from the delivery of services, mostly affecting countries that can least afford it and consequently posing a threat to ongoing development. Unequal distribution of child maltreatment threatens to further widen the health and social divide within and between countries, leading to greater inequity in health and social injustice *(13)*. Improved understanding of the socioeconomic, community and neighbourhood factors that affect child maltreatment depends on the collection and analysis of relevant data.

Several countries in Europe and worldwide have mounted a response to this public health and social problem over the last few decades by implementing evidence-informed interventions and developing safer communities, demonstrating that reductions in child maltreatment can be attained through sustained and coordinated efforts *(14)*. Such multisectoral approaches are a resource to others in the Region, with a high potential for exchange of expertise: involvement of different disciplines and adoption of a "health-in-all-policies" approach to promoting better health outcomes as a key issue for other sectors are central to the new European policy framework for health and well-being, Health 2020 *(15)*. But some countries, particularly in the eastern part of the Region, have been slow to provide coordinated responses to violence prevention *(16)*. This report aims to support the dissemination of good practice throughout the Region by collating successful responses.

The concept of childhood varies between cultures. It is influenced not only by age and developmental stage, but also by gender, family and social background, school and work *(17)*. Article 1 of the United Nations *Convention on*

the Rights of the Child (18) defines children as those under the age of 18 years. This report focuses on routine information (such as mortality data) on children aged 0–14 years, as these data are available only in 5-year age bands. It also reflects the report's main purpose, the highlighting of maltreatment, which mostly (though not exclusively) occurs in private settings and is perpetrated by parents or other family members: the risk of family violence is superseded by interpersonal violence among peers – strangers and non-family members – after the age of 15 years *(19)*.

The report emphasizes that child maltreatment is a public health and societal problem of serious dimensions. It identifies causes, describes evidence-based prevention programmes and calls on policy-makers and practitioners to take greater action. Mounting a response to child maltreatment requires action not only from the health sector, but also from education, social welfare and justice. The report therefore aims to persuade people from multiple disciplines of the benefits of focusing on prevention.

The first chapter examines why child maltreatment is a public health priority in the Region, emphasizing that it is preventable and providing the rationale for preparing the report. The second describes the overall burden in its various forms and consequences across the Region. Chapter 3 examines risk factors for being a victim and perpetrator and protective factors that give children resilience. The fourth reviews evidence-based programmes to prevent occurrence in the general population and among those at high risk, touching upon dealing with the consequences. And the last chapter describes the global- and European-level policy agenda, advocating for greater action and describing specific policy actions needed to overcome child maltreatment. Methods are described in Annex 1 and additional results presented in Annex 2.

1.2 Why children need special attention

Children do not always have a platform to express their views. They need advocates to protect them from violence *(20)*. The *Convention on the Rights of the Child (18)* requires all Member States to offer effective child protection, giving paramount importance to the rights and best interests of children under the age of 18 (unless adulthood is considered in law to be attained earlier). The mandate includes prevention, but in practice has mainly involved providing support and protecting children from further maltreatment. One of the purposes of this report is to shift the current societal emphasis on child protection

to one that equally emphasizes prevention through sustained and organized efforts.

Childhood is a period of extensive brain, physical, emotional and behavioural development that starts in the neonatal period and continues into adolescence. Adversity from maltreatment can result in toxic stress, affecting brain development and causing cognitive impairment and behavioural changes. This in turn can lead to the adoption of health-risk behaviours, impaired physical and mental health, poorer educational attainment and job and relationship difficulties. Preventing child maltreatment is therefore essential if a child's right to realize his or her full health, happiness, education and wealth potential is to be met.

1.3 Adverse childhood experiences

Safe, stable and nurturing relationships with parents and other caregivers are central to a child's healthy development. Early relationships are thought to affect neurodevelopmental changes in the brain and, in turn, the child's emotional, cognitive and behavioural development *(21)*. A lack of safe and nurturing relationships in childhood can therefore lead to a range of problems that continue into adulthood.

Adverse childhood experiences (ACEs) are a major risk factor for psychiatric disorders and suicide and have lifelong sequelae, including depression, anxiety disorders, smoking, alcohol and drug abuse, aggression and violence

towards others, risky sexual behaviours and post-traumatic stress disorders *(22–24)*. Preventing violence against children therefore contributes to preventing a much broader range of mental and physical disorders, including noncommunicable diseases (NCD) *(2,22)*. It also promotes better social and occupational functioning, human capital and security and ultimately economic development *(4)*. These broader health and societal benefits need to be considered when advocating for prevention: it is estimated, for example, that eradication of ACEs would reduce the burden of mental disorder by 30% *(25)*.

Child maltreatment, whether due to physical, sexual or mental abuse or physical or mental neglect, is one of a series of ACEs often occurring simultaneously through household dysfunction *(5,22)* – parental violence or separation, or a household member having an alcohol or drug problem, being incarcerated or suffering from a mental illness, for instance. Witnessing community violence has also recently been identified as a cause of ACEs *(26,27)*.

When taken collectively, ACEs are even more prevalent than child maltreatment. As with child maltreatment, their effects are cumulative, with the likelihood of poor health outcomes increasing with higher exposure.

1.4 Why child maltreatment is an important public health issue in the European Region

Severe abuse can lead to homicide. While homicide rates for children aged under 15 in the Region appear low at about 850 deaths per year, many child deaths are not investigated and the numbers may be much higher *(10)*. But deaths are the tip of the iceberg: it is estimated that for every death, there are between 150 and 2400 substantiated cases of physical abuse *(28)*. The number of children suffering from maltreatment whose plight goes unrecognized is likely to be very much higher and may only come to light through population surveys. Global estimates state that prevalence ranges from 4–47% for moderate-to-severe physical abuse, 15–48% for emotional and 20% for sexual abuse in girls and 5–10% in boys *(3)*, suggesting that tens of millions of children in the Region suffer different forms of maltreatment.

Children may experience more than one type of abuse or neglect concurrently. Maltreatment may be unrelenting for many, increasing exposure to toxic stress *(29)*. The fact that this may lead to long-term ill health, have a negative impact on children's educational and employment opportunities and result in high health and social care costs makes a strong argument for preventive action *(3)*.

The recognition that child maltreatment can be prevented by coordinated public health action has arisen only in the last few decades *(3)*. Responses to date in many countries have tended to focus on child protection implemented through detection of abuse and neglect, with removal to alternative places of care if necessary. But this approach will only detect a small fraction of the maltreatment occurring, making an additional argument in favour of prevention.

The knowledge base for preventive action is growing. Programmes offer value for money *(30,31)*, a feature of great importance given the economic constraints faced by health systems and other sectors *(32)*. Early detection of maltreatment and intervention to prevent adverse health outcomes is, of course, necessary *(33)*, but the report's main focus is prevention.

1.5 Life-course approach and intergenerational transmission of violence

What happens in childhood has a strong influence throughout the life-course. Exposure to violence in childhood, including intimate partner violence *(34)*, increases individuals' risk of becoming both a victim and perpetrator in adolescence and later in life *(3,35–37)*. This can manifest in adolescence with an increased propensity to engage in youth violence (perpetrator or victim) and, in adulthood, through intimate partner violence (again, as perpetrator or victim) *(19)*. Violent and abusive behaviour can continue into older age *(38,39)*. The term "cycle of violence" has been coined to describe this phenomenon *(40)*.

Intergenerational transmission of violence can be prevented by focusing on early childhood and providing the correct societal conditions and support to enable safe, stable and nurturing relationships with parents and other caregivers *(5,41)*.

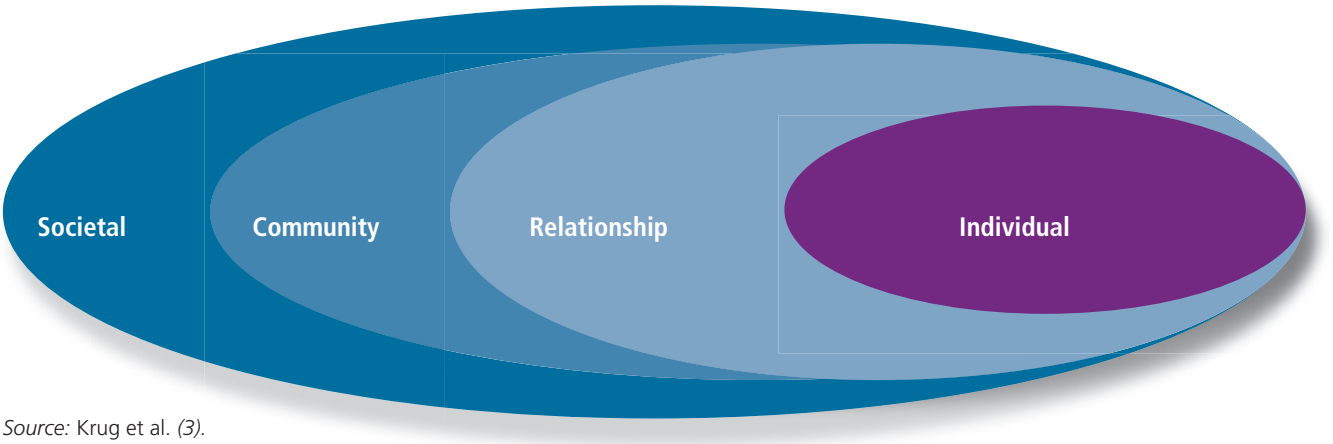
A life-course approach is one of the guiding principles of the WHO *European strategy for child and adolescent health and development (42)*, emphasizing the importance of preventing abuse and neglect during developmental stages in childhood. Many countries have invested in safety as a corporate responsibility, involving different sectors in the delivery of safe physical and social environments for children, but there is increasing acknowledgement that a life-course approach is needed

to reduce interpersonal violence by preventing it in childhood *(3,43)*.

1.6 Overcoming the problem of maltreatment in children

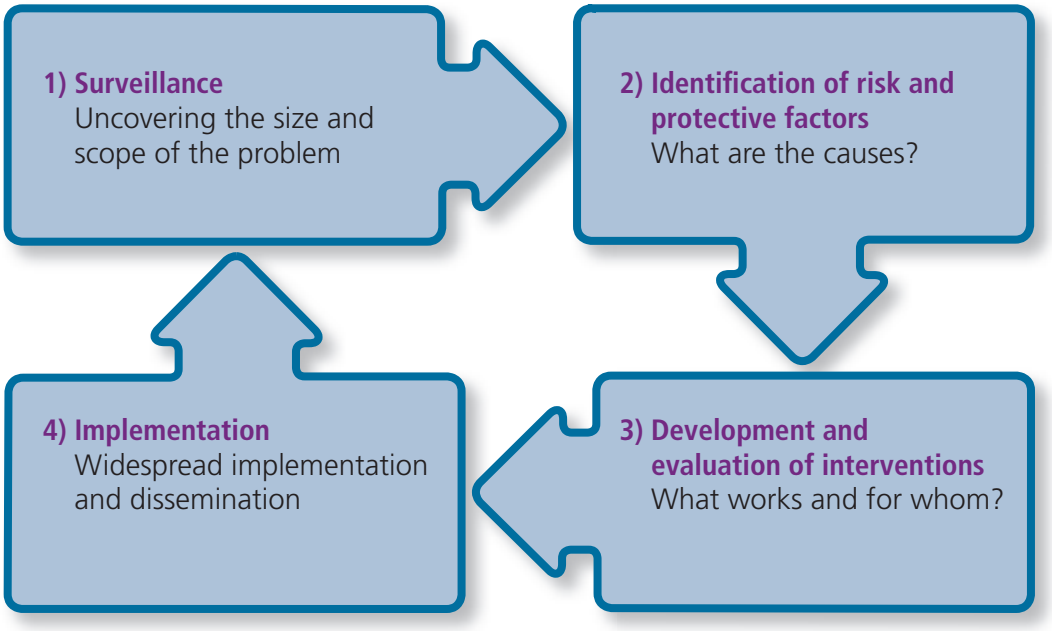
Violence results from a complex interaction among many factors at individual, relationship, community and societal levels (Fig. 1.1). The report uses this ecological model as a framework to describe risk factors for child maltreatment *(3,44)* and to promote understanding of different levels for targeting preventive interventions. Successful responses to child maltreatment involve a four-step public health approach. This evidence-informed multidisciplinary approach takes account of the size of the problem, risk factors and the evidence base of what works (Fig. 1.2) *(45)*

Fig. 1.1. An ecological framework describing the risk factors for child maltreatment and prevention interventions



Source: Krug et al. *(3)*.

Fig. 1.2. A public health approach to preventing child maltreatment



Source: World Health Organization *(45)*.

to provide a model for designing, implementing, evaluating and monitoring interventions.

1.7 Global and European Region policy dimensions of preventing child maltreatment

Numerous policy mandates give importance to preventing maltreatment in children. In addition to the *Convention on the Rights of the Child (18)*, global-level initiatives include World Health Assembly resolution WHA56.24 *(46)* on implementing the recommendations of the *World report on violence and health (3)*. This brought attention to the public health approach to preventing violence (including that inflicted on children), emphasized the importance of tackling child maltreatment to break intergenerational transmission of violence and highlighted the need to identify factors that promote resilience.

The fifty-fifth session of the WHO Regional Committee for Europe passed a resolution on the prevention of injuries, highlighting violence prevention as a key public health concern and promoting national policy development, capacity building and evidence-based prevention *(47)*. It also passed a resolution urging stakeholders to focus on violence prevention in early childhood *(48)*, reaffirmed by the European Council recommendation on injury prevention and safety promotion *(49)*. The child and adolescent health strategy for Europe also highlights the importance of preventing child maltreatment *(42,50)*. More recently, the action plan for implementation of the European strategy for the prevention and control of NCD highlighted ACEs as a risk factor for NCD *(51)*.

The Regional Committee endorsed Health 2020 *(15)* at its sixty-second session. This overarching framework encourages governments to focus on sound policies and interventions to make the greatest gains in the health and well-being of people in the Region. Equity and investing in health through a life-course approach are identified as priority areas for policy action. Promoting well-being and providing protection during childhood and adolescence through preventing maltreatment and other ACEs are integral parts of the approach.

These policies present an opportunity for different sectors to come together and work towards preventing child maltreatment.

Key messages for policy-makers

- Child maltreatment is a grave public health and societal problem.
- Child maltreatment and ACEs have serious far-reaching consequences.
- Inequalities in child maltreatment exist within and between countries.
- The public health approach offers an opportunity for prevention.
- Addressing child maltreatment will reduce inequity in the Region.
- Successes in the Region are a resource for sharing good practice.

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CHAPTER 2
SCALE AND CONSEQUENCES OF THE PROBLEM

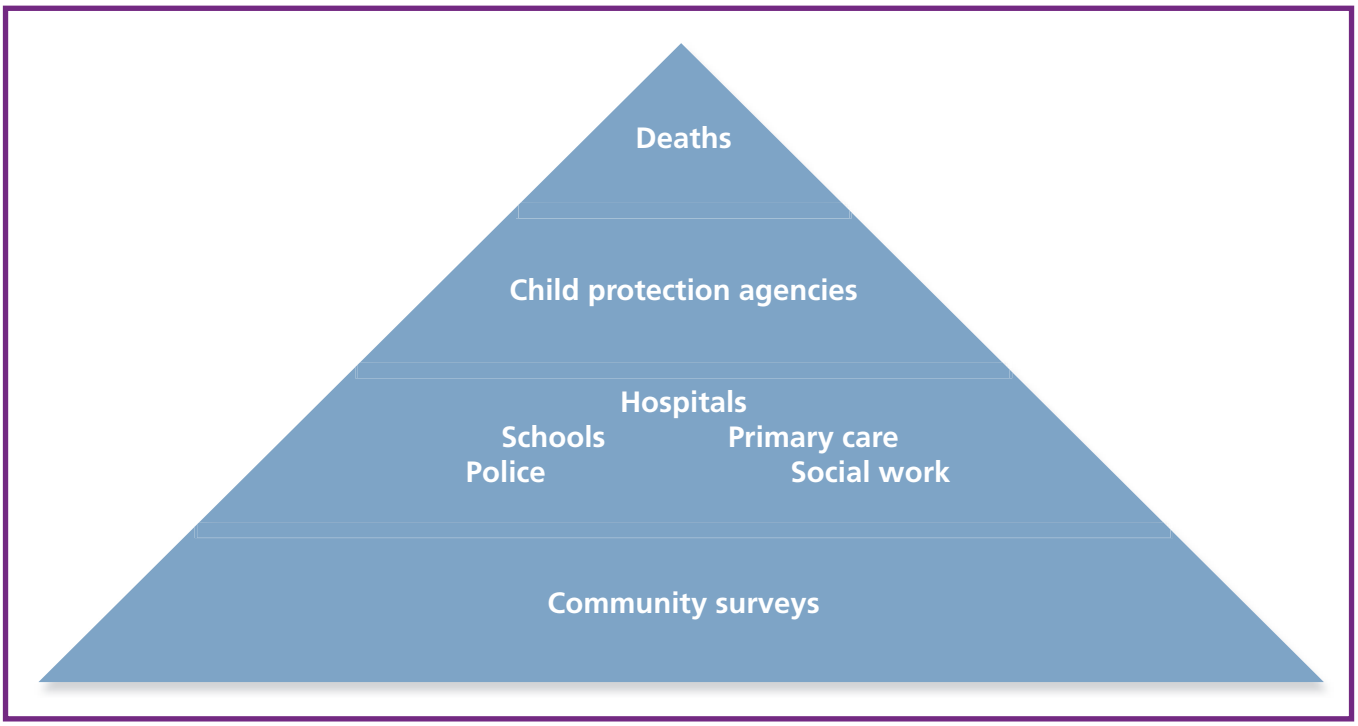
Society has an obligation to protect children from maltreatment *(1)*. Policy-makers need answers to fundamental questions on the size of the problem, whether it is getting worse, and the consequences and costs to society. These questions should be relatively easy to answer in the 21st century, but are hampered by the lack of availability of reliable and valid data in the Region.

This chapter has seven main sections. The first deals with the worst possible outcome of child maltreatment: death (Fig. 2.1, first level). Official statistics on deaths are probably the most reliable data available, even though there is some variability in completeness and coding in countries *(2)*.

Data on severe cases where maltreated children come to the attention of statutory bodies such as child protection agencies are described in the next section (Fig. 2.1, second level). The cases, service responses and outcomes are recorded in official statistics. Laws, working definitions and practices vary between countries, making data difficult to compare. Maltreatment is a criminal act and therefore remains hidden. Children experiencing maltreatment may come to the attention of practitioners in the health, education, justice and welfare sectors. Not all maltreatment that is suspected and recognized by practitioners is recorded, and much goes unreported to child protection agencies. Hospitals are a source of information on admitted children and this is described in the third section (Fig. 2.1, third level).

Much maltreatment in the community may go unrecorded and is only detected when children are asked specific questions in community surveys, although they may be reluctant to say what has happened. Adults (including parents) can also be asked to recall abuse, neglect and other ACEs and abusive parenting practices in childhood (Fig. 2.1, fourth level). This is described in the fourth section.

Fig. 2.1. Sources of data for child maltreatment



The fifth section describes how maltreatment and adversity in childhood can result in health-damaging behaviours, leading to short- and long-term ill health. Children in institutions and street children are discussed in section 6 and the final part describes costs to health services and society.

Key facts about maltreatment deaths in children in the European Region

- At least 850 children aged under 15 die from child maltreatment annually.
- Seventy-one per cent of homicide deaths are in LMIC, where rates are 2.4 times higher than in high-income states.
- Boys account for 60% of homicide deaths.
- Rates are higher in children under 4 years compared to older children aged 5–9 and 10–14.
- Child homicide rates peaked with the economic and political transition in eastern Europe; while declining, they remain higher in this part of the Region.
- Vital registration needs to be improved.

2.1 What is the size of the problem and are death rates getting worse?

Data on homicide deaths among children are reliable in most countries in the Region but may not be complete because of variations in coding practices. Much mortality may not be properly classified, but be described as "undetermined intent" *(3,4)*: it is generally accepted that most of these cases are due to child maltreatment *(5–7)*. Mortality is presented for the 0–14 years age group, as routine mortality data on 0–17-year-olds are not available.

2.1.1 Child homicide deaths

Child homicide deaths are relatively rare. Averages of five years have been presented to improve the effects of variability between different years, and countries with a population of less than one million have been excluded.

As can be seen in Fig. 2.2, more LMIC are in the group of countries within the highest third (tertile) of death rates. High-income countries (HIC) have the lowest child homicide rates and almost exclusively occupy the lowest tertile. Eastern European countries tend to be in the top tertile, with those in the west in the lowest. Some of the lowest rates for infants have been described in Scandinavia and southern Europe *(8)*.

Biological parents are responsible for about 80% of deaths and step-parents most of the remainder *(3)*. Homicides occurring under the age of one year are equally likely to be perpetrated by the mother or father, but it is most likely to be a male with older children *(9)*. The commonest method used to kill children is suffocation or strangulation; sharp objects, drowning, firearms and physical blows are also used quite commonly (see Annex 2).

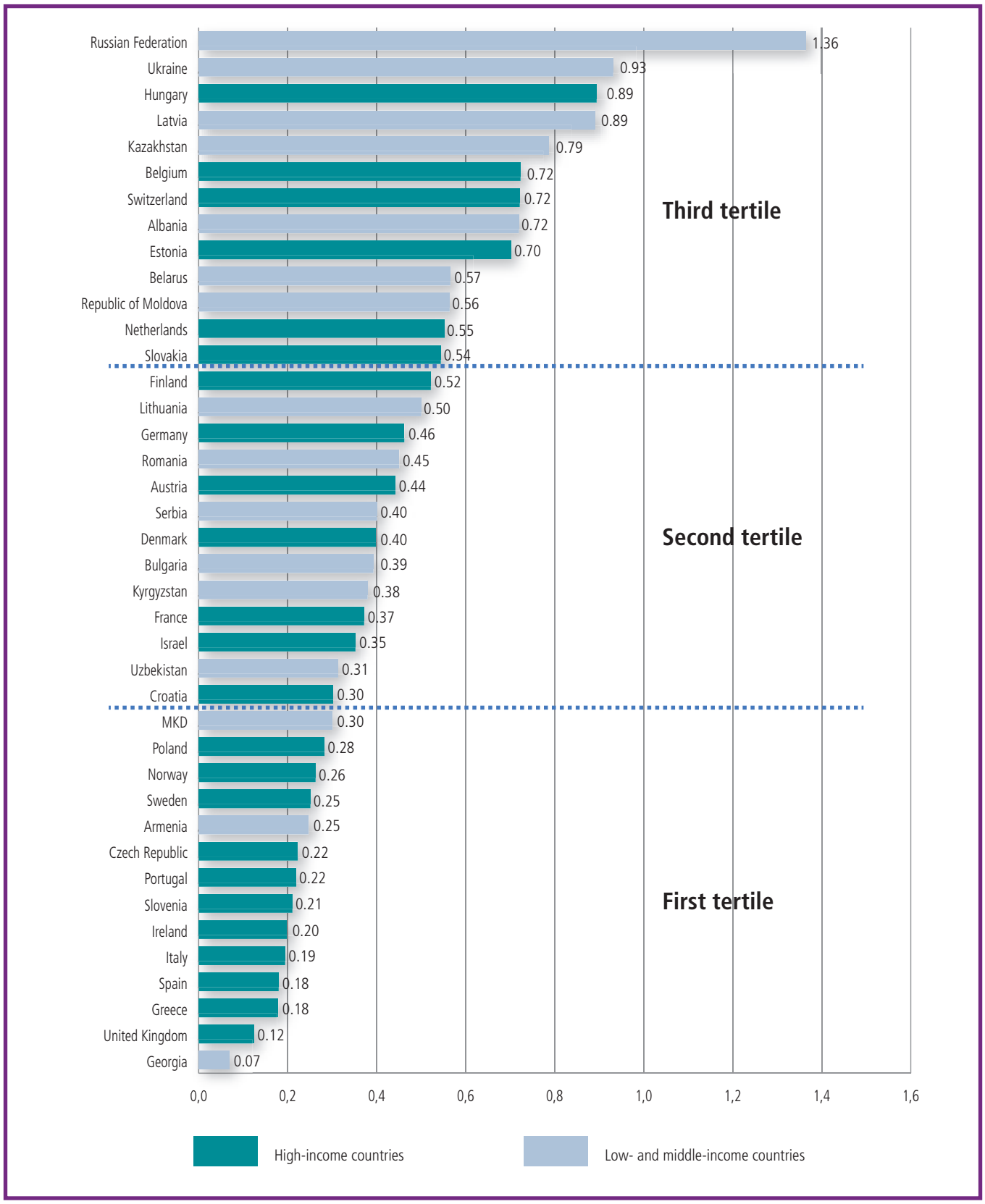
2.1.2 Death rates from child maltreatment when counting homicides and undetermined intent

Deaths from child maltreatment may be easily disguised and require investigation by a multidisciplinary team. Good collaboration involving police, health and child welfare systems is required *(6,11)*. Few European countries, however, investigate thoroughly using multidisciplinary approaches: child deaths may instead be classified as accidental or of undetermined intent in the absence of better information *(3)*.

Judicial data from cases tried in court with perpetrator convictions provide useful additional information to mortality statistics where investigation by autopsy is not obligatory. In France, for example, the adjusted maltreatment rate using judicial data was reported as 2–3.6 times higher than in mortality statistics *(12,13)*. Using more than one data source will give a more complete picture than, for instance, relying on cases where a conviction has been obtained, which is the practice in many European countries.

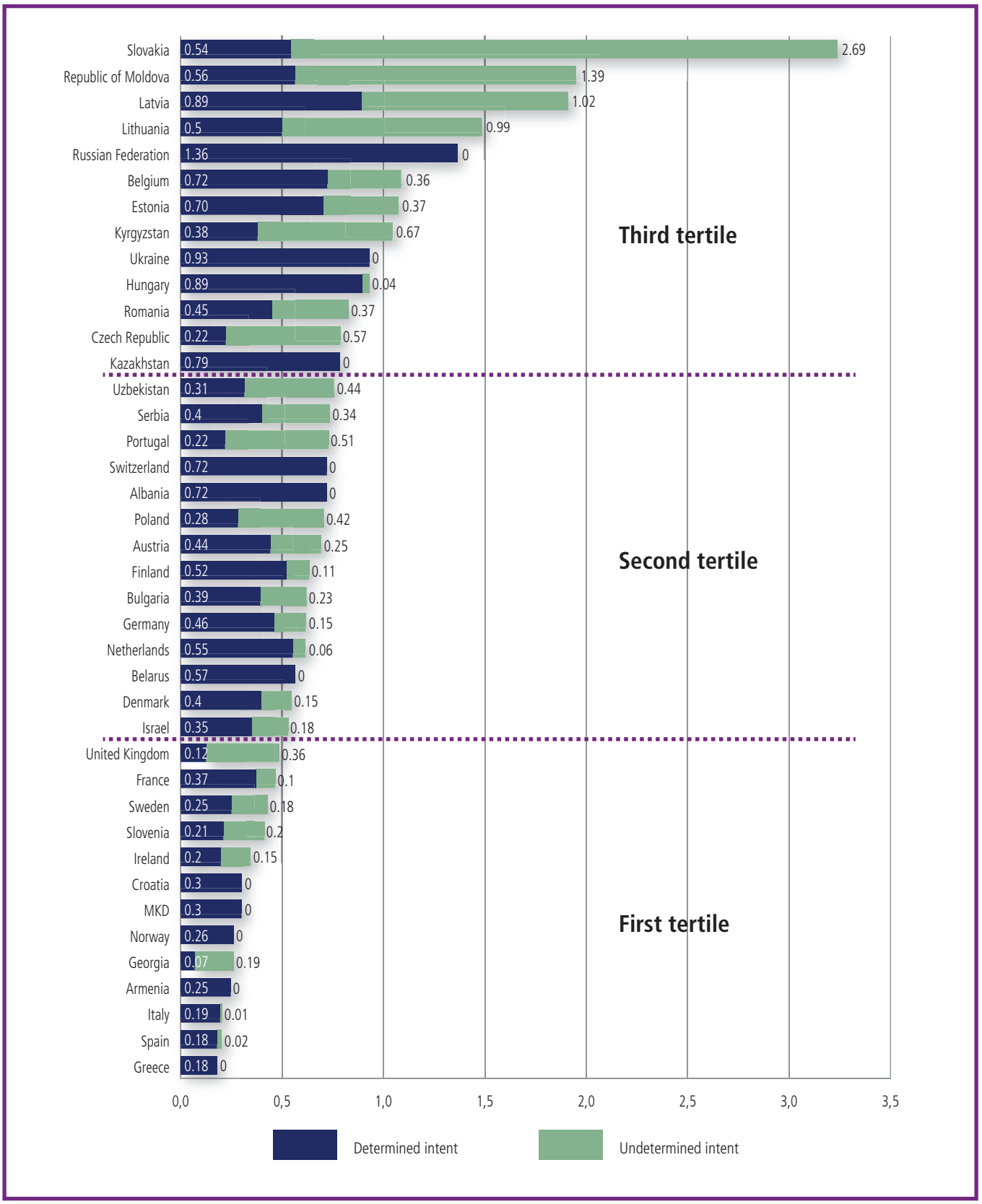
Variation may occur between countries and sometimes between regions within countries. Countries that base their data on reporting cannot be compared to those that rely on criminal records, as only a proportion of substantiated cases will lead to a criminal conviction *(3)*. Global estimates suggest that only 33% of child deaths from maltreatment are classified as homicide; data from Europe are in keeping with this, but some authors report it as low as 20% *(6,11,12,14)*. This is overcome, to a certain extent, by including deaths classified as due to undetermined intent *(3)* (Fig. 2.3), which provide a fuller picture that shows half or more cases may be misclassified in countries such as Slovakia, United Kingdom, Republic of

Fig. 2.2. Homicide rates per 100 000 children aged under 15 years, European Region (average for 2006–2010 or last available 5 years; HIC in dark blue; data available for 40 countries[a]; arrows show tertiles)



[a]Excluded are countries with: a) populations less than 1 million: Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro, San Marino; b) unreliable, or unavailable, data for period: Azerbaijan, Bosnia and Herzegovina, Tajikistan, Turkmenistan and Turkey.
[b]The former Yugoslav Republic of Macedonia (MKD) is an abbreviation of the International Organization for Standardization (ISO).
Source: WHO Regional Office for Europe *(10).*

Fig. 2.3. Maltreatment deaths due to homicide and undetermined intent per 100 000 children aged under 15 years, European Region (average for 2006–2010 or last available 5 years; data available for 40 countries; arrows show tertiles)



[a]The former Yugoslav Republic of Macedonia (MKD) is an abbreviation of the ISO.
Source: WHO Regional Office for Europe *(10)*.

Moldova and the Czech Republic, but less in Denmark, Finland, Germany, Hungary and the Netherlands. This emphasizes that the true picture of deaths due to maltreatment in many countries is higher than actual homicide rates and limits the confidence with which international comparisons can be made.

A disadvantage of such an approach is that some Commonwealth of Independent States (CIS) countries do not use the International Classification of Diseases, but opt for data from the mortality tabulation list 1 of the ICD–10. Data on undetermined intent are therefore not available for Armenia, Belarus, Kazakhstan, the Russian Federation and Ukraine. Actual maltreatment death rates may be higher in these countries.

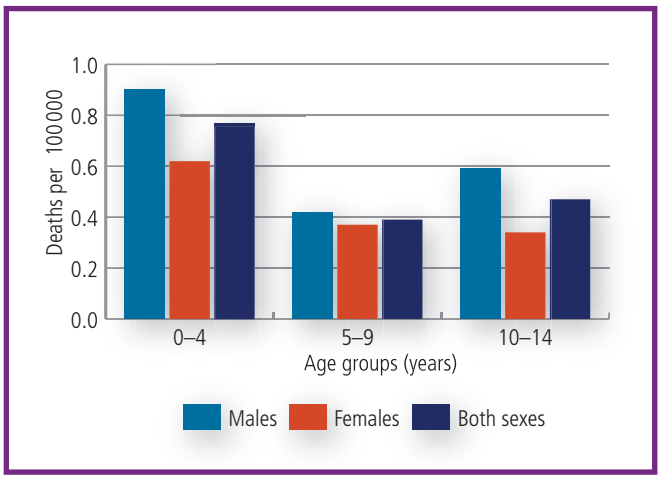
2.1.3 Inequalities by country income

The Global Burden of Disease study[1] provides some of the better estimates of deaths due to maltreatment in the Region, reporting that 852 children younger than 15 years die annually, a mortality rate of 0.54 per 100 000 population *(15)* and representing 67 000 person years of life lost. Violence is the eighth leading cause of death for children aged 5–14 years. Boys account for 61% of these deaths: mortality rates from maltreatment in children are higher among boys at all ages. Rates at age 0–4 years in the Region are higher than those at age 5–9 and 10–14 (Fig. 2.4) irrespective of country income. An increasing proportion of deaths in older age bands will be due to interpersonal violence among youth rather than maltreatment *(16)*. Higher fatality in infants reflects their frailty and vulnerability to assault and neglect and their inability to complain and bring their circumstances to the attention of others. The larger head size relative to their body makes them more liable to head trauma *(3,17)*.

The number of homicide deaths among children aged 0–14 years in the Region is highest in LMIC, where 70% occur (601 deaths). The gradient between HIC and LMIC is large: rates among children under 15 years in LMIC are 2.4 times higher for both sexes (2.7 times for boys and 2.0 for girls) (Table 2.1). Death rate ratios between HIC and LMIC vary by age and are highest for children of 10–14 (5.5 for both sexes, 5.7 for boys, 5.3 for girls) (Annex 2). Higher rate ratios have also been described for older age groups *(16,18)*.

Reports from individual countries also show inequalities by social class. Trends for all injuries in the United Kingdom, for example, are downward, but are markedly less for homicides and injuries of undetermined intent. A steep social class gradient exists, with rates in children of unemployed parents significantly higher *(19,20)*. The influence of social class and unemployment as a risk factor for maltreatment is discussed more fully in Chapter 3.

Fig. 2.4. Age-standardized death rates from violence by age and sex, European Region, 2008



Source: World Health Organization *(15)*.

2.1.4 Are death rates from child homicide getting worse or better?

Fig. 2.5 shows trends in homicide rates in children aged under 15 years for the whole of the European Region, European Union (EU) and CIS.[2]

There was a sharp increase in rates in the early 1990s during the period of social, political and economic transition in CIS countries, then a decline from 2000 onwards as matters stabilized. Trends are downward, but the gap between the CIS and EU countries persists. The effects of socioeconomic and political changes on deaths from interpersonal violence have been described for older age groups *(16,18,22,23)*. For child maltreatment factors such as parental unemployment, cuts in child support and social services, loss of social support networks, weakening of regulatory practices and the liberalization of alcohol policy during this period of transition may have contributed to the peak *(16,22–25)*.

[1] Correction algorithms are applied to the vital registration data to resolve problems of miscoding for injuries involving redistribution of deaths coded as due to events of undetermined intent *(4)*.

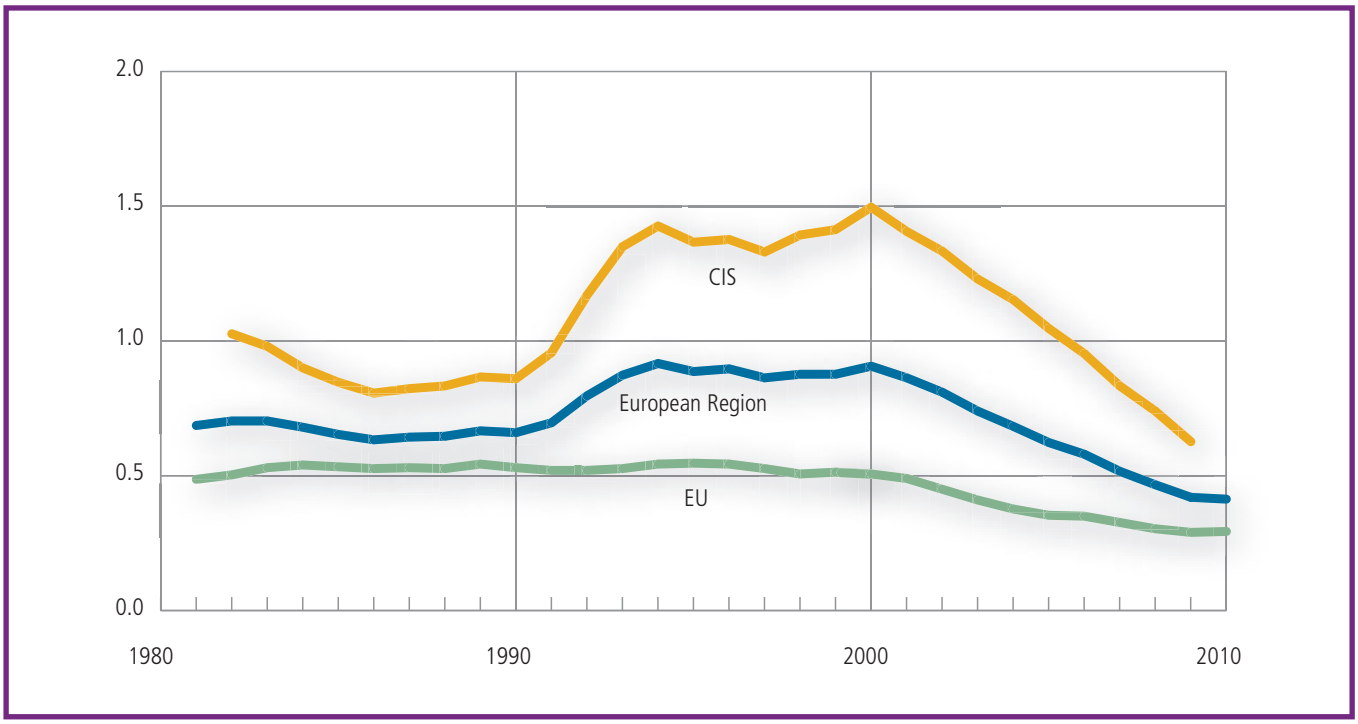
[2] The historical subgroupings of the EU until 2007 and the CIS until 2006 are used. For the CIS, this consists of: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

Table 2.1. Homicide rates and rate ratios per 100 000 population in children aged 0–14 years in LMIC and HIC, European Region, 2008

	Males	Females	Both	Rate ratio males/ females
HIC	0.35	0.3	0.32	1.17
LMIC	0.93	0.59	0.76	1.58
European Region	0.64	0.45	0.54	1.42
Rate ratio LMIC/HIC	2.66	1.97	2.38	

Source: World Health Organization *(15)*.

Fig 2.5. Trends in standardized mortality rates for interpersonal violence in children aged under 15 years, European Region, EU and CIS



Source: WHO Regional Office for Europe *(21)*.

2.2 Information from child protection systems on child maltreatment

Policies that govern recognition and responses to child maltreatment will influence official data on reported rates. Many countries do not have mandatory reporting laws, operative definitions of maltreatment vary and some will record cases that have not been substantiated, making intercountry comparisons even more difficult *(26)*.

Many western European countries have a child and family welfare policy approach in which response and investigation of child maltreatment is offered alongside services to support children who are vulnerable due to other conditions and situations, but it may be associated with inadequate recording of cases *(27)*. This contrasts with child protection services, where the focus is almost entirely on substantiating and responding to cases of child maltreatment. Professionals from multiple sectors report such cases: education services make the largest contribution but with significant numbers also being reported by law-enforcement, social and health services *(27)*.

Underestimation is due to practitioners from these sectors failing to record and report or failure to substantiate reported cases: this is governed by national policy. Reasons

for underreporting include inadequate training, fears about damaging professional–client relationships, hopes that working with the family will improve outcomes, and doubts that referral to child protection agencies will be beneficial *(27)*. The fact that child maltreatment is an illegal act that needs to be substantiated explains some of the reluctance and indicates why it may remain hidden.

A survey of European health ministry focal persons for violence prevention revealed that of 41 respondent countries, only 12 routinely provided official statistics on child maltreatment.[3] The range of proportions of children aged under 18 on child protection registers was very wide: from 0.04% (Slovakia) to 5.4% (United Kingdom), with a median value of 0.6% (WHO Regional Office for Europe, unpublished data, 2013). These survey results show that intercountry comparisons cannot be made with any certainty and that there is an urgent need to standardize policies, processes and registrations. Official statistics are nevertheless important for monitoring trends in child maltreatment within countries. Official data from United Kingdom (England) and Sweden, for example, have been used to determine falling rates in child sexual and physical abuse *(28–30)*.

Even countries that have official statistics on maltreatment need to supplement them with regular community surveys to ascertain the true extent of the problem, as discussed in section 2.3.

2.2.1 Ratio between deaths from child maltreatment and cases reported to child protection agencies

Few European studies examine the iceberg, or pyramid, of maltreatment. It is estimated in France that there are 300 substantiated cases of child maltreatment for every death *(31)*. A study from Australia reported 150 cases of substantiated physical abuse and 600 of child maltreatment for every death from maltreatment in children under 15 *(3)*; the ratio in Canada is 1 to 1000 *(32)* and a study from the United States reported that the ratio between child homicides and cases of maltreatment reported to child protection agencies was 1 to 2400 *(3)*.

2.2.2 Is there a gap between child maltreatment occurring in the community and that reported by official statistics?

Reports suggest a ten-fold difference between official data and those reported in surveys, though the gap may vary considerably between countries *(17)*: reports from the Netherlands, for example, suggest the gap there is three-fold *(33)* (Box 2.1). It is argued that most unascertained child maltreatment occurring in the community does not warrant intervention by child protection services *(17)*; they may instead benefit from support through preventive programmes provided by health, family and welfare services, as discussed in Chapter 4.

[3] Data on officially recorded cases from child protection agencies were reported from Austria, Belgium, Iceland, Lithuania, Latvia, Malta, the Netherlands, Portugal, Serbia, Spain, Slovakia and United Kingdom (England).

Box 2.1. The Netherlands' prevalence study on maltreatment of children and youth

Comprehensive studies using comparable methodologies were conducted in the Netherlands in 2005 and 2010. Three approaches were used:

1) a self-report study among 1920 high-school students aged 12–17 years who reported on their experiences of maltreatment in the previous year;

2) a sentinel study in which 1127 multidisciplinary professionals acted as informants and reported suspected child maltreatment in the previous three months; and

3) substantiated cases reported to child protection services.

The rate of child maltreatment in 2010, based on the combined sentinel and child protection service reports, was 33.8 per 1000 children. In contrast, the rate in the self-report study was 99.4 per 1000. Comparisons between the two periods (2005 and 2010) revealed a large increase in the numbers of cases reported to child protection services. Prevalence rates based on the sentinel and self-report studies did not change between 2005 and 2010, suggesting that the increase was due to greater professional awareness and consequent reporting.

Source: Alink et al. *(33)*; Euser et al. *(34)*; (Euser et al., unpublished data, 2013*)*; Lamers-Winkelman et al. *(35)*.

2.3 Hospital information systems

Given that many cases of maltreatment are never reported to child protection agencies, hospital admission may be a useful additional source of information *(36)*. Severe maltreatment can require admission to hospital, most commonly for physical assault. Examination with the Hospital Morbidity Database showed that only 12 European countries consistently reported complete data

on hospital admissions relating to physical assault in children *(37)*. Few completed coding, so rates due to assaults and undetermined events were calculated for age groups 0–1, 1–4, 5–9 and 10–14 years. Two broad patterns emerged. Some countries, such as the United Kingdom, Switzerland, Finland and Denmark, had highest admission rates for infants, which may reflect their vulnerability to assault. Higher rates in children aged 10–14 years in countries such as the Czech Republic, Lithuania and Latvia may indicate greater levels of peer or self-directed violence (see Fig. A.2, Annex 2).

Several European studies focus on assault admission rates. Some describe how increasing levels of socioeconomic deprivation predict greater risk of hospital admissions for child assault *(38–40)*. One study in United Kingdom (Wales) found that children aged 0–14 in the most deprived quintile had admission rates for assault more than 6 times those of their most-affluent counterparts (63.9 per 100 000 for deprived, 10.3 for affluent) *(40)*. Similar research in United Kingdom (England) during 2005/2006 found that rates for children of the same age group in the poorest quintile were just under 6 times those of their counterparts in the richest (36.2 per 100 000 for poorest, 6.4 for richest) *(38)*. Being born to a teenage mother was associated with increased hospital admission rates in Sweden *(41)* and research conducted in Estonia brought national attention to inflicted traumatic brain injury (also known as "shaken baby syndrome") *(42)*.

The literature reveals that hospital staff will often code maltreatment with some other cause of injury, rather than maltreatment syndrome *(43)*. Various approaches are being proposed to improve coding for maltreatment, including protocols focusing on high-risk injuries, but they remain insufficient to identify all cases *(44)*. The consensus appears to be that potential child maltreatment should be investigated at all stages of treatment and by multiple practitioners, and training for health professionals needs to be better *(45)*.

2.4 Survey information

Key points on prevalence of child maltreatment

- The prevalence of childhood maltreatment in Europe is high. A combined analysis shows:
  - 13.4% for girls and 5.7% boys for sexual abuse
  - 22.9% in both sexes for physical abuse
  - 29.1% for emotional abuse.
- Fewer studies have been done on neglect, but combined analyses of studies around the world shows that prevalence is high:
  - 16.3% for physical neglect
  - 18.4% for emotional neglect.
- More standardized European studies are needed, particularly those dealing with emotional abuse and neglect.

Survey information can be obtained from community populations to determine the incidence and/or prevalence of child maltreatment: a few standardized survey instruments have been developed. Respondents may be children, who are asked about their recent experiences, parents, asked about their care practices and whether they use severe physical punishment, or adults, about their experience as children.

Few countries have repeated surveys using the same methodology. The National Society for the Prevention of Cruelty to Children (NSPCC) survey of 18–24-year-olds in the United Kingdom reported that levels of harsh physical punishment and emotional and sexual abuse in childhood had decreased between successive surveys in 1998 and 2009, though neglect had remained unchanged *(46,47)*. The study of Cawson et al. *(47)* reported an incidence of severe maltreatment of 2.5% in children under 11 and of 6% in those aged 12–17 (Box 2.2).

Box 2.2. What is the iceberg of child maltreatment in United Kingdom (England)?

Around 11 million children aged 0–17 lived in England in 2009. According to the government, 324 000 were considered to be "children in need" (31 March 2010). This means that at any one time, 3% of the nation's children were in need of social care services.

At first assessment, 148 300 children (39.4% of the total) were investigated for maltreatment, with 38 400 having a child protection plan: 44% were aged under 5 years, 12% were infants and 32% were aged 1–4 years. Proportionately more under-fives received a child protection plan than in the national population. One hundred and five serious case reviews took place in 2009/2010, identifying 62 fatal and 43 serious cases of maltreatment.

The NSPCC national prevalence study estimated that 3.9% of 0–17-year-olds had had one or more experiences of physical, sexual or emotional abuse or neglect by a parent or guardian in the previous year: this was also true for 14.1% of children at some point during childhood *(46)*.

These data have been used to calculate population-based estimates, from which a pyramid has been developed (see Annex 1 for methods) suggesting that for every death, there are about 620 cases under a child protection plan, 5520 children in need, 6930 children in the community who have been abused in the past year and about 25 040 who have ever experienced abuse.

Severe emotional abuse in childhood and/or adolescence was reported in a study from Germany *(48)* (Box 2.3).

A self-report survey of 1295 children aged between 13 and 14 years was conducted in 2000 in Romania and reported the following prevalence of maltreatment: physical abuse 24%, emotional abuse 21%, sexual abuse 9%, physical neglect 46% and emotional neglect 44% *(49)*.

Many studies are from western Europe (see, for example Boxes 2.1–2.5), with only a handful from non-EU countries. A multicountry survey of children aged 10–14 showed the following incidence rates of physical abuse: 19% in Latvia, 26% in Lithuania, 12% in the former Yugoslav Republic of Macedonia and 30% in the Republic of Moldova. The respective incidence for emotional abuse was 29%, 33%, 13% and 32% *(55)*. The multiple indicator cluster survey (MICS) studied parenting practices of women of childbearing age from transition countries in Europe and reported a median prevalence of perpetrating emotional abuse over the previous month of 58% (range 12–77%), moderate physical abuse of 46% (range 20–54%) and severe physical abuse of 9% (range 2–21%) *(56)*. The survey also showed high levels of approval of corporal punishment (median 8, range 5–17%), which was strongly associated with perpetration.

Box 2.3. Maltreatment in childhood and adolescence: results from a representative sample of the German population

This cross-sectional study administered standardized questionnaires to people aged 14 and over from a representative sample of the German population. Data on maltreatment in childhood and adolescence were collected with the German version of the childhood trauma questionnaire (28 items).

Of the 4455 people contacted, 2504 (56%) completed the survey. Lifetime prevalence rates were calculated. Severe emotional abuse in childhood and/or adolescence was reported by 1.6%, severe physical abuse by 2.8% and severe sexual abuse by 1.9%. Severe emotional neglect was reported by 6.6% and severe physical neglect by 10.8%. The study also examined risk factors and found the following predictors: female sex for severe sexual abuse, low or middle social class for severe physical abuse, and neglect and older respondent age for severe physical neglect.

Source: Häuser et al. *(48)*.

Most physical and emotional abuse and neglect is attributed to carers, but sexual abuse may be due to peers and adults other than carers *(57)*.

2.4.1 Estimates of the prevalence of child maltreatment using meta-analyses of published studies

Numerous studies with estimated prevalence of child maltreatment in Europe have been published to date in the scientific literature, and results show great variation. Studies have used different methods, whether informant

or self-report, and diverse ways of selecting samples or populations.

Box 2.4. Studies of child sexual abuse in Switzerland

Partly because of its federal structure, no routine information on estimates of child maltreatment is available at national level in Switzerland, but estimates are available for regions or cantons.

An early study from 1996 in the canton of Geneva showed lifetime prevalence for child sexual abuse with penetration in 13–17-year-old adolescents was 5.6% for girls and 1.1% for boys *(50,51).* A more recent nationally representative study of high-school children (the Optimus study) reported contact victimization prevalence rates of 22% for girls and 8% for boys. Serious sexual victimization with penetrative abuse was 2.6% for girls and 0.5% for boys. Forty per cent of girls and 20% of boys reported non-contact victimization such as indecent exposure, harassment or victimization through the electronic media, implying the importance of new media in victimization *(52).*

Others have reported sexual exhibitionism, with a prevalence of 13.4% for girls and 7.7% for boys *(52)*: the abusers were known to the victims in two thirds of cases *(50).*

One approach to obtaining more reliable estimates is to combine the results of published studies using meta-analyses, a statistical procedure that integrates the results of several independent studies into a combined estimate. This has been done to determine a worldwide prevalence of different types of child maltreatment *(58–61).* Estimates are presented in this section using European studies (Fig. 2.6, see Annex 1 for methods) based on 50 English-language publications reporting 105 estimates of prevalence of different types of maltreatment (the global equivalents are 244 publications with 577 estimates of prevalence). Two thirds of these were concerned with sexual abuse, about one quarter studied physical abuse and the remainder emotional abuse and physical neglect.

As shown in Fig. 2.6, there were no differences between worldwide and European prevalence for any of the maltreatment types except for sexual abuse of girls; prevalence for this in Europe seems slightly lower, but the percentage of 13.4% remains substantial. Self-reported European prevalence estimates ranged between 5.7% for sexual abuse among boys and 13.4% among girls, 22.9% for physical abuse and 29.1% for emotional. This warrants the conclusion that child maltreatment in Europe is a phenomenon of considerable extent, touching the lives of millions of children.

This is supported by another review from HIC which reported that 3.7–16.3% of children experienced severe parental violence per year (cumulative 5–35%), 10.3% experienced emotional abuse and 1.4–15.7% severe neglect *(17).* The review also reported that the prevalence of child maltreatment was higher in eastern Europe.

Box 2.5. Surveys from Spain in 2001 and 2011

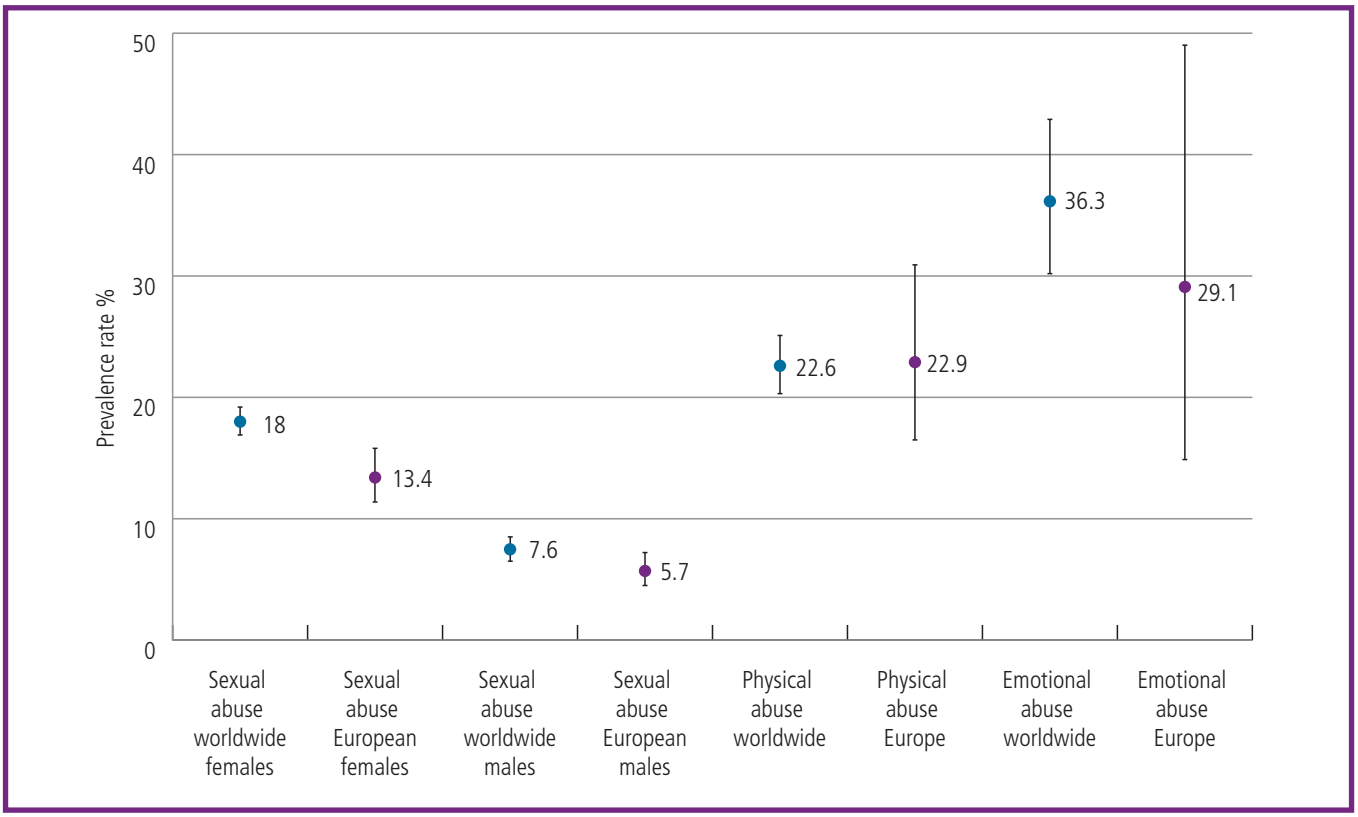
Two studies concerning child maltreatment have been carried out in Spain in recent years, resulting in enhanced awareness among the general population.

A large epidemiological study was conducted in 2001, analysing more than 30 000 open files from child protection services agencies in each autonomous region *(53).* More than 10 000 child victims were detected, resulting in an incidence of 7.16 victims for every 10 000 children. The most frequent type of abuse was neglect, followed by emotional, physical and sexual abuse.

A study conducted in 2007 used a different methodology involving interviews and questionnaires to identify 94 children as abuse victims *(54).* Physical abuse was most common, followed by neglect, psychological abuse and sexual abuse. About 4% of children aged 8–17 years reported being abused during the previous year. Of these, most were victims of 1 form of maltreatment, but nearly 30% reported being exposed to 2 or more. More than 20% of family members reported having abused their child in the previous year. The aggressors were mainly biological mothers and biological fathers. Seventy-five per cent of aggressors justified the abuse, saying that the child provoked them or deserved it.

Although both of these studies contributed to awareness of the issue of child maltreatment in Spain, no direct policy changes have resulted from their findings.

Fig. 2.6. A comparison between worldwide and European estimates of prevalence rates with 85% confidence intervals from self-report studies for sexual, physical and emotional abuse



2.4.2 Informant studies

Informant studies are those involving professionals concerned with reporting to child protection agencies. They consistently report lower rates than those using self-report measures of child abuse *(17,62,63)*. From the analysis in section 2.4.1, for example, the combined prevalence from informant studies for physical abuse was 0.1% (85% confidence interval (CI): 0.0–0.2), significantly lower than that from self-report studies (22.9% [85% CI: 16.5–30.9]). This underestimate was also reported for sexual abuse of between 0.0% and 0.5% for informant studies, compared to self-report studies' 5.7% (85% CI: 4.5–7.2) for boys and 13.4% (85% CI: 11.4–15.8) for girls. The exception to this pattern is the case of studies of neglect arising from persistent acts of omission, where self-report studies may underestimate the extent in contrast to professional concern about the size of the problem.

2.4.3 The Balkan Epidemiological Study of Child Abuse and Neglect

The Balkan Epidemiological Study of Child Abuse and Neglect (BECAN) study focused on a sample of 42 272 children aged 11–16 years who attended or had dropped out of schools in 9 countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Greece, Romania, Serbia, the former Yugoslav Republic of Macedonia and Turkey. The International Society of Child Abuse and Neglect child abuse and neglect screening tools (ICAST) self-completion questionnaire was adapted for the Balkan context, with a 67% return rate. Maltreatment was considered to be positive if respondents reported affirmatively to one or more of the items in each question.

Prevalence rates varied considerably between countries for the different types of maltreatment, ranging from:

- 64.6% (the former Yugoslav Republic of Macedonia) to 83.2% (Greece) for psychological violence;
- 50.6% (the former Yugoslav Republic of Macedonia) to 76.4% (Greece) for physical violence;
- 7.6% (the former Yugoslav Republic of Macedonia) to 18.6% (Bosnia and Herzegovina) for overall sexual violence;
- 3.6% (Romania) to 9.8% (Bosnia and Herzegovina) for contact sexual violence; and

- 22.6%(Romania) to 48.1%(Bosnia and Herzegovina) for subjective feelings of neglect.

Positive parental practices were reported by most responding children in all countries. There were no differences in gender for physical and psychological violence, though sexual violence rates were higher for boys in some countries and neglect prevalence was higher in girls.

Meta-analyses of the responses from each country show the following prevalence: psychological abuse 73%, physical abuse 65%, sexual abuse in boys 11% and girls 9%, and neglect 31%. These rates are higher than those reported by other studies, as the operative definition of maltreatment had a lower threshold and included milder forms.

The study also estimated the ratio between cases notified to child protection agencies and abuse in the community. The authors reported a ratio of 46 for child sexual abuse in, for example, Bosnia and Herzegovina and about 51 in Romania, suggesting that not all maltreatment is detected by child protection services *(64)*.

2.5 Children in institutions and street children

Two groups of children who are not being looked after at home and who warrant special consideration are those living in institutions and those on the streets.

2.5.1 Children in institutions

A high number (and proportion) of children are in institutional care in the Region (Box 2.6). Surveys estimated that there were 44 000 children under 3 in institutional care[4] in 2002 *(66,67)*, ranging from less than 10 per 100 000 in Norway and the United Kingdom to over 500 in Belgium, Bulgaria and Latvia.

The early years are a critical time for child development, so young children placed in institutional care are particularly vulnerable to harm. They are unlikely to develop attachments to a primary carer and spend less time on play and social interaction, which can lead to attachment disorder and delays in social, behavioural and cognitive development. Institutions may have poor standards of care with inadequate staffing, incomplete staff training, poor physical environments, overcrowding, poor cleanliness, hygiene and sanitation, inadequate play and recreational facilities, unfulfilled carers' job satisfaction/enjoyment and substandard regulatory practices *(68)*.

[4] Institutional care was defined as living in an institution for longer than 3 months with 11 or more children without a primary caregiver.

Box 2.6. Children under three at risk of harm in institutions across Europe

A survey of 32 countries[1] reported that 23 099 children aged under 3 years were living in institutions for 3 months or longer – equivalent to 0.11 per 100 000 children under 3. Practice varied greatly. The vast majority (69%) in the 15 founding members of the EU[2] were placed in residential care institutions because of abuse and neglect, 4% due to abandonment, 4% because of disability and 23% for other reasons, such as parental incarceration. No biological orphans were placed in institutions. In other surveyed countries, 14% were placed in institutions due to abuse or neglect, 32% were abandoned, 23% because of disability, 6% because they were biological orphans and 25% for other reasons.

A higher rate of children being placed in institutional care because of "abandonment" was more likely in countries with a lower gross domestic product (GDP), lower health expenditure and a higher abortion rate. The placement of young children in institutional care by parents because of abuse and/or neglect was associated with a higher GDP, higher health expenditure and a higher average age of mothers at first birth. Despite the fact that institutional care was shown to cost 1.5 to 3 times more than surrogate family care, deinstitutionalization was less likely to be practised by LMIC.

International adoption was more likely in LMIC. The high level of intercountry adoption practised by some countries as a solution to institutionalization, rather than the development of national surrogate family care, is of concern. No child under three years should be placed in residential care during this crucial developmental period without a parent/primary caregiver. When high-quality institutions are used as an emergency measure, the length of stay should be no more than three months.

[1] Albania, Croatia, Iceland, Norway and Turkey were the non-EU countries included in the study.
[2] EU countries before 2004: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, United Kingdom.

Source: Browne & Hamilton-Giachritsis *(65)*.

Numbers of children aged under 3 years in institutional care were updated recently for central and eastern European countries (countries of the Balkans and CIS were included) *(69)*. Results show that though the trends are downward, rates of institutional care are still high, ranging from a minimum of 4 per 100 000 in Montenegro to a high of 780 in Bulgaria, with a median value of 83 (Annex 2, Table A.5). Similar information from other European countries needs to be updated.

These data suggest that large numbers of children in the Region are being deprived of their right to a family and would be better placed in family care. Countries that spend less on community health and social services are more likely to opt for institutional care. Very often these countries do not have support services (such as mental health or addiction services) for relatives or parents. Fostering or adoption services may also be underdeveloped. The cost of institutional care is up to 10 times higher than living at home or in foster care. It would be much more cost–effective for countries to provide parents and/or relatives with support services and develop fostering and adoption services rather than resorting to residential care *(68,70,71)*.

2.5.2 Street children in Europe

Street children represent one of the most vulnerable populations, having suffered from previous abuse and neglect and being at greater risk of experiencing future maltreatment. Although perhaps more common in other parts of the world, street children are not uncommon in the Region, particularly in the east.

Street children can broadly be described as those who rely on the street for basic needs, such as shelter, food, socialization and income *(72)*. While it is difficult to determine the precise number in Europe, it is important to focus on improving their situation *(72)*.

Maltreatment, along with poverty and parental alcohol abuse, often prompts these children to turn to the streets *(72,73)*. A Moscow study found that 78.6% reported having suffered physical abuse in their home, while 64.5% said they left home due to arguments with their parents *(74)*.

Turning to the streets often means these children will experience continued maltreatment, with research suggesting they are subject to various forms of violence and abuse *(75–78)*. Researchers found abuse to be quite prevalent among street children in Ankara, Turkey *(76)*: of the 40 participants, 50% reported verbal abuse, 50% physical abuse and 65% sexual abuse *(76)*.

Street children suffer greatly from mental and physical health problems, substance abuse and lack of education *(78–80)*. They are in need of, and deserve, greater consideration.

2.6 Morbidity and the consequences of maltreatment and other ACEs

Abuse and neglect of children will cause immediate and acute emotional and physical harm but may also have far-reaching consequences *(17,81,82)*. More often than not, maltreatment is chronic, with repeated abuse and high levels of neglect *(83)*. It will have an effect on neuronal development and networks and, if severe, will impair cognitive development *(84)*. More than one type of abuse may occur: estimates suggest that clustering of abuse types may be the norm, occurring in between three and nine of every ten cases. Only a small proportion are detected and reported to child protection agencies *(26)*.

Recurrent abuse, multiple in type and of greater severity, is associated with worse health outcomes in ACEs studies (Boxes 2.7 and 2.8), where associations with household dysfunction, such as parental separation, witnessing parental violence or having a house member who is incarcerated, mentally ill or with substance abuse problems, were also found *(77,90)*.

Surveys of ACEs were conducted in representative populations of university and college students in eight eastern European countries (Albania, Latvia, Lithuania, Montenegro, Romania, the Russian Federation, the former Yugoslav Republic of Macedonia and Turkey) in collaboration with the Regional Office. A combined analysis has been conducted (Bellis et al., unpublished data, 2013) on data available for 10 696 people aged 18–25. Provisional results show that more than half reported at least one ACE during their childhood. The prevalence of child maltreatment was physical abuse in 18.6%, emotional neglect in 11.8%, emotional abuse in 8% and sexual abuse in 7.5%. Witnessing domestic violence against the mother was the most frequent ACE, affecting 14.6%.

Such multiple adversity is linked to repeated and more severe victimization and with more severe psychological consequences *(91–94)*. Reports call for the need for early intervention to stop recurrent maltreatment and to institute supportive and rehabilitative regimes (see Chapter 4). A mix of mental disorders, physical health problems

and lower educational attainment has been described as a consequence. Evidence to implicate child maltreatment in the development of conditions such as mental disorders, drug use, risky sexual behaviour and sexually transmitted infections is robust *(95)*: evidence for other plausible outcomes, such as NCD, is limited (Table 2.2).

Table 2.2. Summary of the strength of the evidence for related health outcomes

Robust association	Plausible outcome/limited evidence	Plausible outcome/emerging evidence
Physical abuse		
Depressive disorders	Cardiovascular disease	Allergies
Anxiety disorders	Type II diabetes	Cancer
Eating disorders	Obesity	Neurological disorders
Childhood behavioural/conduct disorders	Hypertension	Underweight/malnutrition
Suicide attempts	Smoking	Uterine leimyoma
Drug use	Ulcers	Chronic spinal pain
Sexually transmitted infections/risky sexual behaviour	Headaches/migraine	Schizophrenia
	Arthritis	Bronchitis/emphysema
	Alcohol problem use	Asthma
Emotional abuse		
Depressive disorders	Eating disorders	Cardiovascular disease
Anxiety disorders	Type II diabetes	Schizophrenia
Suicide attempts	Obesity	Headaches/migraine
Drug use	Smoking	
Sexually transmitted infections/risky sexual behaviour	Alcohol problem use	
Neglect		
Depressive disorders	Eating disorders	Arthritis
Anxiety disorders	Childhood behavioural/conduct disorders	Headaches/migraine
Suicide attempts	Cardiovascular disease	Chronic spinal pain
Drug use	Type II diabetes	Smoking
Sexually transmitted infections/risky sexual behaviour	Alcohol problem use	
	Obesity	
Sexual abuse		
Sexually transmitted infections/risky sexual behaviour	Sexual revictimization as an adult	Chronic non-cyclical pelvic pain
Personality disorders	Sexual perpetration	Non-epileptic seizures
Depressive disorders		
Anxiety disorders		
Self-harm		
Suicide attempts		
Drug abuse		
Eating disorders		
Obesity		

Source: adapted from Norman et al. *(95)*, Maniglio *(96)*.

Key points on the consequences of child maltreatment

- Child maltreatment may lead to health-risk behaviours and adverse outcomes.
- There is strong evidence for the development of mental disorders after child maltreatment including:
  - depressive, anxiety, eating and attention deficit disorders; and
  - drug use, self-harm and suicide.
- There is strong evidence for risky sexual behaviours and sexually transmitted infections after child maltreatment.
- There is plausible but limited evidence for the development of obesity and other NCD after child maltreatment.
- Child maltreatment may undermine educational attainment and future employment prospects.
- Maltreatment may contribute to violence along the life-course.

2.6.1 Mental disorders

Behavioural problems have been described in children whatever age they suffered abuse or neglect. The effects are cumulative, manifesting throughout the life-course. There is an association in childhood with externalizing or aggressive behaviour and internalizing or anxiety–depressive behaviour *(97–99)* and an increased likelihood of developing childhood behavioural disorders with physical abuse and neglect (odds ratio (OR) 2.3 and 2 respectively) *(95)*.

2.6.1.1 Depression

Child abuse is associated with increased mental disorders *(100,101)*, with an almost two-fold risk (range 1.3–2.4) of developing depression in adolescence and early adulthood *(102)*. The burden is quite large, with between a quarter to a third of children depressed by early adulthood *(17)*. Depression is associated with neglect and physical and sexual abuse and has been shown to be worse with increasing severity of physical abuse *(103,104)*.

A meta-analysis examined the odds of depressive disorders with different types of maltreatment *(95)*, showing an OR of 1.5 for physical abuse, 3.1 for emotional abuse and 2.1 for neglect. It also demonstrated increased odds for developing anxiety disorders after physical abuse (OR 1.5) and emotional abuse (OR 3.2). Eating disorders were associated with physical (OR 2.6) and emotional abuse (OR 2.6).

Box 2.7. ACEs study in the United Kingdom

Studies in various countries, including the United States *(81,85),* New Zealand *(86),* the Philippines *(87)* and in eastern Europe (see Chapter 5) are increasingly exploring the relationships between ACEs, health-damaging behaviours and poor health and social outcomes in adulthood. These demonstrate the harmful effects that ACEs (including child maltreatment and household dysfunction) have on adults' lifestyle choices, health and social outcomes *(81,85–87)*.

The first ACE study in the United Kingdom began to explore these relationships in adult residents of a relatively deprived and ethnically diverse area *(88)*. The cross-sectional study of 1500 residents found that increasing numbers of ACEs were strongly related to poor behavioural, health and social outcomes. After adjusting for the confounding effects of deprivation and other demographic factors, participants with 4 or more ACEs had 4 times the odds of current smoking and heavy drinking, 9 times of incarceration in the criminal justice system, and 31 times of having ever been diagnosed with a sexually transmitted infection than those with no ACEs. They also had significantly increased odds of: poor educational and employment outcomes; low mental well-being and life satisfaction; recent involvement in physical violence; recent inpatient hospital care; early unplanned pregnancy; and chronic health conditions.

ACEs' impacts on individuals' criminality, exposure to violence, early unplanned pregnancy and retention in poverty reveal that those affected are more likely to propagate a cycle that exposes their own children to ACEs. The study adds to the growing body of literature supporting the prioritization of cost-effective interventions to prevent childhood maltreatment (see Chapter 4). Based on its findings, further research is being implemented to study the impact of ACEs in a representative sample of 4000 adults across United Kingdom (England) and consequently strengthen the evidence base.

Box 2.8. ACEs survey in young people in Albania

The survey on the prevalence of ACEs in Albania *(89)* was conducted with a representative sample of young adults (N=1437) selected from public universities (971 females (67.6%) and 466 males (32.4%); mean age 21.2 years). The survey aimed to describe the magnitude of ACEs in the young population, identify socioeconomic characteristics and find associations between ACEs, health-risk behaviours and health outcomes.

Results showed that the prevalence of child maltreatment was high (sexual abuse 6%, physical abuse 41.5% and emotional abuse 51%). Overall, 14% reported at least 4 ACEs and almost half 2 or more. ACEs were positively associated with rural place of birth, parental education and father's unemployment and inversely related to income level.

The findings show that the odds of developing health-risk behaviours such as smoking, alcohol, illicit drugs, multiple partners and suicide attempts increases with the number of ACEs, implying a causal relationship. A policy dialogue held by the Ministry of Health discussed these findings and emphasized the need for strategies to prevent child maltreatment.

2.6.1.2 Suicide

There is a doubling in risk of attempted suicide in young people following physical or sexual abuse. The risk increases with multiple adversities, including recurrent abuse and witnessing intimate partner violence *(105,106).* A long-term follow-up study showed that the lifetime risk of attempted suicide among 29-year-olds who had suffered abuse was 19%, compared to 8% in a control group *(91,107).* A meta-analysis reported an increased association of suicidal behaviour with physical abuse (OR 3.0), emotional abuse (OR 3.1) and neglect (OR 1.9) *(95).*

Self-harming behaviour has been reported in children who have been sexually abused: sexual and physical abuse were consistent among a range of childhood adversities for onset and persistence of suicidal behaviour, especially in adolescence, in a multicountry study *(108).* The evidence for psychosis is conflicting, with some studies suggesting a complex interplay between maltreatment, genetic and other environmental factors *(109,110).* Reports indicate that maltreatment increases the likelihood of personality disorders that may start as conduct disorders in childhood *(111).* An association between sexual abuse and eating disorders (anorexia and bulimia) has been described *(112).*

2.6.1.3 Post-traumatic stress disorder

Post-traumatic stress disorder is another adverse outcome associated with child physical or sexual abuse and neglect. Symptoms of intrusive frightening memories, sleep disorders and detachment may persist into adolescence and adulthood, resulting in impaired social functioning. A dose response has been described for sexual abuse. The prevalence of post-traumatic stress disorder was very high in a follow-up study, affecting 23% of those sexually abused, 19% with physical abuse and 17% with neglect; the equivalent in controls was only 10% *(91).*

2.6.1.4 Substance misuse

Child maltreatment increases the risk of alcohol problems in adolescence and adulthood. Prospective studies show the association into adulthood is mainly in girls *(113)*, indicating the importance of interventions to prevent alcohol abuse and associated health and social problems in girls and women. Some evidence suggests this may also be true for drug abuse in both sexes *(114)*: a longitudinal study found increased likelihood of drug use in young adults with childhood sexual abuse, severe physical abuse and serious neglect *(115)* and a meta-analysis showed that drug use was increased after exposure to physical abuse (OR 1.9), emotional abuse (OR 1.4) and neglect (OR 1.4) *(95).*

2.6.1.5 Burden of mental ill health

The overall burden of mental ill health attributed to child maltreatment is large. A longitudinal study in New Zealand found that physical abuse contributed to 5% of mental disorders and sexual abuse to 13% *(116)*. Similar results were reported for the United States, with 3.8% for physical abuse and 13.3% sexual abuse *(105)*; this study also showed the cumulative effect of other adversities, such as those due to household dysfunction.

The WHO world mental health surveys, reporting from 21 countries (including 10 in Europe), show that adverse childhood experiences, including physical abuse, sexual abuse and neglect, are associated with an increased likelihood of mental disorders at all stages of the life-course from childhood to adulthood *(117).* The overall population burden was reported for adverse childhood experiences taken together and showed population-attributable fractions of 30% for all mental disorders. When broken down by type of disorder, it was 23% for mood, 31% for anxiety, 42% for behavioural and 28% for substance. These findings, and others, indicate a need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for interventions to prevent maltreatment occurrence, stop its recurrence and address its long-term emotional and behavioural consequences.

The cumulative burden of child sexual abuse was examined by the Global Burden of Disease study, showing that it contributed to 64 000 deaths worldwide. It also found that sexual abuse and violence is a leading risk factor for premature mortality for all ages, responsible for 200 000 deaths (range 100 000–300 000) and 0.9% (0.7–1.2) of disability-adjusted life-years lost *(118).*

2.6.2 Sexual and reproductive health

Child sexual abuse is associated with increased rates of teenage pregnancy, greater number of sexual partners and increased rates of abortion and sexually transmitted infections, including HIV *(17,96,119).* These effects are stronger with exposure to severe, repeated and multiple sexual adversities. A prospective study found a significant association between physical and sexual abuse and neglect and being paid for sex *(120).* Physical and emotional abuse and neglect are associated with increased likelihood of risky sexual behaviour and sexually transmitted infections (ORs 1.8, 1.8 and 1.6 respectively) *(95).* The likelihood of developing HIV increases with these forms of maltreatment.

2.6.3 NCD

Obesity is strongly associated with sexual abuse, with evidence also emerging of its links to physical and emotional abuse and neglect. Increased risks of smoking have been described in studies that measure child maltreatment as part of ACEs *(79,86).* Obesity and smoking are important risk factors for NCD.

Cross-sectional retrospective surveys examining child maltreatment and other ACEs have described increased risks of cardiovascular disease, diabetes, chronic lung disease, cancer, skeletal fractures and liver disease *(81,121).* Increased prevalence and odds of developing adult-onset asthma have been described in association with childhood physical abuse *(122),* though the evidence is inconsistent (Table 2.2), and limited evidence supports an association between maltreatment and chronic pain and fibromyalgic syndrome *(95,123).* Child maltreatment is associated with increased health service use, which needs to be taken into account when costing child maltreatment (see section 2.7).

2.6.4 Victimization and perpetration of violence

Young people who have experienced physical or sexual abuse or neglect in childhood are at increased risk of being involved in further violence in adolescence and adulthood and of being arrested *(16,111).* Children who receive inadequate, abusive or neglectful care have fewer opportunities to learn nonviolent forms of coping *(124)*: adolescents in the United States who have suffered physical or sexual abuse in childhood have increased risks of perpetrating bullying, physical fighting and dating violence *(125,126).* Associations between violence in childhood, adolescence and young adulthood have also been found in studies in the European Region (such as in Bosnia and Herzegovina *(127)*, Sweden *(128)* and the United Kingdom *(88)*). There is an increased likelihood of victimization which may be sexual or physical in nature in later life: this may occur in the context of intimate partner violence *(83).* Rooting out child maltreatment would have an effect on future violence.

2.6.5 Academic outcomes and employment

Child maltreatment affects schooling. Studies report that maltreated children have lower educational attainment, lower attendance at school and are less likely to finish high school or attend university *(99,129,130).* Special education may be required in exceptionally severe cases. The degree to which educational attainment will be impaired will to some extent be influenced by the child's environment, whether family, community or society. Educational success will affect long-term earning capacity; maltreated children are more likely to have menial or semi-skilled jobs as young adults and are less likely to be employed *(17).*

2.7 The costs of child maltreatment

Child maltreatment occurs alongside other conditions (some of which, such as alcohol, obesity and smoking, are themselves consequences of child maltreatment) with which it competes for attention as a priority issue and for money to fund prevention programmes and victim services. Economic-burden analyses and studies of prevention programmes' cost–effectiveness are at the forefront of advocacy efforts in relation to most leading infectious diseases, NCD and high-risk behaviours (such as smoking and alcohol abuse). As this review shows, however, few studies of the economic impact of child maltreatment have been published, and even fewer on the benefits and costs of prevention programmes. Almost all are from the United States, followed by a handful from wealthy countries in western Europe, Scandinavia and the Asia–Pacific region. More scientific studies of economic burden and the costs and benefits of preventing child maltreatment must be conducted if its priority within the public policy marketplace is to increase.

2.7.1 Economic burden of child maltreatment

Child maltreatment is associated with increased use of health and other services, with associated costs *(131, 132)*. Estimates allow researchers, advocates and policy-makers to assess which consequences (fatal versus non-fatal and direct versus indirect costs, for instance) generate the greatest economic burden, allow it to be compared to that of other conditions (such as stroke and diabetes) and enable advocacy for more resources to prevent maltreatment or enhance victim services. As Corso & Fertig note: "When credible economic burden estimates are available, they are instrumental in bringing the needed attention to a particular condition and for shaping public health policy debates" *(133)*.

Costs to consider in estimating the economic impact of child maltreatment are listed in Table 2.3. They include short-term costs incurred during the acute phase (such as for health care), school and work loses, costs associated with child welfare services and the criminal justice system, and the value of lives lost to fatal child maltreatment. Long-term costs include increased use of health care and social welfare services, productivity losses, special

Table 2.3. Costs to consider in estimating the economic burden of child maltreatment

Short-term costs	Long-term costs
Utilization of health and mental health care Inpatient, outpatient, medication	Marginal increases in utilization of health and mental health care Due to chronic sequelae (depression, drug/alcohol use, obesity, etc.)
Productivity losses School loss for children, work loss for parents	Marginal increases in productivity losses Sustained losses in future education and occupation attainment
Child welfare services Investigation, foster care, in-home treatment	Special education costs Temporary or permanent cognitive disabilities Increased utilization of social welfare services
Criminal justice Police, courts	Increased violence victimization: leads to increase in medical utilization, decreases in productivity, increases in criminal justice system costs
	Increased violence perpetration: leads to increases in criminal justice costs, incarceration
Quality of life Pain and suffering	Quality of life Pain and suffering
Mortality Value of life lost	Reducing life expectancy

Source: Corso & Fertig *(133)*.

education and costs associated with a greater likelihood of violent victimization and perpetration *(133).*

Fang et al. *(134)*, whose study of the economic costs of child maltreatment is the most scientifically rigorous published to January 2013, found that the total lifetime economic burden resulting from new cases of fatal and non-fatal child maltreatment in the United States in 2008 was approximately US$ 124 billion. This included 579 000 cases of non-fatal child maltreatment at US$ 210 012 per victim and 1740 fatal at US$ 1 272 900 per victim. Cost categories included short- and long-term health care costs, productivity losses and child welfare, criminal justice and special education costs. Fang et al. contrast these amounts with the lifetime costs of stroke per person (US$ 159 864) and type II diabetes (US$ 181 000–US$ 253 000), noting that:

> … although stroke and diabetes are clearly different from child maltreatment we reference them to indicate that child maltreatment costs and prevalence are high enough for policy makers to justify allocating resources to effective prevention and mitigation strategies for child maltreatment *(134)*.

The study builds on United States research efforts to estimate the economic burden of child maltreatment that began in the late 1980s *(135).* This has allowed scientists to attain a good understanding of the costs that should, and can, be included in such studies and of the factors that influence findings' reliability and validity *(133).*

Comparable studies from other countries are few, although several less comprehensive efforts to estimate costs have been attempted. For instance, the annual cost of child maltreatment in the United Kingdom was estimated to be £735 million in 1996 *(136).* More recently, Walby *(137)*, drawing on the "Children in need" census, concluded that £1.14 billion of social service funding was being spent on children for reasons of "abuse and neglect". Health insurance and social service data on 54 million people aged 15–64 in Germany were used in 2009 to establish whether they had experienced child maltreatment and estimate lifelong expenditure on health, psychotherapeutic, judicial and social services and unemployment insurance costs and loss of income. They were estimated at €11 billion per year, or €6700 per case per year *(138).* A study in New Zealand estimated that paediatric abusive head trauma cost just over NZ$ 1 million on average per case, taking into account direct hospital care, community rehabilitation, special education, child protection services, criminal justice costs and lifetime care for moderate and severe disability *(139).*

While these studies suggest that the economic burden of child maltreatment is very large, they do not use a common metric. Their findings therefore cannot be directly compared.

Key messages for policy-makers

- Child maltreatment is a common and leading public health problem throughout Europe.
- Many more cases occur in the community than come to the attention of child protection agencies.
- Reports show that child maltreatment is higher in the eastern part of the Region.
- It is a cause of social and health inequality within and between countries.
- There is strong evidence for the development of mental and physical disorders.
- It affects educational and employment prospects, thereby worsening social injustice.
- Maltreatment will contribute to violence throughout the life-course and transmission to successive generations.
- Societal costs of maltreatment are very high.
- Policy-makers need to give greater priority to its prevention.

2.8 Conclusions

This chapter has shown, beyond any doubt, that child maltreatment is a grave health and societal problem in Europe. It leads to the premature death of 852 children under 15 years, is very common in its non-fatal forms and has serious and far-reaching health and social consequences.

Available data show inequalities in the Region, with higher death rates in the east, although trends seem to be declining overall. Vital registration and official statistics need to be improved to give a better picture of the scale of the problem at country level. Substantiation of cases of child maltreatment using reliable and valid investigative methods by multidisciplinary teams would contribute greatly to this.

Deaths are the tip of the iceberg. More abuse, which may or may not come to the attention of child protection services, exists. National policies governing definitions and working practices vary between countries, rendering intercountry comparison of official statistics of little value: they are useful for monitoring trends in countries, but need to be supplemented by periodic surveys to detect the much larger proportion of maltreatment in the community that does not come to the attention of child protection agencies.

Combined analyses of community surveys from Europe and around the world confirm that abuse is greater in the community. Sexual abuse has a prevalence of 13.4% in girls and 5.7% in boys, although some countries have reported higher rates in boys, contradicting conventional wisdom. Prevalence of physical abuse is 22.9% and emotional 29.1%, with no real gender difference. Few studies have focused on neglect, but combined analyses of worldwide research shows that prevalence is also high: 16.3% for physical neglect and 18.4% for emotional. More European studies are needed, particularly in relation to mental abuse and neglect, to understand better not only the scale, but also the risk factors and long-term outcomes (risk factors are discussed in Chapter 3). Most maltreatment occurring in the community is relatively mild and chronic in nature and warrants parental supportive interventions by welfare and family support services, as discussed in Chapter 4, rather than investigation by child protection agencies.

Child maltreatment may cause stress that can be toxic to brain development, especially in the early years but also into adolescence. Toxic stress on brain development may lead to cognitive impairment and the development of health-risk behaviours, with adverse mental and physical health outcomes. The evidence for development of mental ill health, such as depressive, anxiety, eating and childhood behavioural disorders, suicide attempts, self-harm and illicit drug use, is strong and indisputable. Post-traumatic stress disorder has been reported in as many as 25% of abused children. The evidence suggests that child maltreatment may be responsible for almost a quarter of the burden of mental disorders, especially in association with other ACEs. An argument can therefore be made not only for the urgent need for better preventive services, but also for therapeutic services for maltreated children to ameliorate the consequences (see Chapter 4).

Associations with risky sexual behaviour and sexually transmitted infections are also strong, with mixed evidence for the development of obesity and NCD. Alarmingly, the prevalence of children under three years in institutional care is far too high in many European countries: fostering and parental support are better alternatives that need to be encouraged (see Chapter 4). Child maltreatment will affect schooling and can lead to lower educational attainment and employment prospects. The intergenerational transmission of violence and propensity to perpetrate and be a victim of violence are among other long-term costs and consequences.

Societal costs through health care, social welfare, justice and lost productivity appear to be very high. These have not properly been studied, but emerging evidence suggests they run into tens of billions of euros and are of a dimension similar to NCD.

The frequency of maltreatment, its far-reaching health and social consequences and high economic costs make a strong argument that prevention is a societal imperative. The evidence base for risk factors of different types of abuse and neglect and the effect of prevention programmes needs to be clearly understood and widely available, as discussed in Chapters 3 and 4.

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CHAPTER 3
RISK FACTORS FOR CHILD MALTREATMENT

Key facts

- Most individual-level risk factors relate to parents and other adult perpetrators, rather than the child. Children with externalizing behaviour problems, conduct disorders and disabilities can, however, be at increased risk of being maltreated.
- Parents who are young, single, of low socioeconomic status and with low education levels can be more likely to maltreat their children.
- The long-term impacts of childhood abuse on mental and social well-being can mean that adults who have suffered abuse as children are at increased risk of maltreating their own children.
- Poor parental mental health is strongly associated with child maltreatment.
- Alcohol and drug abuse in the family can also predict increased risk of maltreatment, through the impacts of substance use on individuals and their relationships and the links between substance use and other risk factors for child abuse.
- Parenting stress and poor parenting behaviours can contribute to parents maltreating their children.
- Family dysfunction, including intimate partner violence, family conflict and poor family cohesion, is associated with child maltreatment.
- Child maltreatment tends to be more common in families living in communities that are socially and economically deprived, lack social capital and have high densities of alcohol outlets.
- At societal level, factors such as social and cultural norms supporting physical punishment of children, levels of inequality, economic stress and legislation can affect rates.

Key facts *contd*

- Risk factors for child maltreatment can be cumulative in nature, meaning that the more a child or family experiences, the more vulnerable they are to child maltreatment.
- Factors such as strong relationships between parents and children, good parental understanding of child development, parental resilience, strong social support and child emotional and social competence can be protective against children maltreatment.

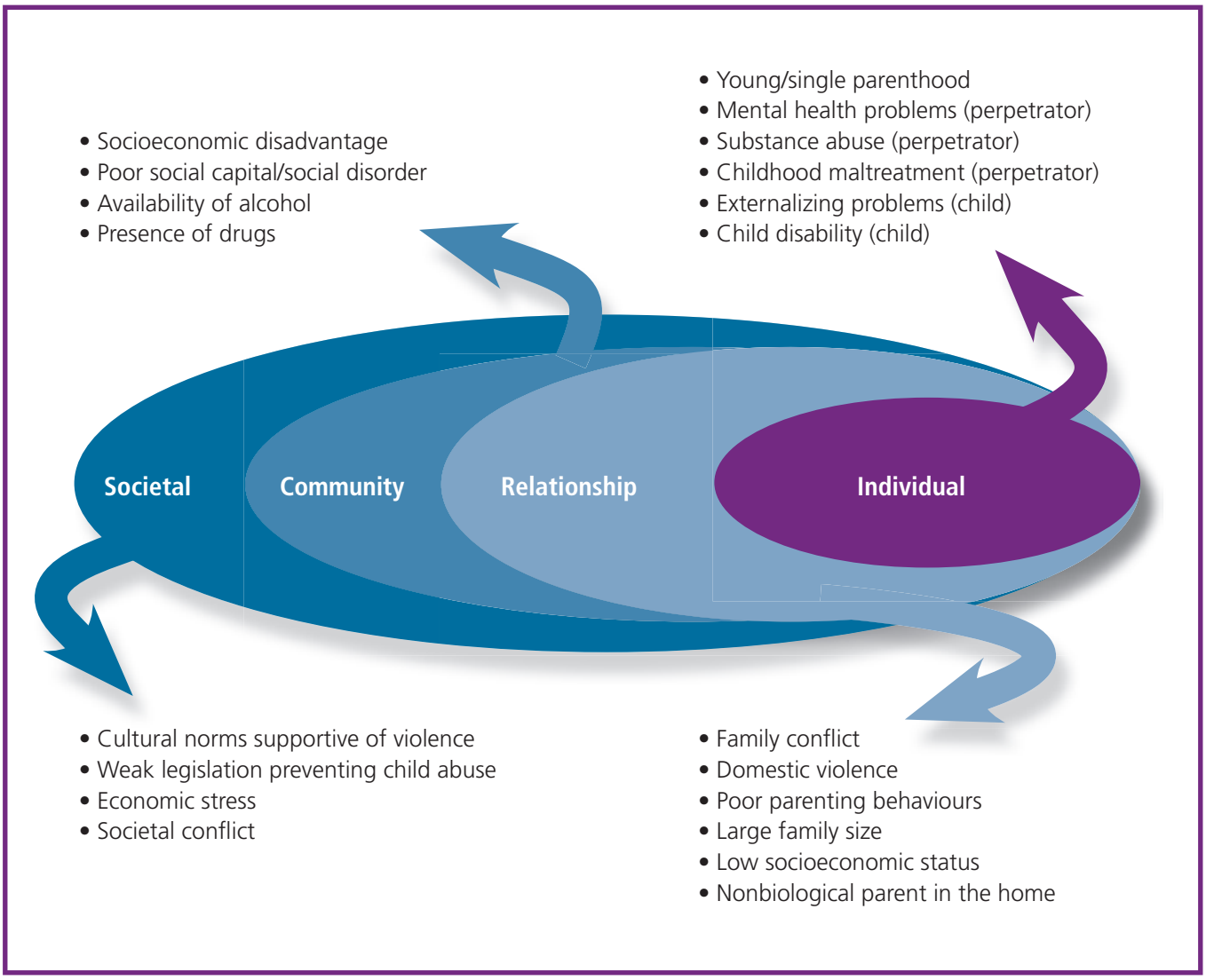
3.1 Introduction

There is no single factor that causes an individual to maltreat a child. Rather, a wide range of factors interacts to increase or reduce the risk. These can relate to the individual characteristics of parents, caregivers, other adults and children, relationships within families and the communities and societies in which people live.

Fig. 3.1 uses the ecological model to show some key factors at these different levels. They can be cumulative in nature, meaning that the more risk factors a child or family experiences, the more vulnerable they are to child maltreatment *(1,2)*. Understanding which factors predict child maltreatment and which can be protective against it is critical to identifying and supporting those at risk and implementing appropriate preventive interventions.

This chapter outlines some key risk and protective factors for child maltreatment at individual, relationship, community and societal levels. It draws on findings from published literature reviews and studies identified through a systematic literature review conducted for this report (Box 3.1). Wherever possible, findings from studies conducted in European settings are presented. As most research has focused on identifying risk rather than protective factors, the chapter focuses on attributes that increase the risk of child maltreatment: factors associated with reduced risks are nevertheless outlined where possible, and section 3.6 summarizes protective factors that can buffer against maltreatment or promote resilience in maltreated children.

Fig. 3.1. Ecological model showing examples of risk factors for child maltreatment



Box 3.1. Studies included in this chapter

The chapter draws on findings from a number of robust systematic reviews and meta-analyses on risk factors for child maltreatment *(3–7),* but even the most recent of these reviews are limited to studies published by 2003, with most included studies being older. A systematic literature review was therefore undertaken in June 2012 of studies published since 2000 to ensure recent literature was included. Searches were undertaken in Pubmed and ScienceDirect, initially retrieving 2649 unique articles. All articles reporting findings from studies of risk factors for child maltreatment were considered, with particular focus placed on those conducted within the European Region. As no structured quality assessment procedures were applied to studies identified through the review, findings from individual studies should be treated with caution, with greater weight given to findings from systematic reviews and meta-analyses. Findings from the two most recent meta-analytical reviews – Stith et al. *(3)*, covering individual and relationship risk factors for physical child abuse and neglect, and Whitaker et al. *(4)*, covering individual risk factors for perpetration of sexual child abuse – have been summarized within tables. Table 3.1 shows effect sizes for individual risk factors for child physical abuse, neglect and sexual abuse and Table 3.2 (section 3.3) shows effect sizes for relationship risk factors for child physical abuse and neglect. Reference is made to these effect sizes throughout the text.

3.2 Individual factors

Individual risk factors for child maltreatment include those relating to perpetrators (often parents and caregivers) and children, but studies generally find that child-related factors have less importance in determining risk. The systematic review and meta-analysis of Stith et al. *(3)*, focusing on parental and child factors associated with child maltreatment, identified 20 individual factors with significant associations with physical child abuse and neglect. Of these, only three were child characteristics, which had small-to-moderate effect sizes (Table 3.1). While this review did not examine risk factors for child sexual abuse, Table 3.2 (section 3.3) also presents individual

Table 3.1. Individual risk factors for child physical abuse (P), neglect (N) and sexual abuse (S) identified through systematic review and meta-analyses

Parental characteristics	P	N	Perpetrator characteristics	S
Anger/hyper-reactivity	◆	◆	Loneliness	◆
Anxiety	❖		Harsh discipline as a child	◆
Psychopathology	❖	❖	Difficulty with intimate relationships	◆
Depression	❖	❖	Antisocial personality disorder	◆
Self-esteem*	❖	❖	History of sexual abuse	◆
Poor relationship with parents	❖	✧	Lifestyle instability/impulsivity	◆ns
Childhood abuse	❖	✧	Non-criminal externalizing problem	◆ns
Criminal behaviours	❖		Cluster A/B personality disorders	❖
Personal stress	✧	◆	External locus of control	❖
Social support*	✧	✧	Cognitions minimizing culpability	❖
Alcohol abuse	✧		Cognitions tolerant of adult–child sex	❖
Unemployment	✧	❖	Paranoia/mistrust	❖
Coping/problem-solving skills*	✧		Low self-esteem	❖
Single parenthood	✧	✧	Poor attachment/bonding	❖
Parent age*	✧	✧	Depression	❖
Drug abuse	✧		Aggression/violence	❖
Health problems	✧ns		History of physical abuse	❖
Gender	✧ns		Substance abuse	❖
Approval of corporal punishment	✧ns		Anger/hostility	✧
Child characteristics			Anxiety	✧
Social competence*	❖	❖	Deviant sexual interest	✧
Externalizing behaviour	❖	❖	Nonviolent delinquency	✧
Internalizing behaviour	✧	✧	Social skills deficit	✧
Gender	✧ns	✧ns	Poor coping strategies	✧ns
Prenatal/neonatal problems	✧ns		General empathy deficits	✧ns
Child disability	✧ns		Somatization/hypochondriasis	✧ns
Child age*	✧ns	✧ns	Controlling coercive parenting	✧ns
			Parental instability	✧ns
			Sexual externalizing problems*	✧ns

◆ Large effects (d>.70); ❖ medium effects (d=.40–.70); ✧ small effects (d<.40); where no symbol is shown, no studies were identified. *Indicates a negative relationship; ns = not significant.

Note: findings have been collated from two separate systematic review and meta-analyses (physical abuse and neglect, Stith et al. *(3)*; sexual abuse, Whitaker et al. *(4)*) that used different methods to calculate effect sizes. Whitaker et al. present effect sizes for sexual offenders against children compared with sexual offenders against adults, non-sex offenders and non-offenders. Effect sizes presented here are for sexual offenders against children compared with non-offenders.

Source: Stith et al. *(3)*; Whitaker et al. *(4)*.

risk factors associated with the perpetration of sexual offences against children in the systematic review and meta-analysis of Whitaker et al. *(4).*

The following section discusses many of the risk factors identified in these reviews, along with others examined in recent studies. It focuses firstly on perpetrator characteristics and then on individual factors related to children.

3.2.1 Perpetrator characteristics

3.2.1.1 Demographic factors

Systematic reviews have concluded that direct associations between child maltreatment and many parental demographic factors are relatively weak (see Table 3.1). Factors such as young parental age, single parenthood, low educational attainment, unemployment and low socioeconomic status, however, are also associated with broader risk factors that increase parents' risks of maltreating their child, such as poor parenting skills, parental stress, depression and reduced social support. Understanding the associations between these and child maltreatment can therefore be useful in targeting interventions at vulnerable population groups, such as young, single and disadvantaged parents (through, for example, the nurse–family partnership (NFP) programme (Chapter 4)).

3.2.1.2 Parental age

Studies regularly identify young parental age as a risk factor for child maltreatment, particularly physical child abuse and neglect *(8–14).* In the United Kingdom, for example, the Avon longitudinal study of parents and children found that parents who were younger than 20 years had a three-fold risk of having a child placed on the child protection register before their sixth birthday *(9)*. Young parents accounted for just 7% of all parents in the study, yet 30% of child maltreatment cases. Less than 4% had a child registered for abuse, however, showing that the vast majority had not been investigated for maltreatment.

Accordingly, systematic reviews have found associations between parental age and child maltreatment to be small once other factors are controlled for (physical abuse and neglect: see Table 3.1). While young parental age may not be directly causal of child maltreatment, young parents can lack the social, cognitive, emotional and economic resources required for effective parenting and often face substantial adversity, which can increase their risks of maltreatment *(15–17).* Consequently, interventions may specifically target young parents to help develop their parenting skills and strengthen factors protective against child maltreatment.

3.2.1.3 Single parenthood

Children in single-parent families are often found to be at increased risk of maltreatment (*11,12,18–21).* While direct associations between single parenting and child maltreatment are likely to be small (physical abuse and neglect: see Table 3.1), single parenthood can involve a range of stressors that increase risks of abuse, such as low financial resources, social isolation and a lack of emotional and caregiving support. Exposure to nonfamilial adults (mothers' intimate partners, for instance) can also contribute to risks. Single parents can therefore be appropriate targets for interventions to offer practical, emotional and social support.

The Avon longitudinal study found that single motherhood more than doubled the risk of having a child placed on the child protection register for maltreatment *(9)*, but analysis of data from 28 developing and transitional countries (including several from the European Region[5]) in the MICS[6] found no consistent relationship between single-parent households and violent disciplinary practices. In some countries (Azerbaijan and Kazakhstan, for instance) violent discipline was more common in single-parent households, whereas in others (Georgia and Tajikistan) it was less common *(22).*

3.2.1.4 Low educational achievement

While parental education has not been identified as a key risk factor in systematic reviews, some studies have found lower parental educational achievement to increase risks for child maltreatment *(9,23,24).* Poorly educated parents can lack the knowledge and skills required to provide appropriate care for their children and can have low access to financial and other resources to help with child care *(24).* A study from the Netherlands examining child maltreatment reports from child protection services and professional sentinels (such as police and health services) found that parents with maltreated children had lower educational attainment than those in the general population. Parents with a very low level of education (primary school or no formal education) were particularly overrepresented in the maltreatment group *(25).* In just over half of countries with

[5] Albania, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia and Ukraine.

[6] The third round of the MICS – a household survey designed to provide nationally-representative data on women's reproductive health and child health – covered over 50 countries in 2005 and 2006. Not all countries completed the child discipline module.

relevant data in the MICS, higher education in mothers/primary caregivers was associated with reduced use of violent disciplinary practices *(22)*.

3.2.1.5 Employment status

Numerous studies have associated parental unemployment, particularly paternal unemployment, with increased risks of child maltreatment *(23,26,27)*. The systematic review by Stith et al. *(3)* found these associations to be small for physical child abuse and moderate for neglect (Table 3.1). Unemployed parents can suffer from economic pressures, stress and low self-esteem and also have greater contact with their children, since they are not at work *(26)*. Large socioeconomic gradients have been found in infant mortality from assaults in United Kingdom (England) and United Kingdom (Wales), with rates being highest in the "non-occupied" class (which includes those who have never worked and the long-term unemployed) followed by the routine and manual occupational classes *(28)*.

3.2.1.6 Ethnicity and immigrant status

Ethnicity and immigrant status have not been identified as key risk factors in recent meta-analytical reviews, although individual studies do report some impacts. The effect of ethnicity on child maltreatment has mainly been studied in the United States. Here, children from minority ethnic groups (Black, Hispanic) are disproportionately represented in child welfare systems *(29)*, while African–American infants have greater risk of child maltreatment and homicide than White infants *(30,31)*.

Adolescents in Sweden with at least one foreign-born parent have been found to have increased risk of physical child abuse, even after socioeconomic factors were accounted for *(20)*. In the Netherlands, traditional immigrants (labour migrants from Turkey, Morocco, Suriname and the Antillean Islands) and nontraditional immigrants (more recent immigrants who were refugees from countries with severe economic hardship or political turmoil) were both found to be overrepresented among families reported for maltreatment. Once family education

level was accounted for, the increased risk of child maltreatment disappeared in traditional immigrant families, yet remained in the nontraditional *(32)*. The reasons why immigrant families have different risks of child maltreatment may include: families having different cultural norms regarding childrearing and the use of physical punishment; problems suffered in the home country increasing the risk factors for maltreatment (such as past trauma contributing to mental health problems); social isolation in the adopted country due to "outsider" status; and other risk factors, including low education and economic hardship.

3.2.1.7 Socioeconomic status

Stith et al. *(3)* found higher family socioeconomic status to have small protective effects against physical child abuse (see Table 3.2). Individual studies have also found associations between low socioeconomic status and increased risk of child maltreatment. In Croatia, for example, parents with poorer economic status have been found to have increased risk of physical child abuse *(33),* while in the MICS study both physical and psychological child abuse was linked to poorer economic status *(34).*

The Avon longitudinal study found that indicators of deprivation (paternal unemployment, overcrowding, housing tenure and car ownership) had the strongest association with substantiated child maltreatment out of all risk factors examined *(9).* Of deprivation indicators, housing tenure (living in social housing) had the strongest relationship with abuse, while the more indicators of deprivation families had, the greater their risk of maltreatment *(26).* A study of adolescents in Sweden also found links between housing tenure and abuse with those who lived in a rented flat being at greater risk of having been hit by an adult than those living in a private house or apartment *(20).*

Other studies have shown that families who receive welfare payments (including financial and medical assistance) or have a low income are at increased risk of maltreatment, including neglect, emotional and physical abuse *(35–38).* A United States study of individuals who were leaving temporary financial aid programmes found that each additional US$ 100 earned in a month reduced the risk of reported child maltreatment in that month by 2.2%. Leaving the programme involuntarily was associated with increased risk of child maltreatment *(39).* Parents with low socioeconomic status may experience a range of further risk factors for violence such as low education, unemployment, poor mental health and family dysfunction. Families with few resources are also likely to live in disadvantaged communities, where there can be higher levels of child maltreatment, violence and crime in general (see section 3.4).

3.2.1.8 Substance use

Systematic reviews have found substance use (alcohol and drug use) by parents and other adults to have small effects on child physical abuse and moderate effects on child sexual abuse (Table 3.1). Substance use can contribute to child maltreatment in several ways *(40,41)*. For example, it can affect cognitive functioning, leading to reduced self-control, misinterpretation of social cues and underestimation of the impacts of aggressive behaviour, all of which can make individuals more likely to act violently. Substance use can lead caregivers to neglect responsibilities towards a child and reduce the resources they have available for them. Children can also be exposed to risk from parents' substance-using acquaintances and, in the case of illicit substances, the violence associated with illicit drug markets *(4,41).* Critically, problematic substance use often features as part of a complex array of life issues that increase individuals' risks of poor parenting and child maltreatment. This array can include a history of childhood abuse, mental illness and socioeconomic deprivation.

3.2.1.9 Alcohol use

Parental alcohol use is commonly associated with increased risks of child maltreatment *(14,42,43).* A study of 10–14-year-olds in Latvia, Lithuania, the Republic of Moldova and the former Yugoslav Republic of Macedonia, for example, found that excessive parental alcohol consumption (as perceived by the child) correlated with emotional and physical abuse in all countries, although relationships were weaker in the sample from the Republic of Moldova *(44).* In the United States, the ACE study found that adults who reported growing up with a parent with problematic alcohol use were more likely to have suffered abuse (physical, emotional and sexual) and neglect (physical and emotional) in childhood. Odds of violence were highest if both parents had problematic alcohol use *(43).* A study in Germany found that a third of child abuse fatalities had occurred when the offender was under the influence of alcohol *(45).* Prior to a child's birth, maternal alcohol use in pregnancy can result in fetal alcohol syndrome and effects, which can manifest in problematic child behaviour and increase risks of child maltreatment *(40).*

3.2.1.10 Drug use

Research has examined associations between parental drug use and child maltreatment *(24,27,46).* Studies of

infants born to drug-using mothers have found they have increased risks of maltreatment and removal from the mothers' care *(47–49).* A United Kingdom study, however, found that the increased risk of child protection proceedings seen among infants born to drug-using mothers (mostly heroin and/or methadone users) was largely accounted for by a small group of children who were taken into care, with child protection concerns being short-lived for most infants *(49).*

A United States study of mothers from the same social group who did and did not use drugs in pregnancy found no direct impact of drug use on child abuse potential *(50).* Rather, findings suggested that the demographic and social factors that lead to drug use also contribute to child abuse. Among substance-using mothers, factors such as a history of childhood abuse and family substance use, anxiety, depression, psychiatric problems and domestic violence exposure can increase the risks of child maltreatment *(2,51).*

3.2.1.11 Maternal smoking

Several studies have identified maternal smoking during pregnancy as a predictor of infant maltreatment *(11,35).* A study linking birth registry and child welfare data in Finland found that 56% of women whose children had been placed in foster care due to maltreatment had smoked during pregnancy, compared with 15% of the population-based comparisons *(12).* Of mothers who smoked, 3.6% had a child placed in foster care compared with 0.4% of non-smoking mothers. Smoking in pregnancy is likely to be a proxy for other child maltreatment risk factors and has been associated with young maternal age, single motherhood, lower maternal education and child behavioural problems *(12).*

3.2.1.12 History of childhood abuse

Systematic reviews have found a history of childhood abuse to have moderate-to-large effects on the perpetration of physical and sexual abuse and small effects on the perpetration of neglect (see Table 3.1). While individual studies have associated parental history of childhood abuse with a range of markers, including hostility towards the child, harsh parenting, severe physical punishment and involvement with child protection services *(8,52–54),* only a minority of abused children become abusers. The Avon longitudinal study, for example, found that just 1.2% of parents with a history of abuse in childhood had a child registered for maltreatment *(9).* Another United Kingdom study found that around 10% of male victims of childhood sexual abuse had committed a sexual offence by their early 20s, mostly against children. Childhood factors linked to later offending were material neglect, low supervision, sexual abuse by a female and witnessing serious family violence *(55).*

There are several mechanisms through which the intergenerational transmission of child maltreatment may occur. For instance, victims of childhood abuse can suffer cognitive, psychiatric, behavioural and social problems throughout adolescence and adulthood that can increase their risks of poor child-bonding, poor parenting and child maltreatment as parents. A systematic review of the "cycle of maltreatment" hypothesis found, however, that the methodological quality of many studies linking abused parents to abusive parenting was weak and that the more robust studies reported mixed findings *(56).*

In line with this, several studies have found that associations between parental childhood abuse and perpetration of child maltreatment disappear once other factors have been taken into account *(9).* Research in the United Kingdom found that the intergenerational transmission of child maltreatment was largely explained by poor parenting styles combined with three risk factors – young parenting (less than 21 years), parental history of mental illness or depression, and living with a violent adult *(57,58).* Depression, adult violence and other life stressors have also been found to mediate relationships between victimization and perpetration of child maltreatment *(59–61).*

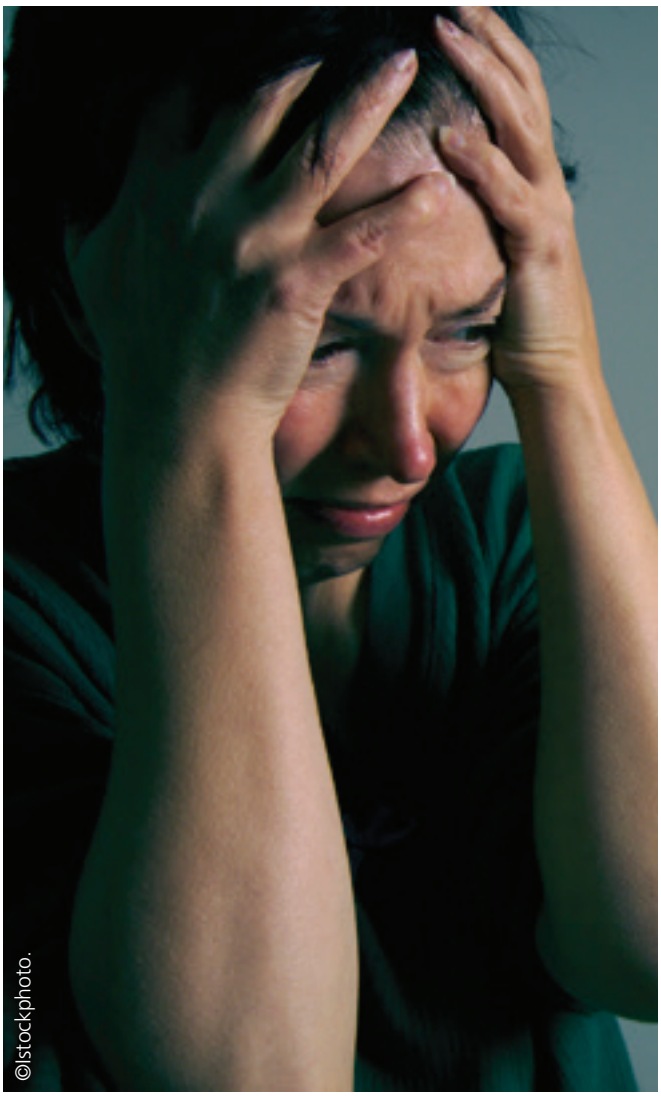
A longitudinal study found that mothers with a history of childhood sexual abuse were more likely than non-abused mothers to be teenagers, to have dropped out of high school, to be obese and to have experienced domestic violence, psychiatric problems and substance dependence; their children had increased risk of involvement in child protection services *(62).* The literature suggests that much of the relationship between childhood abuse and later perpetration results from the complex trauma associated with experiencing child maltreatment, which manifests in increased risks for perpetrating violence against children.

3.2.1.13 Mental illness

Mental illness is a key risk factor for the perpetration of child maltreatment, with systematic reviews having identified moderate-to-strong associations between a range of mental health conditions and child physical abuse, neglect and sexual abuse (Table 3.1). Mental illness typically features as a perpetrator characteristic in most fatal child maltreatment cases *(63).* In an examination of 139 incidents of serious and fatal child maltreatment in United Kingdom (England), for example, parental mental illness was identified in 58% of cases *(64).*

Parental mental illness can directly affect parenting through features such as apathy, irritability, paranoia and delusions *(65).* Numerous studies have identified parental depression, anxiety and other psychiatric disorders as being associated with child abuse, particularly when suffered by the mother *(66)*: in the Avon longitudinal study, for example, children whose parents had a history of psychiatric disorder had more than a two-fold risk of being registered for maltreatment *(9).* A whole-population study in Denmark found that children whose parents had been admitted to a psychiatric hospital had an increased risk of being a homicide victim before the age of 18 *(67).* Risks were particularly high in young children whose mothers were hospitalized with affective disorders or schizophrenia.

Maternal depression has been widely studied as a risk factor for child maltreatment *(24,36,68).* A study in Croatia found that mothers and fathers with mixed anxiety and depressive disorder had increased risks of child physical abuse *(33)* and one in the United States reported that children of depressed mothers had greater risk of physical maltreatment, maternal hostility and exposure to domestic violence if the mother also had a history of antisocial personality disorder symptoms *(69).* Another United States study of women with major psychiatric disorders found that those with more sensitive mothering techniques and better insight into their condition had lower risks of maltreating their child *(70).*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3.2.1.14 Emotional/social processing

Studies suggest that abusive caregivers can lack empathy for their children and have difficulty determining their emotions. Studies in Spain have examined emotional processing in parents at high risk of child maltreatment, finding that high-risk parents show deficits in emotional recognition, reporting less warmth, compassion and concern for others and greater anxiety and discomfort from other people's negative experiences *(71–74).*

Studies elsewhere have found that high-risk mothers have poor attachment and show problems in processing information on their child's behaviours and emotions by, for example, being less likely to recognize sadness and shame *(75,76).* Equally, they can be more likely to see ambiguous child cues as hostile *(77),* to feel more hostile themselves after exposure to a crying infant *(78)*, to perceive greater threat and uncontrollability after repeated child noncompliance *(79)* and to judge their child's behaviour to be problematic *(80).*

3.2.1.15 Personality characteristics

Personality traits such as anger and hostility can be important risk factors for child maltreatment. Systematic reviews have found, for example, that anger has moderate-to-strong effects on parental physical child abuse and neglect and small effects on child sexual abuse (see Table 3.1). As an example, a United States study of mothers with co-occurring substance use and depression found anger arousal and reactivity to be stronger predictors of child abuse potential than diagnostic and demographic factors *(4,81,82).*

3.2.1.16 Social isolation

Loneliness has been found to have large effects on perpetration of child sexual abuse, while social support has some protective effects against child physical abuse and neglect (Table 3.1). Poor social support can mean parents lack emotional, material and child care support, as well as feedback on their behaviour. Equally, abusive parents may avoid social contact and communities may shun abusive adults *(83).*

Poor social support emerged as a key predictor of physical child abuse risk in a Croatian study *(83),* while children of mothers with poor social networks in the Avon longitudinal study had almost double the risk of child maltreatment registration *(9,26).* A United States study of fathers found a lack of social support to be the only significant predictor of child abuse risk *(84),* and research on mothers with trauma exposure identified that use of severe physical punishment towards children was greater in those reporting loneliness and reduced in those who got greater satisfaction from friendships *(59).*

Other studies have shown that social support and social engagement (such as parent participation in school activities) can reduce child maltreatment risk (*19,85).* For example, research in the United States found that adequate social support reduced by a factor of two the risk of child maltreatment reports in mothers who had not graduated from high school *(85).*

3.2.1.17 Paternal uncertainty

From an evolutionary perspective, paternal uncertainty (in which a father is unsure whether or not a child is biologically his) can reduce the amount of investment a father is willing to commit to a child and increase his risks of abusive behaviours. Fathers in a Brazilian study who had not cohabited with the mother at the time of conception (used as a marker of paternal uncertainty) were significantly more likely to have committed child physical abuse in the past year *(86).* Further information on nonbiological fatherhood as a risk factor for child maltreatment is provided in section 3.3.

3.2.2 Child characteristics

3.2.2.1 Demographics

Studies reporting variation in child maltreatment experience by gender and age often report mixed findings. In general, such demographic features are not considered key risk factors for maltreatment, but study findings can be important in understanding the nature of child maltreatment and how best to target interventions.

3.2.2.2 Child gender

The types of maltreatment experienced by children can vary by gender. In particular, girls are routinely found to be at increased risk of sexual abuse. In a study of 17-year-old students in Sweden, for example, 11.2% of females

reported sexual abuse in childhood compared with 3.1% of males *(87).* A study of adults in Finland found that females were more likely to report all childhood sexual abuse experiences examined: whether someone had tried to touch them sexually, threatened to hurt them unless they did something sexual, tried to make them do or watch something sexual or sexually molested them; and whether they believed they had been sexually abused *(88).*

Some studies suggest that males can be at increased risk of physical abuse, including harsh physical punishment. Data from the MICS, for example, found that male children were at increased risk of physical and psychological abuse *(34).* In Israel, research on the maltreatment of schoolchildren by education staff found that males were more likely to report victimization *(89),* but a meta-analysis of the prevalence of child physical abuse across 111 studies found no gender differences *(90).*

3.2.2.3 Child age

The risk of fatal child abuse is greatest in infanthood. Crime data in United Kingdom (England) and United Kingdom (Wales), for example, have shown the risk of homicide to be greatest in children under the age of one *(91).* An analysis of serious child abuse case reviews (resulting in death or serious injury) in United Kingdom (England) found that almost half of cases involved children under the age of one *(92).*

Studies elsewhere have also found infants to be at increased risk of fatal abuse, reported maltreatment and hospitalization for physical injury from child abuse *(31,37,93)*, but surveys of child maltreatment (which also identify less serious cases) show that experience of abuse can vary by age and is often increased in older age groups. In a United States study of 0–17-year-olds, for example, past-year reports of various types of abuse (sexual assault, physical abuse, psychological/emotional abuse and neglect reported by caregivers for under-10s and children aged 10–17) were most commonly reported by 14–17-year-olds *(94).* Similar findings were reported from the United Kingdom *(95).*

The MICS (covering children aged 2–14 years) found those aged 6–10 had increased risk of both psychological and physical abuse *(34).* For sexual abuse, a Swedish study revealed that the mean age of onset of abuse was nine years for boys and girls *(87)*. Studies suggest that older children experience more abuse when there is more than one child in the family *(96,97).*

3.2.2.4 Prenatal/neonatal problems

A meta-analytical review identified no significant effects of prenatal or neonatal problems on children's risk of maltreatment *(3).* More recently, however, the Avon longitudinal study found that low-birth-weight children had more than a two-fold risk of being registered for maltreatment *(9),* while research in Finland revealed that children taken into custody and foster care had poorer health at birth than other children, including those of lower birth weight, lower Apgar scores,[7] greater special care requirement and later nursery discharge *(12).*

Pre- and neonatal complications may increase the risk of child maltreatment by affecting parent–child bonding, parenting stress and child behaviours, but they may also arise through poor maternal behaviours in the prenatal period, which contribute to problems at birth. Perinatal complications in the United States, for example, have been associated with behaviours such as substance use and inadequate medical care during pregnancy *(98).* A study of disadvantaged single adolescent mothers found that those rated as having higher child abuse potential prior to the birth of their child[8] were more likely to smoke, use other substances and have markers of improper diet during pregnancy: higher prenatal child abuse potential correlated with neonatal morbidity *(99).*

3.2.2.5 Child disability

The meta-analytical review of risk factors for child physical abuse and neglect found no significant effects for child disability (Table 3.1), but the five studies included in the review had all been published in the 1980s. A larger and more recent systematic review and meta-analysis found that, compared to their nondisabled peers, children with disabilities were around three times more likely to suffer physical or sexual violence and over four times more likely to suffer emotional abuse or neglect *(100).* Odds of any maltreatment and of sexual violence were increased in children with mental or intellectual disability types, although too few studies were available to examine risks in children with other types of disabilities.

Six of the studies included in the review had been conducted in the European Region, including a whole-population birth cohort study undertaken in West Sussex, United Kingdom *(101)*. This found that children with

[7] The Apgar score is a method of assessing the health of newborn children immediately after birth using five criteria: skin colour/complexion, pulse rate, reflex irritability, muscle tone, and breathing. Each criterion is scored between 0 and 2 and scores are summed. Lower scores represent lower newborn health.

[8] Prenatal child abuse potential was measured using a modified version of the Child Abuse Potential scale with questions adjusted to reflect the fact that the scale was applied to women prenatally.

speech and language disorders, learning difficulties, conduct and psychological disorders were at significantly increased risk of inclusion on the child protection register. Associations between cerebral palsy and child maltreatment were not significant after birth weight, gestational age and socioeconomic factors had been accounted for. No associations were found between autism and sensory disabilities (vision and hearing) and physical child maltreatment, with sample sizes being too small to identify risks of other forms of abuse in these children. Other studies have, however, found increased risks of maltreatment in children with sensory disabilities *(102).* A Swedish study found increased risks of physical abuse seen in children with chronic conditions (including disability and conditions such as epilepsy, asthma, eczema and overweight) were particularly elevated in those who lived in low-income areas or who were born outside of Sweden *(103).*

Studies on disability and violence are often limited by problems in ascertaining the timing of abuse and disability, with disability (such as conduct and other psychological disorders) also being a consequence of childhood abuse. There are, however, various reasons why children with disabilities can be at increased risk of child maltreatment, including the additional stress placed on parents and caregivers in caring for a disabled child, communication barriers preventing children from disclosing abuse (consequently making them appear easy targets to perpetrators) and the placement of children with disabilities in institutional care, where abuse can be common.

3.2.2.6 Child externalizing behaviours and conduct disorders

Children who display externalizing behaviours (aggression, noncompliance and antisocial behaviour) and have conditions such as attention deficit hyperactivity disorder (ADHD) and conduct disorders can be at increased risk of being maltreated (see Table 3.1). Studies have shown that mothers who report their child to have a more difficult temperament and to be aggressive are more likely to use physical punishment and aggression towards them *(42,104).*

Conduct problems in children have been linked to increased parental stress, difficult parent–child relationships, reduced parent self-efficacy and family conflict *(105)*, all of which can increase risks of maltreatment. Equally, ADHD and conduct disorders are partly heritable conditions, meaning that parents and children may share genetic predispositions to aggressive behaviour. Environmental factors are also important in the development of conduct problems.

Parental stress due to child problem behaviours may contribute to harsh physical punishment, while family conflict and dysfunction, including abuse, may contribute to the development of conduct problems in children. A study in the United States found that girls with ADHD had increased rates of child maltreatment compared with comparison children; for some, ADHD behavioural patterns were known to have preceded the abuse, yet for others they emerged following a history of abuse *(106).* A twin study examined the strength of genetic and environmental relationships between conduct problems and child maltreatment and found greater support for parental child maltreatment being a response to genetically-influenced conduct problems in children than for conduct problems being caused by maltreatment *(107).*

Factors such as parents' ability to empathize with their child, tolerance of frustration, locus of control (perceptions of their ability to control events around them) and disciplinary practices have been found to affect child abuse potential in parents of children with externalizing behaviour *(108).*

3.2.2.7 Children who have been abused

Children who have already suffered abuse in childhood are at risk of suffering further abuse. A study in the United States found that those who had suffered sexual abuse were more likely than non-abused children to experience physical and sexual victimization in later childhood *(109).* Children who suffer abuse at home may run away or be placed in care, where they can be exposed to the risk of violence from other adults. Research on adolescents who had run away from home revealed that those who had been maltreated had left home at an earlier age and were more likely to suffer abuse on the street (including robbery, sexual assault, beating, threats and being asked to perform illegal activity) *(110).*

Experiencing abuse in childhood may also affect children's behaviours towards other children. For example, a United States study of girls in foster care who were sexually abusive towards other children found that most had experienced physical (84%) and sexual (81%) abuse themselves *(111).*

3.2.2.8 Homeless and runaway youth

Homeless children can be at high risk of abuse and often have abuse histories that have led to their homelessness. They can live in precarious situations where they are

vulnerable to various forms of exploitation and may engage in risky behaviours such as sex work and crime for survival, which exposes them to potential offenders.

A study of homeless youth (mean age 16) in the United States found that those who engaged in deviant survival strategies such as trading sex for survival (for food, money, somewhere to sleep), shoplifting and mugging had a greater risk of sexual victimization by known perpetrators than those who used other strategies for survival *(112).* A longitudinal study of high-risk youth found that running away from home was associated with childhood abuse and poor parental relationships and practices; children who had run away were more likely to do so again and engage in delinquent behaviours and early sexual activity, which were associated with subsequent reports of physical violence by a noncaregiver *(113).*

3.3 Relationship factors

Risks of child maltreatment can be affected by the relationships that form between parents or caregivers and their children and those of family members. Stith et al. *(3)* identified a range of factors relating to child/parent and family relationships that were associated with increased risks of child maltreatment (Table 3.2). This section discusses some of these factors in more detail.

3.3.1 Poor parenting skills and parental stress

A lack of parenting skills can mean that parents fail to provide adequate care for their children and struggle to cope with the demands of parenting. A retrospective study in the United Kingdom found that incompetent parenting by mothers (such as being impatient, irritable or giving too little time and attention) was associated with their offspring reporting maltreatment during childhood *(114)*. Numerous studies have found associations between parenting stress and risks of child maltreatment, including neglect, harsh discipline and physical abuse *(104,115,116)*, which may be moderated by attitudes towards corporal punishment *(117).*

A systematic review, however, found that parenting stress had only small effects on child maltreatment risk (physical abuse and neglect (see Table 3.2)). Research in the United States revealed that fathers who felt more effective as parents were less likely to have neglected their children *(118),* while another study found that positive paternal involvement with children reduced maternal risk of physical child abuse *(119).* Qualitative research in Finland concluded that a lack of resources for caring within the family was the core feature of families with child maltreatment. The study suggested that the inability to care for and have positive feelings towards others was a consequence of an accumulation of risk factors, including parental histories of abuse, unstable family structures, regular family conflict, unemployment and substance use *(120).*

3.3.2 Parental approval of corporal punishment

The review by Stith et al. *(3)* found no significant relationship between parental approval of corporal punishment and child physical abuse (Table 3.1), yet moderate effects of parental use of corporal punishment (Table 3.2). The MICS, however, found that positive parental attitudes towards corporal punishment (believing that physical punishment is necessary for childrearing) was the strongest predictor of child maltreatment. Children whose mothers reported such attitudes had a three-fold risk of physical abuse and more than two-fold risk of psychological abuse *(34).* Risk increased in those with

Table 3.2. Relationship risk factors for child physical abuse (P) and neglect (N), identified in a systematic review and meta-analysis

Parent/child interaction	P	N	Family characteristics	P	N
Child perceived as a problem	❖	◆	Family conflict	❖	
Unplanned pregnancy	❖		Family cohesion*	❖	
Good parent–child relationships*	❖	◆	Spousal violence	❖	
Use of corporal punishment	❖		Marital satisfaction*	✧	
Parenting behaviours	✧	✧	Family size	✧	❖
Parenting stress	✧	✧	Higher socioeconomic status*	✧	✧
			Nonbiological parent in home	✧ns	

◆ Large effects (d>.70); ❖ medium effects (d=.40–.70); ✧ small effects (d<.40); where no symbol is shown, no studies were identified. *Indicates a negative relationship.
Source: Stith et al. *(3)*

poorer socioeconomic status. In general, European countries included in the study[9] had lower levels of approval of corporal punishment compared to countries in other regions.

Young parents in New Zealand who had controlling, restrictive or overprotective parents have been found to be at increased risk of using severe physical punishment with their own children *(17)*. United States research found that parenting stress was positively associated with physical child abuse in parents who supported corporal punishment, but not in those who had low belief in its value *(117)*. This suggests that parental attitudes towards physical discipline may moderate other risk factors for child maltreatment.

3.3.3 Poor family cohesion and functioning

Dysfunctional family relationships are common features of child maltreatment cases. In a Finnish study that compared families with and without child maltreatment, abusive families were found to have reduced levels of family functioning across a range of domains: family instability/ insecurity and low individuation of family members had significant associations with maltreatment after other factors were controlled for *(23)*.

Qualitative research in Finland also identified significant family dysfunction among maltreating families *(120)*. Other studies have found that markers of poor family cohesion, such as divorce and low paternal support, predict child maltreatment *(68,121)*. A retrospective study in the United Kingdom of mothers at high risk of affective disorder and their offspring found that mothers' reports of poor-quality family relationships (insecure attachment and partner problem behaviours) accounted for their incompetent parenting, which predicted maltreatment towards their children *(114)*. Elsewhere, factors such as stronger parental relationships prior to the birth of a child and supportive relationships between children and grandparents have been linked to lower risk of child maltreatment *(122,123)*. The meta-analytical review by Stith et al. *(3)* (Table 3.2) found family cohesion to have a moderate protective effect against physical child abuse.

Adults who had poor relationships with their own parents can also be at increased risk of maltreating children. For example, adults who commit sexual offences against

[9] Albania, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia and Ukraine.

children report poorer histories of family functioning, including poorer bonding and attachment and more harsh punishment in childhood, than non-offenders (see Table 3.1). Children in the Avon longitudinal study whose fathers were in care during childhood or whose mothers grew up with an absent father were at increased risk of maltreatment *(124).*

3.3.4 Intimate partner violence

Intimate partner violence (often called domestic violence) has been found to have moderate effects on physical child maltreatment (Table 3.2). Individual studies have also found relationships between domestic violence and psychological abuse and neglect in young children *(125),* while intimate partner violence in pregnancy has been found to be predictive of later child maltreatment *(126).*

A review of serious child abuse cases in United Kingdom (England) found that two thirds of cases examined showed evidence of domestic violence *(92)*, while a review in the United States discovered that the prevalence of physical child abuse in domestically violent families ranged from 18% to 67%; in general, lower rates were seen in samples surveyed in the community and higher in those recruited in women's refuges or clinical settings *(127).*

While a violent parent can abuse both their partner and their child *(128)*, families with co-occurring partner and child abuse can often involve both partners as perpetrators of partner violence, with one or both also maltreating the child *(127).* Equally, women who suffer abuse at the hands of a partner can be at increased risk of abusing their children. Maternal experience of intimate partner violence has been associated with increased risks of maternal child neglect, harsh physical punishment and child protection reports *(59,129).*

Increased risk of child maltreatment in families with maternal-reported domestic violence in the Avon longitudinal study disappeared once other family and socioeconomic factors were controlled for *(9).* This suggests that child maltreatment and intimate partner violence share similar risk factors. A United States study found that associations between domestic violence and child maltreatment were only seen in families receiving welfare support *(122).*

Relationships between the two types of abuse have also been linked to factors such as parents' attitudes towards the child: one study found that parents who experience domestic violence have more negative views of their children and that these negative views mediate the relationship between intimate partner violence and child abuse *(130).* Attitudes towards intimate partner violence may also be important. In an Egyptian study, maternal exposure to intimate partner violence and maternal attitudes tolerant of such violence were associated with use of harsh punishment. Mothers with intolerant attitudes to intimate partner violence were more likely to use nonviolent techniques *(131).* Mothers experiencing intimate partner violence may compensate via their parenting with increased warmth towards their children *(132).*

3.3.5 Unwanted/unplanned pregnancy

Unplanned pregnancy has been found to have moderate effects on increasing a resulting child's risk of physical maltreatment (Table 3.2). Children in the Avon longitudinal study who were born from unintended pregnancies were around three times more likely to be registered for maltreatment than children from intended pregnancies *(133)*, but the risk reduced substantially once other parental, family and socioeconomic factors were controlled for *(9).* While parents of unplanned children may be unprepared for parenthood and face a range of financial and other stressors, unintended pregnancy can also be a symptom of the complex array of risk factors that increase risks of child maltreatment in parents.

3.3.6 Family size

Large family size has been found to have small effects on children's risk of physical abuse and moderate effects on risks of neglect (Table 3.2). A study in the Netherlands, for example, found that families with three or more children were overrepresented in child protection services *(21).* Children in the Avon longitudinal study in the United Kingdom born to families with three or more existing children had increased risk of being registered for child maltreatment, although this effect disappeared after other parental, family and socioeconomic factors were controlled for *(9).* Having many children can mean parents have less time and resources available to devote to each child and face greater financial, parenting and relationship stressors. In support of this argument, children who result from multiple births (such as twins) have been found to be at increased risk of abuse *(13).* Equally, large family size may be related to other risk factors, such as unplanned pregnancy, low education and low family stability. A Finnish study comparing families with and without child maltreatment found that having more children in the family was associated with child maltreatment; families with more children had poorer stability and security, and

family members had lower individuation (such as personal identity and ability to think independently) *(23)*.

Crowding in households can also contribute to risks of child abuse *(26)*, as can the number of household members. The MICS study found that children living in households with fewer than eight family members had reduced risk of psychological and physical abuse compared to those with more *(34)*; a study in Latvia, Lithuania, the Republic of Moldova and the former Yugoslav Republic of Macedonia, however, found no association between child abuse and family size *(44)*.

3.3.7 Nonbiological parent in the home

The relationship between having a nonbiological parent in the home and risks of physical child abuse has been found to be insignificant (Table 3.2), but individual studies have suggested that risks can differ based on the surrogate parent's status. For example, a study in the Netherlands found that families with a step-parent had greater involvement with child protection services, yet adoptive families had less involvement than expected *(21)*.

Numerous studies have found children with step-parents to have increased risk of child maltreatment *(21,134–136)*. From an evolutionary perspective, step-parents can be less motivated to invest in children as they gain no genetic benefit from doing so; rather, benefits are accrued by a same-sex rival. A stepchild can therefore be considered a cost rather than a benefit by a step-parent, raising feelings of jealousy and resentment. Equally, biological parents may develop resentment towards a child if seen as a barrier to, or cause of conflict in, a new intimate relationship *(137)*.

Not all studies find children with step-parents to be at greater risk of abuse, however. A Swedish study found no evidence that children living with a stepfather were at greater risk of child homicide *(138)*. A sibling study with maltreated children in United Kingdom (England) found no evidence of increased maltreatment risk among those who were stepsiblings *(97)*, and a study of adolescents in the United States found that while those from stepfamilies had increased risk of victimization, this was fully explained by the greater number of problems experienced in their families, including parental unemployment, substance use, imprisonment and conflict *(136)*.

3.4 Community factors

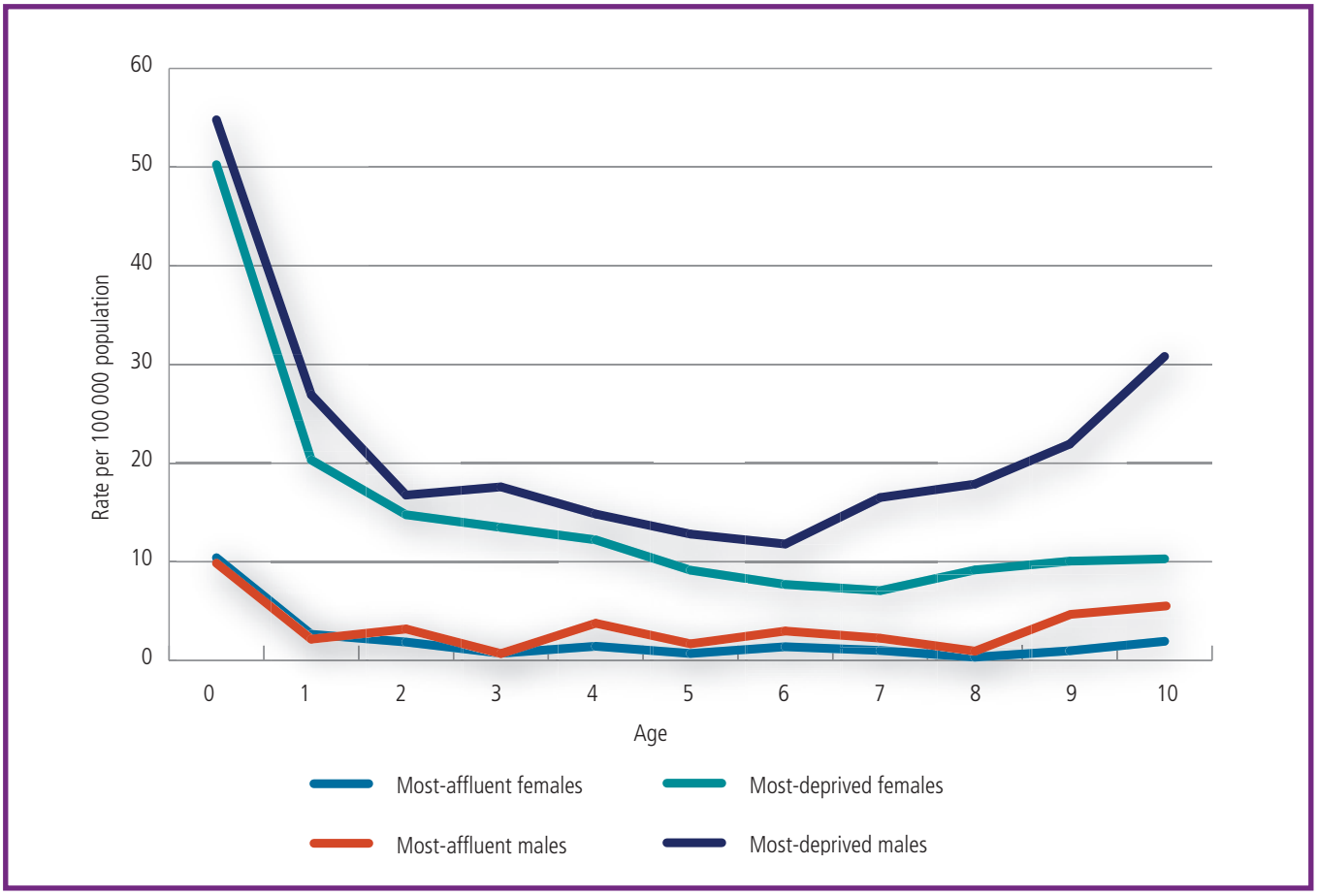
Certain features of the communities or neighbourhoods in which families live and children grow up can affect the risks of child maltreatment. While research into community risk factors for child maltreatment is less well-developed than that for individual and relationship factors, this section outlines some findings from studies that have identified associations between community attributes and levels of child maltreatment.

3.4.1 Socioeconomic disadvantage

Strong relationships have been identified between community deprivation and child maltreatment. Studies from a range of countries have shown that neighbourhoods characterized by factors including high rates of poverty, socioeconomic disadvantage, unemployment or welfare receipt have increased rates of child maltreatment and child homicides *(11,93,139–143)*. Other community-level factors that can be markers of socioeconomic deprivation, such as higher rates of single-parent families, divorce and large families as well as lower property values, have also been associated with child maltreatment *(11,18,141)*. Analysis of national hospital admissions data in United Kingdom (England) has shown that children (aged 0–10 years) living in the most-deprived quintile of communities have rates of emergency hospital admissions for violence around eight times higher than those from the most-affluent quintile (Fig. 3.2) *(142)*.

The relationship between community socioeconomic deprivation and child maltreatment likely represents a clustering of risk factors in disadvantaged communities, including unemployment, low income, single parenthood, domestic violence, substance abuse and poor mental and physical health. Families affected by these issues often have limited resources and can be confined to neighbourhoods where low-cost accommodation or social housing is available. Deprived communities can also experience higher levels of antisocial behaviour and crime, including gang violence, mugging, drug dealing and

Fig. 3.2. Annual rates of emergency hospital admissions for violence in children (aged 0–10) from the most-deprived and most-affluent communities (quintiles) by age, United Kingdom (England) 2004/2005 and 2008/2009



Source: Bellis et al. *(142).*

prostitution. Children growing up in such neighbourhoods may also be more vulnerable to exploitation and victimization via increased exposure to potential offenders outside the family.

3.4.2 Social processes

Poor social capital[10] and social disorder can predict child maltreatment. In the United States, a study explored the impacts of mothers' perceptions of social cohesion (such as willingness to help neighbours), informal social control (how much neighbours would be willing to intervene in situations such as children disrespecting an adult) and social disorder (the presence of drug dealers, drunks and gangs) on their risk of child maltreatment. It found a small direct link, but a strong indirect link. Mothers' negative perceptions of their neighbourhoods affected their child abuse risk by reducing their sense of personal control, which in turn increased parenting stress. Parenting stress was directly related to maltreatment risk *(115).* A different study constructed a four-point social capital scale consisting of factors relating to neighbourhood cohesion, informal social control, religious service attendance and having a partner in the home. Each one point increase on the scale reduced odds of child neglect, harsh parenting and domestic violence by 30% *(145).*

3.4.3 Child care availability

Research in the United States has found associations between inadequate child care provision and child maltreatment *(139).* In one study, neighbourhoods with more licensed child care spaces relative to need (number of 0–5-year-olds with working parents) had fewer child maltreatment referrals, but those with a greater spatial density of child care centre spaces (number of licensed spaces per square mile) had higher rates *(139).*

[10] The World Bank *(144)* describes social capital as "the institutions, relationships and norms that shape the quality and quantity of a society's social interaction", emphasizing that "social capital is not just the sum of the institutions which underpin a society – it is the glue that holds them together."

3.4.4 Urban/rural communities

Several United States studies have reported that children who live in urban areas are more likely to suffer from child maltreatment *(31,79,141).* This is likely to reflect higher levels of socioeconomic disadvantage in inner city areas, as seen in many countries, but a study in Latvia, Lithuania and the former Yugoslav Republic of Macedonia found that student-reported emotional and physical abuse was typically highest in rural areas and lowest in large cities. A potential reason for this was suggested to be the high levels of financial and psychological stress seen in rural families since the breakup of collective farming systems that existed during the Soviet period. Higher rates of parental alcohol use were also seen in rural areas (see section 3.2.1) *(44).*

3.4.5 Availability of alcohol and drugs

The availability of alcohol and drugs within a community can affect levels of violence. Numerous studies have shown that areas with a greater density of alcohol outlets (such as bars and off-license premises) see higher rates of violence, although few have focused on violence towards children. In the United States, however, research has found that neighbourhoods with more alcohol outlets *(139,146)* have higher rates of child maltreatment. Specifically, the density of off-premises has been found to affect levels of child physical abuse and the density of bars on levels of neglect *(147).* Positive relationships have been found between child maltreatment and arrests for drug-related offences in the United States *(140).*

3.5 Societal factors

The risks of a child suffering maltreatment can be affected by various factors that operate at societal level. Research examining associations between societal characteristics and child maltreatment is particularly scarce, but the types of factors that are likely to contribute to increased child maltreatment include the following.

3.5.1 Social and cultural norms

Social and cultural norms surrounding issues such as childrearing, gender roles and family privacy can affect levels of violence towards children *(148).* Norms that can support child maltreatment include beliefs that:

- physical discipline is a normal or necessary part of raising a child;
- men have the right to control women and girls;

- harmful traditional practices such as forced marriage, female genital mutilation and honour-based violence should be supported; and
- violence is a private family matter (which can hamper disclosure of, or social intervention in, child maltreatment).

3.5.2 Economic factors

Levels of child maltreatment can be affected by economic factors in society, such as recession, levels of unemployment, income inequality and poverty. In the United States, a study found that child hospitalizations for abusive head trauma increased during an economic recession *(149)*, although a different study found only weak and inconsistent relationships between official child maltreatment reports and markers of economic recession *(150).* Economic crises can lead to rising unemployment, increased financial hardship and related stress and depression, all of which may increase risks of child maltreatment. They can also result in cuts in government spending on prevention and protective services *(151).* Severe economic problems in society can result in parents struggling to provide for their children, contributing to both child neglect and trafficking. In Albania, for example, a study found that trafficked children often came from families suffering extreme poverty and hardship *(152).*

3.5.3 Levels of inequality

Unequal societies tend to see higher levels of violence, and this effect may also relate to child maltreatment. Inequalities can exist between genders or between different sectors of society, based on factors such as income, ethnicity or access to resources. In the Albanian study of child trafficking, for example, most trafficked children identified were from Gypsy ethnic groups who faced high levels of discrimination and exclusion *(152).*

3.5.4 Legislation and policy

Legislation and policy can directly and indirectly affect child maltreatment. It can prevent the use of corporal punishment towards children and protect them from harmful traditional practices such as forced marriage and female genital mutilation. Legislation was implemented in Sweden in 1979 to abolish physical punishment of children by caregivers. Evidence suggests that both public support for, and the use of, physical punishment towards children declined after its implementation *(153,154).* Other policies that are likely to have an indirect impact on child maltreatment include those affecting access to family planning, parental leave, health services, social welfare, employment, education and effective criminal justice.

3.6 Factors protective against violence

Just as certain factors increase risks of child maltreatment, others are associated with reduced risks. Box 3.2 summarizes some of these factors.

Protective factors can be defined as those that buffer children from maltreatment. Children born to young, poor and low-educated parents can be vulnerable to maltreatment, for example, yet factors such as a supportive family environment and strong social networks may serve to protect the family.

Research focusing on protective factors for child maltreatment is far less developed than that focusing on risk factors: consequently, there is little scientific evidence showing which protective factors can be most important to which groups. Work in the United States, however, has identified six broad protective factors that lay the foundations for preventing child maltreatment and promoting child well-being: these are outlined below *(155).* Strengthening these types of protective factors, particularly in vulnerable families, is a fundamental part of child maltreatment prevention programmes (see Chapter 4).

Box 3.2. Factors that can reduce the risks of child maltreatment

- Supportive family environment
- Strong social networks
- Strong parent–child relationships
- Strong parental relationships
- Nurturing parenting skills
- Parental employment
- Higher parental education
- Parental self-esteem
- Lack of parental support for corporal punishment
- Child social competence
- High levels of social capital

3.6.1 Nurturing and attachment

Parents and carers who form strong bonds with their children in early life and develop nurturing relationships with them throughout childhood can be less likely to become abusive or neglectful. Safe, warm and trusting early relationships also support children's positive social and emotional development, which can in turn facilitate parenting and parent–child relationships.

3.6.2 Knowledge of parenting and child development

Parents and carers who understand child development and have the skills to apply this in their parenting techniques are less likely to have unrealistic expectations of their children and more likely to use age- and developmentally-appropriate communication and discipline strategies.

3.6.3 Parental resilience

Parental resilience refers to parents' ability to cope with stressors in parenting roles and other aspects of life. Resilient parents have the strength and skills to remain positive in the face of challenges and to identify and

address problems in their lives, meaning they can be less likely to take frustrations out on their children. Resilience can be particularly beneficial for parents who face specific challenges, such as a personal history of childhood abuse.

3.6.4 Social connections

A strong social network can support parents with parenting and emotional well-being. Family members, friends and community support systems can offer opportunities for parents to seek advice on parenting and other issues, gain encouragement and reassurance, obtain assistance with child care and have time out from the burdens of parenting. Social interaction can also help develop children's social skills and support networks.

3.6.5 Concrete support for parents

Parents require a range of services and resources to provide adequate care for their children. These can include social welfare, health services, transport services, housing, child care and specialist services such as those addressing substance abuse, domestic violence and mental health. Community and social support systems that help parents access these when needed can be important in preventing child maltreatment.

3.6.6 Social and emotional competence of children

Parents are better able to recognize and respond to their child's needs appropriately when the child is socially and emotionally competent. Effective communication and cooperation between children and parents can strengthen relationships and prevent parental frustration and stress. Child social and emotional competence can also support their interaction with peers and other adults.

3.6.7 Factors that promote resilience in maltreated children

Children who are exposed to maltreatment can suffer adverse health, behavioural, emotional and social outcomes throughout the life-course (see Chapter 2), but a range of factors can promote resilience in maltreated children and protect them from the adverse impacts of abuse. At individual level, these can include social and emotional competencies such as self-control, problem-solving skills and self-esteem *(156)*. There is also growing evidence of the role of genetics in resilience with, for

example, genes coding for monoamine oxidase A and serotonin transporter having been found to moderate the association between child maltreatment and adverse outcomes such as antisocial behaviour and depression *(157,158)*.

Relationship factors can also be important in promoting resilience. These include strong relationships with caregivers and other supportive adults in childhood, and with family, peers and intimate partners throughout adolescence and adulthood. Structured and supportive school environments, social cohesion, community support and safe neighbourhood environments may also offer protective effects *(159–161)*.

3.7 Conclusions

This chapter has highlighted the numerous factors that can affect the risks of child maltreatment. Many of these relate to the individual characteristics of perpetrators (often parents and caregivers) and the relationships that operate within families. They are cumulative in nature and often interrelated. For example, factors such as a parental history of childhood abuse, mental illness and intimate partner violence have been associated with increased risks of various forms of child maltreatment and are strongly related to each other. Equally, factors such as low education, unemployment, substance use, single parenthood, low socioeconomic status, poor social support and depression can cluster in families that suffer child maltreatment and in communities with high child maltreatment rates. Other factors that affect child maltreatment relate to the structures and norms within the communities and societies in which families live. In general, however, such factors have been less-well studied and the strength of their effects on child maltreatment remains largely unknown.

While several systematic reviews have assessed the literature on risk factors for child maltreatment, further work is needed to identify the strength of associations between risk factors and the various forms of child maltreatment. The literature base examining risk and protective factors for child maltreatment is expanding and more studies are emerging from within the Region. Understanding which factors contribute most to risks of child maltreatment and which population groups are likely to be affected is critical to implementing effective preventive and protective programmes where they are needed most. Such programmes can work to address key risk factors and strengthen protective factors among vulnerable groups and communities. The next chapter discusses the evidence behind the various types of programmes that can seek to prevent child maltreatment.

Key action points

- Interventions to prevent child maltreatment and support those who are being maltreated should be built upon a good understanding of the risk and protective factors.
- Preventive interventions can be specifically targeted at population groups and communities that have particular risk factors, such as young single parents from disadvantaged communities.
- Interventions should seek to strengthen protective factors against child maltreatment, such as developing parenting skills and knowledge, strengthening parent–child bonding and providing social and other support to parents.
- Creating societies where child maltreatment is not tolerated and where systems are in place to detect, reduce and prevent child maltreatment is critical. across society.

Key action points *contd*

This may require measures to change social norms regarding children's rights and parental behaviours and to strengthen family and child protection systems across society.

- More robust research is required within the European Region to identify the strength of effects of key risk and protective factors for different types of child maltreatment. The findings from such studies should be widely disseminated.

3.8 References

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CHAPTER 4
EFFECTIVE INTERVENTIONS AND PROGRAMMING

Key facts

- A wide range of interventions has been shown to be effective in preventing risk factors for child maltreatment, such as poor parenting behaviours, parental stress and child conduct problems.
- High-quality evaluation studies examining the impacts of interventions on child maltreatment outcomes are lacking.
- Although the European evidence base is growing, most available evidence stems from the United States.
- Home-visiting and parenting programmes are supported by strong evidence showing their effectiveness in reducing risk factors for child maltreatment; some evidence also supports their effectiveness in preventing child maltreatment.
- These programmes are also supported by studies showing they can generate significant cost savings.

4.1 Introduction

Child maltreatment and the devastating impacts it has on young people throughout their lives can be prevented. Protecting children from abuse is a core function of governments, and child protection systems in the European Region are increasingly operating in holistic contexts that focus on prevention and early identification of risks and provision of specialist services for vulnerable children and their families.

Numerous interventions to prevent child maltreatment are now being implemented in European settings, with some being tested for effectiveness. In general, however, the evidence base on the effectiveness of interventions is scarce. Most studies focus on risk factors, such as parental stress and parenting practices, and few use actual child maltreatment outcomes. Although the European evidence base is growing, most research has been conducted in the United States. Existing studies nevertheless provide much information on the types of interventions that show promise in preventing child maltreatment and associated risks.

This chapter explores a range of types of interventions to prevent child maltreatment and the evidence base behind them. Wherever possible, it provides examples of programmes that have been implemented and evaluated in European settings. The main focus is on universal interventions that target whole populations (section 4.2) and selective interventions targeting populations and individuals at increased risk (section 4.3), with an emphasis on prevention. The chapter includes information on the economic aspects of child maltreatment prevention (section 4.4), which is important in promoting investment, and covers indicative interventions (section 4.5) that target victims or perpetrators. The final section provides some brief information on state-level child protection systems that can bring together universal, selective and indicative interventions into a single coordinated system to promote child welfare and protect children from maltreatment (section 4.6).

Table 4.1 summarizes evidence for the effectiveness of the universal and selective programmes included in this chapter in preventing child maltreatment and risk factors. While this is not a systematic review, evidence has been identified through existing systematic literature reviews, including those conducted through the Violence Prevention Evidence

Base *(1)*. Additional information on European studies has been identified through key term searches within several academic databases and WHO networks. Table 4.1 demonstrates the shortage of robust evidence available internationally, particularly the scarcity of studies identified as having been conducted in the European Region.

4.2 Universal approaches

4.2.1 School-based violence prevention programmes

School-based violence prevention programmes are typically delivered universally to children in classrooms. They aim to: educate children about abuse; teach them to recognize potentially harmful situations; distinguish between appropriate and inappropriate touching and teach them strategies for saying "no" to unwanted approaches; and encourage disclosure of abuse to trusted adults.

Studies have examined the impacts of such programmes, yet many are methodologically flawed *(2–5)*. While most report positive impacts on children's knowledge, few have measured maltreatment outcomes and several have reported negative effects, including increased child anxiety and wariness of touch. Boxes 4.1 and 4.2 provide examples of programmes implemented in the Region.

4.2.2 Media-based public awareness programmes

Media-based public awareness programmes aim to disseminate messages among the general population using channels such as television, radio, printed materials and the Internet. They can be used for a variety of purposes, including raising awareness of child abuse, promoting positive parenting practices, changing social norms regarding the acceptance of abusive behaviour and encouraging the reporting of maltreatment. Mass media programmes have been found to have at least modest

Table 4.1. Summary of evidence for the effectiveness of universal and selective programmes included in Chapter 4

	Impact on		Tested in European Region?	Chapter section
	Child maltreatment	Risk factors		
Universal programmes				
Sexual abuse prevention programmes	✧	◆	✓	4.2.1
Media-based public awareness	✧	❖	✓	4.2.2
Abusive head trauma prevention	❖	❖		4.2.3
Changing social norms	✧	✧	✓	4.2.4
Reducing the availability of alcohol	✧	❖	✓	4.2.5
Reducing poverty	✧	✧		4.2.6
Community interventions	✧	❖		4.2.7
Preventing exposure to IPV[a]	✧	✧		4.2.8
Selective programmes				
Home visiting	❖	◆		4.3.1
Parenting programmes	❖	◆	✓	4.3.2
Multi-component preschool programmes	❖	❖	✓	4.3.3
Enhanced paediatric care	❖	❖		4.3.4
Support and mutual aid groups	✧	✧		4.3.5

◆ Judged to be effective or supported by at least two well-designed studies or a systematic review.
❖ Judged to be promising or supported by one well-designed study.
✧ Judged to have insufficient, weak, or mixed evidence supporting it.
[a] Intimate partner violence.

benefits in addressing a wide range of health-related attitudes and behaviours, can encourage discussion and debate and drive other prevention work *(9,10).* Despite their frequent use in child abuse prevention efforts, few studies have examined the effectiveness of mass media programmes in reducing child maltreatment, and findings from studies have been mixed *(2).*

Box 4.1. "Stay safe" programme in Ireland

"Stay safe" is a primary-school intervention in Ireland to prevent child maltreatment and bullying. The programme includes teacher and parent training components that cover the nature of child sexual abuse, its identification and what to do if a child discloses. Teachers are also trained in delivering the programme, which is provided to children aged 7 and 10 over 12 sessions.

The curriculum uses activities such as class discussion, role play and video and audio tapes to educate children about feelings of safety, bullying, wanted/unwanted touch, disclosure of inappropriate interactions and dealing with strangers. An evaluation study found that three months after the programme, participating children showed improvements in knowledge, skills and self-esteem compared with controls, with the greatest benefits seen in children from higher socioeconomic backgrounds *(6)*. A study of children referred to a sexual abuse assessment unit found that more of those who had participated in "Stay safe" had deliberately disclosed their abuse and been referred to the unit due to their own disclosure *(7)*.

Research has found that public awareness campaigns can be effective in educating the public about the existence of child maltreatment and its effects on victims. For instance, studies in the United States found reductions in corporal punishment and verbal forms of aggression by parents when disciplining their children following several waves of nationwide multimedia public awareness and educational campaigns in the late 1980s and early 1990s. The proportion of parents who reported hitting their child with an object or injuring him or her in the course of "normal discipline", however, remained constant *(11,12).*

Several other studies have reported improvements in parenting practices and competence following mass media programmes. The "Families" television series, for example, used an entertaining format to provide information and advice to parents on child problem behaviours. An evaluation study in Australia using video tapes of the series found that mothers who watched it reported increased parenting competence and improved child behaviour *(13).* Another television series, "Driving Mum and Dad Mad",[11] was aired on national television in the United Kingdom. Its impact was assessed by comparing families who watched the series with those who watched and received enhanced Internet-based support. The study reported that both groups showed improvements in parental anger, dysfunctional parenting, depression, self-efficacy and child behaviour following the intervention *(14).*

Box 4.2. School-based life-skills programme in the former Yugoslav Republic of Macedonia

Schools in the former Yugoslav Republic of Macedonia introduced a life-skills programme in 2010 to help prevent violence against children in families, schools and the community. The programme covers all forms of violence, including physical, psychological and sexual, and promotes children's rights. It offers workshops for children, incorporating problem-solving, role play, peer support and counselling, and analysis of real-life situations. All primary schools throughout the country are involved. Teachers have been intensively trained and special attention has been given to suburban and rural schools as well as those with an ethnic mix.

Source: Bureau for the Development of Education of the Republic of Macedonia *(8).*

4.2.3 Interventions to prevent abusive head trauma

Abusive head trauma is a severe form of child abuse that can result in serious brain, neck and spinal injury. It is often referred to as "shaken baby" or "shaken infant" syndrome, due to injuries commonly being sustained through violent shaking of infants by their caregivers (in response, for example, to frustration at crying).

Preventive responses largely take the form of educating new parents about the dangers of shaking their child. Little research has examined the impacts of such interventions on head injuries specifically, but one study in the United States reported positive effects. The intervention was introduced to all hospitals providing maternity care in New York State, providing information to all new parents (including fathers or father-figures wherever possible) on

[11] Both of these television series were components of the Triple-P parenting programme (see section 4.3.2).

the dangers of shaking their baby and on alternative strategies for dealing with persistent crying. Parents were also invited to voluntarily sign a statement of commitment to confirm that they had received and understood the intervention. The programme was associated with a 47% reduction in the incidence of abusive head trauma injuries over the 5.5-year study period, with no comparable reduction seen in a comparative state *(15).* Other studies have reported that use of caregiver educational materials has led to improvements in behaviours such as taking a break when frustrated with an infant crying or when crying is unsoothable *(16–18).*

4.2.4 Changing social norms supportive of child maltreatment

Social norms programmes aim to prevent violence by changing beliefs and attitudes in society that tolerate or even promote violence *(19).* These can include beliefs that physical punishment is a normal or acceptable part of raising a child.

Social norms programmes often include mass media campaigns (see section 4.2.2) but extend beyond this to include measures such as changes to legislation. Very few have been assessed or subjected to rigorous evaluation. A combination of legislation (a ban on corporal punishment of children by caregivers) and mass education over a period of some 50 years in Sweden failed to show an impact on deaths or reported assaults on children, but coincided with a decrease in social norms supporting the use of *(20)*, and frequency and harshness of *(21)*, physical punishment.

4.2.5 Reducing the availability of alcohol

Many acts of violence towards children and within families occur when perpetrators have been drinking alcohol, and studies show that greater alcohol availability in communities is associated with increased child maltreatment (see Chapter 3). Consequently, lowering levels of alcohol consumption in the population by reducing its availability has the potential to reduce child maltreatment.

Availability can be reduced by regulating alcohol sales (by, for instance, controlling the times at which alcohol can be sold) and increasing prices (through measures such as implementing minimum prices for alcohol or increased taxation) *(22)*. Few studies have measured the effects of reducing alcohol availability on child maltreatment, yet economic modelling studies suggest benefits would be gained. A study in the United States, for example, estimated that a 10% increase in beer tax would reduce the probability of severe violence towards children by 2.3% and overall violence by 1.2%, while a reduction of one alcohol outlet per 1000 population would reduce the probability of severe violence towards children by 4% *(23)*.

To date, no European studies have assessed the impacts of reductions in alcohol availability specifically on child maltreatment, but research has shown effects on broader markers of violence and child health. In the former Soviet Union, for example, a major anti-alcohol campaign implemented in 1985 reduced state alcohol production and the number of alcohol outlets, increased alcohol prices and raised the purchase age to 21, banned the use of alcohol in public places and at official functions and increased enforcement of, and penalties for, the production and sale of home-made alcohol. Violent deaths reduced by 33% in 1985/1986 *(24,25)* and boys born during the campaign period had significant improvements in height, immunization rates and chronic conditions, suggesting a positive impact of limiting parental alcohol consumption on investment in children during the first few years of life *(26).*

Changes in alcohol outlet density have been shown specifically to affect violence in Norway *(27)* and economic studies in the United Kingdom have suggested that increases in alcohol prices would also have significant violence-prevention benefits *(28)*.

4.2.6 Reducing poverty

There is a dearth of evaluated interventions of reducing poverty to prevent child maltreatment. Available studies have focused on the impacts of welfare reforms and have reported somewhat conflicting results *(29).* The welfare system in Delaware, United States, was reformed in 1995 to focus on employment services and financial supports and penalties to encourage those receiving welfare to find employment and adhere to child support requirements. Welfare recipients also had to meet a set of child-focused provisions, such as ensuring their children met immunization standards and attending parenting programmes. A study found that the reforms had no impact on physical or sexual child abuse or foster care placement, but were associated with an increase in child neglect *(30).* A state-level analysis of welfare provision across the United States examined its impacts on work behaviour, family structure and child maltreatment, finding that increases in welfare benefits were correlated with large reductions in child neglect but also small increases in physical abuse *(31).*

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4.2.7 Community interventions

Community interventions aim to enhance community capacity to prevent child maltreatment by expanding formal and informal resources and establishing a normative cultural context that promotes collective responsibility for more positive child development.

A review *(32)* examined five different community prevention programmes to prevent child maltreatment, mostly in the United States – the "Triple-P" positive parenting programme, "Strengthening families", the "Durham family initiative", "Strong communities" and "Community partnerships for protecting children". Using multiple methodologies to assess their effectiveness, the review concluded that these programmes are well-grounded in theories of change and, in some cases, are supported by evidence of effectiveness. The two programme components that appeared to be the most promising were social capital development and community coordination of individualized services. In the case of "Triple-P", a multi-level programme, the contribution of the community-level component to its overall effectiveness could not be separated out. The authors of the review warned that such multifaceted community prevention initiatives are costly and that policy-makers must consider the trade-offs between investing in strategies to alter community context and those that expand services for known high-risk individuals *(32)*.

4.2.8 Preventing exposure to intimate partner violence

Parental intimate partner violence is a key risk factor for child maltreatment (see Chapter 3), while witnessing violence between parents can have long-term impacts on children's well-being (see Chapter 2). A review of interventions to prevent and reduce intimate partner violence is beyond the scope of this report, although evidence for primary prevention approaches is relatively limited. There is evidence from the United States that school-based programmes can have benefits in preventing dating violence, while empowerment and participatory approaches to addressing gender equality (such as communication- and relationship-skills training) and broader strategies to change social and cultural gender norms and reduce access to, and harmful use of, alcohol show promise *(33)*.

4.3 Selective approaches

4.3.1 Home-visiting programmes

Home-visiting programmes provide parenting, health and social support to new mothers in their own homes, typically via specially trained nurses. They have been implemented universally in several European countries (such as the United Kingdom and Denmark *(34)*) for many years as part of routine maternal and child health services. Intensive programmes can also be targeted specifically at vulnerable mothers whose children are at risk of poor outcomes, including child maltreatment.

Evidence suggests that these types of selective interventions can be effective in reducing risk factors for child maltreatment, but their impacts specifically on child maltreatment are less clear. The delivery and content of home-visiting programmes can vary widely and not all have shown benefits in preventing child abuse. Two models – the NFP programme from the United States and the "Early start" programme from New Zealand – have nevertheless been subjected to well-designed evaluation studies and have been shown to be effective in reducing child maltreatment *(2,4)*.

The NFP programme targets low-income first-time mothers. Visits are conducted by public health nurses or other health professionals starting in the early stages of pregnancy and continuing through to the child's second

birthday. Nurses provide health advice and support, child development education and life coaching to mothers to help them improve the family's circumstances. A randomized controlled trial found that the programme was associated with reduced emergency department attendance for injury in early childhood *(35)*. A 15-year follow up found that participating mothers were 48% less likely to be identified as perpetrators of child abuse and neglect than the control group *(36)*. It did not, however, reduce child maltreatment among mothers who were experiencing high levels of domestic violence *(37)*.

In addition to parenting benefits, NFP has been found to reduce welfare service use and criminal behaviour by mothers *(36)* and to have benefits for children, including improved academic achievement *(38)* and reduced serious criminal behaviour in young adulthood (particularly in girls) *(39)*. The programme has been found to generate a saving of US$ 2.88 for every US$ 1 invested, with savings greatest when targeted at high-risk groups *(40,41)*. The NFP model is being implemented in several European countries (Box 4.3).

Box 4.3. NFP programmes in Europe

The NFP programme conducts nurse-led home visits with low-income first-time mothers from early in pregnancy up to their child's second birthday, offering health and child/maternal development support. Randomized controlled trials are under way in the Netherlands *(42)* and the United Kingdom *(43)*. It has been culturally adapted in the Netherlands through the "VoorZorg" ["For care"] programme, which specifically aims to prevent child maltreatment. The programme delivers approximately 10 home visits during pregnancy and 20 per year during the first 2 years of life. Research is examining its impact on risk factors for, and actual reports of, child maltreatment *(42)*.

The "Early start" programme in New Zealand provides intensive home visiting for vulnerable families throughout their child's preschool years. It is delivered by family support workers (with nursing or social work backgrounds) who assess families' needs and work with them to resolve problems, providing support and mentoring to improve parenting skills, encourage positive family relations and improve child health. The programme has been associated with reductions in hospital attendance for childhood injury, hospital admission for severe child abuse and neglect, and parent-reported physical abuse *(44)*.

Other models of home visiting have produced mixed results. "Healthy families America", for example, is an intensive parenting programme for parents deemed at risk of child maltreatment. It is delivered by paraprofessionals and involves home visits from pregnancy through to the child's fifth birthday or enrolment in kindergarten or preschool programmes. Home visits focus on promoting healthy behaviours, child development, coping with stress, parenting skills and parental self-sufficiency. Evaluations of the programme have been undertaken in several sites, with varied results. In New York, for example, it was found to have effects on maternal self-reports of some abusive behaviours (such as serious physical abuse), but no effects on substantiated child maltreatment reports. Benefits in terms of maternal self-reported abuse were most pronounced among new teenage mothers and psychologically vulnerable women who are targeted directly by programmes such as NFP *(45)*. In Germany, the STEEP™ (Steps Towards Effective Enjoyable Parenting) intervention involves home visits and group sessions beginning prenatally and continuing for two years. STEEP™ was designed to increase understanding of child development and enhance maternal sensitivity. A preliminary evaluation has reported positive results relating to mother–child attachments and maternal depression (Box 4.4) *(46)*.

4.3.2 Parenting programmes

Parenting programmes aim to improve parents' knowledge of child development, increase their parenting skills and strengthen relationships with their children. They are often delivered through group sessions and can be implemented universally and to high-risk groups. Systematic reviews have generally concluded that while they can reduce risk factors for child maltreatment, the evidence for their effectiveness in reducing actual maltreatment remains limited, with few studies measuring actual child abuse outcomes *(2,4)*.

"Triple-P", developed in Australia, is one of the most widely used parenting programmes. It aims to strengthen parents' skills, knowledge and confidence and reduce child problem behaviours *(47)*, targeting five developmental levels from infancy to adolescence, offering various levels of support ranging from universal media messages to intensive parent training and being delivered in a variety of settings. Most evaluations of "Triple-P" have focused on child behaviour outcomes rather than child maltreatment, but a United States study that trained service providers in nine counties to provide "Triple-P" at population level reported preventive effects on child maltreatment injuries, substantiated child maltreatment

and out-of-home placements compared with counties with standard care and support *(48)*. The strength of the evidence supporting "Triple-P" has been questioned due to issues including a lack of active comparison groups and prespecified outcome measures, use of small, self-selected samples and author affiliation to "Triple-P" *(49)*.

Box 4.4. Preliminary evaluation of early intervention from the STEEP™ practice research project WiEge (Wie Elternschaft gelingt) [How parenting succeeds]

The multisite longitudinal intervention study "WiEge" enabled pregnant women or mothers whose children were no older than 4 months, who themselves were younger than 25 years and who needed support from the youth welfare system, to access the STEEP™ intervention through certified youth system health care providers. Additional inclusion criteria were low education level, living on state benefits and/or experiencing other risk factors.

Data on depression (Edinburgh Postnatal Depression Scale), parenting stress or risky parental attitudes (Adult–Adolescent Parenting Interview®) were collected at the beginning, middle and end of the programme and compared to that from a control group, who met the same inclusion criteria but received only standard programmes. Fifty-nine per cent of mother–child pairs in the treatment group showed secure bonding qualities after a year, compared to 33% in the control group. The number of mothers in the treatment group with clinically symptomatic depression dropped by half over the one-year course.

Source: Suess GJ et al. *(46)*.

"Triple-P" is already used in several European countries, including Germany, Switzerland, the Netherlands and the United Kingdom. Effects on child maltreatment have yet to be reported, although studies have identified positive impacts on risk factors *(50–54)*. In Switzerland, for example, the efficacy of "Triple-P" was compared with a no-treatment parental control group and parents taking part in a marital distress programme. Mothers who had participated in "Triple-P" showed reductions in parenting stress, improvements in parenting practices and parenting self-esteem and less problem behaviour in their children, but few positive effects were seen among fathers participating in the programme *(50)*.

Other internationally-developed parenting programmes have been tested in European settings, although again, outcomes have been limited to risk factors rather than child maltreatment per se. The "Incredible years" programme, for example, developed in the United States, targets children at risk of conduct disorder and works with parents and teachers to help them manage children's behaviour and strengthen their social and emotional competency. It has been found to reduce parental stress and depression when delivered to parents via children's centres in United Kingdom (Wales) *(55)* and has shown benefits in improving maternal well-being in Sweden *(56)*. Several parenting programmes have also been developed and tested in European settings (Boxes 4.5, 4.6 and 4.7).

Box 4.5. Video-feedback intervention to promote positive parenting

The "Video-feedback intervention to promote positive parenting" (VIPP) in the Netherlands is an early attachment-focused programme developed to promote sensitive parenting behaviour in parents with children at risk of behavioural problems.

The VIPP method videotapes parent–child interactions during an everyday situation in the home and provides personalized feedback to parents during follow-up home visits. The basic VIPP approach predominantly targets infants: it has been enhanced for children over one year with a sensitive-discipline component (VIPP–SD).

Studies examining the impact of the basic VIPP method have reported positive impacts on parent–child attachment and interaction in specific groups, including mothers with adopted children (the Netherlands *(57)*) and those with eating disorders (United Kingdom *(58)*). A randomized controlled trial in the Netherlands evaluated the VIPP–SD in families with children aged 1–3 years with externalizing behaviour problems and parents with relatively high levels of stress. VIPP–SD mothers received six home visits providing video-feedback on their parenting techniques, while control mothers received six telephone calls to talk about their child's general development. The VIPP–SD was found to have positive impacts on maternal attitudes towards sensitivity and sensitive discipline and actual sensitive disciplinary interactions *(59)*.

Box 4.6. "Apoyo personal y familiar" ["Personal and family support programme"]

"Apoyo personal y familiar" is a community-based programme for parents in Spain who are at high risk of (or are already) maltreating their children *(60)*. Parents are referred to the programme by social services (such as social workers or psychologists) based on assessment of psychosocial risk that includes poor or neglectful parenting practices and inadequate life management.

The programme runs weekly group sessions for parents (typically mothers) over an eight-month period with a set curriculum covering: organization of family life; coping with children with problems; parenting under situations that change family life; communication and problem-solving skills; and coping with difficult situations. An evaluation of the programme in Tenerife found it improved mothers' attitudes towards parenting, their reported parenting practices and their sense of personal efficacy and control *(61)*. A study in Castile and Leon found that improvements to parenting achieved through the programme were moderated by parental social support. Informal social support (from family, friends and neighbours, for instance) was found to always have a positive impact on parenting outcomes from the programme, while formal social support (from such as social and community services) only had benefits when applied at the start *(62)*.

Box 4.7. "Keiner fällt durchs Netz" [No-one falls through the net]

"Keiner fällt durchs Netz" is a psychosocial prevention programme in Germany for at-risk families with young children. It works with families in the first year of a child's life and includes parent education and training, outreach work by family midwives and a local coordination office to support referrals. A study evaluating the programme found that it had positive impacts on maternal-reported child social development, temperamental "difficulty" and mother–child interaction *(63)*.

4.3.3 Multicomponent preschool programmes

Multicomponent preschool programmes provide preschool education for young children alongside services such as

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parenting programmes and family support. They can be universal but often target families living in deprived communities.

Although evidence for the effectiveness of multicomponent preschool programmes is mixed *(2)*, some positive effects have been reported. The Chicago child–parent centre in the United States, for example, serves children aged 3–9 years from low-income families. It provides preschool education, parent programmes, outreach services and ongoing family support when children enter formal schooling. Preschool education develops children's physical, social, emotional and cognitive skills, including literacy, numeracy and communication, to prepare them for school. Parent programmes include the development of parenting skills, education and vocation skills, and engagement of parents in school activities, while family support includes health and nutrition advice and health screening.

A long-term evaluation of the centre found that participating children had lower lifetime rates of child maltreatment (by age 17) measured by court petitions and referrals to child protection services (overall, the rate of child maltreatment or neglect was 7.2% in the intervention group and 9.7% in the control). The study also reported programme benefits in improving children's academic and vocational achievement and reducing violent offending *(64,65)*. By age 21, the programme was estimated to have saved over US$ 7 per US$ 1 invested *(66)*.

Box 4.8 provides an example of a multicomponent preschool programme in United Kingdom (England).

Box 4.8. "Sure start" children's centres in United Kingdom (England)

"Sure start" children's centres provide a broad range of services for children and families, including preschool education, child care services, parenting programmes, health services and parental support in accessing training, employment and education. Initially targeted at children from the most deprived communities, "Sure start" services are now provided across much of the country. Some are offered universally and others target disadvantaged families.

An evaluation found that parents of three-year-old children living in deprived areas served by the programme had less risk of negative parenting than those of children living in similarly disadvantaged areas without "Sure start" *(67)*. Impacts on child maltreatment have not yet been measured.

4.3.4 Enhanced paediatric care

Health settings such as primary care and paediatric services present opportunities to identify families at risk of maltreatment and provide them with appropriate support, advice and referral. The "Safe environment for every kid" (SEEK) programme in the United States trained health care providers in an inner-city clinic to identify and address parental risk factors for child maltreatment. It also provided on-site social worker services to offer support to at-risk families and referrals to other agencies.

Parents of young children were asked to complete a screening questionnaire in the waiting room prior to their child's health appointment, identifying risk factors such as alcohol and drug use, depression, stress, intimate partner violence and use of harsh physical punishment towards their child. Any risk factors identified were discussed with health professionals during the child's appointment and parents were referred to a social worker when deemed appropriate by both parties.

An evaluation study found that the SEEK programme was associated with reduced child maltreatment, measured through involvement in child protection services, medical problems relating to possible neglect and self-reported child assault by parents *(68)*. It has also shown benefits in reducing psychological aggression and minor physical assaults towards children in relatively low-risk mothers from a largely middle-income suburban population *(69)*.

4.3.5 Support and mutual aid groups for parents

Support and mutual aid groups aim to strengthen family support networks by providing opportunities for parents to meet and interact with peers in the community. In addition to developing parents' social connections, they can also provide peer support, help with family problem-solving and activities to strengthen parenting, coping and communication skills.

Few studies have evaluated the impact of support groups in preventing child maltreatment, while those examining their impacts on risk factors have reported mixed results *(2)*. Some have nevertheless reported benefits. Research in Canada found that parents participating in parent mutual-aid organizations had increased self-esteem and reduced stress after a one-year period, while the proportion of participating parents in contact with child protection professionals reduced *(70)*. A national evaluation of Parents Anonymous® groups in the United States reported that new participants showed improvements over six months across a range of scales measuring aggressive parenting behaviours, risk factors for abuse and protective factors. Improvements were greatest for high-risk parents *(71)*.

4.4 Benefits and costs of child maltreatment prevention programmes

To accelerate the development of child maltreatment prevention policy, and to increase investment in prevention programming, information is needed to estimate the economic returns that investments in these interventions will provide to society. This requires comparison of estimates of economic burden to the costs of the programme designed to reduce that burden, and to the outcomes achieved by the intervention (such as the benefits to society (see Table 4.2), incorporating reduced child welfare, health care, remedial education and criminal justice and prison service costs and increased tax revenue through greater workforce participation and earnings in adulthood).

Assessments of programme or intervention costs should include all financial and economic costs associated with the programme *(72)*. These can be categorized, for example, into fixed and variable costs, those associated directly with the provision of services and those that indirectly relate to service provision (such as administrative and infrastructure costs). Findings on programme costs are then compared with economic burden information and the size of prevention outcomes achieved by the intervention. The results of such comparisons are typically presented as a benefit–cost ratio.

Table 4.2 presents the benefit–cost results for selected United States early childhood programmes, some of which include child maltreatment prevention as an outcome *(73)*.

Since all the programmes listed in Table 4.2 included child maltreatment prevention as one among multiple outcomes, it is not possible to specify the benefit–costs for child maltreatment prevention in isolation. The findings nevertheless highlight several important features.

First, early childhood programmes with child maltreatment prevention as an outcome clearly have the potential to produce benefits that offset their costs. All of the programmes listed, and the meta-analyses, returned benefit–cost ratios greater than one, with benefits ranging from US$ 2 to US$ 17 for each US$ 1 invested.

Note: poster reads: "It is not violence that rules the world – it is love!"

Table 4.2. Benefit–cost results of selected United States early childhood programmes that included child maltreatment prevention as an outcome at most recent follow up

Programme	Age at last follow up	Programme cost (US$)	Total benefit to society (US$)	Benefit–cost ratio
NFP (full sample): public health nurses provide home visits to low-income first-time mothers from prenatal period to age 2	15 years	9 118	26 298	2.88
NFP (higher-risk sample): public health nurses provide home visits to low-income first-time mothers from prenatal period to age 2	15 years	7 271	41 419	5.7
NFP (lower-risk sample): public health nurses provide home visits to low-income first-time mothers from prenatal period to age 2	15 years	7 271	9 151	1.26
Home visiting for at-risk mothers and children (meta-analysis): average effect across 13 home-visiting programmes	Varies	4 892	10 969	2.24
Abecedarian programme: comprehensive, centre-based child development programme for at-risk children from infancy to age 5	21 years	42 871	138 635	3.23
Chicago child-parent centre programme: centre-based, one- or two-year, part-day academic-year preschool programme with parent participation	21 years	6 913	49 337	7.14
Perry preschool project: centre-based, one- or two-year, part-day academic-year preschool programme with home visiting	40 years	14 830	253 154	17.07
Early childhood education for low-income 3- and 4-year-olds (meta-analysis): average effect across 48 preschool programmes	Varies	6 681	9 061	2.36

Note: all dollar values are 2003 US $ per child and reflect the present value of amounts over time where future values are discounted to age 0 years of the participating child, using a 3% annual real discount rate.
Source: adapted from Kilburn & Karoly *(73)*.

Second, the benefit–cost ratio is likely to be higher for programmes that address higher-risk subgroups where the programme can make more of a difference, as illustrated by the NFP, which returned benefit–cost ratios of 5.70 for the higher-risk group versus 1.26 for the lower-risk.

Third, the longer the duration between programme exposure and follow up, and the broader the range of outcomes measured, the higher the benefit–cost ratio is likely to be. The Perry preschool project, for instance, which had the highest benefit–cost ratio of 17.07, followed participants until age 40 years and measured an array of adult outcomes that showed improvements such as increased earnings and decreased criminal activity.

The literature on the economic burden of child maltreatment has few published benefit–costs studies of prevention and early childhood programmes from beyond the United States. A 2011 study in Germany modelled the potential cost savings of a programme providing early childhood support to high-risk families with the aim of preventing child maltreatment and other adversities. It showed that an investment of €34 105 in the first 6 years of a child's life would produce savings of €398 845 per child up to age 6 (benefit–cost ratio 11.7) and €1 125 190 per child in lifetime costs (benefit–cost ratio 33.0) *(74)*.

Not all programmes subject to such analysis are cost–effective. One of the key reasons for conducting economic studies is to identify those that are cost–effective and isolate the key features that differentiate them from programmes that are not. Commenting upon the importance of getting child maltreatment prevention right – owing to its pervasiveness, damage and high economic costs – Leventhal *(75)* noted that the budget for home visiting and related preventive services for the state of Connecticut in 2004 was US$ 7.2 million per year. This contrasted with the US$ 650 million budget for the state's child protective service agency: "The ratio of child protection to prevention was 90 to 1. Imagine how much more prevention could be accomplished if in every community the ratio were closer to 10 to 1" *(75)*.

Scarcity of data on the costs of child maltreatment prevention programmes and protective services within the European Region, quite apart from data on their effectiveness and cost–effectiveness, makes it difficult to know if European countries are characterized by a similarly extreme imbalance between prevention and child

protective services. A 2010 report on a survey of Member States, however, found that while 80% of countries indicated they had national plans/policies in place to address child maltreatment, most said they focused on child protection services. This strongly suggests that the same imbalance, where prevention is deeply overshadowed by protection, is manifest in Europe. Further, there is some evidence that the disparity between preventive and protective services may be increasing in some countries due to the distribution of budgetary cuts *(76)*.

There is an urgent need for more research (using a uniform costing template) into the economic burden of child maltreatment within the Region, the costs of prevention programmes and protective services and the benefit–cost ratios of such programmes and services. The United Stated studies cited above provide excellent examples of how this work can be done; many European countries are well-versed in applying relevant methodologies to other public health issues and therefore already have the necessary research capacity. Many also have good administrative data by which to assess the economic burden of child maltreatment and the costs of programmes.

4.5 Indicated approaches

4.5.1 Out-of-home care

Children who are identified as being at significant risk of maltreatment at home may be placed in out-of-home care. This can take several forms, including foster care, kinship care, residential treatment and group homes or institutional care *(4)*. Rates of out-of-home care placement can be difficult to compare cross-nationally but are thought to vary widely across Europe *(77)*. Although poor environmental conditions, lack of medical and social services and neglect have been widely reported within some institutional care homes (Romanian orphanages in the 1990s, for instance *(78)*), out-of-home care primarily aims to improve the safety of maltreated children compared with leaving them in their home.

While the specific goals of out-of-home care are rarely described, safer care in foster homes is expected to meet the child's needs for nurturing, supportive parenting and thereby result in improved well-being in the long term. The trauma of being removed from the family, disruptions due to multiple placements and inadequate parenting for children with complex needs can, however, cause adverse outcomes for children placed out of home. Placement is often coercive, is increasing in frequency and occurring at an earlier age in many countries *(79)*.

Given the potential for harms and benefits of out-of-home care, evidence on its effectiveness is essential to guide placement decisions. A systematic review conducted for this report found no clear evidence that out-of-home care improves outcomes for maltreated children compared with in-home care, but methodological weaknesses also prevented inference that it is harmful (see Box 4.9).

Importantly, as identified in Box 4.9, only one study identified in the review had been conducted in Europe. This was a Swedish investigation that used national register data for a 10–12-year birth cohort to examine outcomes for young adults who had received child welfare interventions (including foster care), peers who had received in-home interventions in childhood and national adoptees, compared with general population peers. Three papers from this study were included *(80–82)*.

The study found children who had been in foster care had worse outcomes across a range of measures, including school attainment, substance use, teenage parenthood, serious criminality, psychiatric disorders and suicide attempts. Poor school performance was found to be a major risk factor for poor outcomes in foster care leavers *(80)*. Accounting for sociodemographic differences reduced the difference in risk, such that the in-home intervention group and foster care groups tended to have comparable levels of risk at around two to three times higher than the general population *(81,82)*. The significance of differences between these two groups was not reported, but a trend remained in some analyses for worse outcomes among those who had been in long-term care *(80)*.

Several studies have compared outcomes of different forms of out-of-home care. A systematic review of studies on kinship care placement, for example, found that children placed in kinship foster care experience better outcomes than those in non-kinship foster care. Improved outcomes included better mental health functioning, behavioural development and foster-care placement stability *(99)*.

Outcomes appear to be better for children receiving foster rather than institutionalized care. A randomized controlled trial of abandoned children in Romania found that those who remained in institutional care had poorer cognitive development at age 54 months than those removed from institutional care and placed in foster care *(100)*. In contrast, a study of maltreated children in the United Kingdom who remained in care found they had higher levels of well-being than those who were reunified with

Box 4.9. Systematic review on out-of-home care

Systematic evaluations of the impacts of out-of-home care on outcomes for maltreated children are scarce, so a systematic review was undertaken for this report, examining the effectiveness of out-of-home care compared with in-home for child well-being outcomes. It identified 19 articles (reporting findings from 8 cohort studies). One study *(80–82)* had been conducted in Sweden; the rest were from the United States.

The review highlighted methodological weaknesses in the literature – notably issues around selection bias, as children suffering from greater adversity and more severe maltreatment are more likely to be placed in out-of-home care *(83)*. Only two United States studies *(84,85)* had low risk of selection bias and neither showed any clear benefit of out-of-home care: one *(84)* found no differences in cognitive test scores, internalizing or externalizing behaviour, while the other *(85)* identified higher levels of juvenile delinquency among children who had caseworkers with a high propensity to place children in out-of-home care compared with those whose caseworkers had a low propensity to do so.

The remaining studies found a lack of evidence for a beneficial effect of out-of-home care (such as language or cognitive outcomes *(86,87)* and mental health outcomes *(82,88,89)*). In addition, there were significant harms for some outcomes. Juvenile justice involvement was generally higher in maltreated children placed in out-of-home care, although this may be related to multiple placements *(90–93)*. The Swedish study *(80)* reported worse outcomes across a range of risky behaviours, while others showed few differences between groups *(81,82,94)*. One study found some evidence for improved school attendance in children placed out-of-home and levels of passing grades were similar despite a more disadvantaged starting point *(95)*. The Swedish study found better primary school grades but no difference in the likelihood of completing secondary school education after poor results in primary school *(80)*. Use of special education and mental health services was increased for children placed out of home in one United States study *(96–98)*.

The review concluded that there was no clear evidence that out-of-home care improves outcomes for maltreated children compared with in-home care. As potential selection biases inherent in cohort studies are likely to favour worse outcomes for those placed out of home, however, it also does not establish that out-of-home care is harmful. Information from large, high-quality cohort studies can provide insights into variation in practice and outcomes and is urgently needed for countries other than the United States. Determination of the effectiveness of out-of-home care requires randomized controlled trials of out-of-home versus in-home placement to minimize potential biases in quantifying benefits and harms. Randomized trials are needed for children where there is collective uncertainty about placement, but would not be appropriate for many children for whom the decision to place in or out of home is not uncertain.

their families. Reunifications were found to be more stable when they were well-planned with strong evidence of improved parenting and the provision of family support services *(101)*.

4.5.2 Psychological interventions to reduce the impacts of child maltreatment

Child maltreatment has serious impacts on children's mental and social well-being in the short and long term (see Chapter 2). A range of interventions can be used with maltreated children and their families to limit these effects. Interventions can be delivered to children individually or with parents and often use therapeutic approaches such as cognitive behavioural therapy (CBT) or play, family or group therapy.

Several systematic reviews have examined the effectiveness of such interventions in improving outcomes for abused children (most commonly sexually abused), largely identifying positive impacts but often raising methodological limitations *(102–104)*. One meta-analysis of psychological interventions for victims of child maltreatment reported that on average, participating children fared better than those in control groups *(103)*. Another review focusing specifically on CBT programmes for sexually abused children and their non-abusive parents confirmed programmes' potential in addressing the sequelae of abuse, finding the strongest evidence for reduced post-traumatic stress disorder and anxiety symptoms, although overall effects were moderate *(104)*. The vast majority of studies included in these reviews were from the United States.

A number of European studies have examined outcomes from psychological interventions for victims of child maltreatment. One in the United Kingdom, for example, assessed the impact of a multicomponent intervention for adolescent victims of child sexual abuse. It incorporated a range of therapies including individual, dyadic (child and mother, child and sibling), group (child) and family therapy delivered over an average of two years. Participating children had improved self-esteem and reduced depression and problem behaviours compared to a control group *(105)*. A study in Germany explored the efficacy of narrative exposure therapy[12] on traumatized refugee children who had been exposed to various forms of violence, such as sexual abuse, domestic violence and war. It found that children receiving the intervention were less affected by post-traumatic stress disorder and had improved functioning compared to a waiting-list control group *(106)*.

4.5.3 Addressing the needs of children affected by parental intimate partner violence

Witnessing intimate partner violence can have a wide range of negative effects on children, including emotional problems (such as depression and anxiety), behavioural problems (including externalizing behaviour), poor academic performance and poor social competence *(107–109)*.

Studies have focused on interventions that address the needs of children affected by parental intimate partner violence. In the United Kingdom, for instance, groups of young children and their mothers who had experienced intimate partner violence took part in therapeutic group work that involved fun (therapeutic play for the children), a parenting and support group for the mothers and activities for children and mothers to carry out together to improve parent–child relationships. A qualitative evaluation of the intervention reported a range of positive findings, with some mothers noting improvements in their child's behaviour and development *(110)*.

A systematic review of evidence for such interventions *(111)* identified four broad types of: counselling and therapy (to improve child functioning though strengthening coping, safety, communication, problem-solving and conflict-resolution skills); crisis and outreach (to improve, for instance, maternal safety behaviours and use of community resources); parenting programmes (to improve child–parent relationships and reduce parenting stress); and multicomponent interventions, often providing a combination of parenting programmes, therapy and advocacy. Promising results were reported in studies across all categories of intervention, with measures of various outcomes including children's personal and social skills, psychological well-being, self-esteem and problem behaviours. The authors concluded, however, that the evidence base suffered from several methodological limitations and was currently insufficient to identify the most promising approach.

[12] Narrative exposure therapy is a treatment for individuals exposed to multiple traumatic events. Rather than focusing on a single event, the patient is asked to construct a narrative of his or her whole life.

4.6 Policy interventions

At national level, governments can run a range of services, known as child protection or child welfare systems, to protect children from abuse. Although these are widespread and huge amounts of money are invested in their development, very little evidence for their effectiveness in improving child outcomes exists. While assessment of their effectiveness is challenging, it is not impossible.

International comparisons of child protection systems have shown that their nature, extent and focus can vary widely. An exploration of systems in nine countries in the 1990s identified two main approaches: systems oriented towards child protection (dualistic services) and those oriented towards family service (holistic services) *(112)*. United Kingdom (England), United States and Canada were classed as following the child protection type of system, focused on the needs of the child and on

"rescuing" children from abusive situations *(113)*. Family support services function separately in these systems. All other countries were found to generally follow the family service approach, through which child protection systems are integrated into broader family services that focus on early intervention, prevention and family support. An update of this work published in 2011 *(77)*, however, found that child protection services in all countries studied had expanded and that the distinction between system types had blurred: countries originally categorized as having family-service-focused systems had adopted some features of child protection systems and vice versa.

United Kingdom (England) has seen a substantial shift since the 1990s in the way that child services are delivered. Child protection is now seen within the broader context of supporting families and meeting children's needs *(114)*. The Children Act 2004 set out a process for integrating services for children and placed a duty on local authorities and partners, including police, health services and youth justice bodies, to work together to promote child well-being and protect child welfare through the mandatory establishment of local safeguarding-children boards *(114,115)*. Local areas now provide a continuum of care and services to children, young people and families, including universal services (such as home visiting, health services and "Sure start" children's centres (see section 4.3.3)), targeted support for children with additional needs and integrated support from statutory or specialist services for those with complex needs.

A common assessment framework was also introduced for use by all organizations working with children *(116)*, providing a consistent mechanism for assessing the needs of children for whom there are concerns and referring them to the additional services they require. The system aims to promote earlier intervention, improve referral processes between agencies, promote information sharing and strengthen partnership working with families. Further reforms are being instigated to reduce bureaucracy and enable agencies to focus on meeting the needs of children and respond effectively to problems, following an independent review of the child protection system *(117)*.

A comparison of child welfare systems in Germany, Hungary, Portugal, Sweden and the Netherlands found variations between systems *(118)*. Sweden, for example, was considered to fit the family service model, the Netherlands to fit the child protection model, and Portugal to aspects of both. There were some common features across countries, however: all had decentralized child protection services to local government and provided a range of universal and preventive services, including (in most countries) health care for pregnant women, children and young people, early child education and support and parenting support. All countries also provided care services for victims of child abuse and their families, such as psychological services and parenting programmes, but different models of service integration were identified and wide variation was found in levels of professional training and education on preventing and identifying child maltreatment.

Based on the findings of this European study, Box 4.10 provides a brief summary of services provided by the child welfare system in Sweden as an example of a family-oriented approach.

4.7 Conclusions

Despite a scarcity of rigorous research programmes measuring child maltreatment outcomes, existing evidence suggests that child maltreatment and the risk factors that contribute to individuals becoming abusive towards a child can be prevented. There is already a wide range of interventions in place across Europe to prevent child maltreatment, many of which are implemented as part of state child welfare systems.

The largest and strongest body of evidence within Europe and internationally is for programmes that intervene early with at-risk families, providing parenting support throughout the first few years of children's lives. These programmes can improve parenting practices, reduce parenting stress and improve child outcomes; some have also proven effective in preventing child maltreatment. Parenting programmes implemented and evaluated in European settings have shown success in addressing risk factors for child maltreatment, although child maltreatment per se has not been examined.

Box 4.10. The child welfare system in Sweden

The system is predominantly delivered through local authorities, operating to legislation and goals established nationally. It provides a holistic range of services with a focus on early intervention and prevention, with measures taken to protect children when necessary. Services range from universal support to intensive specialist for children with complex needs.

Universal services include:

- antenatal care for all parents
- financial support in the form of parental leave for families with small children
- nursery school for all children from the age of one until formal school entry at age six
- child allowance for all children and accommodation allowance for low-income families
- child health care, school health care and free medical care for all children
- family centres providing antenatal, health, preschool and social welfare activities.

Specialist services for children with additional needs include:

- parental support and/or counselling
- group activities for children and parents
- supportive interventions for disabled children
- parental pedagogic interventions
- family counselling.

Intensive services for children with complex needs include:

- out-of-home care
- child and adolescent psychiatric interventions
- specialized interventions for disabled children, such as facilities, counselling and training
- coordinated interventions in "children's houses".

The last of these, coordinated interventions in "children's houses", brings together prosecutors, police, social services, medicolegal experts, paediatricians and child psychiatric care for children who have been abused.

Source: Berg-le Clercq *(118).*

Evidence-based programmes such as the United States NFP are being adapted for practice in European countries. Emerging research from this programme should provide valuable information to demonstrate whether the positive impacts it has had in the United States can also be achieved in Europe. With child welfare and protection systems in the United States traditionally being very different to those in much of Europe, there is an urgent need to understand how applicable programmes developed in the United States and elsewhere are to European settings.

Importantly, however, numerous studies from the United States (and some from Europe) have shown that early interventions with at risk-families can produce significant economic benefits through preventing child maltreatment and a range of other negative outcomes for children. Expanding knowledge on the economic benefits of child maltreatment prevention programmes is critical in promoting further investment in such work.

Less research has examined the effectiveness of universal approaches to preventing child maltreatment, despite the widespread use of measures such as mass media campaigns, social norms programmes and measures to alleviate poverty across Europe. Developing this knowledge should be a priority to inform the development and delivery of community and societal interventions. Equally, further research is needed to understand the aspects of effective interventions to promote resilience in children who have been abused.

Overall, however, the outlook for child maltreatment prevention in Europe is positive. Many countries have the required collaborative systems in place to plan and implement a wide range of services catering for children at all levels of risk, and there are good examples of how such structures have been built. Developing evidence on their effectiveness, on what measures work with which groups, and on the economic aspects of child maltreatment

is now critical to moving the child maltreatment agenda in Europe forward.

Key action points

- Information on the effectiveness of universal approaches to preventing child maltreatment needs to be collected to inform the development and delivery of community and societal interventions.
- Given the wide differences in child welfare provision between the United States and many European countries, there is an urgent need to identify how applicable effective programmes from the former (and elsewhere) are to the latter and to identify key elements from such programmes that could be incorporated into practice in European health settings.
- Expanding knowledge on the economic benefits of child maltreatment prevention programmes in Europe is critical to promoting further investment in such work.
- Further research is needed to understand the aspects of effective interventions that can promote resilience in children who have been abused.

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CHAPTER 5

TACKLING CHILD MALTREATMENT IN THE EUROPEAN REGION: OPPORTUNITIES FOR ACTION

Child maltreatment is very common in the European Region. This report presents policy-makers and practitioners with the evidence they need to confront the challenge it poses.

This concluding chapter summarizes key findings on the size and consequences of child abuse and neglect. It identifies those most at risk, describes inequalities and explains what can be done to prevent maltreatment. It then goes on to suggest key actions linked with other policy priorities in the Region, stressing that action needs to focus on preventing abuse and neglect from occurring: while much attention has been given to detecting abuse and protecting children from further harm, the report argues that it is time to focus on prevention.

5.1 An assessment of the current situation

Child abuse and neglect has its root causes in family, cultural and economic conditions and exists in all countries in the Region.

5.1.1 Why child maltreatment matters in the Region

Child maltreatment is a hidden form of violence with an unacceptably high prevalence in the Region. Its severity and duration varies: at its worst, it causes the premature death of 852 children aged under 15 every year. This, however, is the tip of the iceberg: it is much more common in its non-fatal forms, with serious and far-reaching health and social consequences. There is much more abuse and neglect than that which comes to the attention of child protection services.

Community surveys provide a better picture of the scale of the problem, with a combined analysis showing prevalence of childhood sexual abuse in Europe at 9.6% (girls 13.4%, boys 5.7%). Prevalence of physical abuse is 22.9% and emotional 29.1%. Global estimates show physical neglect prevalence is 16.3% and emotional 18.4%. Projections based on a conservative estimate that at least 10% of children suffer from maltreatment suggest that about 18 million (range 18 million to 55 million) children in the Region have experienced some kind of maltreatment.[13]

Vital registration and official statistics need to be improved to assess and monitor the scale of the problem at country level, particularly to measure trends in the most severe cases *(1,2)*. Professionals need to record their concerns about children better *(3),* supplemented by regular surveys to detect the much larger proportion of maltreatment in the community that occurs without coming to the attention of child protection agencies.

Most maltreatment in the community may not be acute, but is chronic in nature. Most families warrant supportive interventions for familial dysfunctional and need help with parenting, rather than retribution and blame, but there is concern about the capacity of child protection agencies to respond to any increase in cases notified, should all maltreatment occurring in the community be identified.

5.1.2 Child maltreatment has far-reaching consequences, yet little is being done for prevention

Safe, stable and nurturing relationships with parents and other caregivers are central to a child's healthy development *(4)*. Severe and recurrent maltreatment may cause toxic stress, affect brain development in childhood and lead to cognitive impairment and the adoption of health-risk behaviours, with adverse mental and physical health outcomes. Post-traumatic stress disorder has been reported in as many as one quarter of abused children and child maltreatment may be responsible for almost a quarter of the burden of mental ill health, especially when associated with other ACEs. There is also a strong association with developing risky sexual behaviour, sexually transmitted infections and obesity in later life, with limited but plausible evidence for the development of NCD.

[13] This figure is based on a conservative estimate that the prevalence of maltreatment up to the age of 18 is 9.6% in the Region and is applied to the Regional population of children of 204 million. The estimated number of children affected by physical abuse is 44 million, emotional abuse 55 million, physical neglect 31 million and emotional neglect 35 million. For full methods and results, see Annex 1 and Annex 2, section A2.7.

Child maltreatment detrimentally affects schooling, leading to lower educational attainment and poorer employment prospects. It increases the propensity for being a future victim and perpetrator of violence, leading to the perpetuation of violence along the life-course and its transmission across generations. Societal costs incurred through health care, social welfare and justice responses and lost productivity are very high.

These facts make a compelling argument for urgent action to prevent harm, stop it from recurring and rehabilitate those who have been maltreated. Longitudinal studies are needed in the Region to better understand the risks and long-term health, social and economic costs of the different types of child maltreatment. These may be challenging to achieve ethically and are resource-intensive; meantime, results from cross-sectional studies support the drive for policy action.

Concern about child maltreatment is growing within the Region *(5)*. This was highlighted in a recent survey of focal persons for preventing violence from the health ministries of 41 countries, with 93% reporting it as a "moderate" or "big" problem and only 7% as "slight" (Table 5.1 and Annex 2). Most countries have laws for protecting children from maltreatment, but only 54% have policies for preventing its occurrence: advocates in some countries have used surveys to develop national policies (see Box 5.1). Prevention programmes, laws for protection and health and social support for children in need vary: unequal practices in the Region represent an opportunity for countries to learn from others' successes, with the transfer of good practice.

5.1.3 Children at risk and inequalities in the European Region

Social determinants are central to a child's development, and there is gross inequity throughout the Region *(8–12)*. Children from disadvantaged backgrounds have greater exposure to risk factors that can be cumulative in nature, increasing the likelihood of violence and neglect. Much of the risk of maltreatment a child faces is related to parents, other adult perpetrators and the community or the society in which they live, rather than to the child. Cultural attitudes that support corporal punishment (see Annex 2) are also associated with higher levels of child maltreatment *(13,14)*.

Countries with high levels of inequality and few societal safeguards to buffer families from economic stress, and in which social and cultural norms support the physical punishment of children, are more likely to have higher levels of maltreatment. Many HIC are also seeing widening health and social inequalities, putting disadvantaged children, including those from minority groups, at risk *(15,16)*.

Box 5.1. How survey results were used to develop a policy to prevent child maltreatment in the former Yugoslav Republic of Macedonia

A survey of ACEs was undertaken with a representative sample of 1277 students aged over 18 years attending high school and university *(6)*.

High prevalence of physical abuse (21%), emotional abuse (10.8%), sexual abuse (12.7%), physical neglect (20%) and emotional neglect (30.6%) was reported. Household dysfunction was also common: 10% had witnessed parental violence, 3.8% had experienced parental separation and some lived in a household with someone who had abused drugs (3.7%), misused alcohol (10.7%) had a mental illness (6.9%) or had been incarcerated (5%). There was a strong association between adversity in childhood and health-risk behaviours. Emotional abuse doubled the likelihood of drug abuse, tripled the likelihood of attempting suicide and increased the chances of early pregnancy by 3.5 times. Physical abuse increased the likelihood of early pregnancy by 8.3 times and doubled the chances of attempting suicide.

Study findings were presented at a national policy dialogue on child maltreatment in early 2011. This stimulated the establishment of a national commission on the prevention of child abuse and neglect in late 2011, initiated by the Minister of Labour and Social Policy and Ministry of Health in collaboration with other ministries. The government developed and adopted a national action plan on the prevention and protection of child abuse and neglect in 2012 *(7)*. The plan aims to ensure the safety and well-being of children by preventing maltreatment through a coordinated multisectoral approach at national and local levels, with a leading role for health. It also emphasizes child protection, makes provision for detection, treatment and rehabilitation and presents indicators for monitoring and evaluation, with activity budget lines.

As Box 5.2 shows, legislative approaches have been successful in eliminating corporal punishment in some

Table 5.1. Survey reporting national policy responses to child maltreatment

Country	Does a CM[a] prevention action plan exist?[b]	CM as a risk factor for health risk behaviours[c]	Policies and programmes		
			Laws to protect against CM	Health and social service response to CM	Evidence-based prevention measures
Albania	√√	×	80%	80%	50%
Armenia	√√	×	60%	80%	0%
Austria	×	NA	100%	80%	100%
Belarus	×	NA	80%	100%	25%
Belgium	√	√	80%	80%	100%
Bosnia and Herzegovina[d]	√	√	20%	80%	75%
Bulgaria	√	√	20%	100%	75%
Croatia	√√	√	100%	80%	100%
Cyprus	√√	√	60%	100%	100%
Czech Republic	√√	√	80%	100%	100%
Denmark	√√	√	100%	80%	100%
Estonia	×	NA	80%	40%	0%
Finland	√	√	100%	80%	100%
Germany	√√	×	100%	100%	100%
Hungary	×	NA	80%	40%	75%
Iceland	√√	×	80%	100%	100%
Israel	×	NA	60%	80%	50%
Italy	√√	√	60%	80%	100%
Kazakhstan	√	√	80%	100%	100%
Kyrgyzstan	√	√	80%	80%	0%
Latvia	√	√	80%	60%	75%
Lithuania	√√	×	0%	40%	50%
Malta	√√	×	60%	100%	75%
Montenegro	√√	√	100%	100%	75%
Netherlands	√√	√	20%	100%	75%
Norway	√	√	80%	100%	50%
Poland	√√	×	80%	60%	25%
Portugal	√√	√	100%	100%	100%
Republic of Moldova	√√	√	100%	100%	100%
Romania	√√	√	100%	100%	100%
Russian Federation	×	NA	60%	40%	0%
San Marino	×	NA	100%	100%	50%
Serbia	√√	√	60%	100%	100%
Slovakia	√√	√	100%	80%	25%
Slovenia	√√	×	60%	80%	50%
Spain	√√	√	100%	100%	75%
Sweden	√	NA	100%	100%	100%
Switzerland	√	√	100%	100%	100%
MKD[e]	×	NA	100%	100%	75%
United Kingdom (England)	√√	√	80%	100%	100%
Uzbekistan	×	NA	60%	60%	75%

[a] CM=child maltreatment. [b] √√=yes at national level; √=yes at subnational level; ×=no. [c] √=yes; ×=no; NA=no answer.

[d] Only Republika Srpska. [e]The former Yugoslav Republic of Macedonia (MKD) is an abbreviation of the ISO.

Box 5.2. Research shows the effects of prohibition

Research shows significant progress has been made in eliminating corporal punishment in countries where it has been prohibited by law. Most young children in Sweden in the 1960s were "smacked" *(17)*, and half the adult population believed that corporal punishment was necessary *(18)*. After its prohibition in 1979, however, over 90% of parents agreed that "nonviolent childrearing is the ideal" and few children in 2007 reported being beaten *(19)*. Similar declines have been found in Finland *(20,21)* and Austria (prohibition achieved in 1983 and 1989 respectively) *(22)*. In Germany, where prohibition was introduced in 2000, 30% of young people aged 12–18 in 1992 reported that they had been "thrashed", but only 3% in 2001 *(23)*.

Similar results were confirmed by a comparative study carried out in 2007 involving Sweden, Austria, Germany, Spain and France. Corporal punishment was rarer in countries with prohibition: over half of parents in France and Spain had "spanked" their child's bottom, compared to 17% in Germany and Austria and 4% in Sweden. Progress in eliminating corporal punishment with prohibition has also been reported from a multicountry study in eastern European countries *(19)*. Teachers reported declines in estimates of the prevalence of "spanking" by parents between 2005 and 2009 in Latvia (prohibition in 1998), Bulgaria (2000), Ukraine (2004) and the Republic of Moldova (2008). The reduction was from 53% to 31% in Latvia, 58% to 44% in Bulgaria, 41% to 29% in Ukraine and 52% to 38% in the Republic of Moldova *(24)*. Social acceptance of parents hitting children decreases with prohibition, as shown by studies in Poland and Sweden *(20,25)*.

Research suggests that large proportions of children experience corporal punishment at home in countries where it is not prohibited. Studies carried out by UNICEF in LMIC in 2005/2006 and between 2010 and 2012 found high percentages of children aged 2–14 years had experienced physical punishment and/or psychological aggression in the home in the previous month: Azerbaijan (76%) *(26)*, Bosnia and Herzegovina (55%) *(27)*, Georgia (67%) *(26)*, Kazakhstan (49%) *(28)*, Kyrgyzstan (54%) *(26)*, Montenegro (63%) *(26)*, Serbia (67%) *(29)* and Tajikistan (78%) *(26)*. These figures were confirmed by research in which parents reported the use of physical punishment *(30,31)*.

A similar picture emerges in HIC that have not enacted prohibition. A study in France found that 96% of children had been "smacked" and 30% had been punished with a whip *(32)*. Recent studies from Italy report that 63% of parents of children aged 3–5 years had slapped their children *(33,34)* and a 2010 study in Ireland found 37% of parents of 2–4-year-olds had used physical punishment *(35,36)*. Thirty-seven per cent of parents of children aged 9–10 in Slovenia also reported this, with 48.7% claiming to use their hand, 8.4% pulling the child's hair, 2.5% hitting them with an object and 1.8% drenching them with water *(37)*. A survey of parents in the United Kingdom reported that 41.6% had "smacked" their child in the previous year *(38)* (see Annex 2 for legislation). Many countries in Europe have not conducted research on corporal punishment and were excluded from this analysis (see Annex 2).

The use of corporal punishment in care settings in many countries in the Region in which it remains lawful is also of concern *(39–42)*. Studies show this can be severe, with punishments including being locked in isolation and denied food.

countries, including Sweden, and those that strictly enforce national legislation to protect children and whose cultural attitudes promote the safeguarding of children's rights tend to have lower rates. Policies that support universal access to antenatal care, parental leave, nursery education, child health care, welfare services and support for low-income families are associated with reduced risks of maltreatment *(2,43)*.

Community socioeconomic conditions also influence maltreatment. It is more common in families living in communities that are socially and economically deprived, lack social capital and have high densities of alcohol outlets. Families in poorer neighbourhoods are more likely to experience parenting stress and have poor parenting behaviours, and children born to parents who are young, single, of low socioeconomic status and with low education levels are more likely to be maltreated.

Similarly, poor family cohesion, intimate partner violence, family conflict and disadvantage in the form of alcohol and drug abuse in the family or having a member who is incarcerated or with mental illness are associated with child maltreatment. At individual level, children with

chronic illness, disabilities and those with externalizing behaviour problems and conduct disorders are at increased risk of being maltreated and need greater vigilance and preventive efforts *(3,44)*. These different forms of adversity in childhood, whether due to maltreatment or household dysfunction, have a cumulative negative effect on health and social outcomes *(45)*, as several studies in the Region report *(6,46,47)*. Adverse early experiences greatly increase the likelihood of poor health across the life-course and pose a threat to social justice and development *(48)*.

5.1.4 Rapid change in the European Region and increased risk in children

The Region has seen rapid change in the last 30 years *(10,49)*. Child abuse and neglect occurs in every country, but available data show inequalities, with higher death rates in the east. Countries in the eastern part of the Region have rapidly changed to market economies, putting regulatory and support systems under strain. Deregulation and increased levels of alcohol consumption have led to increased interpersonal violence and greater exposure of children to intimate partner violence.

There are few official reports of child abuse and neglect during the period of Soviet influence *(50–52)*. Surveys of adults nevertheless confirm the presence of maltreatment *(53,54)*: systems to deal with it were not, however, in place *(55)*. Institutional care for children under three years, at a time when they are at their most vulnerable, was more widespread than in western countries *(56,57)*. These so-called "social orphans" were abandoned or relinquished by their parents for reasons such as unwanted pregnancy, poverty, single parenthood, lack of family support, drug or alcohol misuse, chronic illness or disability in the child. In the absence of social support networks and fostering systems, institutional care was used to protect children. The practice of fostering younger children and providing welfare support to families has since been introduced in some countries, but is still poorly developed in many. Much progress has been made in recent years, but gaps in child protection and prevention practices still exist in comparison with provision in western European countries (see Annex 2) *(57)*.

The economic crisis since 2008 has put children at further risk even in HIC, where increased levels of interpersonal and self-directed violence are being witnessed *(16,58,59)*. Decreased levels of spending on social welfare may adversely affect families experiencing unemployment, with the loss of social support safety nets leading to familial strife and putting children at increased risk of maltreatment *(60)*. It is argued that these austerity measures have been fatal and are counterproductive to health and, ultimately, economic prosperity *(16,58)*. Cutbacks in public health and welfare services may jeopardize previous gains in child well-being. Increasing unemployment has led to depression, anxiety and suicidal thinking, which are harmful to parent–child bonding.

The Region is also witnessing large population movements involving economic and political migrants and travellers, putting families and children under greater stress. The plight of millions of children who are left behind in the care of grandparents or other relatives as parents seek economic opportunities in cities or abroad is of great concern *(61)*. Up to a quarter of the GDP and a major part of foreign exchange earned in some countries comes from international remittances from migrant workers abroad *(61,62)*.

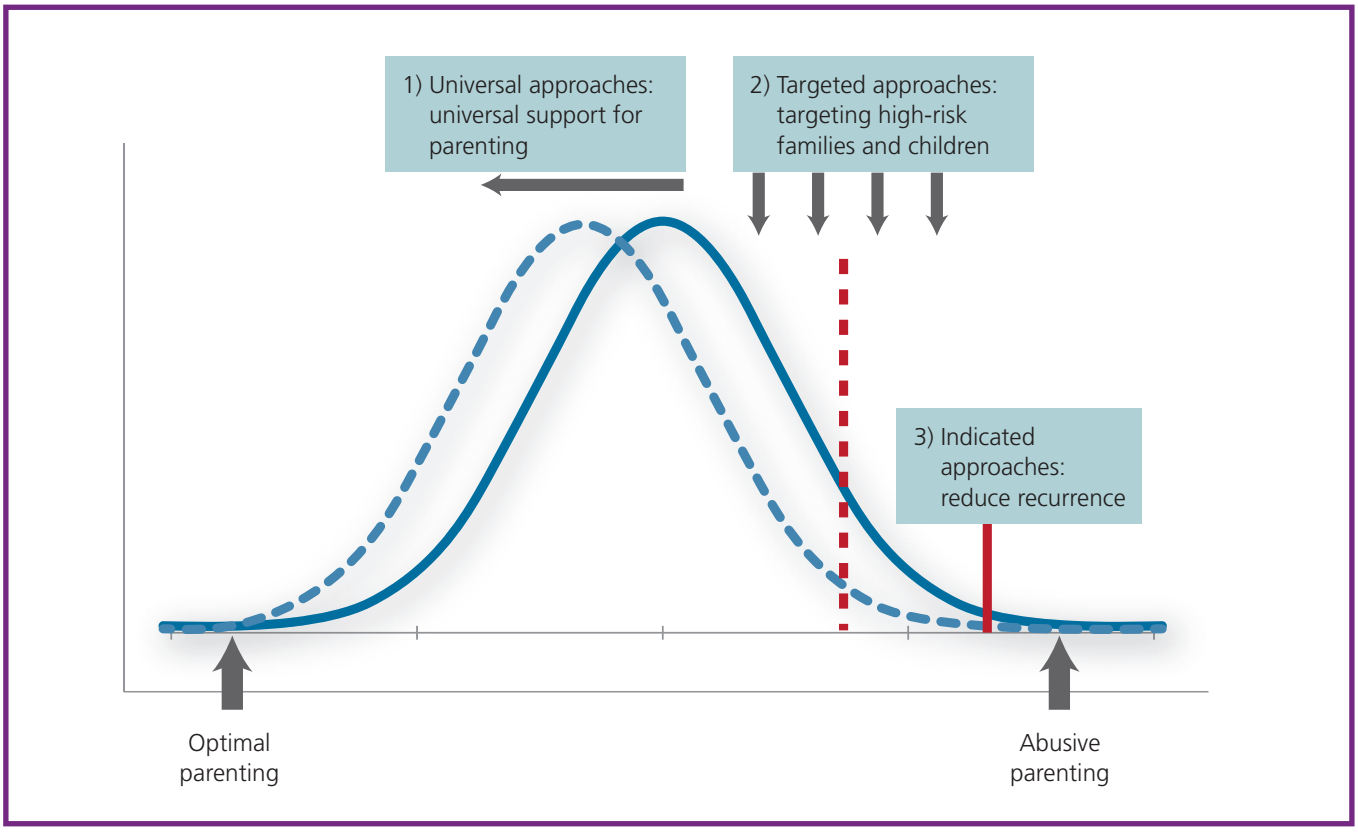
5.1.5 Child maltreatment is preventable

Evidence shows that children are vulnerable to maltreatment and that it is linked to cultural and social determinants, parenting practices, household dysfunction and inadequate social support networks. Parenting practices range from the optimal to the abusive (Fig. 5.1). The vast majority are adequate, though surveys report that many children are raised with episodic harsh parenting consistent with maltreatment. Only a small proportion of these are severely abusive and neglectful: many of the children affected may be known to child protection services.

A range of strategies is proposed to respond to maltreatment at population level. Universal approaches have the potential to shift the population curve to the left towards better parenting, with the prospect of better outcomes for children, and to strengthen protective factors against child maltreatment, such as developing parenting skills and knowledge, improving parent–child bonding and providing social and other support to parents. Prevention approaches require community and societal interventions (the evidence for this was summarized in Chapter 4). The evidence base for universal approaches needs to be better understood; it is therefore proposed that they are implemented using an evaluative framework *(2,64,65)*.

Targeted approaches focus on families with risk factors for maltreatment and address poor parenting behaviours, parental stress and child conduct problems. Home-visiting and parenting programmes are more cost–effective (see Table 4.2) than child protection services and long-term

Fig. 5.1. The continuum of parenting and approaches proposed for the prevention of child maltreatment



Source: British Medical Association Board of Science *(63)*.

welfare, health and criminal justice costs *(2)*. Access to these services needs to be improved and successful programmes adapted to local contexts. Indicated approaches to reduce maltreatment recurrence and harm are required for severe cases that come to the attention of services. More research is needed to assess who needs support and protection and the form and extent of services, and interventions to promote resilience in maltreated children need to be developed and implemented.

This report endorses the public health approach promoted in the *World report on violence and health (66)* rather than one that aspires to address the acute and far-reaching consequences of neglect and violence against children *(2,66)*. Investing in prevention is as important as investing in child protection services, which are essential to limit the damage from maltreatment and safeguard children. The report draws from the experience of countries with programmes and systems that have delivered improvements through sustained political will and commitment. It proposes that the economic benefits of child maltreatment prevention programmes across health, criminal justice, social and education systems in Europe justify further investment in prevention.

5.2 The way forward

5.2.1 Health 2020 – a policy framework for action

Health 2020 *(12)* has two strategic objectives and four priority action areas (Box 5.3). The vision of a "WHO European Region in which all people are enabled and supported in achieving their full health potential and well-being and in which countries, individually and jointly, work towards reducing inequities in health within the Region and beyond" *(12)* will only be achieved if sufficient attention is given to the prevention of maltreatment and other ACEs. This presents an opportunity to frame strategies for child maltreatment prevention into the policy framework and incorporate evidence-based programmes synergistically with other public health areas.

The first years of life are crucial for healthy physical and mental development. Children need safe and supportive environments to realize their full potential. Not only do they require clean air, safe housing, nutritious food, clean water and a healthy way of life, but also a nurturing family

environment that is free of violence and neglect and which promotes physical, cognitive, social and emotional development from the earliest years. Children who experience a good start are likely to do well at school, attain better-paid employment and enjoy better physical and mental health in adulthood *(11,67,68).* The development of skills and a sense of well-being in early childhood is essential for well-being across the life-course.

Box 5.3. Health 2020 strategic objectives and priority action areas

Health 2020's two main strategic objectives are:

- improving health for all and reducing health inequalities; and
- improving leadership and participatory governance for health.

Health 2020's four priority action areas are:

- investing in health through a life-course approach and empowering people;
- tackling Europe's major health challenges of noncommunicable and communicable diseases;
- strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response; and
- creating resilient communities and supportive environments.

Source: WHO Regional Office for Europe *(12).*

As this report has shown, child maltreatment will affect the physical, cognitive, emotional and social well-being of children and has far-reaching health and social consequences through the life-course. Maltreatment is linked with the development of health-risk behaviours, poorer mental health and reproductive health outcomes, propensity to interpersonal violence and the development of obesity and the likelihood of NCD. Children born into disadvantaged home, family, community and societal circumstances have a higher risk of child abuse and neglect, which may be concurrent with other ACEs.

Child maltreatment perpetuates the cycle of disadvantage and social injustice. Breaking this cycle requires investment in programmes for the prevention of maltreatment and other ACEs. Such programmes require a whole-of-society approach and multisectoral action, with the health sector taking leadership in participating and coordinating responses. Reducing child maltreatment is therefore among the mainstay of actions required to reduce health inequality in Europe and achieve the goals of Health 2020.

5.2.2 Linking national policy to global and European policy initiatives

The *Convention on the Rights of the Child (69)* requires all Member States to offer effective child protection, giving paramount importance to the rights and best interests of children under the age of 18 years and supporting their right to a safe environment free from violence and neglect. The United Nations Secretary-General's study on violence against children has brought renewed policy attention to the issue of child maltreatment prevention *(70)*. World Health Assembly resolution 49.25 *(71)* declared violence a major and growing public health problem and World Health Assembly resolution 56.24 on implementing the recommendations of the *World report on violence and health (72)* has brought global attention to the prevention of violence, including that inflicted on children *(66,72)*.

At European level, Regional Committee resolution RC55/R9 highlights violence prevention as a key public health concern *(73).* Child abuse is also highlighted as a priority area in the WHO European child and adolescent health and development strategy *(11)*, with integration of maltreatment prevention programmes into early child development considered critical. ACEs have been highlighted as risk factors for NCD *(74)* and alcohol has been identified as a risk factor for violence *(75)*.

Policy development for preventing child maltreatment would be in synergy with recent EU and European Commission developments, with several recommendations and directives addressing related issues. The 2013 European Commission "Investing in children" recommendation *(76)* outlines strategies for tackling child poverty through provision of resources and services to the Region's most disadvantaged children. It could prove instrumental in reducing violence against children, as socioeconomic deprivation is a common risk factor for child maltreatment. The 2011 EU directive on "Combating the sexual abuse and sexual exploitation of children and child pornography" *(77)* calls for increased efforts to prevent abuse and exploitation, to report and prosecute offenders, and to provide support and services for victims, while several articles of the 2011 directive on "Preventing and combating trafficking in human beings and protecting

its victims" *(78)* specifically address provision of long-term support for child victims of trafficking.

Policy-makers in the Region need to focus attention on, and coordinate action by, different disciplines within health and other sectors to tackle this neglected public health issue. Most health ministry focal people for violence prevention confirmed strong support for the development of public health policy to prevent child maltreatment and other ACEs in nearly half the countries taking part in a survey (see Annex 2).

5.3 Key action points for the European Region

In view of the emerging evidence on the scale of maltreatment, its recurrent and chronic nature and the fact that there is good evidence to support preventive approaches, there is a need to focus on prevention. Child abuse has received much adverse publicity, with a populist media-driven focus on finding the culpable and bringing them to justice. Maltreatment of children instils a sense of moral outrage, but it is important to go beyond this reaction to address the problem through a public health, science-informed approach.

1. Develop national policy for prevention through multisectoral action

Health ministries need to take a leadership role in ensuring the development of national policies for child maltreatment prevention *(79)*. National responses should involve other sectors, including education, social welfare, justice and stakeholders representing local authorities, practitioners and nongovernmental organizations. Areas such as public health, social services, early education, crime prevention and neighbourhood development need to develop partnerships at national and municipal levels *(80)*.

A good starting point would be to assess the existing national situation in terms of prevalence, nature, causes and current policies, laws and regulations to safeguard children. The creation of governance mechanisms to ensure high-level cross-sectoral commitment, with budgets for programme action, is essential. Monitoring and evaluation to assess progress towards objectives should be part of planning.

The report's findings on the short- and long-term health effects of maltreatment legitimize health ministries taking a lead role in prevention. The coordination skills of public health would be a valuable asset. Sweden provides an example of a sustained effort with multiple approaches, including a law banning corporal punishment (Box 5.4). Policy development in Norway followed a cruel case of child maltreatment that increased awareness of the issues (Box 5.5).

2. Take action with evidence-based prevention

Prevention programmes, which focus on the social, economic, cultural and biological determinants of child maltreatment, are cost–effective *(82)*. Key approaches include reducing risk factors by providing parenting support through home-visitation and parenting programmes. More upstream activities that focus on deprivation, social and gender inequalities, social norms towards violence, beliefs in using corporal punishment to discipline children and access to alcohol are also worthwhile investments in the long term.

Universal population-level approaches require intersectoral action and coordination for successful implementation and are more likely to be successful in the longer term. There is a need to invest in factors that are protective against child maltreatment and adversity, such as strong relationships between parents and children, good parental understanding of child development, parental resilience, strong social support and child emotional and social competence.

3. Strengthen health systems' response for prevention and rehabilitation

Health systems should provide high-quality detection, recording, treatment, support and rehabilitation services, using a holistic approach in coordination with other sectors. This would go beyond their traditional role of gathering, recording and presenting forensic evidence for child protection cases. Services need to respond to the physical and mental consequences of violence and neglect and provide families in situations of chronic maltreatment with support and therapy.

Box 5.4. A 34-year ban on corporal punishment of children in Sweden

In March 1979, the Swedish Parliament voted almost unanimously in favour of an amendment to the Parental Act, where Chapter 6 section 1 read: "Children have the right to care, security and a good upbringing. Children are to be treated with respect for their person and individuality and they shall not be subjected to corporal punishment or any other humiliating treatment."

This law, the first in the world to ban corporal punishment of children, prohibits parents from using physical or emotional violence against their children. Parents may still restrain children to prevent harm to themselves or others. Ahead of the legislation, the Swedish government launched an extensive publicity campaign entitled "Can children be raised without smacking?" Leaflets were distributed to all households and translated into several immigrant languages. Antenatal clinics, paediatric wards, well-baby clinics and voluntary organizations joined the campaign to provide information and support to parents. Information was printed on milk cartons and debates were held all around the country.

The success of the legislation and social marketing campaign has been evaluated through successive surveys using comparable methodology. As Box 5.2 describes, most parents in the 1960s reported "smacking" preschool children once or several times a year, but this has decreased over the last decade to 7–8% (findings verified by surveys of schoolchildren). Swedish parents in the 1960s looked upon corporal punishment as a natural and necessary part of good upbringing, but "smacking" was considered "disgusting" by over 90% of parents in 2011. An initial worry that the new legislation would result in a large number of prosecutions did not materialize.

Multiple reasons have been proposed to explain parents' attitudinal and behaviour change. Swedish society was early to incorporate new psychological insights of child development and children's rights were actively discussed in the mass media by influential scientists, writers and politicians. Prior legislation had discouraged parents from using corporal punishment. When the definitive ban was instituted in 1979, two thirds of the population agreed with it: the government was merely legitimizing an idea that had been developing for decades. Other reasons suggested are the Swedish welfare state, gender equity, high education levels and early preschool enrolment. Similar developments from Norway report decreases in corporal punishment on par with the successes in Sweden.

Source: Janson et al. *(81).*

Primary health care and paediatric services are well placed to detect at-risk families, refer and provide multidisciplinary support services for prevention and promote child development. Children under five consult primary care services frequently, presenting an opportunity to intervene, especially with high-risk families. General practitioners and primary care teams may care for families for many years and can monitor family functioning: if concerned, they can refer to welfare support. Having access to multidisciplinary support across sectors is essential to successfully mounting a preventive or protective response.

4. Build capacity and exchange good practice

To fulfil their preventive roles, general practitioners, paediatricians, nurses and other professionals need to build their knowledge and skills in detecting families at risk, recording data, responding to needs through provision of parenting and family support, and referring to welfare and specialist services. Prevention of child maltreatment needs to be mainstreamed into the curricula of health and other professionals *(83)*. Exchange of best practice should be promoted through existing networks, including focal people *(79)*, practitioners from different sectors (such as paediatricians, general practitioners, nurses, teachers, social workers, police personnel and lawyers), researchers and nongovernmental organizations.

5. Improve data collection for monitoring and evaluation

There is an urgent need for reliable and valid data on mortality, morbidity, socioeconomic factors, risk factors, outcomes and costs to monitor prevention policies at local, national and regional levels. Data can be collected from routine sources such as health and child protection services, but need to use standardized definitions and approaches.

Data are incomplete in many countries and a concerted effort needs to be made to improve their reliability and validity. Sharing data between health and other sectors is central to the effective monitoring and evaluation of individual cases and overall service quality (see Boxes 5.6 and 5.7). Information needs to be supplemented by regular community surveys to determine trends in prevalence, risks and outcomes, as is already done in some

Box 5.5. Norwegian experience: joining forces and resources

Norwegians became acutely aware of the harsh reality of child maltreatment when the "Christoffer case" came to light. Christoffer was an 8-year-old boy who lost his life in spite of repeated referrals to health services for injuries resulting from severe violence. Although Christoffer was suffering at home at the hands of his parents, no one in the family, school or health services notified child protection authorities or the police. The response to this tragedy led to improvements in the quality of services dealing with children and channelling of more resources for research and development.

The backbone of Norway's efforts to prevent violence, including child maltreatment, is fruitful collaboration involving several ministries with responsibility for different aspects of prevention and protection. The Ministry of Health and Care Services, the Ministry of Children, Equality and Social Inclusion, the Ministry of Justice and Public Security and the Ministry of Education and Research share a common vision that combines strategic thinking with urgent action. The Norwegian Centre for Violence and Traumatic Stress Studies was established in 2004 through the ministries' joint action. The centre also has five regional outposts and has proven to be responsive to changing demands.

Child maltreatment is now firmly on the political agenda. The strategic plan for prevention of sexual and physical violence against children was implemented between 2005 and 2009, targeting physical abuse by parents, step-parents and carers and sexual violence inside and outside the family. There are four main areas of focus: prevention; identification; support and treatment; and research and capacity building.

Exchange of knowledge and information among services on issues such as organizational culture and practices has proven instrumental in prevention and for identification of, and support for, child maltreatment victims. A new strategy on child maltreatment for 2014–2017 will build on this success, featuring an even-greater focus on collaboration between sectors and reflecting the views of service users, including children. Long-term investments in research and development are central to scaling-up services and ensuring well-informed policy decisions to tailor interventions using the best available evidence.

Ultimately, the views of individual children count, as demonstrated by the quote of an 8-year-old boy after his school reported long-term maltreatment to the police: "Thank you for believing that I'm telling the truth – those working in the kindergarten didn't!"

countries *(38,88–90)*. Internationally accepted classification systems are needed: the international classification of causes of injuries *(91)*, *Guidelines on community surveys of injuries and violence (92)* and *Preventing child maltreatment: a guide to taking action and generating evidence (2)* are steps in the right direction. The use of tools such as ICAST in children and the Adverse Childhood Experiences International Questionnaire in adults would allow more standardized approaches *(2,93,94)*. A cost-effective way of implementing this would be to include key questions in existing or planned surveys, as has been done with the United States Behavioral Risk Factor Surveillance System and the World Mental Health Survey *(95,96)*.

6. Define priorities for research

Much of the research is from the United States; there is a need to expand the European evidence base and test programmes' transferability in different contexts with different welfare provision. Case-control and cohort studies are needed in the Region to better understand the risks and protective factors for different types of maltreatment and long-term costs and consequences. Well-designed intervention studies are necessary to evaluate preventive programmes and for formative research to adapt interventions in different cultural contexts.

Research on targeted interventions is emerging, but more investment is required to assess universal interventions and out-of-home care. More research is needed on aspects of effective interventions that promote resilience in abused children and, at operational level, on identifying types of abuse that represent immediate threats and require a swift and legalistic approach rather than family-oriented welfare support to help family members provide better parenting. Findings from such studies should be widely disseminated to change frontline practice. Some countries, such as Germany (see Box 5.8) and the United Kingdom, have set up institutions (the National Centre on Early Prevention (NZFH) and the National Institute for Health and Care Excellence respectively) to promote evidence-based practice.

Box 5.6. Multisectoral approach to child protection in the United Kingdom (England and Wales)

A multisectoral approach is used to ensure the protection of children and promote their welfare. While the Department for Children, Schools and Families has overarching responsibility for child protection, local safeguarding-children boards provide the means for local-level delivery. Members include representatives from key agencies such as local authorities, health bodies, probation services, youth offending teams and police. Boards are responsible for ensuring that local child protection activities are coordinated, agreeing on how relevant agencies will work together and ensuring the effectiveness of individually and collaboratively led activities. They produce local child protection procedures and guidance on best practice to support partnership working in their local area. The Children Act 2004 provides a legal framework for this multisectoral approach, making it a requirement for relevant organizations to share necessary information and work together to protect children from significant harm and promote their welfare.

Source: NSPCC *(84).*

Box 5.7. Foster care placement in Denmark

Danish population-based registers for public health and welfare research have been used in a number of studies to analyse the outcome of placement of children in different forms of foster care and institutional out-of-home care *(85)*.

The National Social Research Centre conducted a longitudinal study of all Danish children born in 1995 who were, or formerly had been, placed in care. The major research questions were as follows.

(1) Which risk and protective factors are children in care exposed to and in which phases of their childhood?

(2) Which child welfare/child protection interventions are the children subjected to during childhood and adolescence?

(3) What are the developmental outcomes for children and for subgroups of children in care *(86)*?

Comparisons between children placed in traditional family foster care and in close-relationship foster care showed better social networking and integration, less criminality and greater contact with biological parents among the latter *(87)*.

7. Raise awareness and target investment in best buys

The good evidence for cost-effective interventions for preventing child maltreatment needs to be used to advocate for preventive approaches. Broader government policy and a whole-of-society approach should focus on developing nurturing and safer environments for children in families, communities and societies *(12).* International agencies, nongovernmental organizations and health and other sectors need to advocate for this course of action. The benefits of such policies far outweigh the costs and would be advantageous to all sectors and society as a whole.

Advocates need to produce a shift in societal responses from one of child protection, culpability and blame to one that promotes welfare support to help families and children develop healthily and realize their full potential. Social marketing, mass media and education programmes should be used to raise awareness of the effects of child maltreatment and promote positive parenting and nonviolent behaviour.

8. Address equity in child maltreatment in the Region

The underlying determinants of child maltreatment are rooted in political, economic, social and cultural factors. Equity needs to be incorporated at all levels of government policy if the inequitable distribution of child maltreatment is to be addressed to achieve greater social justice for children. The health sector should fulfil its obligation to advocate for just action for children across government by using the Health 2020 framework to promote equity for children's health in all government policies and by developing the case that child maltreatment is a consequence of economic and social activity. Policies should also promote gender equity in preventing intimate partner violence, a strong risk factor for child maltreatment.

Policies in areas such as universal health care, education, early child development, fair employment for parents and social protection should address the needs of the disadvantaged to give children a fairer start in life. The health sector should ensure that child maltreatment

prevention is universally incorporated within primary care and child health services, paying particular attention to the socially disadvantaged. Families at risk need to be supported through targeted interventions delivered via primary care and community-based welfare support programmes.

Active labour-market programmes and greater investments in public health and welfare interventions are being pursued in countries such as Sweden and Finland.

5.4 Conclusions

Child maltreatment is a serious public health and societal problem in the European Region, with far-reaching consequences for the mental, reproductive and physical health of children and societal development. The full scale of the problem is emerging, with conservative estimates suggesting that 18 million children are affected and that many tens of millions will suffer from adverse consequences through the life-course. It is a leading cause of health inequality, with the socioeconomically disadvantaged more at risk: its far-reaching health and development consequences ensure that child maltreatment per se will worsen inequity and perpetuate social injustice.

Child maltreatment is a priority in most countries in the Region, but few have devoted adequate resources and attention to its prevention. This report proposes a set of actions by Member States, international agencies, nongovernmental organizations and other stakeholders to address inadequate responses in the Region. It has outlined the high burden of child maltreatment, its causes and consequences, and the cost–effectiveness of prevention programmes. These make compelling arguments for increased investment in prevention and for mainstreaming prevention objectives into other areas of health and social policy, reflecting the whole-of-society approach promoted by Health 2020 and calling for increased intersectoral working and coordination.

The report offers policy-makers a preventive approach based on strong evidence and shared experience to support them in responding to increased demands from the public to tackle child maltreatment. Prevention programmes that stop maltreatment from occurring in the first place and reduce children's exposure to adversity have wide-ranging public health and societal benefits.

Child maltreatment is unacceptable – this report challenges policy-makers and practitioners to invest in prevention.

Box 5.8. Prevention of child abuse and neglect in policy development in Germany

Child welfare and the prevention of child abuse and neglect occupy a central role in public and political debate in Germany, triggered by harrowing cases of abuse and neglect and public debate sparked by the disclosure of sexual abuse involving the Roman Catholic Church in orphanages and foster-care homes.

The government has launched a large number of initiatives and prevention projects in response. NZFH was set up in 2007 as part of a Ministry for Family Affairs programme to lead and coordinate efforts. It supports research-based knowledge and the systematic embedding of early prevention into professional practice by generating and disseminating knowledge. The promotion and coordination of pilot research projects in every federal state is an important element of the centre's activity.

The Federal Child Protection Act, relaunched on 1 January 2012, provides a legal basis for the federal initiative on early prevention to promote stronger support for families, parents and children, increased cooperation among relevant stakeholders and strong networks for child protection. It especially aims to strengthen prevention through improved cooperation between health care and child and youth welfare systems and has created a legal framework for action on childhood maltreatment by different partners.

Several ministries have worked to improve services for survivors of childhood abuse in recent years. At the heart of this initiative was a national "round table" on sexual abuse, and an independent national commissioner for childhood sexual abuse has been appointed.

Despite increasing awareness of the problem among the public and scientific and political communities, a number of problems still need to be resolved, including the dissemination of financial and other resources and resolution of the conflict of responsibilities between communal, federal and state levels.

Source: NZFH *(97).*

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ANNEX 1
METHODS USED

A1.1 Background on statistical information

This report relies on the following WHO sources of information for the statistical data, tables, figures and annexes:

a) the WHO Global Burden of Disease *(1)*

b) the WHO European health for all mortality database *(2)*

c) the WHO detailed mortality *(3)* and hospital admission *(4)* databases.

WHO data for the European Region are collected every six months.

A1.2 How can violence be measured?

Deaths and health states resulting from violence are categorically attributed to one underlying cause using the rules and conventions of the international classification of diseases (ICD) *(5,6)*. ICD–10 codes, which are not available for all countries, were used for specific causes, as reported in Table A.1, for age groups 14 years and younger and for deaths due to undetermined intent. Table A.1 shows the ICD codes used for assaults. Details for codes related to undetermined intent are reported in Table A.2.

A1.3 Global Burden of Disease database

The Global Burden of Disease database *(1)* combines mortality data derived from national vital registration systems with information obtained from surveys, censuses, epidemiological studies and health service data. It represents the most comprehensive view of global mortality and morbidity available today. The Global Burden of Disease data are disaggregated into six geographic WHO regions and 14 subregions. The estimates provided are for the year 2008. The cause list used for the Global Burden of Disease 2011 project has four levels of disaggregation that include 135 specific diseases and injuries.

Overall mortality is divided into three broad groups of causes:

A. group I: communicable diseases, maternal causes, conditions arising in the perinatal period and nutritional deficiencies;

B. group II: noncommunicable diseases; and

C. group III: intentional and unintentional injuries, with external cause codes.

Table A.1. ICD X assault-related codes

ALL CASES (excluding undetermined intent)	X85-Y09
POISONING	X85-X90
HANGING, STRANGULATION AND SUFFOCATION	X91
DROWNING AND SUBMERSION	X92
FIREARM	X93-X96
SHARP OBJECT	X99
BLUNT OBJECT	Y00
BODILY FORCE, INCLUDING SEXUAL	Y04-Y05
NEGLECT, ABANDONMENT AND OTHER MALTREATMENT SYNDROMES	Y06-Y07
OTHER ASSAULTS, SPECIFIED MEANS	X97-X98, Y01-Y03, Y08
OTHER ASSAULTS, UNSPECIFIED MEANS	Y09

Table A.2. ICD X codes for undetermined intent

UNDETERMINED INTENT	Y10-Y34
POISONING	Y10-Y19
HANGING, STRANGULATION AND SUFFOCATION	Y20
DROWNING AND SUBMERSION	Y21
FIREARM	Y22-Y25
SHARP OBJECT	Y28
BLUNT OBJECT	Y29
OTHER ASSAULTS, SPECIFIED MEANS	Y26-Y27, Y30-Y33
OTHER ASSAULTS, UNSPECIFIED MEANS	Y34

Global Burden of Disease data were used to calculate rates and rate ratios.

A1.4 WHO European health for all database (HFA–MDB): mortality supplement by 67 causes of death, age and sex (offline version, July 2012)

This contains data on health indicators, including mortality, morbidity and disability from multiple causes, including external causes of injuries *(2)*. The data allow trend analysis and international comparisons for several health statistics and also contain age-standardized mortality indicators. Age-standardized rates per 100 000 population in the European Region are presented by sex and for the age groups 0–4, 5–14, 15–29, and older. Data are compiled, validated and processed uniformly to improve the international comparability of statistics. Data are available from 1979 onwards. This report used the version of the database dated July 2012.

A1.5 WHO European detailed mortality (and hospital admissions) database

The WHO European detailed mortality database *(3)* is the most complete mortality data source for the European Region. It includes, for the available countries, mortality data by five-year age groups in ICD–9, ICD–10 and mortality tabulation list 1 of the ICD–10 code officially reported by Member States. The data are available from 1990 onwards. For the purposes of this report, data were downloaded for 2007–2011 (or the most recent 5 years) for people aged 14 years and younger. Data with similar age bands are also available for hospital admissions but only for a limited number of countries *(4)*. The report used the July 2012 update of the detailed mortality database and the update of January 2013 for the hospital admissions. The database was also used to analyse data by mode of homicide.

A1.6 Limitations of current routine information systems

These data have several limitations. First, vital registration data are missing in a few countries. This is particularly the case in some of the countries affected by transition and conflict. Mortality data are also not adequate for Andorra, Monaco and Turkey. Second, the Global Burden of Disease 2008 estimates are based on extrapolations of information compiled to estimate the burden of disease. Although these have been updated using more recent studies than those in 1990, those measuring disability are still scarce. Third, since systems and practices for recording and handling health data vary between countries, the availability and accuracy of the data reported to WHO may be variable. Fourth, the data are prone to sociocultural contexts, and intentional injuries may be misclassified as unintentional or of undetermined intent. International comparisons between countries and their interpretation should therefore be carried out with caution. Fifth, few countries provided reliable morbidity data to WHO information systems, leaving the regional picture incomplete.

A1.7 The WHO survey questionnaire on prevention of child maltreatment

A short questionnaire on the prevention of child maltreatment and other adverse childhood experiences was drafted in spring 2012 and piloted by several countries. The final version of the questionnaire was then sent to the network of focal persons on violence

prevention. Detailed results are described in Annex 2. The questionnaire is available on request.

A1.8 Classification of countries by income

Gross national income (GNI) per capita for the year 2010 came from World Bank estimates *(7)*. Where no data were available for 2010, published data for the latest year were used. The World Bank atlas method was used to categorize GNI into bands:

Low income	US$ 1005 or less
Middle income	US$ 1006 to US$ 12 275
High income	US$ 12 276 or more

A1.9 Calculation of standardized mortality rate ratios

Standardized mortality rate ratios were calculated – for people aged 14 years and younger – to determine the excess risk of dying from interpersonal violence for people living in low- and middle-income countries compared with high-income countries. To do this, death data were downloaded from the Global Burden of Disease 2011 and age-standardized mortality rates were calculated using the European Region population for standardization. Confidence intervals were calculated but are not included because they are narrow.

A1.10 Methods for meta-analysis of published studies

In this section we provide a synopsis of the methods used in the series of meta-analyses on the prevalence of child sexual abuse *(8)*, child physical abuse *(9)*, child emotional abuse *(10)* and child physical and emotional neglect *(11)*. More detailed information can be found in these publications.

Studies were included in (one of) the meta-analyses if the prevalence of at least one of the pertinent types of maltreatment was reported in English: (a) in terms of proportions at the child level (excluding studies only reporting estimates at the family level); (b) for victims under the age of 18 years in (c) non-clinical samples, and if (d) sufficient data were provided to determine the proportion under (a) as well as the sample size. Studies were included when either self-report measures were used or when informants such as medical professionals, child protection workers or teachers reported on the maltreatment experiences of the children with whom they were in touch. When publications reported the prevalence of maltreatment separately for more than one sample, for example for male and female participants, the prevalence rates were treated as independent rates. The outcome coded was the proportion of children who were abused or neglected. Sample size was also coded to weight effect sizes. Because of the overlap between European and worldwide samples, 85% confidence intervals (CIs) were used as a conservative way of testing *(12)* whether European and worldwide prevalence rates were statistically different. Nonoverlapping CIs suggest a significant difference between combined effect sizes *(13)*. Results are presented in section 2.4.1 and details of prevalence rates reported in studies are shown in Annex 2.

A1.11 Calculation of European estimates

In the main report, prevalence rates were used to roughly estimate the number of cases of child maltreatment in the European Region. They were applied to the European population under 18 years of age. Considering the WHO mortality database only provides population data for some specific age groups (0–1, 1–4, 5–9, 10–14, 15–19), the population for the age group 0–17 was estimated. Under the plausible hypothesis that the population under the age group 15–19 has a uniform distribution for every age group, both in males and females, 60% of the population of that age group (from 15 to 17.9 years old) was calculated and added to the population up to 14 years old. In this way, a total of 190 304 122 children under 18 years in the European Region (97 573 896 males and 92 730 226 females) was calculated.

A1.12 Methods for meta-analyses of the Balkan Epidemiological Study of Child Abuse and Neglect (BECAN) studies

A fixed effect meta-analysis was used to calculate meta-analytical estimates for the results coming from the studies of the nine BECAN countries: 95% CIs were calculated but they are not reported since they are very narrow.

A1.13 References

1. Global burden of disease [web site]. Geneva, World Health Organization, 2011 (http://www.who.int/healthinfo/global_burden_disease/estimates_regional/en/index.html, accessed 25 July 2013).

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4. European hospital morbidity database [online database]. Copenhagen, WHO Regional Office for Europe, 2013 (http://www.euro.who.int/en/what-we-do/data-and-evidence/databases, accessed 25 July 2013).

5. *International classification of diseases, ninth revision (ICD–9)*. Geneva, World Health Organization, 1977.

6. *International statistical classification of diseases and related health problems. 10th revision, version for 2007*. Geneva, World Health Organization, 2007 (http://apps.who.int/classifications/apps/icd/icd10online, accessed 25 July 2013).

7. World development indicators database [online database]. Washington, DC, The World Bank, 2012 (http://data.worldbank.org/indicator/NY.GNP.PCAP.CD/countries, accessed 25 July 2013).

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ANNEX 2
ADDITIONAL RESULTS

A2.1 Homicide among children

Data on the methods used to commit homicide among children are available for 37 European countries. When assault is considered together with cases of undetermined intent, most homicides are carried out as assaults by hanging, strangulation and suffocation (23%), by the use of sharp objects (8%), neglect (7%), drowning (5%) and firearms (5%). However, the coding of deaths is far from complete, and 37% of deaths are classified as having been committed by unspecified means (Fig. A.1). Data on individual countries are available on request.

A2.2 Inequalities by country income

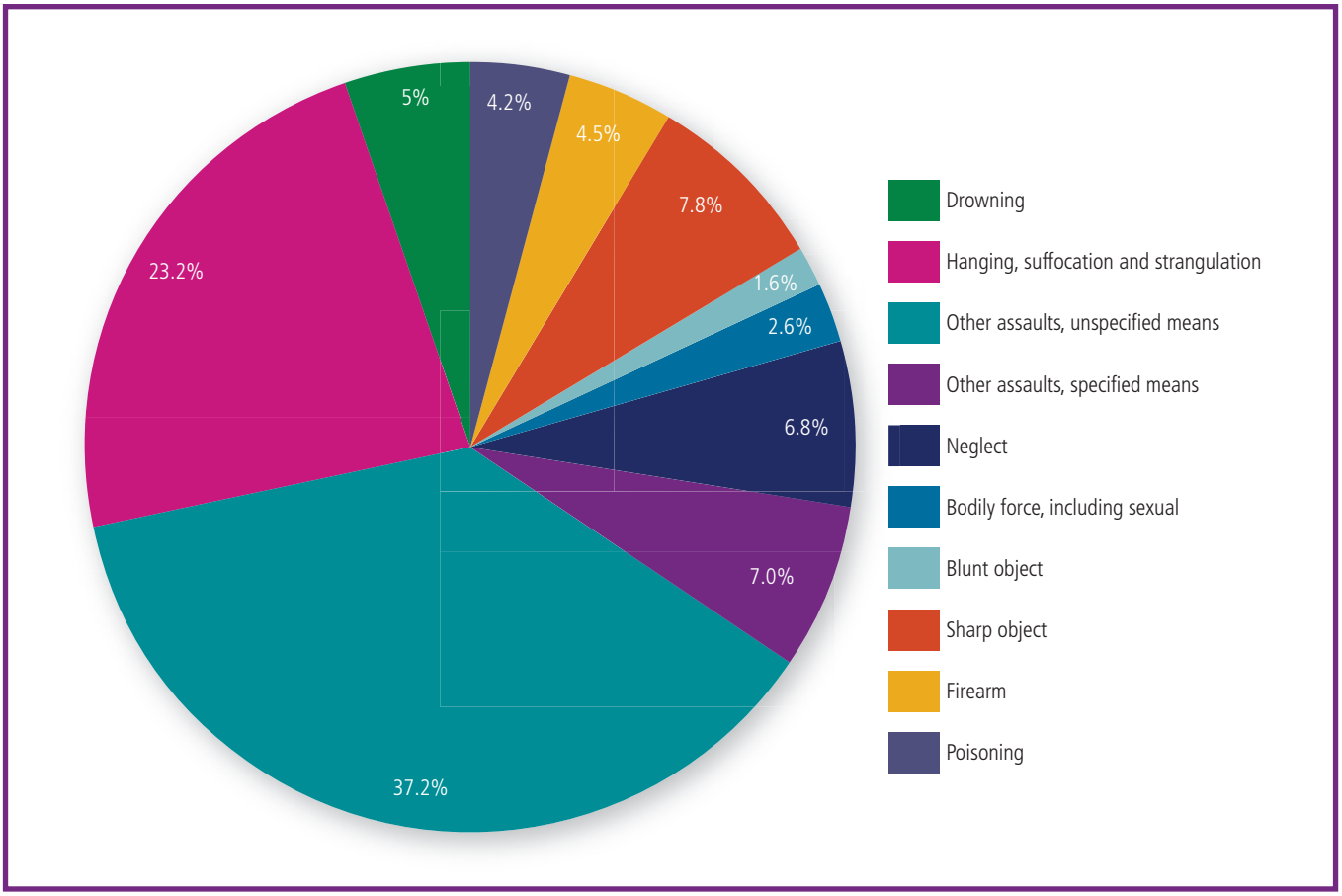
Table A.3. shows rate ratios among children aged 0–14 years (and subgroups) in low- and middle-income countries and high-income countries in the European Region, 2008.

Table A.3. Rate ratios

Age groups	Rate ratios		
	Males	Females	Both sexes
0–4	1.9	1.7	1.8
5–9	2.3	1.3	1.8
10–14	5.7	5.3	5.5
0–14	2.7	2	2.4

Source: World Health Organization *(2)*.

Fig. A.1. Deaths caused by assault by mode among people younger than 15 years in 37 countries in the European Region for which data are available



Source: WHO Regional Office for Europe *(1)*.

A2.3 Hospital admissions due to assaults

Fig. A.2. shows hospital admissions (per 100 000 population) due to assault in children aged under 15 years by age for 12 countries in the European Region who report these data.

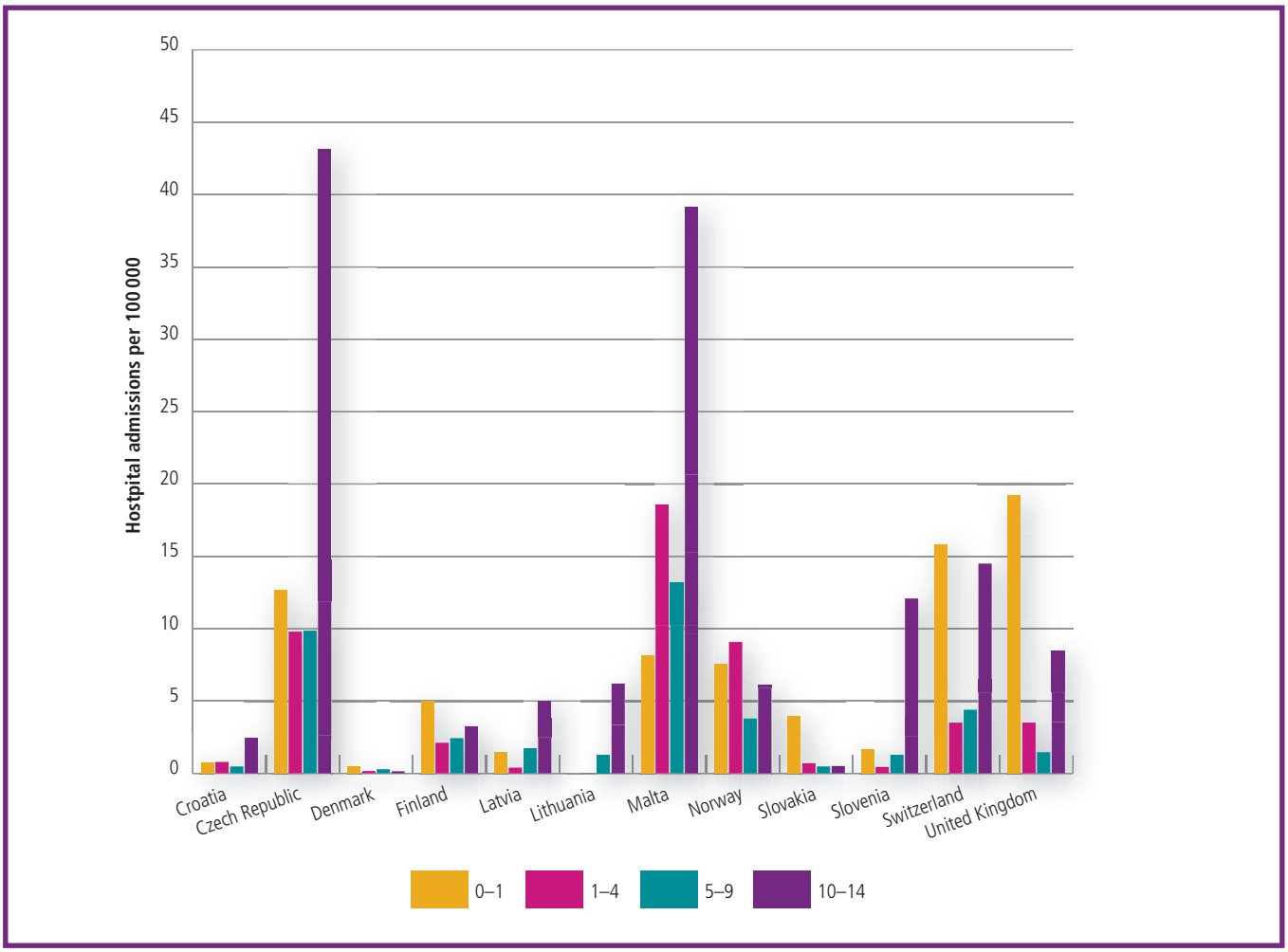
A2.4 Results for the meta-analysis of published studies: geographic distribution of prevalence studies of maltreatment

The search procedure yielded 244 English-language publications published from 1982 to 2008, including 50 reporting on European samples covering a total of 577 prevalence rates of different types of maltreatment, including 105 for Europe. The vast majority of the 105 European prevalence rates related to sexual abuse (67 self-report; 3 informant-report). The European subset included 24 prevalence rates for physical abuse (19 self-report; 5 informant-report), 8 for emotional abuse (6 self-report, 2 informant-report) and 3 for physical neglect (2 self-report, 1 informant-report).

No European prevalence studies were found for emotional and educational neglect. An overview of the countries from which the self-reported prevalence rates originated is provided in Fig. A.3. All informant-reported prevalence studies originated from the United Kingdom.

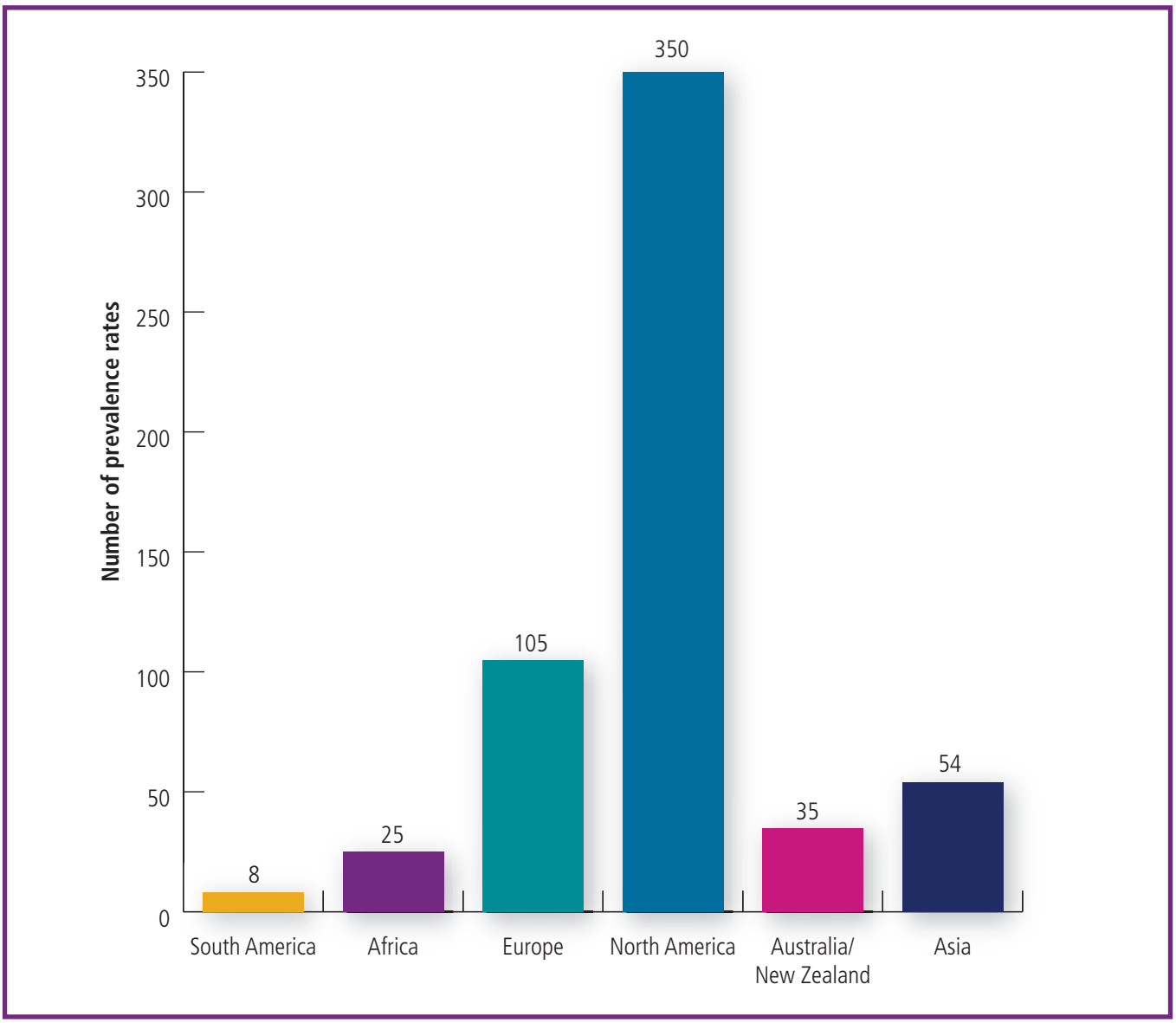
Three conclusions can be drawn from the distribution of child maltreatment research over geographic origin of samples and types of maltreatment. First, the number of studies originating from Europe is approximately one third of those from North America. Relatively more maltreatment research is carried out in Europe compared to Asia and Africa. Second, in spite of the fact that the first publication on maltreatment was on child physical abuse *(4),* research in the field seems to be predominantly on sexual abuse,

Fig. A.2. Hospital admissions



Source: WHO Regional Office for Europe *(3).*

Fig. A.3. Distribution of worldwide child maltreatment prevalence rates per geographic area of origin.

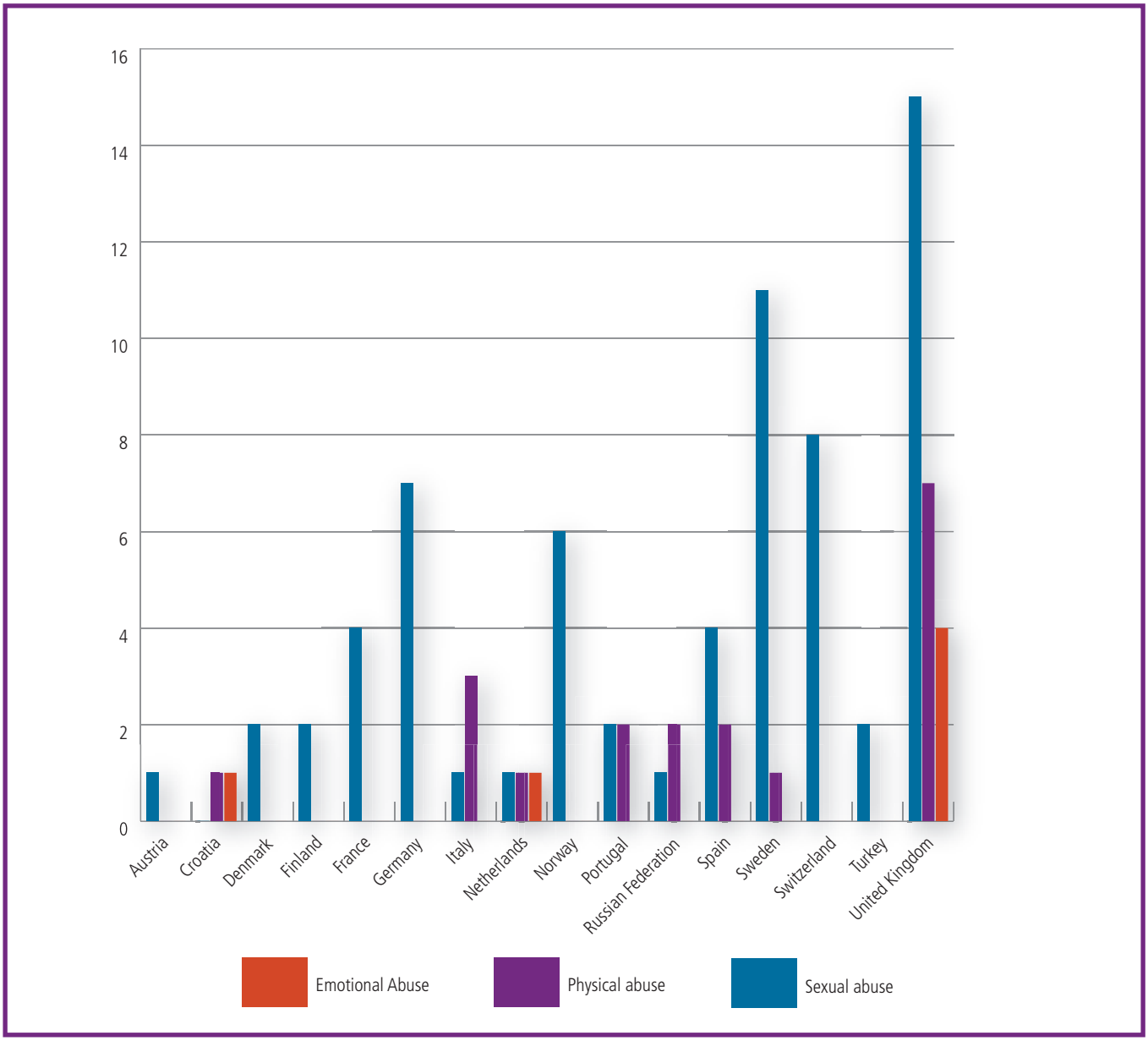


Source: Alink et al., unpublished data, 2013.

with far fewer studies on emotional abuse and neglect, including in Europe (Fig. A.4 (Alink et al., unpublished data, 2013)). This predominance may be due to the greater ease of operationalization due to clearer definitions and boundaries between right and wrong. There is also a better-described association with adverse consequences. In contrast, physical abuse, emotional abuse and neglect were attributed to parental disciplinarian behaviours, which could be seen alongside normative, good-enough parenting, although harsh or inappropriate.

Third, the number of informant studies is only a fraction of the number of self-report studies. From a practical point of view, informant studies are more difficult to carry out than self-report studies, as recruiting informants and requests for official information from social work, education, health and police may be more cumbersome than recruiting participants for self-report studies. Retrospective reports of adverse childhood experiences by adults are thought to be valid if definitions are clear and do not rely on judgment and interpretation of events. The latter can introduce bias, especially when reporting emotional abuse and neglect *(5).* One of the limitations of the review is restricting it to the English language and some reports may be published in national languages *(6)*.

Fig. A.4. Distribution over countries of origin for self-reported prevalence rates per type of maltreatment in self-report studies included in the meta-analyses



Source: Alink et al., unpublished data, 2013.

A2.5 Additional results from the WHO survey on child maltreatment

A2.5.1 Is child maltreatment a problem?

Forty-one completed questionnaires were received from the 46 countries (response 89%) with a health ministry focal person for violence prevention in the European Region (WHO Regional Office for Europe, unpublished results, 2013). Child maltreatment is perceived as a "very big" (5%), "big" (41%) or "moderate" problem (39%) in most countries, with only 15% perceiving it as a "slight" problem. The perception of the problem is similar to the judgement on the size of problem for which it is defined a "very big" problem in 5% of countries, "big" in 37%, "moderate" in 51% and "slight" in 7% (Table 5.1 has country responses).

A2.5.2 National policy development

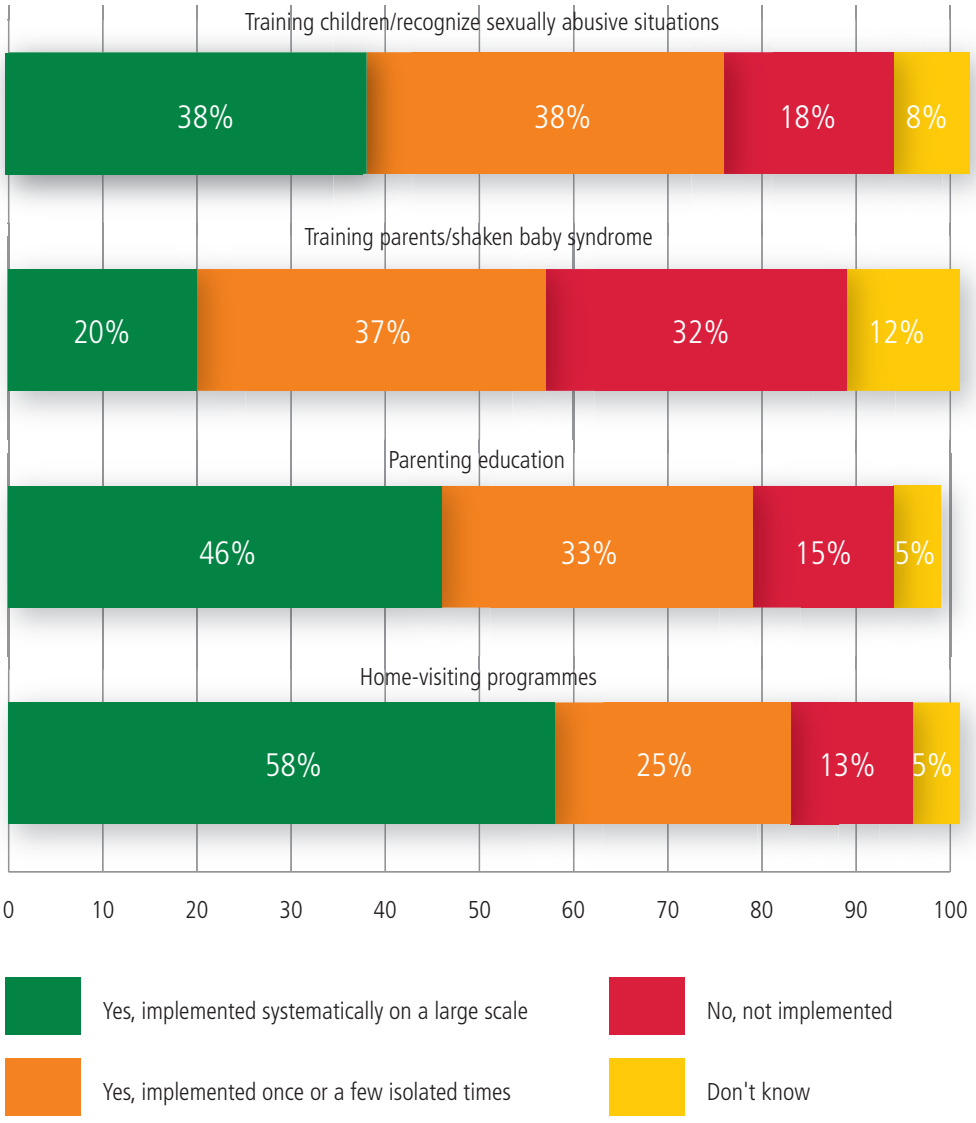
The problem of child maltreatment is not well recognized at government level, with only 54% of responding

countries having a policy on child maltreatment prevention at national level and 22% at subnational level. Fifty-six per cent have a policy on child maltreatment protection at national level and 20% at subnational level, but none had time-bound and quantified targets defined in their policies. Two countries (United Kingdom (Scotland) and Spain) have a set of quantifiable indicators for monitoring. In 80% of responding countries, multiple agencies/departments take (out of 41 countries) responsibility for overseeing and/or coordinating child maltreatment prevention activities, while in 20% of countries this task is in the hands of a single agency.

A2.5.3 Child maltreatment and noncommunicable diseases

Eighty-seven per cent of the responding countries recognize in their policy/plan that child maltreatment may co-exist with other adverse childhood experiences and 74% of them explicitly recognize it as a risk factor for the development of health risk behaviours, but only 6% explicitly recognize that child maltreatment is a risk factor for the development of noncommunicable diseases. While two thirds of the responding countries have an action plan for the prevention of noncommunicable diseases, less than half recognize child maltreatment as a risk factor for this.

Fig. A.5. Implementation of evidence-based interventions



Source: WHO Regional Office for Europe, unpublished data, 2013.

A2.5.4 Evidence-based interventions

Interventions, such as home-visiting programmes or parenting education, are implemented systematically on a large scale in 58% and 46% of countries respectively (Fig. A.5). Fewer countries reported training parents in the prevention of shaken baby syndrome (20%) and training children in recognizing sexually abusive situations.

A2.5.5 Laws

Most responding countries have national laws on mandatory reporting of suspected child abuse for specific groups of professionals or individuals (79%), national laws against child marriage (90%) and statutory rape (93%). Only 70% reported having laws banning corporal punishment in children and 50% reported having laws against female genital mutilation.

A2.5.6 Health and social services

All countries have child protection services for the victims of child maltreatment: in 82%, this is implemented systematically on a large scale and in 18% once or a few isolated times. Medicolegal services for child victims of rape and sexual assaults are active on a large scale in 76% of countries and in 17% this is more sporadic. The systematic identification and appropriate referral of child maltreatment cases is practised in 66% systematically and more sporadically in 20%, and not at all in 12%. Screening by prenatal services of risk for child maltreatment and intimate partner and sexual violence is present only in 58% of countries (28% systematic and 30% sporadic) and does not exist in 30% of responding countries. Only 56% of countries systematically provide mental health services for child victims of violence: this is sporadic in 39% but non-existent in 5%.

A2.6 Corporal punishment of children across the Region

A summary of the legislative situation on corporal punishment in the Region is reported in Table A.4. These data have been contributed by the Global Initiative to End All Corporal Punishment of Children. Data have been systematically gathered for Member States and are based upon assessments for the universal periodic review (UPR). The UPR is a unique process that involves a review of the human rights records of all United Nations Member States. It is a state-driven process under the auspices of the Human Rights Council that provides the opportunity for each state to declare what actions they have taken to improve the human rights situations in their countries and

Notes for Table A.4

[a] Government accepted UPR recommendation to prohibit (2009); draft legislation to prohibit under discussion (2011).

[b] Government accepted UPR recommendation to prohibit (2010).

[c] Prohibited in Republic of Srpska.

[d] Government committed to prohibition (2007).

[e] Government committed to prohibition; government accepted UPR recommendation to prohibit (2011); legislation which would prohibit being drafted (2011).

[f] Government "partially accepted" UPR recommendation to prohibit in the home (2011).

[g] 2000 Supreme Court ruled against all violence in childrearing; "reasonable chastisement" defence repealed the same year.

[h] 1996 Supreme Court ruling prohibited all violence in childrearing but this not yet confirmed in legislation.

[i] Prohibited in Children's Rights Protection Law 1998.

[j] Government stated intention to prohibit to United Nations Committee on the Rights of the Child (2006); government accepted UPR recommendation to prohibit in the home (2011); draft legislation under discussion (2012).

[k] Government accepted UPR recommendations to prohibit in all settings (2013).

[l] Government committed to prohibition (2007); government accepted UPR recommendations to prohibit in the home and settings (2008, 2013).

[m] Government committed to prohibition (2005); government accepted UPR recommendation to prohibit in all settings (2009); current legislation prohibits some but not all corporal punishment.

[n] Government accepted UPR recommendation to prohibit (2010); bill which would have prohibited rejected by referendum (2012).

[o] Government accepted UPR recommendation to consider prohibition (2008); draft legislation to prohibit rejected by parliament in 2008; government rejected second-cycle UPR recommendation to prohibit in the home (2012).

[p] 2003 Federal Court ruling stated repeated and habitual corporal punishment unacceptable but did not rule out the right of parents to use corporal punishment.

[q] Prohibited by federal law pursuant to cantonal legislation; 1991 Federal Court ruled it permissible in certain circumstances but this considered impossible under current law.

[r] Government accepted UPR recommendation to prohibit in all settings (2011); government stated legislation is being improved to prohibit corporal punishment in the family and education settings (2012).

[s] Government accepted UPR recommendation to prohibit (2010).

[t] Rights of the Child (Guarantees) Act 2002 prohibits some but not all corporal punishment; government accepted UPR recommendation to prohibit in all settings (2013).

[u] Law reform in 2003 (Scotland), 2004 (England and Wales) and 2006 (Northern Ireland) limited but did not prohibit all corporal punishment.

[v] Prohibited in residential institutions and foster care arranged by local authorities or voluntary organizations throughout the United Kingdom; prohibited in day care and childminding in England, Wales and Scotland.

Table A.4. Legislation on corporal punishment in different settings in the European Region

Country	Prohibited in the home	Prohibited in schools	Prohibited in penal system		Prohibited in alternative care settings
			As sentence for crime	As disciplinary measure in penal institutions	
Albania	YES	YES	YES	YES	YES
Andorra	NO	YES	YES	YES	SOME
Armenia	NO	YES	YES	YES	-
Austria	YES	YES	YES	YES	YES
Azerbaijan[a]	NO	YES	YES	YES	NO
Belarus[b]	NO	-	YES	YES	NO
Belgium	NO	YES	YES	YES	SOME
Bosnia and Herzegovina	SOME[c]	YES	YES	YES	SOME[c]
Bulgaria	YES	YES	YES	YES	YES
Croatia	YES	YES	YES	YES	YES
Cyprus	YES	YES	YES	YES	YES
Czech Republic[d]	NO	YES	YES	YES	SOME
Denmark	YES	YES	YES	YES	YES
Estonia[e]	NO	YES	YES	YES	NO
Finland	YES	YES	YES	YES	YES
France	NO	YES	YES	YES	NO
Georgia	YES	YES	YES	YES	YES
Germany	YES	YES	YES	YES	YES
Greece	YES	YES	YES	YES	YES
Hungary	YES	YES	YES	YES	YES
Iceland	YES	YES	YES	YES	YES
Ireland[f]	NO	YES	YES	YES	SOME
Israel	YES[g]	YES	YES	YES	YES
Italy	NO[h]	YES	YES	YES	YES
Kazakhstan	NO	YES	YES	YES	SOME
Kyrgyzstan	NO	YES	YES	YES	SOME
Latvia	YES[i]	YES	YES	YES	YES
Lithuania[j]	NO	YES	YES	YES	NO
Luxembourg	YES	YES	YES	YES	YES
Malta	NO	YES	YES	-	NO
Monaco	NO	YES	YES	YES	NO
Montenegro[k]	NO	YES	YES	YES	NO
Netherlands	YES	YES	YES	YES	YES
Norway	YES	YES	YES	YES	YES
Poland	YES	YES	YES	YES	YES
Portugal	YES	YES	YES	YES	YES
Republic of Moldova	YES	YES	YES	YES	YES
Romania	YES	YES	YES	YES	YES
Russian Federation	NO	YES	YES	YES	NO
San Marino	NO	YES	YES	YES	NO
Serbia[l]	NO	YES	YES	YES	SOME
Slovakia[m]	NO	YES	YES	YES	YES
Slovenia[n]	NO	YES	YES	YES	SOME
Spain	YES	YES	YES	YES	YES
Sweden	YES	YES	YES	YES	YES
Switzerland[o]	YES[p]	YES[q]	YES	YES	YES
Tajikistan[r]	NO	YES	YES	NO	NO
The former Yugoslav Republic of Macedonia	NO	YES	YES	YES	YES
Turkey[s]	NO	YES	YES	YES	NO
Turkmenistan[t]	NO	YES	YES	-	NO
United Kingdom	NO[u]	YES	YES	YES	SOME[v]
Ukraine	YES	YES	YES	YES	YES
Uzbekistan	NO	YES	YES	YES	NO

Notes: prepared for this report by the Global Initiative to End All Corporal Punishment of Children. Data were shared with national focal persons for violence prevention for comment.

to fulfil their human rights obligations. In this case, data have been compiled about legislation for banning corporal punishment against children in different settings.

Little or no research into corporal punishment of children in the past 10 years has been identified in Andorra, Armenia, Belgium, Cyprus, Greece, Hungary, Luxembourg, Malta, Monaco, the Netherlands, Portugal, Russian Federation, San Marino, Slovakia, Turkmenistan and Uzbekistan.

A2.7 Estimation of number of children affected by maltreatment in the Region

Section A1.11 describes the methodology for estimating the number of children affected by maltreatment in the Region by applying estimates of lifetime prevalence obtained in the meta-analysis (Chapter 2) to the population of children aged under 18 years. These are:

- sexual abuse in males: 5 561 712 cases (prevalence 5.7%);
- sexual abuse in females: 12 425 850 cases (prevalence 13.4%);
- sexual abuse for both: 17 987 562 cases (prevalence 9.6%);
- physical abuse for both: 43 579 644 cases (prevalence 22.9%);

- emotional abuse for both: 55 378 499 cases (prevalence 29.1%);
- physical neglect for both: 31 019 572 cases (prevalence 16.3%); and
- emotional neglect for both: 35 015 958 (prevalence 18.4%).

A2.8 Seeking children's views to improve societal responses

Increasing importance is being given to children's perspectives on child maltreatment and related issues. By involving children in the discussion of their own well-being and basic rights, researchers and practitioners can show respect for children while also empowering them to speak up when their rights are violated. A study from Norway showed that children found it difficult to disclose sexual abuse due to lack of opportunity as well as fear of others' reactions and potential repercussions *(7)*. When abuse was discussed directly, children felt more comfortable as it gave them an opportunity and a purpose to speak *(7)*. Cultural factors, such as filial piety and loyalty to parents, as well as their personal beliefs may influence children's readiness to disclose abuse *(8)*.

When children are asked about corporal punishment, they consistently say that it is physically and emotionally painful and that it should not be used. Children aged 4–10 years in the United Kingdom said that corporal punishment "burns", "stings" and makes them cry and feel upset *(9)*. Two thirds of children in Serbia thought that corporal punishment made them fearful rather than teaching them to understand *(10)*. In a study from the Nordic countries, large majorities of 12–16-year-olds agreed that children must be protected from all forms of violence and disagreed that parents have a right to use corporal punishment, in support of existing policy *(11)*. Children's views can therefore be used to improve services and monitor policy directions.

A2.9 Children in institutional care

Several surveys have been conducted to identify children under three in institutional care across the Region *(12,13)*. Detailed results are reported in Table A.5. Recent data are not available for western Europe.

Table A.5. Children under three in institutional care (prevalence rates)

Country	Rates per 10 000 children under age 3				
	2000	2002	2005	2007	2009
Albania	7.8	6	6.5	7.5	7.6
Andorra	–	33	–	–	–
Armenia	3.2	1	3.4	3.7	2.9
Austria	–	3	–	–	–
Azerbaijan	4.2	3	3.2	1.8	2
Belarus	35.6	25	35.3	28.7	27.5
Belgium	–	56	–	–	
Bosnia and Herzegovina	18	4	21.6	13.3	29.8
Bulgaria	124.4	88	109.5	95.6	78
Croatia	–	6	–	–	–
Cyprus	–	4	–	–	–
Czech Republic	–	34	–	–	–
Denmark	–	7	–	–	–
Estonia	–	10	–	–	–
Finland	–	28	–	–	–
France	–	13	–	–	–
Georgia	9.6	3	12.1	11.9	5.6
Germany	–	7	–	–	–
Greece	–	3	–	–	–
Hungary	–	22	–	–	–
Iceland	–	0	–	–	–
Ireland	–	6	–	–	–
Italy	–	2	–	–	–
Kazakhstan	28.6	20	20.7	18.4	16.9
Kyrgyzstan	6.3	5	6.3	5.3	5.5
Latvia	–	60	–	–	–
Lithuania	–	26	–	–	–
Malta	–	27	–	–	–
Montenegro	0.3	–	0.5	0.4	0.4
Netherlands	–	16	–	–	–
Norway	–	<1	–	–	–
Poland	–	15	–	–	–
Portugal	–	16	–	–	–
Republic of Moldova	22.3	20	24.7	24.1	18.8
Romania	–	71	–	–	6.6
Russian Federation	38.3	28	35.8	30.9	27.3
Serbia	11.9	50	10.8	11.6	8.3
Slovakia	–	21	–	–	–
Slovenia	–	2	–	–	–
Spain	–	23	–	–	–
Sweden	–	8	–	–	–
Tajikistan	2.8	4	2.5	2.3	3.9
The former Yugoslav Republic of Macedonia	6.8	5	10.8	11.8	10.8
Turkey	–	2	–	–	–
Turkmenistan	4.9	4	5.2	4.8	–
Ukraine	30.8	26	31.8	24.9	19.1
United Kingdom	–	<1	–	–	–
Uzbekistan	3.5	3	3.4	3.5	–

Source: adapted from UNICEF *(12)*; Browne et al. *(13)*.

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ANNEX 3

HEALTH MINISTRY FOCAL PERSON FOR VIOLENCE PREVENTION AND OTHER RESPONDENTS TO THE SURVEY

Albania	Gentiana Qirjako, Public Health Department
Armenia	Ruzanna Yuzbashyan, Ministry of Health
Austria	Maria Orthofer, Federal Ministry of Economy, Family and Youth
Belarus	Leonid Lomat, Republican Scientific and Practical Centre for Traumatology and Orthopaedics
Belgium	Charles Denonne, FPS Public Health, Food Chain Safety and Environment
Bosnia and Herzegovina[1]	Jasminka Vučković, Ministry of Health and Social Welfare of Republika Srpska
Bulgaria	Rumyana Dinolova, National Centre of Public Health and Analysis
Croatia	Ivana Bkrić Biloš, Croatian National Institute of Public Health
Cyprus	Myrto Azina-Chronides, Ministry of Health
Czech Republic	Iva Truellova, Ministry of Health
Denmark	Karin Helweg-Larsen, National Institute of Public Health
Estonia	Ann Lind, Ministry of Social Affairs of Estonia
Finland	Heidi Manns-Haatanen, Ministry of Social Affairs and Health
Germany	Almut Hornschild, Bundesministerium für Familie, Senioren, Frauen and Jugend
Hungary	Maria Herczog, Eszterházy Károly College
Iceland	Sigrun Danielsdottir and Dóra Guðmundsdóttir, Directorate of Health
Israel	Kobi Peleg, Israel National Center for Trauma and Emergency Medicine and The National Council of the Child
Italy	Maria Giuseppina Lecce, Ministry of Health
Kazakhstan	Gulnara Sitkasinova, Ministry of Health
Kyrgyzstan	Bektur Anarkulov, Scientific Research Centre of Trauma and Orthopaedics
Latvia	Jana Feldmane, Ministry of Health
Lithuania	Robertas Povilaitis, Childline
Malta	Taygeta Firman, General Directorate for Health
Montenegro	Svetlana Stojanovic, Ministry of Health
Netherlands	Pepijn Sleyfer, Ministry of Security and Justice
Norway	Freja Ulvestad Kärki, Norwegian Directorate of Health

[1] Only the Republic of Srpska.

Poland	Anna Trzewik, Ministry of Health
Portugal	Barbara Menezes, Directorate-General of Health
Republic of Moldova	Luminita Avornic, Ministry of Health
Romania	Daniel Verman, Ministry of Health
Russian Federation	Margarita Kachaeva, Centre for Social and Forensic Psychiatry
San Marino	Andrea Gualtieri, Authority of Public Health
Serbia	Milena Paunovic and Marija Markovic, Institute of Public Health of Belgrade; Oliver Vidojevic, Institute of Mental Health, Child and Adolescent Clinic
Slovakia	Martin Smrek, University Children's Hospital
Slovenia	Barbara Mihevc Ponikvar, Institute for Public Health
Spain	Begoña Merino, Ministry of Health, Social Services and Equality
Sweden	Kerstin Nordstrand, National Board of Health and Welfare and Staffan Janson, Karlstads University
Switzerland	Marie-Claude Hofner, University Institute for Legal Medicine
The former Yugoslav Republic of Macedonia	Marija Raleva, Clinic for Psychiatry, Clinical Centre, Skopje
United Kingdom	Mark Bellis, Liverpool John Moores University
Uzbekistan	Alisher Iskandarov, Paediatric Medical Institute

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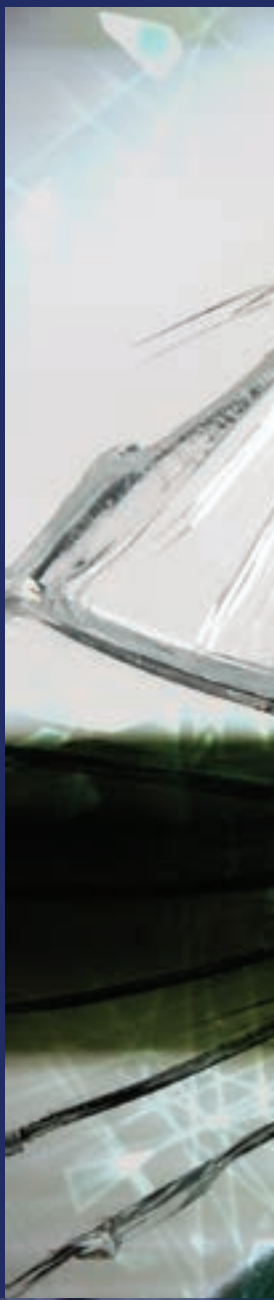

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