

***Children at increased risk of death from
maltreatment
and strategies for prevention***



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Foreword

Children are among the most vulnerable in society and when a child dies it is not unusual for the impact to extend beyond the boundaries of the immediate family. Children die in a range of circumstances, but when a child dies through homicide the response is particularly reactive. Stories of these deaths touch the very hearts of New Zealanders and it is not surprising when grieving communities demand answers and seek assurances that this will never happen again.

That it does happen again is not a reflection of a lack of community care, nor does it reflect a lack of professional diligence. More frequently children die in situations that are difficult to see in advance.

When a violent death of a child occurs in New Zealand the question is often asked: does this mean that New Zealand is more violent to children than other countries? Invariably it is a question that never receives a satisfactory answer. Experts become equivocal when pressed by media wanting a straightforward answer. The problem is statistics about child death by homicide present difficulties both with respect to interpretation and comparison. The challenge is that the number of children who are killed through maltreatment is small and the circumstances leading to their deaths are varied – making it difficult to draw patterns from the data.

This report reassures us that child homicide in New Zealand is a relatively rare occurrence. It also goes some way toward clarifying the problems with respect to international comparisons, and summarises the most up-to-date research in New Zealand and internationally. It is a step toward better understanding child homicide, cycles of abuse and the risk factors associated with fatal child maltreatment.

Ultimately, of course, every death of a child is one death too many and agencies across the sector will continue to strive to improve their services for children most at risk. While it will never be possible to make systems of response infallible, this report will help to inform discussion about the ways in which services can more effectively support vulnerable children. Working together across the spectrum of services is more likely to ensure that the right services are provided at the right time for families. In turn this is more likely to break cycles of abuse and neglect.

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Contents

Foreword.....	iii
Executive summary.....	v
SECTION ONE: UNDERSTANDING THE PROBLEM	1
Child death and injury from maltreatment	1
Child deaths from maltreatment – differences by age of child	3
Challenges in predicting which children are at risk of fatal maltreatment	6
Hospital admissions for intentional injury, children aged under five.....	8
Child, Youth and Family notifications.....	10
Pathways and precursors to fatal child maltreatment	13
Typology of child death from maltreatment.....	16
Factors associated with an increased risk of fatal child maltreatment	19
Accumulation of risk factors	21
Conclusion	25
SECTION TWO: RESPONDING TO VULNERABLE CHILDREN.....	26
Developing services for children and families	26
Conclusions	35
APPENDICES.....	37
Appendix 1: Expanded elements of research	38
Appendix 2: Strategies for preventing family violence in New Zealand	44
Bibliography	49

Executive summary

Recent research into child homicide has highlighted the need for us to better understand the care and safety needs of children, and to strengthen co-ordinated systems of response.

This report is in two sections. Section One seeks to identify factors from the research literature associated with an increased risk of fatal child maltreatment. Indicators associated with an increased risk are provided and existing data sets are reviewed. Section Two looks at ways in which the research can inform responses to vulnerable children.

Section One: Understanding the problem

Child maltreatment death rates

In the five years to 2003, 38 children under 15 years of age died in New Zealand as a result of maltreatment¹, a decline from 50 in the previous five-year period. On a population basis, the latest figures represent an average of 0.9 per 100,000 each year.

UNICEF's 2003 report A league table of child maltreatment deaths in rich countries showed that, in the 1990s, New Zealand had a child maltreatment death rate of 1.2 per 100,000 per year of the child population aged under 15² – the third highest out of 27 countries.

International comparisons must be interpreted with caution, however, as child deaths from maltreatment are a rare event. In a small country like New Zealand, the very small numbers involved produce highly volatile rates. For example, compared to the 1990s when the rate was 1.2 per 100,000, the annual average child maltreatment death rate for the five years to 2003 has declined to 0.9 per 100,000. This is partly the result of an unusually low number of maltreatment deaths in 2003 (2 children died from maltreatment in 2003 compared with 8 in 2001 and 2002, 9 in 2000, and 11 in 1999).

The fact that such small changes in the absolute number substantially alter the rate of child deaths from maltreatment reinforces the need for care when using this measure.

Younger children more at risk than older children

Rates of death from maltreatment are higher for children under five years of age than for older children, and are highest for children aged under one. In the 10 years to 2003, the average annual rate for children under one was 4.6 deaths per 100,000, more than three times higher than the rate for 1–4 year olds (1.3 per 100,000), and eight times higher than the rate for 5–14 year olds (0.6 per 100,000). Thirty percent of the children killed over that period were aged under one, and 63% were aged under five.

These findings are largely consistent with Doolan's 2004 study of child homicides in New Zealand and international studies.³

¹ "Maltreatment" is the internationally recognised generic term used to describe all aspects of abuse and neglect.

² This is an unrevised rate. When deaths classified as "of undetermined intent" are included, the rate is 1.3 per 100,000 of the child population aged 0–14 years.

³ UNICEF 2003.

Predicting which children are most at-risk

The challenge for families, support services and society more generally is that the number of children who are killed through maltreatment or neglect is small and the circumstances leading to their deaths are varied. This makes it extremely hard to predict which children are at risk of being killed through maltreatment or neglect. UNICEF (2003) noted that trying to predict children at risk of fatal maltreatment in advance presents almost insuperable difficulties.

Doolan (2004) found that, over the period 1996–2000, only 20% of families where a child homicide occurred had had contact with Child, Youth and Family (CYF) prior to the child's death. Other indicators of increased risk for children – such as hospital admissions for intentional injury – also have low numbers and rates. In the five years to 2004, there were 426 hospital admissions for intentional injury involving children under five. On a population basis, this represents an average of 30 admissions per 100,000 children in that age group during each year.⁴

Identifying children at risk using available data is difficult, as agencies collect different types of data according to their function. A further challenge is that a child's contact with agencies prior to their death varies: some children who die from maltreatment will have been recorded in the data held by several agencies (eg a child who is admitted to hospital with intentional injuries and then dies will appear in hospital records and in police records), while others will appear only in police records.

There is also likely to be less administrative data available from which to identify children at risk, as they are young and have had less time to come into contact with agencies. This is particularly the case for those children most at risk of death from maltreatment – those who are killed before they turn one.

To address some of the challenges in identifying children most at risk using child-related information, this review sought to identify possible perpetrator-related indicators, based on a review of the pathways and precursors to fatal child maltreatment. Again, challenges were encountered, as the literature on child death from maltreatment varies in focus: some studies look only at the children who died from maltreatment, while others look at the perpetrators, or both; some focused on psychological factors, others on broader socio-economic factors; some covered large populations over long periods, while others were small scale and qualitative.

With all these variations in mind, some common themes emerged from the literature related to fatal child maltreatment. Care is needed when looking at perpetrator-related factors associated with an increased risk of fatal child maltreatment: many people with one or many of these factors never harm a child, and there is a risk that presenting information this way could be misused to stigmatise people or create "guilt by association".

Perpetrators' risk factors were seen to accumulate from childhood to adulthood, and some of the factors are captured by administrative data (eg perpetrators' offending histories, receiving income support, low educational attainment). Analysis of the literature was used to suggest how adversity could transfer between childhood and adulthood – noting that this does not always happen. And it is likely that it is the accumulation of factors that increases risk, rather than any one factor in isolation.

⁴ Ministry of Health, Public Health Intelligence data analysed by the Ministry of Social Development. This count excludes admissions that occur on or before the discharge date for a preceding admission for a given child.

More sophisticated analysis is required before causal pathways or predictors can be developed and, even then, such an approach is contentious. It would be inappropriate, for example, to suggest the risk of fatal child maltreatment is higher on the basis of being a child of a sole parent or a child having a low birth weight. Any approach would also need to take into account the impact of individual and family resilience, which has been proven to reduce the impact or transfer of family adversity. Life or economic opportunities – like entering a healthy relationship or having a good job – also help to reduce or remove risk, as do timely access to quality interventions.

The intention is to use this information with care, to better understand what early indicators there are that an adult, child or family needs help, and to activate access to appropriate and timely interventions.

Section Two: Responding to vulnerable children

The vulnerability of the younger child

While it is clearly important to seek to address all forms of child abuse and neglect, analysis of hospital admissions, child homicides and CYF data suggests that the care and safety needs of the very young child is an issue of particular concern. Children who come to the attention of CYF when they are young also tend to have longer contact with the agency, suggesting a high and ongoing level of vulnerability and risk.

Accumulated family adversity: Taking a life course perspective

Section One of the report shows how accumulated family adversity can increase the risk of child maltreatment, which supports a life course perspective in responding to the needs of vulnerable children. Moving away from the ambulance at the bottom of the cliff approach, a life course perspective supports the building of preventative solutions that have the potential to reduce the accumulation of risk factors over time.

In the past, a common response to child death and perceived system failure has been to develop bureaucratic solutions, including the introduction of more and more guidelines and compliance requirements. Nevertheless, “quick-fix” solutions have done little to solve the problem. Indeed, there is evidence to suggest that such solutions have unintended negative consequences in the long term. An alternative to providing increasingly reactive services is to approach the issue from a life course perspective, providing universal, targeted and specialist services for vulnerable children and their families.

New Zealand currently has services that extend across the universal, targeted and specialist services spectrum, aimed at addressing underlying contributory factors and early treatment issues. New Zealand is therefore well placed to strengthen these services to respond more appropriately to the diverse needs of children and families.

Universal, targeted and specialist services for families

UNICEF (2003:21) notes that strategies to reduce child abuse will not be successful “without addressing the question of economic poverty, which ... is the close companion of physical abuse and neglect”.

Children and adults living in lone-parent or workless families are more likely than others to be in persistent poverty.⁵ Services aimed at helping sole parents and unemployed parents

⁵ Office of the Deputy Prime Minister 2004:42.

enter and remain in sustainable employment can help improve immediate and longer-term living standards and life opportunities, as well as lowering their risk of abuse.

New Zealand has made significant progress toward reducing unemployment, which is the lowest it has been for over 20 years. Numbers receiving Domestic Purposes Benefit – Sole Parent are the lowest in over a decade. The Working for Families package also aims to help people enter and stay in work.

While progress is clearly being made with respect to low-income families, recent research continues to demonstrate that approximately a quarter of New Zealanders face some degree of financial hardship, and that just over a third of all children have been found to experience severe hardship.⁶ Highest rates of severe hardship were found among Māori, Pacific and sole-parent beneficiary families. With the fall in the overall number of people receiving Unemployment and Domestic Purposes Benefits, it is likely that a greater proportion of those remaining on benefit experience labour market and social disadvantage associated with low skills, poor health, low confidence, and living in areas where employment opportunities have declined.

Services across the sectors, variously well established or in development, provide support for all children, including the most vulnerable children in our communities. These services include Early Childhood Centre Based Parent Support and Development projects, Well Child, Strategies with Kids – Information for Parents (SKIP), and Plunket.

Specifically targeted services for vulnerable families are also well established. These services include Early Start, Family Start, and a variety of quality services for Māori and Pacific families.

Specialist services are provided for children and families considered to be at high risk. CYF provide services for those children who are abused or neglected. Police, Health and Education agencies are frequently involved in child protection investigations and there is a high degree of co-ordination required across the spectrum of services. Acknowledging that no single, prescribed response will be appropriate to all reports of child abuse or neglect, a Differential Response Model (DRM) is being developed to more appropriately respond to the range of care and protection concerns. In expanding the range of service pathways, DRM offers a way of targeting resources to ensure reports of abuse, neglect or insecurity of care receive the most appropriate response.

Within the specialist services area, parents with high health needs (such as mental health issues or intellectual or physical disability) may require additional support to adequately care for their children. Currently, however, the extent of these support services is underdeveloped.

Developing co-ordinated services for high-risk infants

Building the capacity of agencies across the spectrum of services to identify those at risk and to respond quickly in a co-ordinated way is more likely to meet the needs of those vulnerable children who have been specifically identified as high risk. Four key elements have been identified to strengthen work with this vulnerable group:

- targeting resources toward greatest need through: shared understanding of risk factors; activating systems to identify and target at-risk infants; and providing high-quality, timely responses across the spectrum of services

⁶ Jensen et al 2006.

- building capacity across the sector by: strengthening services responding to diverse need; developing and sharing specialist expertise across the sector; and exploring appropriate means of sharing information
- co-ordinating cross-agency responses by: engaging agencies across the spectrum of services; providing timely information across agencies; and facilitating cross-agency training and education
- monitoring and responding to infants at risk through: developing co-ordinated review and monitoring systems; exploring appropriate screening for risk; and providing swift co-ordinated responses to elevated risk.

Building cross-sectoral capacity and providing a co-ordinated response that captures these key elements has the potential to strengthen the safety net around vulnerable children.

Conclusion

The report signals a need for systems to focus greater attention on younger children at risk, and also the specific needs within families across the service spectrum. The life course approach to understanding individual and family need over time provides a framework for identifying service gaps across the spectrum of universal, targeted and specialist services. Strengthening the service continuum to address the diverse needs of families over time has the greatest potential to break cycles and produce good outcomes for children in the long term.

Finally, the research reinforces strongly the difficulties in predicting risk of child death by maltreatment. Acts of violence toward children cannot always be anticipated and, as Ferguson (2004:218) insightfully notes, “ultimately, we even have to be prepared to face the uncomfortable fact that any guarantees in protecting children are simply beyond the capacities of what human beings are capable of, even trained professional ones”. What is important, however, is that we collectively strengthen our services so they are the best they can be in responding to the needs of vulnerable infants.

SECTION ONE: UNDERSTANDING THE PROBLEM

Child death and injury from maltreatment

Section One of this report looks at child homicide in the national and international context, and then seeks to identify from the literature factors associated with an increased risk of fatal child maltreatment. Indicators associated with increased child homicide are given and existing data sets are reviewed.

How does New Zealand compare with OECD countries?

UNICEF's 2003 report *A league table of child maltreatment deaths in rich countries* showed that, during the 1990s, New Zealand had an average child maltreatment death rate of 1.2 per 100,000⁷ per year of the child population aged under 15 – the third highest out of 27 countries.

International comparisons must be interpreted with caution, however, as child deaths from maltreatment are a rare event. In a small country like New Zealand, the very small numbers involved produce highly volatile rates. In addition, although the figures come from the same data source (the World Health Organisation) and use the same international classification of death by cause, there may be differences between countries, and within countries over time, in the classification of death by intention.

All child deaths from maltreatment in New Zealand up to 2003

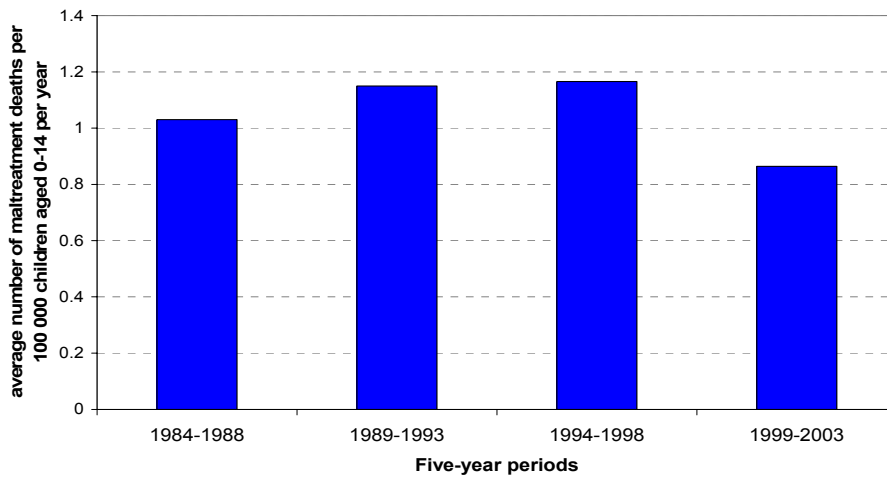
This section looks at New Zealand Health Information Service (NZHIS) data on all child deaths from maltreatment – combining deaths from homicide, intentional injury and other forms of maltreatment.⁸ In the five years to 2003, 38 children under 15 years of age died as a result of maltreatment, a decline from 50 in the previous five-year period. On a population basis, this represents an average of 0.9 per 100,000 each year.

Figure 1 shows that the five-year average annual rate increased slightly over the period 1984–1988 to 1994–1998 (from 1.0 to 1.2 per 100,000), and declined to 0.9 per 100,000 in 1999–2003. However, it should be noted that trends are difficult to discern, as rates based on very small numbers are volatile, even when averaged over five years.

⁷ This is an unrevised rate. When deaths classified as 'of undetermined intent' are included, the rate is 1.3 per 100,000 of the child population aged 0–14 years.

⁸ All suspicious, violent and accidental deaths are referred to the coroner's office for investigation. Once a death is reported to the coroner's office, a court case is filed. Medical and post-mortem reports and police evidence are then collated to establish a detailed summary on the cause(s) of death. With the aid of the coroner's report, NZHIS then codes these deaths according to classifications specified in the International Classification of Diseases (ICD) (ICD-10). This process means the data is likely to be consistently coded, which increases the robustness of data.

Figure 1: Five-year average annual child maltreatment death rates per 100,000 for children aged 0–14 years, 1984–1988 to 1999–2003

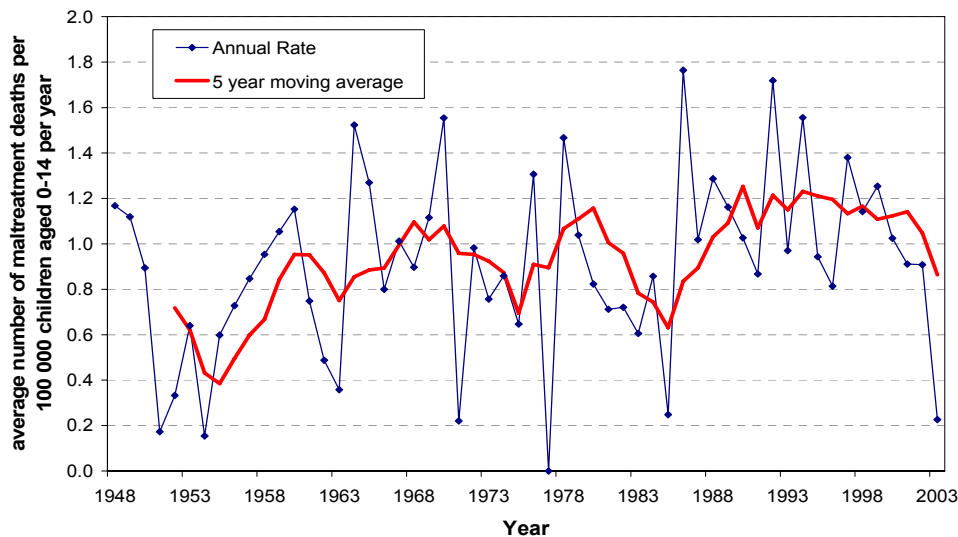


Source: Ministry of Health, NZHIS (ICD–9 codes E960–E969, ICD–10 codes X85–Y09); Statistics New Zealand, mean resident population estimates for years ended December.

The volatility of the series is highlighted by figure 2, which plots the annual rate together with the five-year annual average over a longer time period. The lower average rate for the five years to 2003 is partly the result of an unusually low number of maltreatment deaths in 2003 (2 children died from maltreatment in 2003 compared with 8 in 2001 and 2002, 9 in 2000, and 11 in 1999).

The fact that such small changes in the absolute number substantially alter the rate of child deaths from maltreatment reinforces the care needed when using this measure.

Figure 2: Annual and five-yearly moving average of child maltreatment deaths (homicide and intentional injury) for children 0–14 years per 100,000, 1948–2003



Source: Ministry of Health, NZHIS (ICD–9 codes E960–E969, ICD–10 codes X85–Y09); Statistics New Zealand, mean resident population estimates for years ended December.

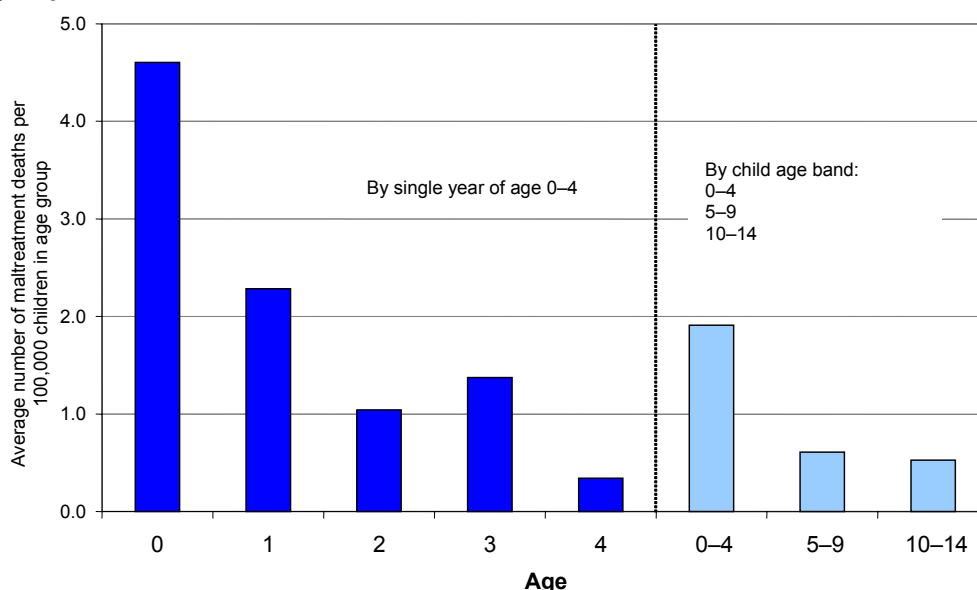
Child deaths from maltreatment – differences by age of child

Rates of death from maltreatment are higher for children under five years of age than for older children, and are highest for children aged under one (figure 3).

In the 10 years to 2003, the average annual rate for children under one was 4.6 deaths per 100,000, more than three times higher than the rate for 1–4 year olds (1.3 per 100,000), and eight times higher than the rate for 5–14 year olds (0.6 per 100,000). Thirty percent of the children killed over that period were aged under one, and 63% were aged under five.

These findings are largely consistent with Doolan’s 2004 study of child homicides in New Zealand and international studies.⁹

Figure 3: Annual average number of child maltreatment deaths per 100,000 children, by age group, 1994–2003



Source: Ministry of Health, NZHIS (ICD–9 codes E960–E969, ICD–10 codes X85–Y09); Statistics New Zealand, mean resident population estimates for years ended December.

Babies and infants are more vulnerable to fatal maltreatment due to their inability to speak or escape, and their dependence also contributes to the stresses parents face when caring for them.

Most newborns who are killed are killed by their mothers, and the majority of young children are killed by family member. In part this reflects the fact young children spend most of their time within family contexts. The majority of children who are killed under age 14 are killed by a family member, and nearly all are killed by someone known to the child. As girls get older, the risk of fatal sexual assault increases, although these are rare.

Teenagers – with their greater mobility and broader social contexts – are more likely than younger children to be killed by their boyfriends, friends, acquaintances or strangers.

A range of cross-national studies¹⁰ show that child death from maltreatment occurs predominantly in the context of poverty,¹¹ psychological stress and limited support,¹² while

⁹ UNICEF 2003.

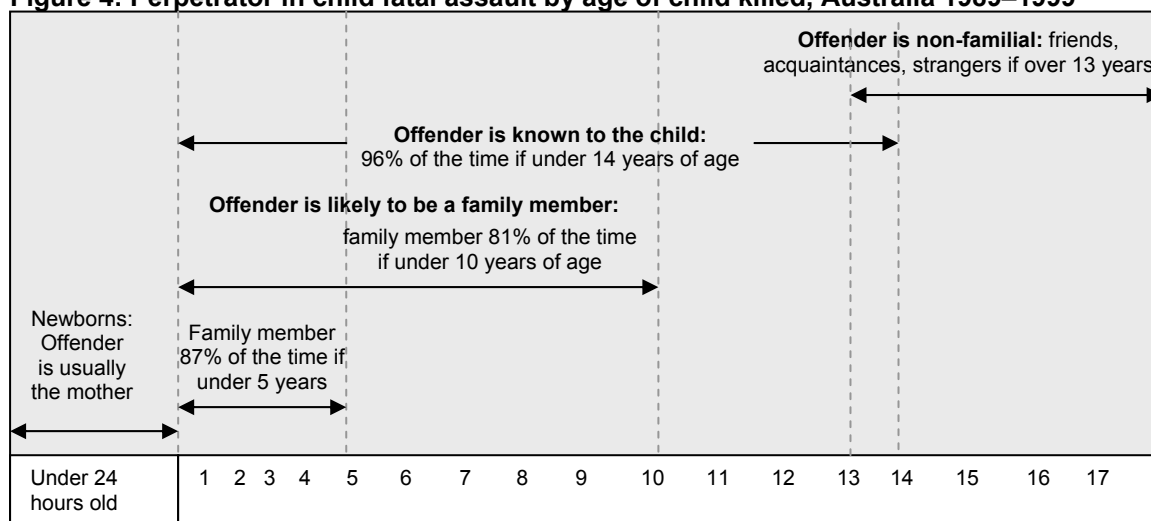
¹⁰ Nixon et al 1981, Strang 1996, cited in Fiala and LaFree 1988; UNICEF 2003.

child murders (defined as a wilful act to kill the child) occur across the spectrum of socio-economic status, including high-income groups.¹³

Some children killed within families had been seriously abused by the perpetrator prior to their death, while others die following a single massive assault (eg shaken baby syndrome or as part of a parent’s murder-suicide).¹⁴

Figure 4 shows the perpetrator’s relationship with the child by the age of the child killed, based on an Australian review of 316 children killed over the 10 years to 1999.^{15,16}

Figure 4: Perpetrator in child fatal assault by age of child killed, Australia 1989–1999



Doolan’s 2004 study of the 91 victims of child homicide (aged 0–14) between 1991 and 2000 had very similar proportions: 81% of the children were killed by a family member and 90% were killed by someone known to them. A minority (6%) were killed by strangers, and in 4% of the cases the relationship of the perpetrator to the child was unknown.^{17,18}

Figure 5 shows the proportion of perpetrators who were the child’s father, mother or de facto parent, as well as other relatives, people known to the child and strangers. (Note that some

¹¹ This may also reflect the fact poorer families are also more likely to come into contact with health and welfare services, so face higher chances of abuse being identified (UNICEF 2003).

¹² UNICEF 2003, Staton et al 2000.

¹³ Nixon et al 1981, cited in Fiala and LaFree 1988.

¹⁴ Greenland 1987, Bourget and Bradford 1990, Crittenden and Craig 1990, Somander and Rammer 1991, Reder et al 1993, Strang 1995, Vanamo et al 2001, Lyman et al 2003, as cited in Cavanagh et al 2005. Two studies found less than half the children who were killed had been abused in the past. A Canadian study found previous abuse was a feature in less than half (40%) of child deaths, and similarly a US study found there had been no evidence of escalating violence in 60% of child deaths from abuse. In the US study, deaths from “single assault” were almost as common as deaths from repeated abuse. (Canadian study: Trocme et al 2001; and US study: Finkelhor 1997, cited in UNICEF 2003.)

¹⁵ Lawrence et al 2004.

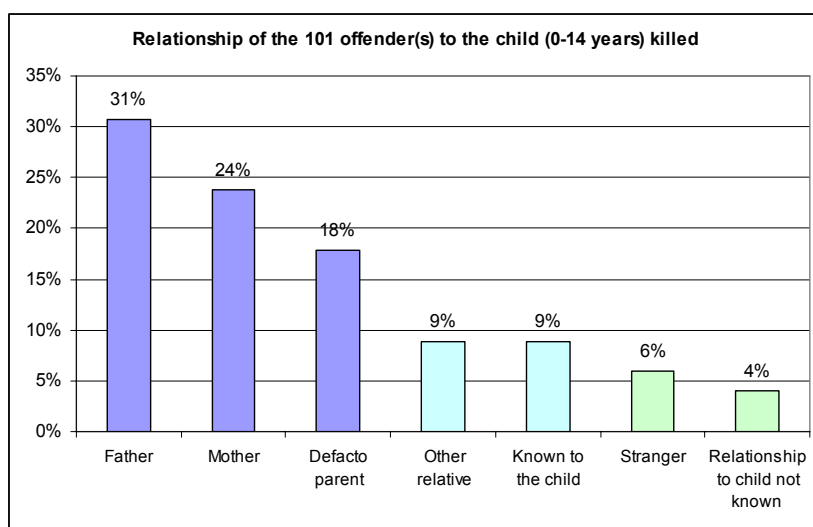
¹⁶ The proportion of children killed by family members in the UK is slightly lower, with 71% of children killed by family members (Wilczynski 1997, cited in UNICEF 2003).

¹⁷ Doolan 2004.

¹⁸ Doolan (2004) found that fathers were perpetrators in 54% of the deaths where a parent was the perpetrator. Mothers were the perpetrators in 40% of these cases, and both parents in 6% of these cases. These proportions differ slightly from an Australian review of children killed by their parents or stepparents (including de facto parents), which found the majority of perpetrators were fathers or stepfathers (67%) and the minority were mothers or stepmothers (37%), but this could reflect different population sizes. (Mouszos and Rushforth 2003.)

children were killed by two perpetrators, usually a mother and father-figure, and both are counted in figure 5.)

Figure 5: Relationship of perpetrator to child (aged 0–14) killed, New Zealand 1991–2000¹⁹



Children living in households with an adult unrelated to them were almost 50 times as likely to die of an inflicted injury as children living in households with two biological parents.²⁰

Parents who are co-habiting are more likely to commit child homicide than married parents.²¹ Stepchildren are at greater risk of being killed than other children, even after controlling for other factors.²² For example, a US study found that children aged under five years were 8.5 times more likely to be killed by a stepfather than a biological father.²³ Other research shows that children are less likely to be killed by their biological father as they grow older.²⁴

Māori children are more exposed to the risk of fatal child maltreatment associated with having a stepparent, as Māori children are twice as likely as New Zealand European and other children to be raised in a blended family.²⁵ As noted already, the small numbers and volatility for child death statistics means even more caution is needed when disaggregating the data by ethnic groups. With this additional caution in mind, in the five years from 1999 to 2003, Māori children died from maltreatment at an average annual rate of 1.5 per 100,000 children. Over the same period, New Zealand European and other children died at an average annual rate of 0.7 per 100,000 children.

¹⁹ Doolan 2004.

²⁰ Schnitzer and Ewigman 2005.

²¹ Daly and Wilson 1988, Strang 1995, cited in Cavanagh et al 2005.

²² Wilson et al 1995, UNICEF 2003.

²³ 60 vs 7 children killed per million per annum. (Methods of filicide: stepparents and genetic parents kill differently. Violence and Victims, Volume 19, Number 1, February 2001.) This study also found while the majority of children were killed from being beaten or bludgeoned to death, biological fathers were more likely than stepfathers to asphyxiate or shoot their children: methods which produce relatively quick and painless deaths.

²⁴ Daly and Wilson 1988, Adler and Polk 1996, as cited in Cavanagh et al 2005.

²⁵ A 1995 survey found that 14% of Māori children had been part of a blended family by the time they were aged five, compared with 7% of children of all other ethnic groups. Similarly, by the time they are 10, 22% of Māori children had been part of a blended family by age 10, compared with 12% of children of all other ethnic groups (Dharmalingam et al 2004).

Challenges in predicting which children are at risk of fatal maltreatment

The challenge for families, support services, and society more generally is that the number of children who are killed through maltreatment or neglect is small and the circumstances leading to their deaths are varied. This makes it extremely hard to predict children at risk of being killed through maltreatment or neglect. UNICEF (2003) noted that trying to predict children at risk of fatal maltreatment in advance presents almost insuperable difficulties.

As well as being rare events with varied circumstances, other challenges in understanding fatal child maltreatment arise from inconsistencies in available data, as:

- data is recorded for administrative purposes by agencies with different functions who become engaged at different stages (if at all), eg child protection agencies, hospitals, police and coroners' offices
- different agencies collect different types of data according to their function, eg some agencies deal with children up to only a certain age
- agencies use different definitions, coding protocols and levels of scrutiny, eg social workers will update case files guided by professional practice, which is a different order of data to that entered by the coroner's office following an investigation.

To add to these challenges, data definitions and coding practices can change within an agency over time. These issues become even more problematic when comparing data across countries.

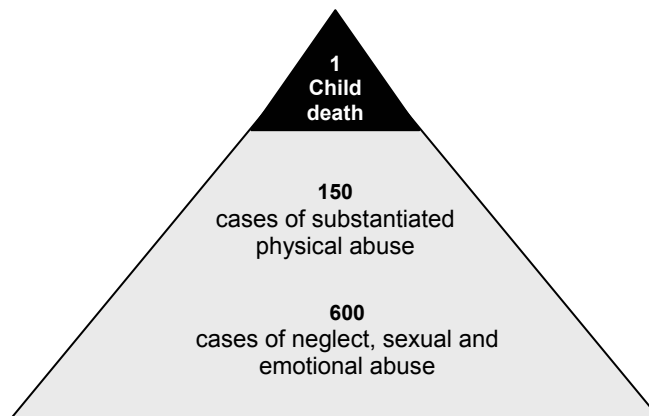
How much is known about children in part depends on which agencies had contact with them before they died. For example, a child who is admitted to hospital with intentional injuries and then dies will appear in both hospital records and police records, while other children who die from maltreatment will only appear in police records.

The numbers of children who die from maltreatment represent the "tip of the iceberg" of children who are maltreated, neglected or abused. An Australian study²⁶ found that for every child death from maltreatment there will be on average 150 substantiated cases of physical abuse, and 600 cases if neglect, and sexual and emotional abuse are included²⁷ (figure 6).

²⁶ Australian Institute of Health and Welfare 2001, cited in UNICEF 2003.

²⁷ In the UNICEF (2003) report, estimates from different countries (using different measures) were given that for every one child death from maltreatment there will be anywhere from 300 cases of substantiated abuse (from the French study *Rapport au parlement sur l'enfance maltraitee*, 2000) and 1,000 cases of substantiated abuse (from the Canadian study, Trocme et al 2001, cited in UNICEF 2003). The ratio is substantially higher if reported rather than substantiated abuse is used, eg a 1996 US study found that the 1,400 child deaths from maltreatment represented less than 0.5% of the over 3 million cases of non-fatal child abuse and neglect reported to state child protection agencies (Paxson et al 1999, cited in UNICEF 2003).

Figure 6: Australian estimates of abuse relative to one child death from maltreatment

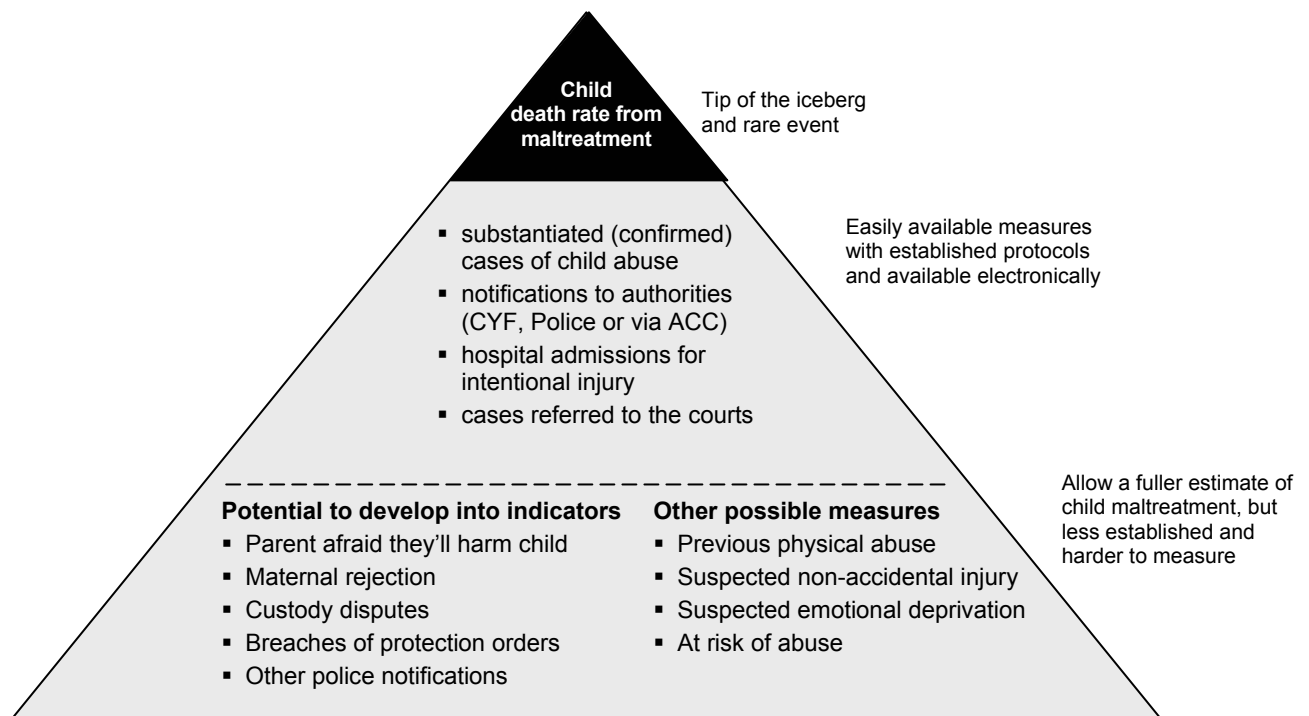


Adapted from UNICEF 2003

To help understand what lies below the “tip” of the iceberg, other measures of child maltreatment are needed. Three readily available measures that get below the “tip” are notifications to CYF, admissions to hospital for intentional injury, and court referrals for cases of child abuse and neglect. As well as being relatively easy to collect and analyse, these indicators have established definitions and recording protocols.

Reviews have suggested a range of other indicators that could, when more developed and accessible, provide a fuller understanding of child maltreatment and neglect. Figure 7 shows the range of child maltreatment indicators, noting their quality and availability.²⁸

Figure 7: Measuring below the “tip” of the iceberg – indicators of child maltreatment



The following section looks at two of the available measures: hospital admissions for intentional injury and notifications to CYF. (The number of convictions for assault on a child and cruelty to a child are given in appendix 1.)

²⁸ Altmore 1984, cited in unpublished report, MSD 2006.

Hospital admissions for intentional injury, children aged under five

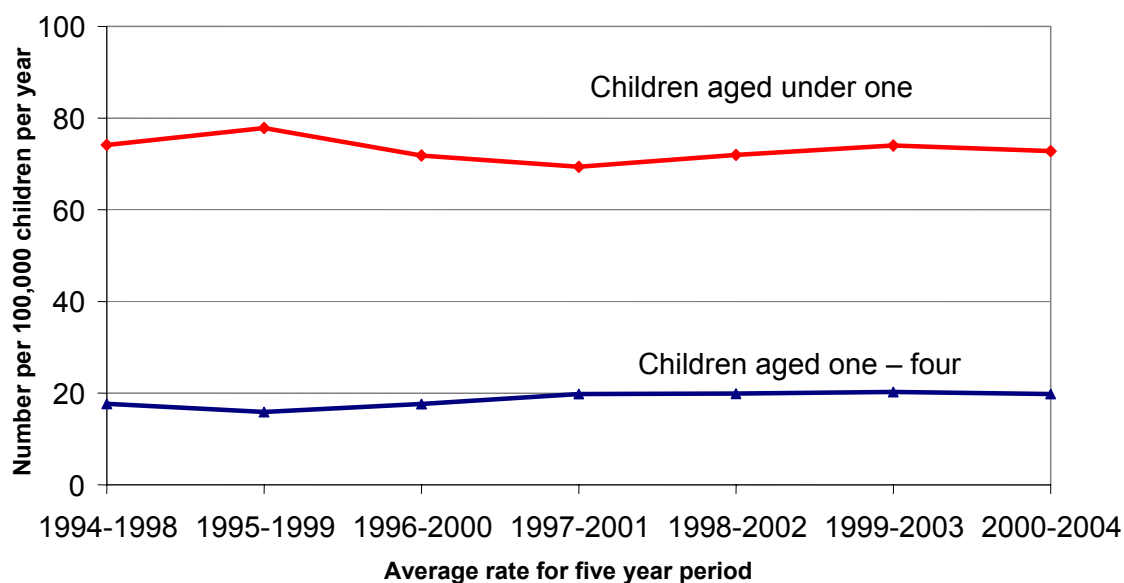
Hospital admissions for intentional injury are another source of information on trends in child maltreatment.

In the five years to 2004, there were 426 hospital admissions for intentional injury involving children under five.²⁹ On a population basis, this represents an average of 30 admissions per 100,000 children in that age group each year.

Figure 8 shows a five-year moving average of the rates of hospital admissions for children aged under one and 1–4 years between 1994 and 2004. These data show no discernable pattern of increase or decline in rates for the two groups, but show a consistently higher rate for the younger group.

Children aged under one year are around four times more likely to be admitted to hospital with intentional injuries than children aged from 1–4 years. In the five years to 2004, the average annual rate of hospital admission for intentional injuries for children aged under one year was 73 per 100,000 children in this age group, compared with 20 per 100,000 children aged 1–4 years.

Figure 8: Annual average number of hospital admissions for intentional injury per 100,000 children, five-year moving average 1994–2004

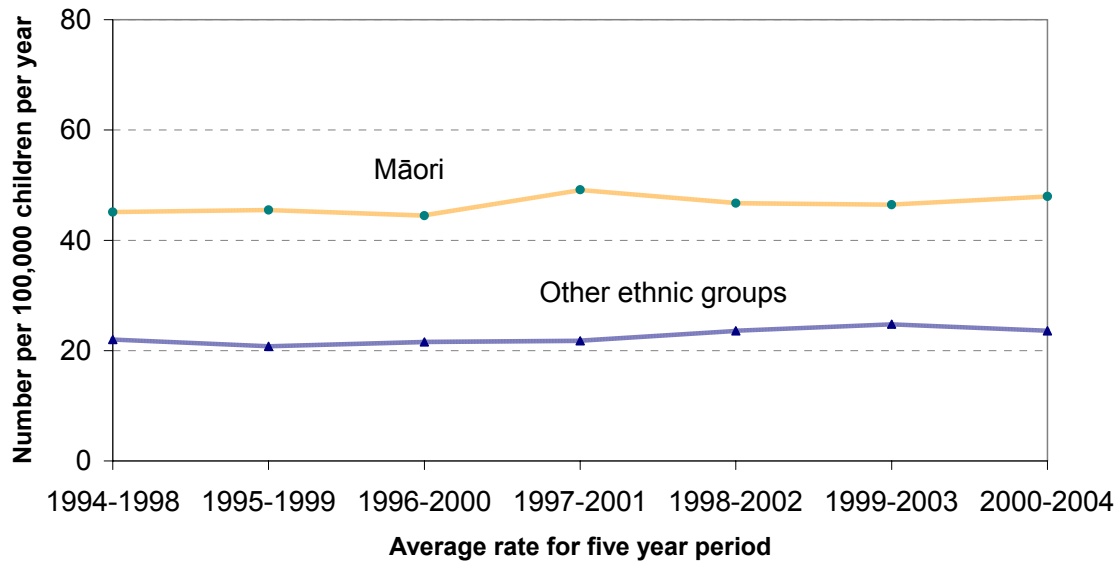


Source: Ministry of Health, Public Health intelligence (excluding admissions that occur on or before the discharge date for a preceding admission); Statistics New Zealand, mean resident population estimates for years ended December.

²⁹ Ministry of Health, Public Health Intelligence data analysed by the Ministry of Social Development. This count excludes admissions that occur on or before the discharge date for a preceding admission for a given child.

Figure 9 shows the average rate of hospital admissions for Māori and children from other ethnic groups aged under five between 1994 and 2004. Throughout this period, the rate of hospital admissions for intentional injury for Māori children under five has consistently been around twice the rate for children from other ethnic groups.

Figure 9: Annual average number of hospital admissions for intentional injury per 100,000 children, five-year moving average 1994–2004, Māori and other ethnic groups



Sources: Ministry of Health, Public Health intelligence (excluding admissions that occur on or before the discharge date for a preceding admission); Statistics New Zealand, mean resident population estimates for years ended December (non-Maori population obtained by subtraction).

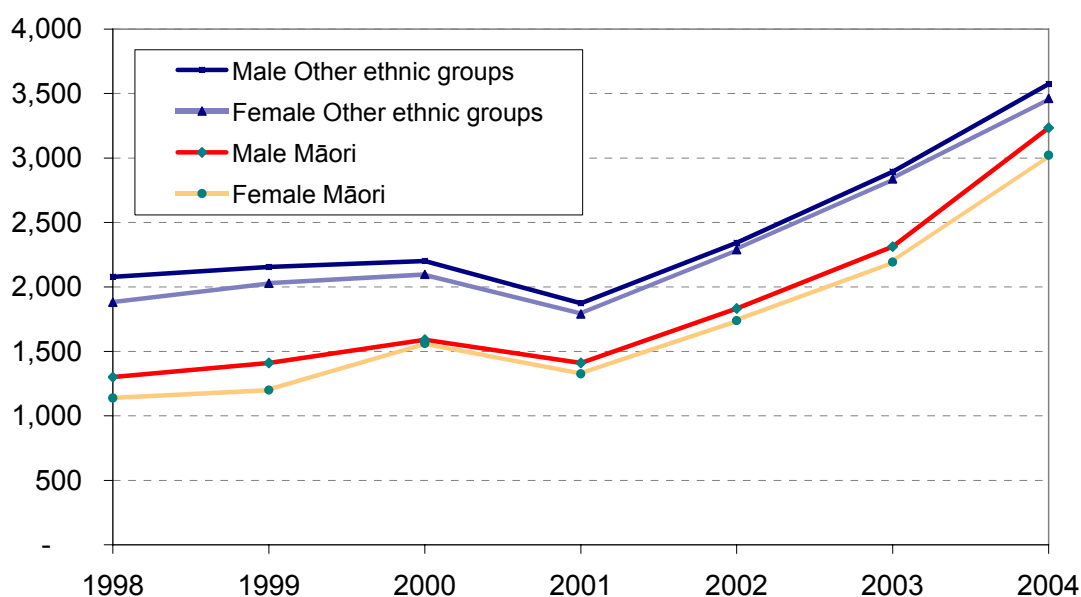
Child, Youth and Family notifications

As seen in the previous section, the rate of hospital admissions for intentional injury for children aged under five has remained relatively static over the 10-year period to 2004. During this period, the rate of CYF notifications has increased substantially. However, it is important to note that these increases do not necessarily reflect real increases in the numbers of children being abused.³⁰ It more likely reflects a change in notifier behaviour, an increased willingness for families and health, welfare and protection services to make referrals to statutory child protection systems, and limited access to more appropriate referral opportunities.

Figures 10 and 11 show the number and rates of notifications to CYF for children aged under five for the period 1998–2004. When looking at this data, it is important to note that notifications are not the same as substantiated abuse, and CYF may receive multiple notifications for one child.

As figure 10 shows, from 2000 to 2001, there was a slight dip in the number of notifications to CYF for children aged under five, but the number of notifications has risen steeply and steadily since 2001.

Figure 10: Number of CYF notifications for children under five, calendar years 1998–2004



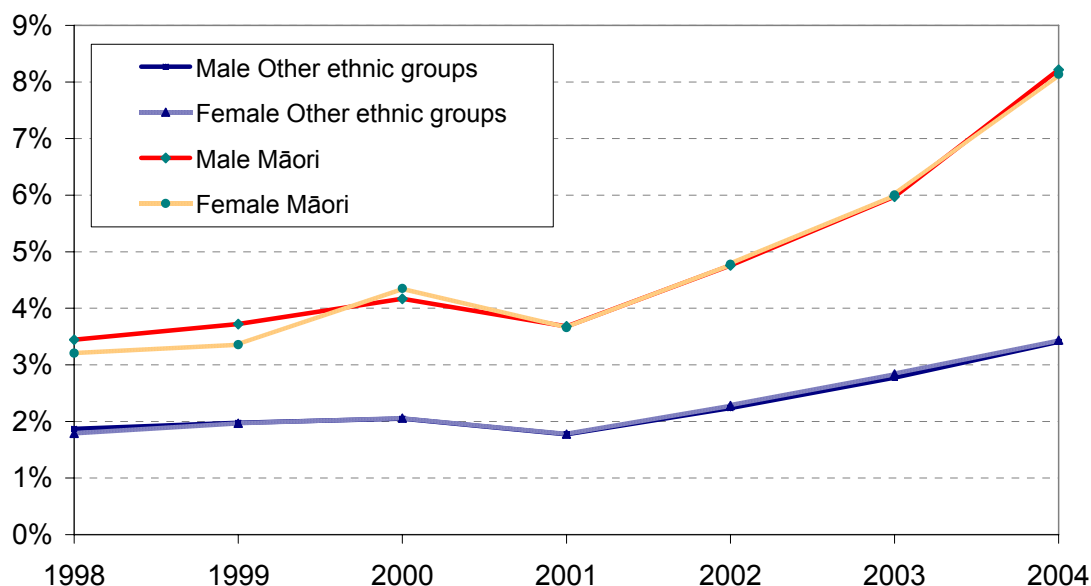
Source: CYRAS notifications data. Excludes notifications where age and/or gender is unknown. There can be more than one notification in respect of a given child.

³⁰ Connolly 2004.

Figure 11 shows that using a rate (to adjust for different population sizes) removes any notable differences between notifications for boys and girls.

The rate of CYF notifications for Māori children aged under five has almost doubled since 2001 – from just under 4% of all children in this group to nearly 8% by 2004.

Figure 11: Rate of CYF notifications for all children under five, calendar years 1998–2004



Sources: CYRAS notifications data; Statistics New Zealand, mean resident population estimates for years ended December (non-Maori population obtained by subtraction). Excludes notifications where age and/or gender is unknown. There can be more than one notification in respect of a given child.

How many victims of child homicide had previous contact with CYF?

Doolan (2004) found that over the period 1996–2000 only 20%³¹ of families where a child homicide occurred had contact with CYF prior to the child’s death. An Australian study estimated one in four families where child homicides occurred had prior contact with child protection authorities, a rate similar to that observed in New Zealand.³² Doolan notes that other countries report much higher rates of prior contact (eg 80% in the US³³), but this may reflect different definitions of what constitutes a “child protection service”.³⁴

A total of 15 reports had been made to CYF regarding the nine children who died from maltreatment between 1996 and 2000 and whose families had been in contact with CYF. Of these 15 reports, 12 had been made by professionals or helping agencies, and three by family members.³⁵

³¹ Nine out of 47 families.

³² Armytage and Reeves 1992, cited in Doolan 2005.

³³ Pecora et al 1992, cited in Doolan 2005.

³⁴ Doolan 2005.

³⁵ Doolan 2005.

How can at-risk children be identified?

The low numbers and varied circumstances of fatal child maltreatment imply that trying to predict children at risk of fatal maltreatment in advance is extremely difficult.

CYF operates a “Risk Estimation System”, where social workers assess the risk of future abuse once abuse has been substantiated. However, only 20% of children who died from fatal maltreatment had been in previous contact with CYF.

Other indicators of increased risk for children – such as hospital admissions for intentional injury – also have low numbers and rates. In 2004, there were 426 hospital admissions for intentional injury involving children under five. On a population basis, this represents an average of 30 admissions per 100,000 children in that age group each year.³⁶

As well as challenges caused by low numbers and rates, limited data is available on children simply because they are young and have had less time to come into contact with agencies. This is particularly the case for those children most at risk of death from maltreatment – those who are killed before they turn one.

To better understand the risk factors for children, the following section looks at the pathways and precursors to fatal child maltreatment. This analysis is used to identify perpetrator-related factors that can be associated with an increased risk of fatal child maltreatment. Factors associated with increased risks – for both perpetrators and children – are then summarised, followed by a discussion on how these could be developed into potential indicators of elevated risk.

³⁶ Ministry of Health, Public Health Intelligence data analysed by the Ministry of Social Development. This count excludes admissions that occur on or before the discharge date for a preceding admission for a given child.

Pathways and precursors to fatal child maltreatment

Child death from maltreatment occurs predominantly in the context of poverty,³⁷ psychological stress and limited support.³⁸ Common factors, identified in the literature, associated with an increased risk of fatal child maltreatment are:

- being poor
- having low education and being unemployed
- being young
- having poor mental health, including alcohol or drug abuse
- being the victim of family violence as a child
- having a history of offending, and early offending.

These factors are discussed below in turn, but it is important to note that they overlap, mutually reinforce and accumulate. For example, low educational attainment reduces employment opportunity, which contributes to poverty, and poverty is associated with drug and alcohol abuse, which in turn is associated with poor mental health.

Being poor

While noting that the wilful murder of children spans the economic spectrum,³⁹ children who live in poor families have a higher risk of fatal child maltreatment.⁴⁰ One study found that all the children aged under five who died from fatal maltreatment were poor.⁴¹

UNICEF's cross-nation study found that, while ethnic minorities often have higher levels of child maltreatment, "... it seems likely that the operative factor is not ethnicity but poverty (which disproportionately affects ethnic minority families)".⁴²

Low education and unemployment

Adults who kill children are typically undereducated and regularly unemployed.^{43,44}

Being young

Young people are more likely to be both perpetrators and victims of crime generally.⁴⁵ Perpetrators of fatal child maltreatment tend to be young in age (ie in their 20s).⁴⁶ Becoming a parent at a young age increases the risk of fatal child maltreatment.⁴⁷

³⁷ This may also reflect the fact that poorer families are also more likely to come into contact with health and welfare services, so face higher chances of abuse being identified (UNICEF 2003).

³⁸ UNICEF 2003, Staton et al 2000.

³⁹ Nixon et al 1981, cited in Fiala and LaFree 1988.

⁴⁰ UNICEF 2003: US rates of children harmed as a result of physical maltreatment by a parent or caregiver per 1,000 children by family income in 1993: 11.0 per 1,000 children for family incomes under US\$15,000, 5.0 per 1,000 children for family incomes US\$15,000–29,000 and 0.7 per 1,000 children for family incomes US\$30,000 or more.

⁴¹ Nixon et al 1981, cited in Fiala and LaFree 1988.

⁴² UNICEF 2003.

⁴³ Campion et al 1988, Goetting 1988, Schloesser et al 1992, Marleau et al 1999, Adinkrah 2003, as cited in Cavanagh et al 2005.

⁴⁴ Strang 1996, cited in Fiala and LaFree 1988.

⁴⁵ New Zealand National Survey of Crime, 1996, British Crime Survey, 1996, Graham J and Bowling B, 1995. Young People and Crime, Home Office Research Study 145.

⁴⁶ Strang 1995, Alder and Poly 1996, as cited in Cavanagh et al.

⁴⁷ UNICEF 2003.

For women, childbearing at an early age is strongly associated with infant homicide. The strongest risk factors are a maternal age of less than 17 years, a second or subsequent birth for a mother 19 years or younger and no pre-natal care. Early childbearing with large numbers of closely spaced children is also a risk factor for non-fatal child abuse. Compared to mothers aged over 25 years, mothers were 11 times more likely to kill their children if aged under 17 years, and nine times more likely if aged between 17 and 19 years.⁴⁸

Children born to poor mothers are also more likely to have low birth weights (as a result of poorer nutrition and increased likelihood of smoking during pregnancy: both associated with poverty).⁴⁹

Young parents are more likely to be poor, lack support and resources, and have come from a background of family adversity.⁵⁰ Young parents are therefore more likely to experience high environmental stress and have few resources to draw on, including knowledge on child behaviour and good parenting. The fatal combination of these factors is illustrated in UK research, which found that child deaths within the family often occurred when a young crying child was left in the temporary care of a father or stepfather, and the primary intention was to “silence” the victim.⁵¹

The relationship between family violence and fatal child maltreatment is discussed below. Worth noting here is the Dunedin study findings that women who became mothers at a young age (before 21) were twice as likely to have been victims of family violence than those without children at this age. (See appendix 1, figure 16.) Men who fathered children by 21 were more than three times as likely to be perpetrators of partner abuse as men who were not fathers by age 21, and the most violent relationships occurred among young parents.⁵² (See appendix 1, figure 17.)

Poor mental health, including alcohol or drug abuse

Poor mental health, including substance abuse, has been identified as a factor associated with a higher risk of child maltreatment and neglect.^{53,54,55} For example, in an American survey of child welfare professionals, the majority (80%) said substance abuse caused or contributed to at least half of all cases of child maltreatment.⁵⁶ Other research has concluded that substance abuse triples the risk of maltreatment.⁵⁷

A UK study found that over half the perpetrators who killed children had, as children themselves, a history of abusing alcohol, and just under a third used drugs as children. About 40% were chronic alcohol abusers as adults. Chronic drug abuse was a feature for a third of those who killed children within the family and a quarter of those who killed outside the family.⁵⁸ (See appendix 1, figure 20.) The same study found that about a third (31%) of men who killed within the family had been drinking prior to the murder, as had 43% of men who killed outside the family. About a quarter in both groups had been consuming drugs.

⁴⁸ Overpick et al 1998, UNICEF, 2003.

⁴⁹ Overpick et al 1998: low birth weight is an infant characteristic associated with a increased risk of fatal child maltreatment.

⁵⁰ Salmond et al 1998b, Fergusson et al 1998, cited in Howden-Chapman and Tobias 2000.

⁵¹ Cavanagh et al 2005.

⁵² Moffitt and Caspi 1999.

⁵³ Falkov 1996, Stroud 1997, Reder and Duncan 1999, cited in Cavanagh et al 2005; UNICEF 2003.

⁵⁴ Lewis and Bunce 2003.

⁵⁵ UNICEF 2003.

⁵⁶ Peddle and Wang 2001, cited in UNICEF 2003.

⁵⁷ Guterman 2001, cited in UNICEF 2003.

⁵⁸ Cavanagh et al 2005.

Family violence

Some children killed within families had been seriously abused by the perpetrator prior to their death.⁵⁹ Ongoing violence to an intimate partner at the time of the murder was reported in over two-thirds of the family killings; in over three-quarters of these cases, previous violence to the victim was also reported.⁶⁰

Children are more likely to be abused in homes where partner abuse occurs.^{61,62} Surveys from industrialised countries show that 40% to 70% of men who use violence against their partners also physically abuse their children and about half of women who are physically abused by their partners also abuse their children.^{63,64}

Family violence increases the likelihood of mental illness. For example, the Christchurch Health and Development Study found that exposure to family violence was significantly related to increased risk of depression at age 25, after controlling for other factors.⁶⁵ And poor mental health⁶⁶ and alcohol and drug problems, in turn, are associated with a higher risk of early childhood neglect or violence.⁶⁷ A summary of the strategies aimed at reducing family violence in New Zealand can be found in appendix 2.

History of offending, and early offending

A UK study found 80% of all men who killed children – either inside or outside the family – had at least one conviction prior to the murder, and over half the men in both groups had at least five previous convictions – although the proportion was higher for men who killed outside the family (see appendix 1, figure 24.) Men who killed children outside the family were more likely to have been convicted before the age of 13, and have had more contact with psychiatric or psychological services, probation and social services – mainly due to their problems at school and violent and offending behaviour⁶⁸ (see appendix 1, figure 25).

Risks of being violent also increase for perpetrators with problems with alcohol and/or drug abuse or a history of offending.⁶⁹ For example, in the Dunedin study, over a third (38%) of males with any conviction and more than half convicted of a violent crime (51%) also physically abused their partners⁷⁰ (see appendix, figures 18 and 19).

Over a third of men who killed children within the family had spent time in prison, as had over half the men who killed children outside the family.⁷¹

⁵⁹Greenland 1987, Bourget and Bradford 1990, Crittenden and Craig 1990, Somander and Rammer 1991, Reder et al 1993, Strang 1995, Vanamo et al 2001, Lyman et al 2003, cited in Cavanagh et al 2005; Trocme et al 2001; Finkelhor 1997, cited in UNICEF 2003.

⁶⁰ Alder and Polk 2003, Adinkrah 2003.

⁶¹ Ministry of Health 1998.

⁶² Different studies found different levels lower estimates were that child abuse occurred in 30% of the cases where women were also abused, and upper estimates were that child abuse occurred in 70% of the cases where women were also abused. Edelson 1999, cited in UNICEF 2003; Robertson and Busch 1994, cited in Hughes 2004.

⁶³ Tajima 2002, cited in UNICEF 2003.

⁶⁴ Fanslow 2002, Robertson and Busch 1994, cited in Hughes 2004.

⁶⁵ Ferguson et al 2005.

⁶⁶ For example psychiatric illnesses, such as maternal depression, post-partum psychosis and personality disorders.

⁶⁷ Goodman and Brumley 1990, Klein 1997, cited in Jost 2004.

⁶⁸ Cavanagh et al 2005.

⁶⁹ Wallace 1986, Somander and Rammer 1991, Alder and Polk 1996, Donnelly et al 2001, Lucas et al 2002, cited in Cavanagh et al 2005

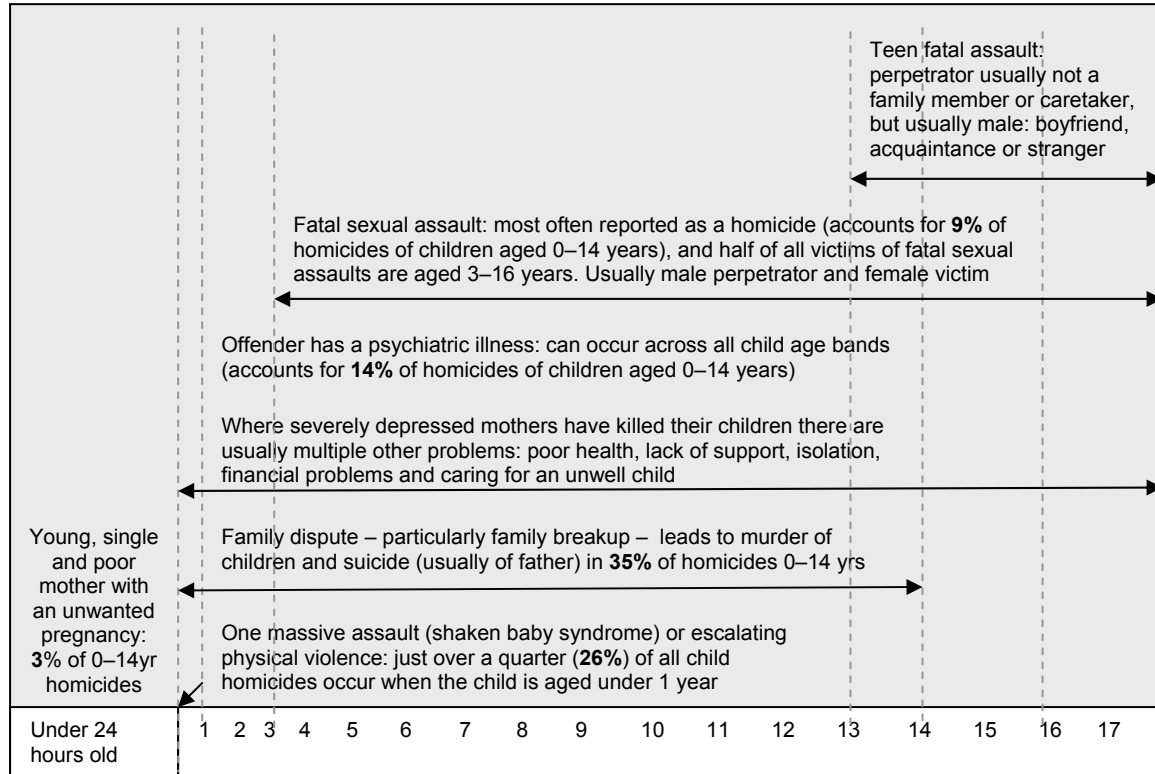
⁷⁰ Moffitt and Caspi 1999.

⁷¹ Cavanagh et al 2005.

Typology of child death from maltreatment

Figure 12 takes the data from the Australian review of 316 children killed over the 10 years to 1999 to create a “typology” of child fatal assaults by the age of the child killed. The figure also gives the relative proportion of children killed during this period by the age of child and the circumstances surrounding the child’s death.⁷²

Figure 12: Typology of child fatal assaults from the Australian review of 316 children killed over the 10 years to 1999



Five “pathways or precursors” to child death from maltreatment emerge from Lawrence’s (2004) work and other studies. They are:

- killing of newborn and very young babies
- children killed by a parent who is severely mentally ill
- murder-suicide in the context of a parent’s relationship ending
- fatal sexual assault
- teenagers who are killed by their boyfriends, friends, acquaintances or strangers.

Newborn and very young babies

When newborn babies are killed by their mother, it is likely that their deaths result from a process of “denial and dissociation”,⁷³ the mothers (usually young, unmarried and poorly educated) having concealed or not acknowledged their pregnancy.⁷⁴

⁷² Lawrence 2004.

⁷³ Stanton et al 2000.

⁷⁴ Resnick 1970, cited in Stanton et al 2000; Lawrence 2004.

Children killed by a parent who is severely mentally ill

Psychotically motivated child abuse differs from child abuse associated with accumulated family adversity. When children are killed from maltreatment, there is “not a clear impulse to kill” and the child’s death was “unexpected and undesired”.⁷⁵

Women who killed in the context of a major mental illness were older, more often married and had a lower level of psychosocial stress than those who killed in the context of accumulated family adversity.⁷⁶ These mothers often felt that killing their child(ren) was an act of saving or protecting them.⁷⁷

For example, Pritchard’s (2001) small study of women who killed their children found common themes of depression, suicidal thinking and previous suicide attempts, over-identification with the child or children, “saving” the child from a dangerous situation or a life of chronic illness.⁷⁸

A qualitative study of mentally ill mothers who killed their children found that those who were psychotic had experienced an abrupt change in their illness prior to the killing, and would have been “unable to identify their filicidal impulses before the event even if asked by a clinician with whom they would share such a thought”. In contrast, depressed women had contemplated killing their children over a longer period of time.⁷⁹

Children killed in psychotically motivated child abuse were older than those killed through maltreatment. The method used to kill was often more violent, and often more than one child would be killed.⁸⁰

In a UK study of 29 fathers who killed their children under the age of five, none had a major mental disorder, but many had a personality disorder and high environmental stresses. The child killed was often seen as a threat, ascribed malevolent characteristics or regarded as acting (or not acting) wilfully.⁸¹

Murder-suicide in the context of a parent’s relationship ending

A UK study found that, in a third of the cases where a parent killed their child(ren) and then themselves, there was no evidence of previous abuse of the children, and the deaths were committed in response to the threat of the relationship ending.⁸²

A similar pattern was found in Australia. Family disputes – particularly family breakups – were found to lead to murder of children followed by the parent’s suicide in just over a third (35%) of the 316 child homicides (0–14 years) in Australia between 1989 and 1999.⁸³

In another Australian review, of the 24 cases of murder-suicide in Australia between 1973 and 1992 where the victims were children of the offender, half were killed by their mothers and half by their fathers. Other studies found perpetrators in murder-suicides were more likely to be fathers.⁸⁴

⁷⁵ UNICEF 2003; d’Orban 1979, Steel 1987, cited in Stanton et al 2000.

⁷⁶ Cheung 1986, d’Orban 1979, cited in Stanton 2000.

⁷⁷ Resnick 1969, McGrath 1992, cited in Stanton 2000.

⁷⁸ Pritchard 2001.

⁷⁹ Stanton and Simpson 2000:1458.

⁸⁰ d’Orban 1979, Lewis et al, cited in Stanton 2000.

⁸¹ Scott 1973, cited in Stanton and Simpson 2002.

⁸² Cavanagh et al 2005.

⁸³ Lawrence 2004.

⁸⁴ Somander and Rammer 1991, cited in Stanton and Simpson 2002.

In most cases, the males killed their children after a marriage had ended, and jealousy, possessiveness and a sense that the children were being taken away were themes.⁸⁵ One study also found male perpetrators in murder-suicides had histories of offending and alcohol abuse.⁸⁶

A review of almost 100 child deaths in Sweden found more than half involved a mother or father killing their child before committing suicide. Similar studies from other countries found the majority of parents who kill their children were severely mentally disturbed.⁸⁷

A study that calculated the odds of suicide following different kinds of homicide found those involving the perpetrator's children raised the odds of suicide nearly 10 times, compared with nearly five times for an ex-spouse and three times for a current spouse.⁸⁸

Fatal sexual assault

Lawrence (2004) found that in Australia half of all victims of fatal sexual assaults were aged 3–16 years, and the perpetrator was usually male and the victim female. Fatal sexual assault accounted for 9% of child homicides (aged 0–14) in Australia over the 10 years to 1999.

A UK study⁸⁹ found that one-fifth (20%) of murders within the family involved sexual contact, while four-fifths (78%) of those outside the family had sexual contact.

In addition to the aspects of family adversity already discussed, men who murdered children outside the family were more likely to have been sexually abused as children and have convictions for sexual and/or serious assault.

A third of men who murdered outside the family had at least one prior conviction for sexual assault and a quarter of these men had admitted to being sexually abused themselves as children (see appendix 1, figure 21.) A third had a history of violence to others starting in childhood: they were more likely to have been convicted before the age of 13, and have had more contact with psychiatric or psychological services, probation and social services – mainly due to their problems at school and violent and offending behaviour.⁹⁰ (See appendix, figures 24 and 25.)

Teenagers who are killed by their boyfriends, friends, acquaintances or strangers

The rate of maltreatment deaths is much lower for teenagers than younger children, which reflects their increased ability to seek help, escape or defend themselves. Teenagers – with their greater mobility and broader social contexts – are more likely than younger children to be killed by their boyfriends, friends, acquaintances or strangers.

There are relatively small numbers of teenage deaths from maltreatment, and the circumstances are varied. The literature also tends to focus on deaths of younger children. However, it seems likely that teenagers killed by strangers are likely to be fatal sexual assaults or possibly gang related. Deaths where the perpetrator is a boyfriend may reflect a history of partner violence or killing in response to a dispute or a relationship breakup.

⁸⁵ Pritchard 2001.

⁸⁶ Somander and Rammer 1991, cited in Stanton and Simson 2002.

⁸⁷ Somander and Rammer 1991; Trocme and Lindsay 1996, cited in UNICEF 2003.

⁸⁸ Carcach and Grabosky 1998, cited in Pritchard 2001.

⁸⁹ Cavanagh et al 2005.

⁹⁰ Cavanagh et al 2005.

Factors associated with an increased risk of fatal child maltreatment

As seen in the previous section, the literature on child death from maltreatment varies in focus. Some studies look only at the children who died from maltreatment, while others look at the perpetrators, or both. Some perpetrator-focused studies look only at mothers, while others focus only on men. Some studies take a psychological approach to understanding perpetrator behaviour, while others consider broader socio-economic factors. Some cover large populations over long periods, while others are small scale and qualitative.

With all these variations in mind, a broad range of literature was reviewed. While noting child maltreatment deaths are rare events with varied circumstances, some common themes emerged from the literature. Figure 13 shows factors associated with an increased risk of fatal child maltreatment within the family context and child homicides outside the family context (often sexually motivated). Figure 14 then shows how perpetrators' risk factors accumulate from childhood to adulthood. The role of individual and family resilience, access to timely, quality interventions, and economic and life opportunities in reducing or removing risk is noted, but not discussed in depth.

Figure 13: Factors associated with increased risk of child death from maltreatment

Caveats: This table summarises common factors emerging from the literature (see appendix 1) that increase the risk of an adult killing a child, and of children being killed, but the literature also provides a caution on how these factors are interpreted, noting that:

- many people with one or many of these factors will never harm children
- individual and family resilience, access to timely, quality interventions and economic and life opportunities may reduce or remove risks
- the most useful guide to risk is not the presence or relative weight of individual factors, but the accumulation of factors
- the factors overlap and interact, and the pathways to abuse are complex and varied.

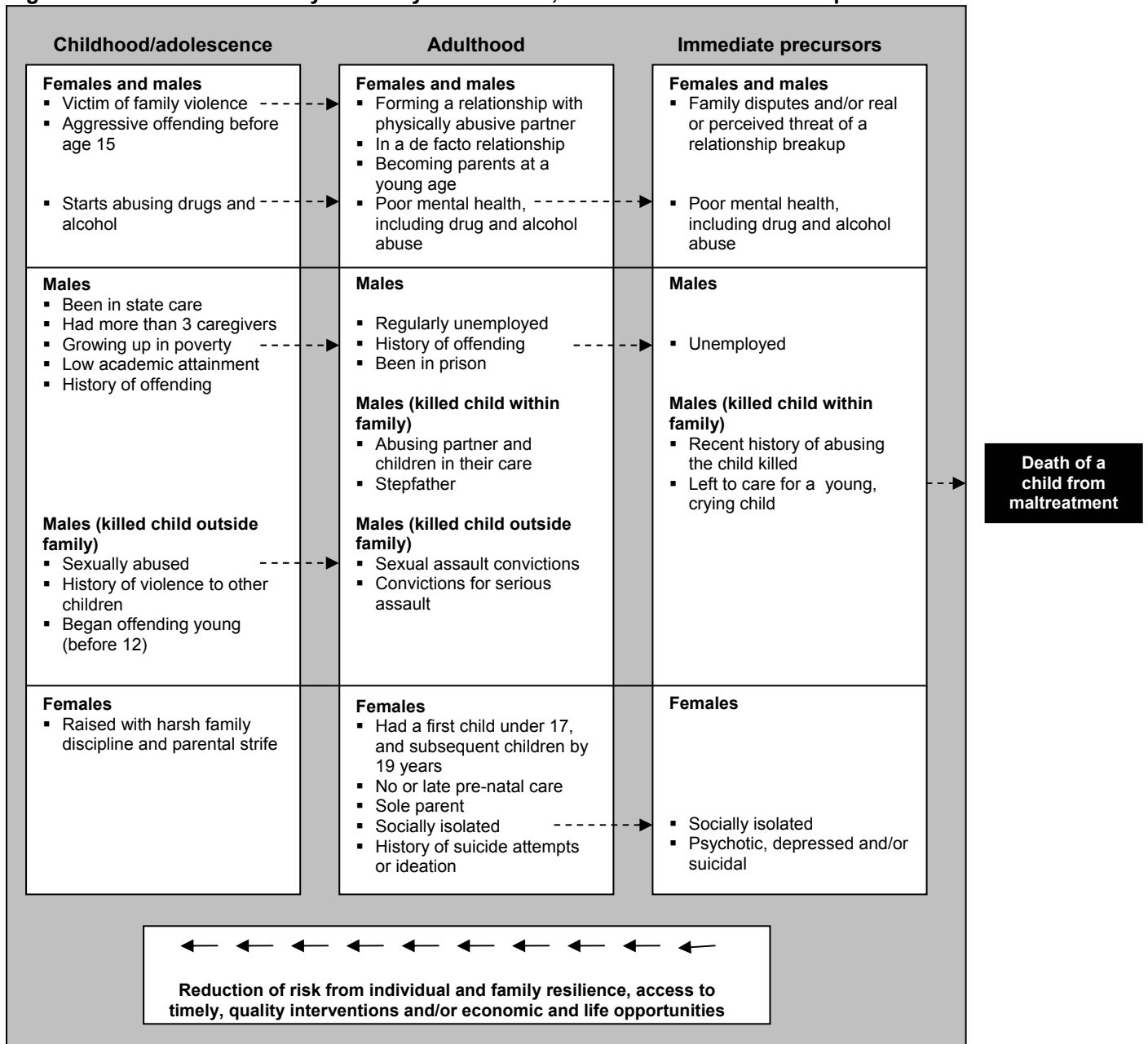
Perpetrator characteristics associated with an increased risk of fatal child maltreatment

Perpetrator inside family		Perpetrator outside family
Women	Men who killed within the family	Men who killed outside the family
<ul style="list-style-type: none"> ▪ Poor ▪ Low education ▪ Young ▪ Poor mental health, including alcohol or drug abuse ▪ Victim of family violence as a child ▪ Early offending 		
<ul style="list-style-type: none"> ▪ Had children young (under 17), and in quick succession ▪ Did not access pre-natal care, or did so late in the pregnancy ▪ Sole parent ▪ Socially isolated ▪ Victim of family violence as an adult ▪ Raised with harsh family discipline and parental strife ▪ History of suicide attempts or suicidal ideation 	<ul style="list-style-type: none"> ▪ Regularly unemployed ▪ Unemployed at time of killing ▪ Had been in state care ▪ Had more than three caregivers growing up ▪ Started using alcohol and drugs as a child ▪ History of offending as a child ▪ History of offending as an adult 	<ul style="list-style-type: none"> ▪ Single at the time of killing ▪ History of violence to other children as a child ▪ Began offending young (before 12) ▪ Sexually abused as a child ▪ Convictions for serious and/or sexual assault
<p><i>Events occurring in the perpetrator's life prior to a child's death</i></p>		
<ul style="list-style-type: none"> ▪ Drinking or using drugs just before killing the child 		
<ul style="list-style-type: none"> ▪ Relationship ending or fearing a relationship is ending 		
<ul style="list-style-type: none"> ▪ Depressed ▪ Psychotic ▪ Suicidal 	<ul style="list-style-type: none"> ▪ Left to care for a young crying child 	

Accumulation of risk factors

Figure 14 shows how perpetrators' risk factors accumulate from childhood to adulthood. As with figure 13, figure 14 comes with important caveats: many people with one or many of these factors will never harm children, and adversity in childhood does not necessarily transfer into adulthood. Individual and family resilience can reduce the impact or transfer of family adversity, as can timely access to quality interventions, and the presence of life or economic opportunities (eg entering a healthy relationship, having a good job).

Figure 14: Accumulated family adversity – childhood, adulthood and immediate precursors



Factors associated with increased risk of child death from maltreatment can start to accumulate from childhood, and then continue into adulthood – but not always. As noted earlier, individual and family resilience can reduce the impact or transfer of family adversity, as can timely access to quality interventions and the presence of life or economic opportunities (eg entering a healthy relationship, having a good job). It would be a misuse of this analysis to stigmatise particular groups of people. The intention here is to seek better understanding of early indicators that could signal activation of timely interventions. This type of life course analysis creates greater opportunities to intervene early and therefore impact on the accumulation of these risk factors over time.

Family violence offers an example of how factors can transfer from childhood to adulthood, and then be repeated into the next generation. For example, the Dunedin study found that young people who became involved in violent relationships were more likely to have come from backgrounds marked with family adversity, low educational attainment and crime. And these problems often continued into adulthood.

As the factors accumulate, they can mutually reinforce. For example, the Dunedin study also found that partner violence was most likely to occur alongside other problems: for male perpetrators, this included long-term unemployment, mental illness, drug abuse and violence to people outside the family.⁹¹

Women in the Dunedin study who were abused by their partners were three times more likely to suffer a mental illness than non-abused women. And nearly two-thirds (65%) of women who suffered serious physical abuse had one or more mental disorders.⁹²

Experience of violence, abuse and poorer mental health directly affects sole mothers' ability to gain and maintain employment.⁹³ A range of studies have found that mentally ill mothers tend to live alone with their children and, as a result, face greater social isolation and economic problems than other mothers.^{94,95,96}

A recent US study also found that having an unrelated (usually male) adult in the household increases the risk of fatal maltreatment in sole-parent households, not sole parenthood in itself.⁹⁷

While findings from the New Zealand National Survey of Crime Victims are not stratified by family composition and benefit status, they do indicate that characteristics associated with being the victim of repeated partner violence included being female, being a sole parent and being a beneficiary. And Australian research found that close to half of sole mothers on a

⁹¹ The Dunedin study found male perpetrators of partner violence were 13 times more likely to be mentally ill than non-perpetrators (assessed using the DSM-III-R). Male perpetrators of severe physical violence had extreme polydrug abuse and antisocial personality disorders. Just over half of the male perpetrators of severe physical violence towards partners had assaulted someone else in addition to their partner in the last year on average. On average these men had been unemployed for 20 months since leaving school (Moffitt and Caspi 1999).

⁹² As did the great majority (88%) of male perpetrators (assessed using the DSM-III-R) (Moffitt and Caspi 1999).

⁹³ Bancroft 2004:73, Lloyd 1997, cited in Bancroft 2004; Levine et al 1993.

⁹⁴ Deneke 1998, Goodman and Brumley 1990, Hinze and Jost 2004, cited in Jost 2004.

⁹⁵ A small-scale study of 5 New Zealand women who killed their children found all the mothers were socially isolated except for a relationship with the father of the children – which contributed to an intense dependency (Pritchard 2001).

⁹⁶ Crimmins' (1997) study of 42 women who killed their children found that a combination of abuse, mental pathology, absence of social support and an inability to rely on others in times of need led to a woman's sense of self being too damaged for her to care about another human being (Pritchard 2001).

⁹⁷ Schnitzer and Ewigman 2005.

benefit have experienced some form of physical or sexual violence, a rate more than twice as high as that of either sole mothers in work or partnered mothers on a benefit.⁹⁸

The New Zealand National Survey of Crime Victims also found the almost half of Māori women surveyed reported that they had experienced partner violence, a rate very much higher than that for New Zealand European/European women and for Pacific women.⁹⁹

Māori women tend to have their children younger and to have more children than the average for the whole population. Māori are more likely to experience the socio-economic factors associated with increased risk of death from child maltreatment:

- sole parenthood^{100,101}
- living with a partner who is not a biological parent of some or all of their children¹⁰²
- low educational attainment¹⁰³ and limited employment opportunities^{104,105,106}
- poorer physical and mental health, making it more difficult to find and sustain work¹⁰⁷
- be poor, and on benefit.¹⁰⁸

These factors may help explain the higher rate of child maltreatment deaths for Māori. No discussion on differences in rates between Māori and non-Māori should ignore the underlying differences in socio-economic status, which are shown to be operative factors in increasing the risk of child maltreatment deaths.¹⁰⁹

The findings from the 2004 Living Standards survey¹¹⁰ also provide insight into the effect of adverse life shocks (eg marriage breakup, redundancy) and restrictions resulting from health problems. Lower living standards tend to be associated with life shocks generally, but particularly when a person has had a large number of life shocks (eight or more). While many types of life shocks do not appear to have a significant impact when they occur in

⁹⁸ Butterworth 2003.

⁹⁹ Morris et al 2003:148.

¹⁰⁰ At the 2001 Census, the percentage of mothers of dependent children who were sole mothers was 45% for Māori and 26% for the total New Zealand population of mothers.

¹⁰¹ High incarceration rates of Māori men may also contribute to high rates of sole parenthood among Māori women and represent an added layer of labour market disadvantage for Māori men who have been imprisoned in the past.

¹⁰² Dharmalingam et al 2004.

¹⁰³ Māori and Pacific peoples are overrepresented among those with educational and labour market disadvantage (Dixon 1996, Callister 1998).

¹⁰⁴ Caused by low skill and educational attainment and concentration in regions, occupations and industries with more limited labour market opportunities. Labour market discrimination may also affect their employment opportunities.

¹⁰⁵ There is a strong link between low education and skills and low pay, and between higher education and skill and higher pay (Office of the Deputy Prime Minister 2004:33). The 2001 New Zealand Census showed people with a university degree were most likely to earn over \$40,000 per annum, those with vocational qualifications \$29,000 per annum, while the majority (55%) of those with no qualifications had annual incomes of \$15,000 or less.

¹⁰⁶ Lack of qualifications and skills limit the range of jobs that can be obtained, and low-wage jobs also often have limited opportunities for skill development (Aimer 2003, Fforde 2001, Booth et al 2002, in Kellard).

¹⁰⁷ Māori and Pacific peoples are overrepresented among those with poor health outcomes. While not necessarily representative of the prevalence of mental health issues in the community, the MaGPIe study of people consulting a general practitioner found that Māori women were more than twice as likely as non-Māori women to have anxiety, depressive and substance use disorders, even after adjusting for social and material deprivation. Almost three-quarters of Māori women in the study experienced some mental health disorder (MaGPIe Research Group 2005).

¹⁰⁸ Māori are three times more likely to receive one of the four main benefits than the total population. In part, this reflects the more youthful age structure of the Māori population, as a higher proportion of Māori are in the younger age groups that form the peak years for DPB and UB receipt, in particular.

¹⁰⁹ UNICEF 2003.

¹¹⁰ Jensen et al 2006.

isolation, multiple shocks can combine to produce a large effect and substantially lower living standards when the overall burden of adversity reaches a certain level – the threshold effect.

Among those with substantially depressed living standards, income-tested beneficiary families with children are the most prominent group: nearly one in three is in “severe hardship”, with few economic advantages and a high rate of multiple adversity. Other groups with comparatively depressed living standards distributions are Māori, Pacific peoples and people with large families.¹¹¹

¹¹¹ The result for the Māori and Pacific groups partly reflects their comparatively high proportions of beneficiary families, whose low living standards pull down the overall averages for those groups.

Conclusion

This first section of the report looked at child homicide in the national and international context and identified factors from the literature that are associated with an increased risk of fatal child maltreatment – noting that many people with one or many of these factors will never harm children. Analysis of the literature was used to suggest how adversity could transfer between childhood and adulthood – noting that this does not always happen. And it is likely that it is the accumulation of factors that increases risk, rather than any one factor in isolation.

Individual and family resilience can reduce the impact or transfer of family adversity, as can timely access to quality interventions, and the presence of life or economic opportunities (eg entering a healthy relationship, having a good job).

Stopping the transfer of accumulated family adversity is now explored in Section Two of the report, with particular reference to responding to vulnerable children.

SECTION TWO: RESPONDING TO VULNERABLE CHILDREN

Developing services for children and families

The vulnerability of the younger child

The research reviewed in this report reinforces the challenges in developing indicators of risk with respect to child homicide. The numbers are small, and trying to identify children at risk of fatal child maltreatment in advance presents almost “insuperable difficulties”.¹¹²

The research does, however, indicate the particular vulnerability of the younger child. In the five years to 2003, the average annual rate of child maltreatment deaths in New Zealand for children under one was 4.6 deaths per 100,000, more than three times higher than the rate for 1–4 year olds (1.3 per 100,000), and eight times higher than the rate for 5–14 year olds (0.6 per 100,000).

Other indicators of increased risk for children, such as hospital admissions for intentional injury, also have low numbers and rates. In 2004, there were 426 hospital admissions for intentional injury involving children under five. On a population basis, this represents an average of 30 admissions per 100,000 children in that age group each year.¹¹³

While it is clearly important to seek to address all forms of child abuse and neglect, analysis of hospital admissions, child homicides and CYF data suggests that the care and safety needs of the very young child is an issue of particular concern. Children who come to the attention of CYF when they are young also tend to have longer contact with the agency, suggesting a high and ongoing level of vulnerability and risk.

Accumulated family adversity: Taking a life course perspective

Analysis of the literature shows how adversity could accumulate and transfer between childhood and adulthood. This supports taking a life course perspective in responding to the needs of vulnerable children and their families. Moving away from the “ambulance at the bottom of the cliff” approach, a life course perspective supports the building of preventative solutions that have the potential to reduce the accumulation of risk factors over time. Most families need support at one time or another. Many families call upon their own resources at these times, or seek to access universal services that are designed to respond to the adverse challenges that modern families face. Some families, however, remain isolated and struggle to manage alone.

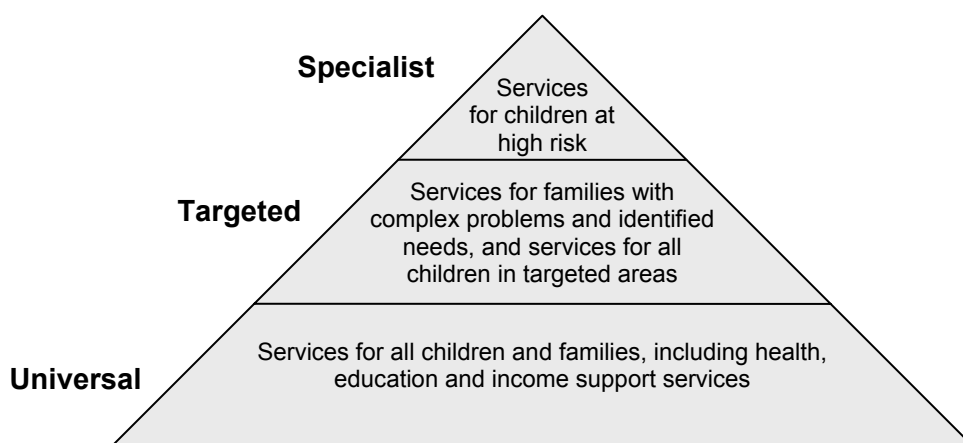
The problem with providing more ambulances

In recent years, writers have raised questions about the way in which child protection systems respond to the death of a child by homicide (Munro 2002, Scott 2006). Ferguson (2004:10) notes that “the overwhelming response by welfare states to child deaths and other system failures has been to seek bureaucratic solutions by introducing more and more laws, procedures and guidelines”. Although this has been a common response in New Zealand and Australia, it has been increasingly clear that these quick-fix solutions are doing little to solve the problem. Indeed, writers have argued that screening the population for at-risk children and undertaking more and more child abuse investigations has the potential to actually *increase* the risk of child abuse for many children by destabilising families and

¹¹² UNICEF 2003.

¹¹³ Ministry of Health, Public Health Intelligence data analysed by the Ministry of Social Development. This count excludes admissions that occur on or before the discharge date for a preceding admission for a given child.

creating an overburdened system that struggles to respond to children who really are at high risk (Scott 2006). Scott (2006:6) goes on to argue that as a consequence western systems have become “like a giant Casualty Department required to respond to a flood of patients, the vast majority of whom do not require hospitalisation and would be much better managed by the local GP”. In addition, recent research looking at the effect of developing more risk-averse and reactive systems has suggested that short-term solutions can also have unintended negative consequences for children in the longer term (Mansell 2006). An alternative to providing increasingly reactive services is to approach the issue from a life course perspective, providing universal, targeted and specialist services for families.



New Zealand currently has services that extend across the universal, targeted and specialist services spectrum, aimed at addressing both underlying contributory factors and early treatment issues. New Zealand is therefore well placed to strengthen these services to more appropriately respond to children and families across the range of need. Research clearly shows that intervening early in the life of a child brings the best long-term results. Early intervention helps children do better socially and educationally, helps improve health and wellbeing, and can reduce violence within the family over the long term. The strengthening and integration of services across the universal, targeted and specialist spectrum is more likely, therefore, to ensure that the right services are provided at the optimum time in the life of a family. It is not the intention of this report to discuss all the services that are available across the spectrum. Rather it will look at some examples of the type of services currently available to families, and will then explore some of the issues of service gaps and co-ordination.

Universal services for all families

Income services

The UNICEF (2003:21) report noted that “experience would suggest that no national strategy to prevent or reduce the maltreatment of children will achieve major gains without addressing the question of economic poverty, which ... is the close companion of physical abuse and neglect”.

Children and adults living in lone-parent or workless families are more likely than others to be in persistent poverty.¹¹⁴ Services aimed at helping sole parents and unemployed parents

¹¹⁴ Office of the Deputy Prime Minister 2004:42.

enter and remain in sustainable employment can help improve both parents' and children's immediate and longer-term living standards and life opportunities, as well as lowering their risk of abuse.

Unemployment in New Zealand is now the lowest it has been for over 20 years. In July 2006, the number of people receiving Unemployment Benefit (UB) had dropped to below 40,000 – the first time since 1982. Numbers receiving Domestic Purposes Benefit (DPB) – Sole Parents are also the lowest in over a decade.¹¹⁵ Strong economic growth has contributed to this fall in UB and DPB beneficiary numbers. Social and economic changes have also contributed to the fall in DPB numbers, through later childbearing, lower unemployment rates, higher educational attainment and changing attitudes to parenting and work.

The Working for Families package aims to help people enter and stay in work by increasing the financial gains from work and reducing costs associated with going to work. Working for Families¹¹⁶ helps make “work pay” by:

- ensuring more people will be financially better off in work through increases in Family Income Assistance and the In-Work Payment
- reducing costs associated with going to work through increases to Childcare and OSCAR subsidies and income thresholds.¹¹⁷

Work and Income case managers work with benefit recipients to ensure they receive full and correct benefit entitlements.

While progress is clearly being made with respect to low-income working families, recent research continues to demonstrate that approximately a quarter of New Zealanders face some degree of financial hardship. According to *New Zealand Living Standards 2004* (Jensen et al 2006), over half of all sole-parent families experienced hardship, and more than one-third of all children experienced severe hardship. Highest rates of severe hardship were found among Māori, Pacific and sole-parent beneficiary families. Children from these families are more likely to experience constraints that may adversely affect their health, education and general development (Jensen et al 2006). With the fall in overall UB and DPB numbers, it is likely that a greater proportion of those remaining on benefits experience labour market and social disadvantage associated with low skills, poor health, low confidence, and living in areas remote from employment.¹¹⁸

The likelihood of increasing levels of disadvantage among those remaining on benefits suggests the need to consider closer collaboration and joint responses with the health sector. As an illustration of this need, in the evaluation of the 2002 DPB and WB reform, case managers consistently said that the most pressing gap was mental health services for both children and adults.¹¹⁹

¹¹⁵ MSD 2006a.

¹¹⁶ Latest poverty data analysis shows that there has been a drop in the proportion of New Zealanders with incomes less than 60% of the median income, adjusted for family size, housing and inflation since 1998. Child poverty has also decreased between 2001 and 2004, with the proportion of children living in households below the poverty threshold dropping from 27% to 21%. Rates of child poverty remain high for children in sole-parent families, but these too have dropped from 61% to 43%.

¹¹⁷ Ministry research estimates that, when the Working for Families reforms have been fully implemented in 2007, the reductions in child poverty will be considerable, ranging from 70% to 30% depending on the poverty thresholds referred to (Perry 2004).

¹¹⁸ UK research noted that “the penalty of having no qualifications or poor basic skills in a knowledge-driven economy has grown” as, despite overall economic growth, those with no or low skills are less likely to be working unless they live in areas with high economic growth (Office of the Deputy Prime Minister 2004:74)

¹¹⁹ MSD 2006a

A major challenge arising from the *New Zealand Living Standards 2004* report is to better understand the impact of multiple disadvantage and develop ameliorative strategies.

Educational services

Evidence internationally indicates that strengthening a parent's engagement with their child's education by achieving a connection between the family and an early childhood centre environment leads to positive social and educational outcomes for children.¹²⁰ A package (see appendix 2) of services approved in 2005 is currently being piloted across New Zealand with the aim of:

- developing parenting education: helping parents learn about child development, promoting positive parenting and developing parenting skills
- providing parent social support: developing opportunities for parents to meet and share experiences, addressing social support issues, providing information about, and connecting families to support services, and working with other agencies to ensure families receive co-ordinated services
- providing outreach services: extending and promoting services externally, developing awareness of service providers working with vulnerable families (eg Family Start, Plunket, Well Child, Work and Income), identifying barriers to family participation and actively offering services.

Parents of vulnerable children from birth to three years of age are targeted for these services, as these vulnerable children are likely to be the most at risk of poor social, educational and health outcomes.

Health services

New Zealand's *Child Health Strategy* was developed to improve child health services, and ultimately the health of children, over the decade through to 2010. The strategy prioritises four populations: tamariki Māori, Pacific children, children with high health and disability support needs, and children from families with multiple social and economic disadvantages (Ministry of Health 1998). A key principle within the strategy is that children should have their needs treated as paramount, and the strategy signalled a greater focus on health promotion, prevention, early intervention and better co-ordination of services. Well Child Services provides a comprehensive system of screening, surveillance, education and support to all New Zealand children and their families from birth to five years. Well Child providers give information and support to parents to help them understand and manage the stages of their child's development. Through health surveillance and assessments, it provides added reassurance for parents that their child is developing normally. A key objective of the service is the promotion of attachment and positive parenting.

It is recognised that optimal levels and types of universal and targeted services for newborns are critical for the best possible start in life.¹²¹ Maternity and health care services for the newborn are a critical component of New Zealand public health services.¹²²

In addition, Plunket has provided universal services for families with children under five since 1907. Plunket provides a range of services, including educational parenting groups, home

¹²⁰ Ministry of Health 2006.

¹²¹ MSD 2004.

¹²² Ministry of Health 2006.

visits for families offering support, health and development assessments, and free clinic visits at key stages of a child's development.¹²³

UNICEF (2003) regards home visiting to be "the best and most immediate practical method of bringing about a significant reduction in child abuse and neglect". Key features of successful home visiting programmes are ones that:

- work to build parenting skills, value parents and enable them to cope more successfully
- monitor children's development and provide families and support services with early warning of any problems
- link families with special needs to government and voluntary services.

The UNICEF report notes that early and ongoing contact means families can be supported, and resources eventually targeted to those most at risk "with less risk of confrontation, lack of co-operation or stigma, to those families who might otherwise begin the descent into the kind of problems which are the favoured breeding grounds of child abuse and neglect".¹²⁴

In May 2004, MSD also launched Strategies with Kids – Information for Parents (SKIP) to promote positive parenting, including setting limits and boundaries instead of punitive or physical methods of discipline.

SKIP is aimed at parents and caregivers of children from birth to five. It has three strands:

- the development of national resources for community organisations, parents and caregivers: these include pamphlets, tip sheets, research information and support for training
- strengthening existing parent support and education: a range of training packages are being developed and new ways of engaging parents and caregivers explored
- a local initiatives fund: community groups are funded to promote positive parenting through workshops, support groups and promotional events and guest speakers.

Across the spectrum of services, there are also targeted services provided specifically for vulnerable families.

Targeted services for children and families

Two home visiting services to families with young children – Early Start and Family Start – provide good examples of services that have aspects of the best practice features identified by UNICEF.

Early Start

The impetus for the development of Early Start came from the findings of the Christchurch Health and Development study (CHDS). The CHDS is a longitudinal study of a birth cohort of Christchurch children born in 1977. A consortium of social service and health care providers and cultural advisors came together and formed the Early Start Board in order to develop an intensive long-term home-based family support service that addressed a wide range of family problems and it was targeted at high-risk families caring for children under five.

Following an initial pilot study, the Early Start Programme has been operating since 1995. The delivery of Early Start centres around the process of home visitations and aims to

¹²³ Plunket On Line www.plunket.org.nz

¹²⁴ UNICEF 2003:21.

achieve a series of goals in the areas of improvement in child health, reduction of child abuse, improvement in parenting skills, supporting parental physical and mental health, encouraging family economic and material wellbeing and encouraging stable relationships. Qualified family support workers build collaborative, trusting partnerships with the participating families using a problem-solving solution-focused approach. This enables the participating families and the family support worker to build on strengths in order to overcome problems. Promoting a positive and enjoyable childhood is an aim of the programme.

Family Start

Family Start was established in 1998. There are currently 21 services available nationally, and it is expected that a further 10 will be in place by the end of 2006. Family Start delivers an integrated package of intensive, home-based support services to high-needs families to ensure that their children have the best possible start in life. Family Start's goals are to:

- improve health, education and social outcomes for children
- improve parents' parenting capability and practice
- improve children and parents' personal and family circumstances.

The Family Start family/whānau worker helps families identify priorities and supports them in achieving their goals.

Support to other high-needs families comes through the Strengthening Families programme, which provides co-ordinated support to families in contact with more than two government or community agencies.

The agencies and the family work together to develop joint solutions, where the bigger picture is considered rather than each agency working in isolation to address the part of the problem they see. The co-ordinated approach increases the ability to address the whole, rather than a part, of the problem, and helps agencies co-ordinate and mobilise resources to more effectively support families in need. Strengthening Families services are available throughout New Zealand, in over 50 urban and rural centres.

Strong and vibrant services for Māori families have also developed over time and provide a blueprint for the kind of services that enhance Māori health and wellbeing. For example, He Waka Tapu is a Māori Health and Social Service organisation that operates in the South Island, operating in the rohe of Ngai Tahu ki Otautahi. Providing services to prevent family violence, the agency holistically promotes strong, healthy families that will provide intergenerational strength. Based on values that are fundamental to Māori kaupapa, He Waka Tapu supports te taha wairua (spiritual wellbeing), te taha tinana (physical wellbeing), te taha hinengaro (mental wellbeing) and te taha whanau (family wellbeing).

CYF also contracts with Māori providers for whānau wellbeing, counselling and rehabilitation services, and for the delivery of family violence prevention programmes. These services specifically acknowledge tikanga and holistic approaches to Māori wellbeing in the support of family violence prevention strategies.¹²⁵

Services for Pacific families also feature across the service spectrum. Parenting support and development programmes targeted to Pacific families caring for young children include Anau Ako Pasifika, Taea o manino Trust and a range of Family Start intensive home-based

¹²⁵ MSD 2004.

support programmes that are delivered by Pacific providers in areas with high Pacific populations.

There are a number of such services that respond to the particular needs of Māori and Pacific families, and ongoing effort is needed to build on these services and provide the support they need to carry out their important work.

Specialist services for children and families

Specialist services are provided for children and families considered to be at high risk. With respect to child protection, CYF provides services for those New Zealand children who are abused or neglected. CYF works with families, young and old, to help make them safe. When abuse, neglect or insecurity of care is reported to CYF, the situation is assessed and, when necessary, investigated. In situations requiring urgent child safety, CYF has the legal authority to arrange care for a child. Police, Health and Education agencies are frequently involved in investigations and a high degree of co-ordination is required across the spectrum of services.

In recent years, notifications of child abuse and neglect have risen significantly. However, it is not certain that this trend reflects higher actual levels of child abuse and neglect. As noted in Section One of this report, increased notifications may be reflecting changes in notifier behaviour and the lack of more appropriate services that would better suit the presenting need. CYF currently responds to most reports by carrying out a formal child protection investigation, which is designed to gather evidence about whether a specific case of abuse has taken place and to confirm whether further departmental involvement is needed. Acknowledging that no single, prescribed response will be appropriate to all reports of child abuse or neglect, a Differential Response Model (DRM) is being developed to more appropriately respond to the range of presenting care and protection concerns.

Research indicates that cases where a child's needs are high but the risk of immediate maltreatment is low respond better to family preservation programmes than to formal investigations. The DRM recognises this. It also recognises the role of non-governmental organisations (NGOs) in the area of child care and protection, and the strengths and abilities they can bring to the work. In expanding the range of service pathways for families, DRM offers a way of targeting resources to ensure reports of abuse, neglect or insecurity of care receive the most appropriate response.

Within the specialist services area, parents with high health needs such as mental health issues or intellectual or physical disability may require additional support to adequately care for their children. In some cases, these needs lead to concerns over parental adequacy resulting in self-referrals or notifications to CYF.

Currently the extent of these support services is underdeveloped. Small-scale provision of support to parents with these needs is undertaken by CYF, District Health Boards (DHBs), Disability Support Services and the Ministry of Social Development. In respect of parental mental health needs, a limited number of maternal mental health services provide support to some women who are taking medication prior to the birth of a baby and follow-up for 6–12 months post birth. Some DHBs are developing services that include support for parents with mental health issues, through Primary Health Organisations, but as yet this is on a pilot basis. In addition the newly evolving models that provide a home-based alternative to in-patient care are also likely to involve provision of support for parenting. Work is needed across agencies to further develop and co-ordinate support services.

Developing co-ordinated services for high-risk infants

Building the capacity of CYF and partner agencies to identify those at risk and to respond quickly in a co-ordinated way is more likely to meet the needs of those vulnerable children who have been specifically identified as high risk. Drawing on successful features of earlier CYF child safety programmes,¹²⁶ key elements have been identified as important to the development of responsive systems across the specialist services sector:

- the development and dissemination of a list of risk factors identified from the literature
- the application of appropriate risk assessment processes
- communication between health, welfare and protection professionals and support services
- protocols for responding to children and young people assessed as at risk
- ready access to experts who can advise on best practice
- management and monitoring of responses.

Extending these ideas to work with vulnerable infants, four key elements have been identified that will contribute positively to this response (table 1).

Table 1: Four key elements in the response to vulnerable infants

Target resources toward greatest need, through:

- shared understandings of risk factors
- activating systems to identify and target at-risk infants
- developing high-quality, timely responses across the spectrum of services.

Build capacity across the sector, by:

- strengthening services that respond to the diverse needs of children and families
- developing and sharing specialist expertise across the sector
- exploring appropriate means of sharing information.

Co-ordinate cross-agency response, by:

- engaging agencies across the spectrum of services
- sharing timely information across agencies
- facilitating cross-agency training and education.

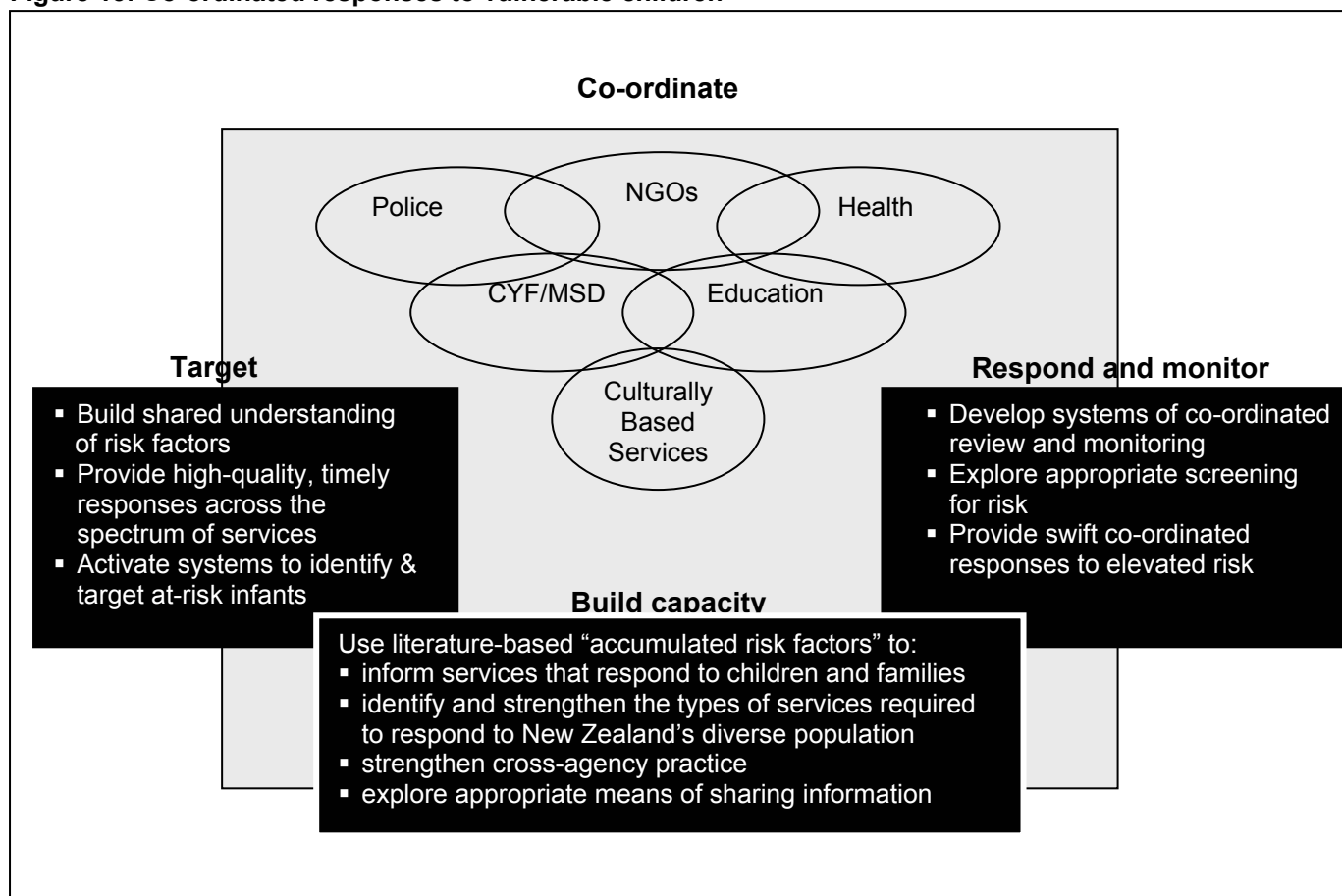
Monitor and respond to infants at risk, through

- developing co-ordinated review and monitoring systems
- exploring appropriate screening mechanisms for infants at risk
- providing swift co-ordinated responses to elevated risk.

¹²⁶ The Toward Wellbeing (TWB) suicide risk assessment and management system has operated successfully now for five years.

Building cross-sectoral capacity and providing co-ordinated responses that capture these key elements has the potential to strengthen the safety net around vulnerable children (figure 15).

Figure 15: Co-ordinated responses to vulnerable children



Across the spectrum, universal, targeted and specialist services complement a whole-of-system response that is necessary to address the needs of vulnerable children and families. However, they only have the capacity to do this if they are supported as a whole system and care is taken to build the sector strategically. A life course approach to building services requires more than just support services for young families. It requires services for young people who will become tomorrow's parents. It requires specialist services for young people and adults who need to address drug and alcohol problems, mental health issues and family violence. Although the social service infrastructure continues to develop in New Zealand, gaps in specialist service delivery have resulted in too few pathways for families, and a dependency on statutory systems of child welfare – what Scott (2006) refers to as the "giant Casualty Department".

Conclusions

The research that has contributed to this report signals a need to focus greater attention on the care and protection needs of the younger child. Clearly the challenge of reducing child abuse goes wider than any one agency. However, it is important that we better understand which services work best, for whom, and under what circumstances.

The life course approach to understanding individual and family need over time provides a framework for identifying service gaps across the spectrum of universal, targeted and specialist services. Strengthening the service continuum to address the changing needs of families over time has the greatest potential to break cycles and produce good outcomes for children in the longer term. The merger of MSD and CYF has the potential to provide increased opportunities for strengthening co-ordinated responses to child abuse and family violence as together these agencies provide and co-ordinate services across the spectrum from early intervention to statutory care and protection. However, the challenge of responding to child abuse extends beyond the responsibility of any one, or even two, agencies. It calls for an integrated response across the spectrum of services.

The research that forms the basis of this report also reinforces the importance of focusing attention on the specific needs within families across the spectrum of services. New Zealand's child welfare system is unique and the most successful future developments are likely to be those built around the strengths of New Zealand's cultural systems. Internationally in the field of child welfare, New Zealand is looked to as being innovative, largely because of its family-responsive law and the development of the family group conference. In particular, its potential strength lies in legislative initiatives that could pave the way for iwi and cultural involvement in child welfare service development. One of the challenges to improve the system is to develop iwi social services and cultural authorities. This was clearly envisaged in the Children, Young Persons and their Families Act in 1989.

Building systems that resonate with cultural practices is more likely to impact positively and be accessed more readily by Māori and Pacific families. Cultural social services will be essential to the development of appropriately responsive services for New Zealand's diverse family groups. Because of the particular needs of indigenous people and the over-representation of Māori children in child welfare, any strategy for developing integrated services needs to be considered in the context of culturally responsive service delivery.

The research has also raised some practical issues in terms of identifying children at risk of fatal child maltreatment across the spectrum of services. Different agencies collect data for different administrative purposes, and agencies collect different types of data according to their function. There is also likely to be less administrative data available from which to identify children at risk, as they are young and have less time to come into contact with agencies. This is particularly the case for those children most at risk of death from maltreatment who are killed before they turn one.

Government is already undertaking work to improve data quality and how it is used to enhance child care and protection systems. Nevertheless, information exchange and issues relating to confidentiality have been identified as potential barriers to collaboration. While the sharing of data systems seems like a sensible way to identify children at risk and to monitor their progress, international experience suggests the need to approach the sharing of data with caution.¹²⁷ Potentially it can produce negative consequences for the child. Professional opinions that find their way into databases can be misunderstood by others, and information

¹²⁷ Eileen Munro, London School of Economics, personal communication, June 2006.

taken out of context may cause errors of judgment. Sharing poor-quality data can also result in poor services to children and families. As such, work needs to be done early to identify legal, ethical, policy and practice issues relating to the sharing of information. Families being the carriers of information, more commonly found in medical practice, may be one way of addressing issues of data accuracy and confidentiality.

Finally, the research reinforces strongly the difficulties in predicting risk of child death by maltreatment. Most acts of violence toward children cannot be seen in advance and, as Ferguson (2004:218) insightfully notes, “ultimately, we even have to be prepared to face the uncomfortable fact that any guarantees in protecting children are simply beyond the capacities of what human beings are capable of, even trained professional ones”. What is important, however, is that we collectively strengthen our services so they are the best they can be in responding to the needs of vulnerable infants.

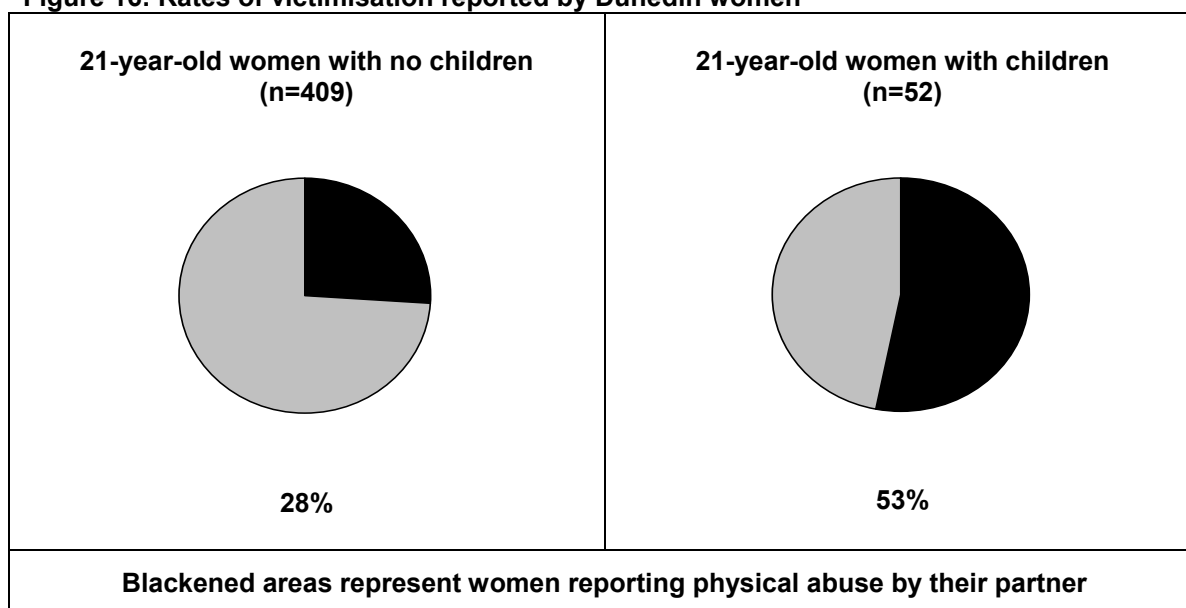
APPENDICES

Appendix 1: Expanded elements of research

New Zealand – Moffitt and Caspi (1999) Findings about partner violence from the Dunedin multidisciplinary health and development study, Office of Justice Programs, US Department of Justice.

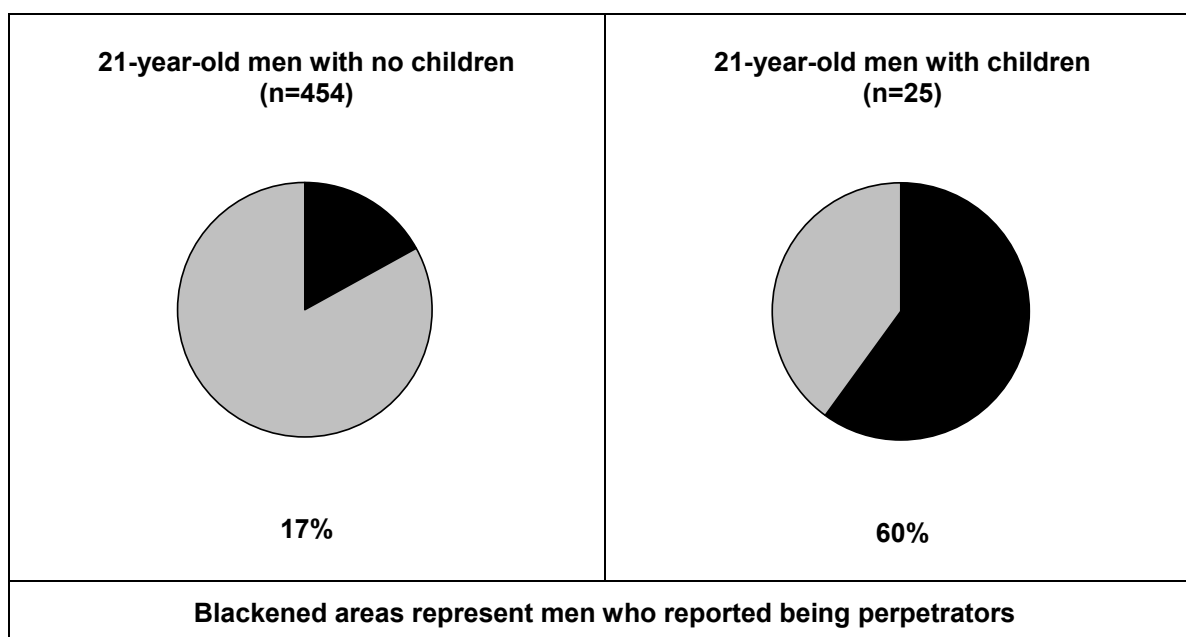
Women who became mothers at a young age (before 21) were twice as likely to be victims of family violence than those without children at this age (figure 16). Men who fathered children by 21 were more than three times as likely to be perpetrators of partner abuse as men who were not fathers by age 21 (figure 17).

Figure 16: Rates of victimisation reported by Dunedin women



Source: Moffitt and Caspi 1999

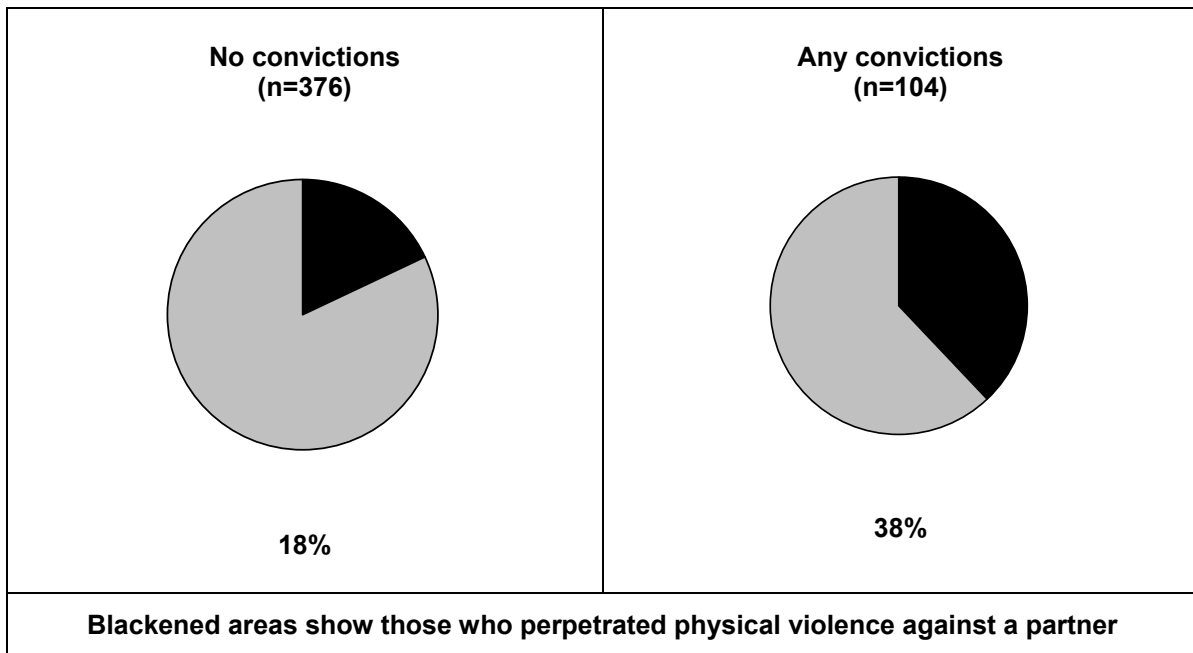
Figure 17: Rates of perpetration (of physical abuse to partner) reported by Dunedin males



Source: Moffitt and Caspi 1999

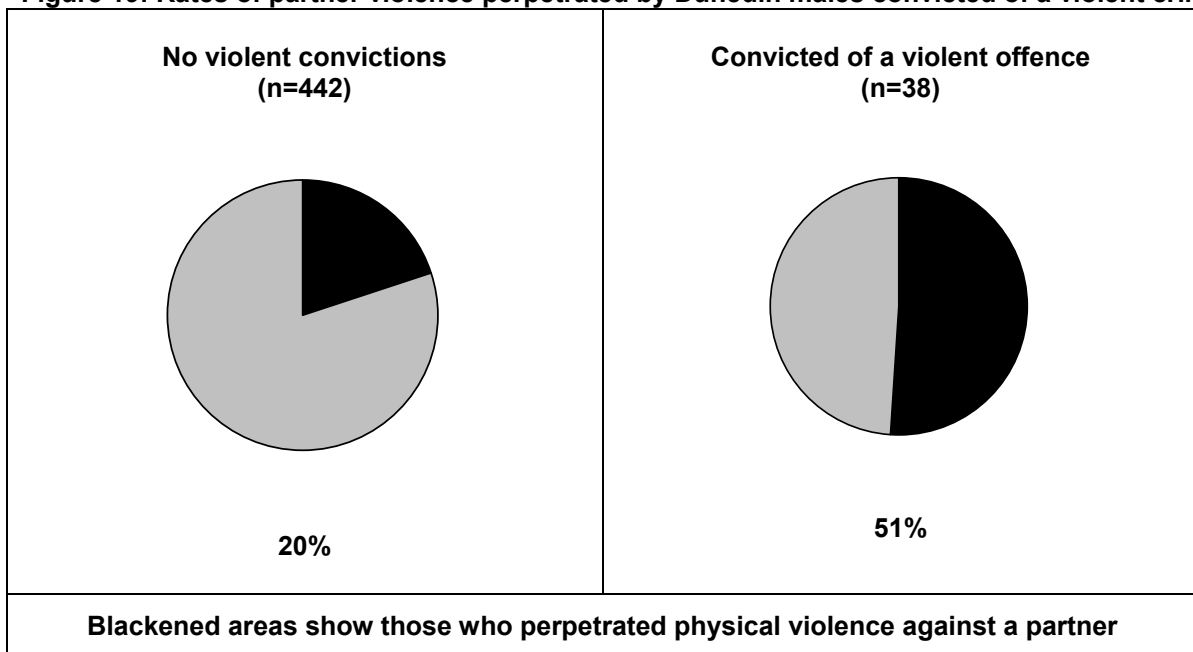
In the Dunedin study, over a third (38%) of males with any conviction and more than half convicted of a violent crime (51%) also physically abused their partners (figures 18 and 19).

Figure 18: Rates of partner violence perpetrated by Dunedin males convicted of any crime



Source: Moffitt and Caspi 1999

Figure 19: Rates of partner violence perpetrated by Dunedin males convicted of a violent crime

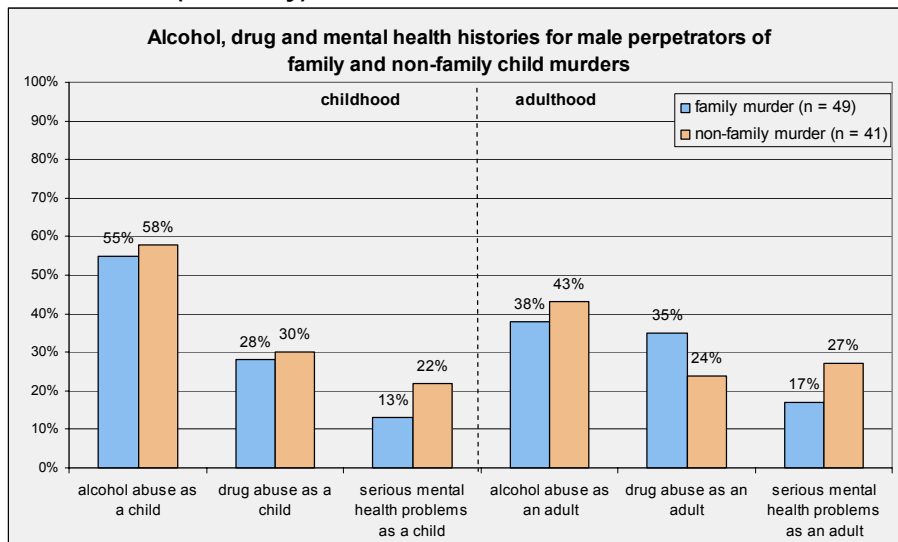


Source: Moffitt and Caspi 1999

UK research – Cavanagh K, Emerson Dobash R and Dobash R (2005) “Men who murder children inside and outside the family”, *British Journal of Social Work* 35:667–688.

Cavanagh et al (2005) found that over half the perpetrators had abused alcohol and just under a third had abused drugs as children. About 40% were chronic alcohol abusers as adults. Chronic drug abuse was a feature for a third of those who killed children within the family and a quarter of those who killed outside the family (see figure 20).

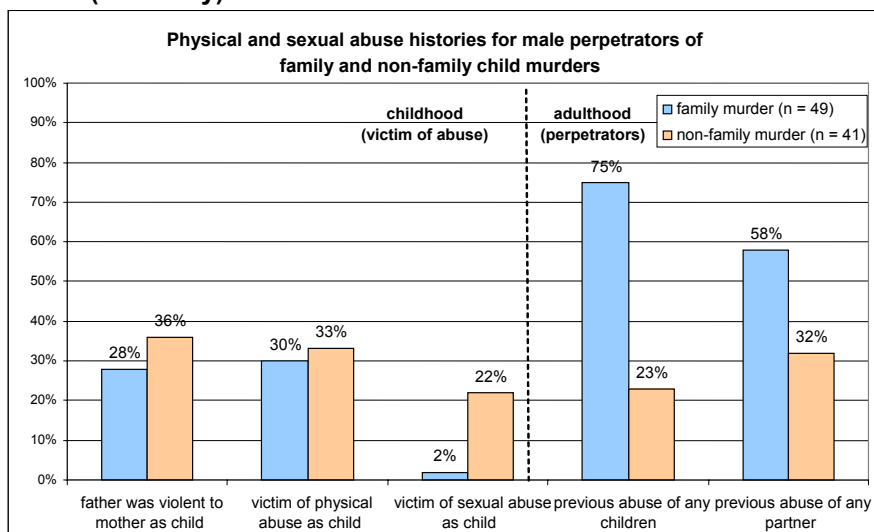
Figure 20: Alcohol, drug and mental health histories for male perpetrators of family and non-family child murders (UK study)



Source: Cavanagh et al 2005

A third of men who murdered outside the family had at least one prior conviction for sexual assault and a quarter of these men had been sexually abused themselves as children (figure 21).

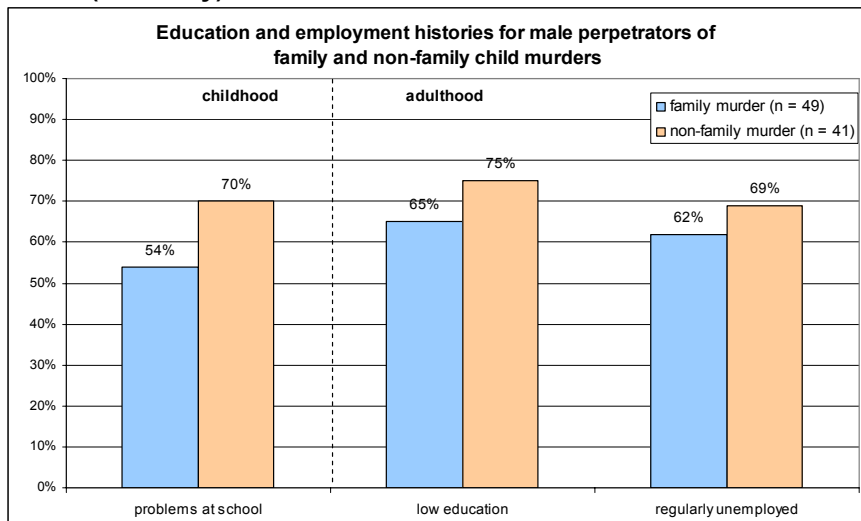
Figure 21: Physical and sexual abuse histories for male perpetrators of family and non-family child murders (UK study)



Source: Cavanagh et al 2005

Of those who killed within the family, 61% were unemployed at the time of the murder compared with 43% of those who killed outside the family (figure 22).

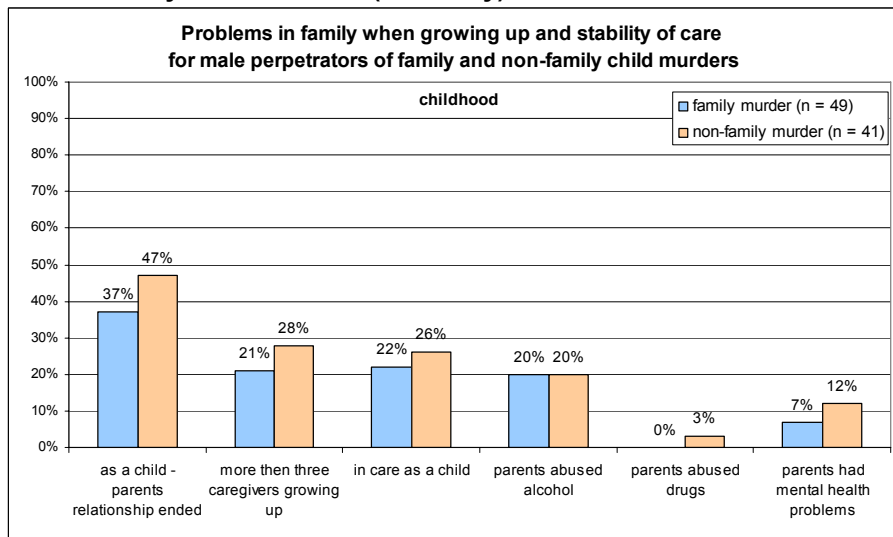
Figure 22: Education and employment histories for male perpetrators of family and non-family child murders (UK study)



Source: Cavanagh et al 2005

Over a third (37%) of men who killed within the family and just under a half (47%) who killed outside the family experienced a family breakup as children. About a quarter of both groups had more than three caregivers growing up, and about a quarter had been cared for by the state at some stage (figure 23).

Figure 23: Problems in family when growing up and stability of care for male perpetrators of family and non-family child murders (UK study)

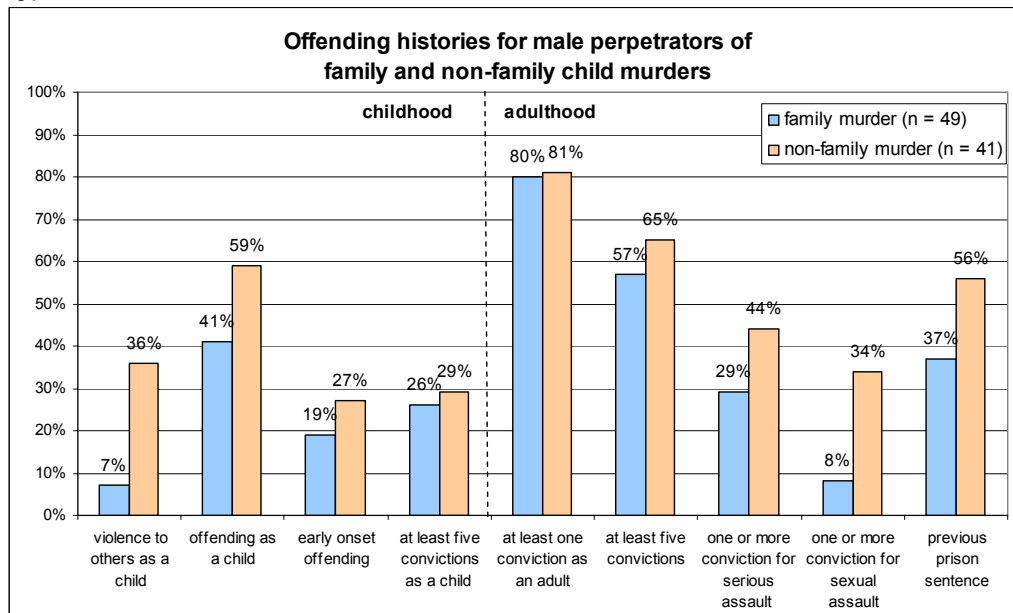


Source: Cavanagh et al 2005

Cavanagh et al's 2005 UK study found the majority (80%) of all men who killed children – both inside and outside the family – had at least one conviction prior to the murder, and over half the men in both groups had at least five previous convictions – although the proportion was higher for men who killed children outside the family. Men who killed children outside the family

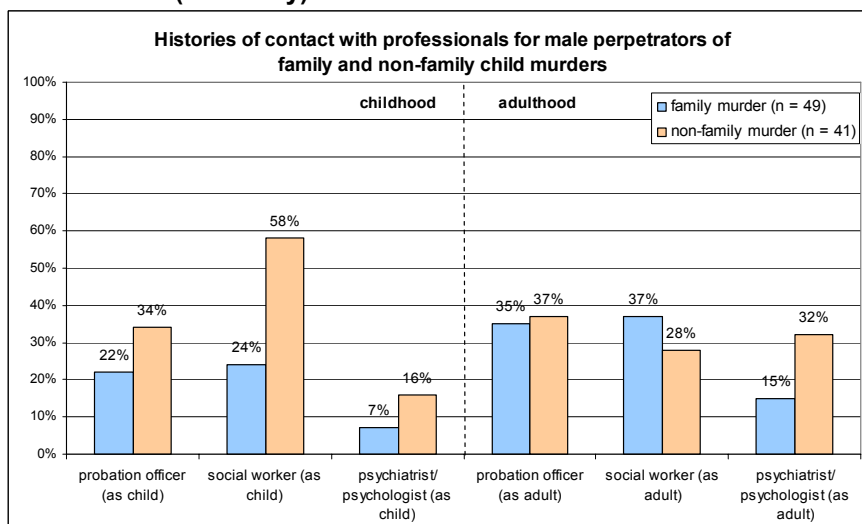
were more likely to be convicted before the age of 13, and have had more contact with psychiatric or psychological services, probation and social services – mainly due to their problems at school and violent and offending behaviour (figure 24).

Figure 24: Offending histories for male perpetrators of family and non-family child murders (UK study)



Source: Cavanagh et al 2005

Figure 25: Histories of contact with professionals for male perpetrators of family and non-family child murders (UK study)



Source: Cavanagh et al 2005

Courts data

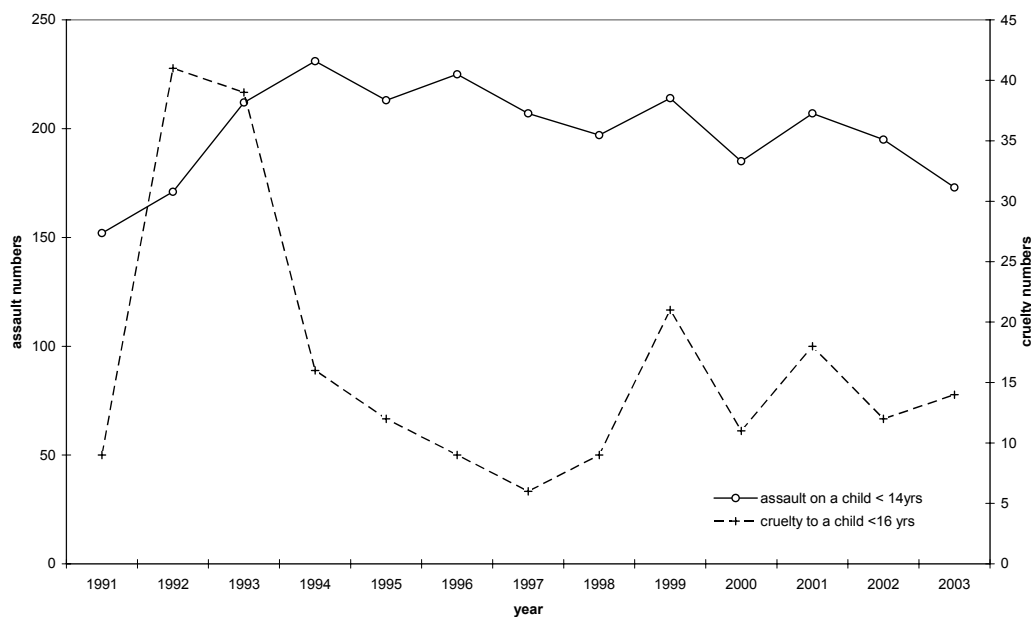
The number of convictions for *assault on a child* and *cruelty to a child* provide another useful and direct measure of the levels of violence against children. This section looks at *assault on a child* convictions and *cruelty to a child* convictions between 1991 and 2003.

The number of convictions for *assault on a child* is robust as there are sufficient numbers, and the definition of *assault on a child* has not changed since the Crimes Act was introduced

in 1961.¹²⁸ The data is readily available from the Ministry of Justice and provides information on serious cases of child maltreatment potentially not recorded elsewhere.

As figure 26 shows, the number of convicted cases involving assault on a child under 14 years increased in the early 1990s, but has been declining gradually over the last decade. Figure 26 also suggests that convictions for *cruelty to a child* aged under 16 years seem to have been on the rise since 1997.¹²⁹ However, after a dramatic rise between 1991 and 1993, the number of cruelty convictions decreased from 1994 to 1997, followed by seemingly large fluctuations thereafter. The number of children involved is considerably smaller when considering cruelty rather than assault offences, which contributes to the greater fluctuations in the numbers observed. These fluctuations highlight the challenge in assessing and classifying cruelty to children and the difficulties in finding a reliable measure for child abuse.

Figure 26: Number of convicted cases involving assault on a child under 14 years and cruelty to a child under 16 years, from 1991–2003¹³⁰



Source: Ministry of Justice 2004.

One of the drawbacks in using *assault on a child* and *cruelty to a child* statistics is the fact that the data is not a timely reflection of the actual crime. Convictions for crimes may take place years or potentially decades after the incident occurred.

¹²⁸ 194 (a) of the Crimes Act 1961 – Assault on a child under the age of 14 years.

¹²⁹ 195 of the Crimes Act 1961 – Cruelty to a Child: *Everyone is liable to imprisonment for a term not exceeding 5 years who, having the custody, control, or charge of any child under the age of 16 years, wilfully ill-treats or neglects the child, or wilfully causes or permits the child to be ill-treated, in a manner likely to cause him unnecessary suffering, actual bodily harm, injury to health, or any mental disorder or disability.*

¹³⁰ Spier and Lash 2004.

Appendix 2: Strategies for preventing family violence in New Zealand

This appendix describes current work being undertaken to prevent and reduce family violence. The agency or business unit is noted, as well as what research or evaluation is being undertaken and when findings will be publicly available.

The key MSD business units mentioned are:

- Family and Community Services (FACS)
- Work and Income
- Centre for Social Research and Evaluation (CSRE).

Taskforce for Action on Violence within Families – Taskforce Secretariat

The government is strengthening its response to violence within families by building on the vision and progress made under Te Rito New Zealand Family Violence Prevention Strategy. Following the release of *Opportunity for All New Zealanders* (MSD 2004), which identified family violence as a priority issue for Government, a Family Violence Ministerial Team and an Interagency Taskforce for Action on Violence within Families were established to provide leadership at the highest levels of government.

The Taskforce is made up of Chief Executives from a number of key government agencies, the Chief District Court Judge, the Principal Family Court Judge, non-government organisation (NGO) representatives, the Children's Commissioner and the Chief Families Commissioner.

It will build on current work and look at what else can be done to make a real difference to the prevalence of family violence in New Zealand. The Taskforce is looking at what can be done immediately and what longer-term actions are needed to eliminate society's tolerance of family violence, to change people's behaviour and achieve our vision of families and whānau living free of violence. The Taskforce is due to report to the Ministerial Team in July 2006.

Te Rito New Zealand Family Violence Prevention Strategy – MSD

Te Rito sets out the Government's key goals and objectives, and a framework for action for maximising progress toward the vision of families and whānau living free from violence. It was developed by government and NGOs working in partnership, and was published in February 2002. The strategy sets out five key goals, a number of objectives for achieving those goals and a five-year implementation plan, detailing 18 specific, interrelated areas of action.

Family Violence Death Reviews – Taskforce initiative being co-led by MSD and Ministry of Justice

A research-based review of existing information on family violence deaths has commenced. This will inform the development of an ongoing system for reviewing family violence deaths in New Zealand. The findings of the research-based review will be available in June 2007.

Supporting Communities – MSD, Families Commission, ACC

Budget 2006 announced funding of \$11 million over four years for the Changing Attitudes and Behaviours community prevention campaign. This campaign will support community initiatives that change attitudes to family violence.

Initial work includes support and training for community groups to help them highlight family violence as a community issue and motivate people to get involved in family violence prevention. This includes:

- a Family Violence Community Action Toolkit, currently being trialled in at least five communities, which has information on collaboration, planning, evaluation and media management
- media kits and training for community groups on placing key family violence prevention messages in local media
- seminars on family violence for trainee journalists and family violence prevention resources for journalists.

Market research is underway to contribute to programme development. Planning for the evaluation is subject to the finalisation of the programme delivery specifications in 2006/2007. The evaluation is likely to include a formative and process evaluation to provide early feedback for programme development and an outcome evaluation in the later stages of the initiative in 2009/2010.

Increasing support for people affected by family violence – MSD (FACS/CYF)

The government has provided \$9 million funding over the next four years to increase support for people affected by family violence. Funding will be increased for a range of family violence prevention and support services, including 24-hour crisis lines, counselling, social work support, safe-house accommodation, advocacy and information. The intention of the funding is to help ease the pressure on providers from the increased demand for their services. Officials from CYF and FACS in MSD are currently working on the criteria for the distribution of the funds.

This is an increase in funding to existing programmes that are already subject to standard contract monitoring and reporting.

Family Violence Intervention Programme – MSD (FACS/Work and Income)

The MSD Family Violence Intervention Programme is providing ongoing safety for all Work and Income clients and their families who are experiencing family violence. Case managers provide appropriate income support and refer clients to specialised family violence prevention services that are approved by the Ministry of Justice and/or CYF.

Funding of \$19 million (GST inclusive) over three years covered set-up costs associated with the project, the establishment of 23 new regionally based family violence co-ordinators and a national co-ordinator, training of all Work and Income staff, evaluation of the programme and resources to support the programme.

By 30 June 2006, all Work and Income staff had received training in family violence awareness.

The Centre for Social Research and Evaluation (CSRE) carried out a real-time formative evaluation to support the implementation of the initiative. The programme had a three-stage roll-out, and CSRE evaluators visited the “stage one” Work and Income regions to provide

feedback to the project team for improvements to the programme, and to assist in the implementation of the programme in stage two and stage three regions. The report is due to be completed in August 2006.

Te Rito Collaborative Fund – MSD (FACS)

Funding was approved in Budget 2003 for funding of \$5.840 million over four years to establish a contestable fund for community-based collaborative initiatives to prevent family violence, and to undertake a four-year evaluation. There are 30 funded collaborative networks throughout New Zealand undertaking projects on collaboration, education, awareness and training.

All the networks provide annual reports to MSD on the work they have undertaken. CYF has commenced a process/formative evaluation of the project and the report is due in July 2006. The outcome evaluation is due to finish in June 2007.

Everyday Communities – MSD (CYF)

Everyday Communities is a CYF programme that uses a community engagement approach to raise public awareness about child abuse, neglect and family violence. Everyday Communities recognises that all New Zealanders have a part to play in preventing child abuse and encourages everyone to take action to achieve wellbeing and safety for our children.

The programme uses media and community events to engage people at a community level. It is a 12-month programme and is adapted for each community. It includes the Everyday Theatre project, which creates a forum for children at Intermediate or Year 7 and Year 8 levels to openly discuss child abuse, neglect and family violence in a highly structured and safe way.

BRC (in partnership with Independent Pacific Research and Evaluation) has carried out a two-stage evaluation. The MSD website carries a report on this evaluation that gives methodologies and findings, as well as noting that the evaluation is ongoing.

Strong Pacific Families – MSD (FACS)

Funding was approved in Budget 2004 to:

- enhance and increase knowledge to assist government and communities to work collaboratively to prevent and address violence in Pacific families and communities
- increase awareness and ownership of family violence prevention issues among Pacific leaders and encourage community action.

Since the project's inception in 2004, FACS has engaged with Pacific communities in Auckland, Porirua and Christchurch.

- A *Pacific Advisory Group* has been established to provide external review and advice on the Strong Pacific Families Strategy. The group is made up of recognised leaders within Pacific communities in Auckland, Porirua and Christchurch.
- *Community meetings* have been held in Auckland, Porirua and Christchurch and now those communities are working through a list of goals that they have identified with the support of the Strong Pacific Families team.

- *Church ministers and leaders* have been working with the FACS team to educate and build an awareness of the effects of family violence and to develop strategies that they can then work on within their own churches to combat family violence within Pacific communities. A range of strategies is being implemented to integrate this work across the Strong Pacific Families Strategy.
- A *Resource Kit* is being developed in collaboration with community leaders and organisations and will be used by Pacific families to further grow their strengths, talents and abilities so that they will be better equipped to deal with life's challenges. The Resource Kit will be launched by December 2006.

CSRE is conducting a formative evaluation for the Strong Pacific Families Resource Kit and a process evaluation for the Strong Pacific Families project. These two evaluations will identify indicators for monitoring progress as the Strong Pacific Families project is implemented. The final report is due in September 2007.

Advocates for Children and Young People who Witness Family Violence – MSD (FACS/CYF)

This initiative provides funding of \$12 million (GST exclusive) over four years for:

- the provision of 45 full-time equivalent Advocates for Children and Young People nationwide. The advocates will sit within a community-based NGO, and will be a community-wide resource for people working with children and young people in family violence situations. Initially advocates will be based in Waitakere (three advocates), North Shore/Rodney (three advocates); the East Coast (three advocates) and Hauraki (one advocate)
- the establishment of a national and community infrastructure to provide professional support, leadership, training and co-ordination for the Advocates for Children and Young People
- the development of a training and information package for individuals and organisations working with children and young people on the effects of witnessing family violence
- additional services for the children and young people who witness family violence, such as education programmes and therapeutic interventions, funded through CYF.

Planning for the evaluation of the Advocates for Children and Young People Who Witness Family Violence initiative is being finalised in consultation with key stakeholders. The evaluation to be carried out by CSRE includes a formative component in relation to the early implementation phase and a longer-term process/outcome evaluation. Fieldwork for the formative phase of the evaluation will commence shortly. A formative evaluation report is due in December 2006.

Non-mandated services for victims and perpetrators of family violence – MSD (CYF)

Budget 2002 allocated funding of \$1 million per year to service providers to provide programmes and services for victims of family violence without protection orders and for perpetrators not mandated by the Court, to attend family violence intervention programmes. CYF implement this fund.

Providers of these services provide quarterly, six-monthly or annual reporting (depending on the funding level) to CYF through standard contract monitoring and reporting lines.

Family Safety Teams – Police, Ministry of Justice, MSD (CYF)

The Family Safety Team (FST) pilot project is a joint initiative between Police, Ministry of Justice, CYF and the community sector. Each FST comprises 10 members, including police investigators, victim advocates and child advocates. The Auckland City team is a split team with Hamilton City. The Christchurch and Wairarapa/Hutt Valley FST are also now operational. The South Auckland site commenced on 1 July 2006.

FST roles include:

- information gathering and assessment
- monitoring and evaluating practice and systems
- developing new practice and systemic change
- proactive intervention
- advocacy – ensuring access and connection to 24/7 services and wrap-around services across all sectors; ensuring the voices of women and children are integral to all systems and services; helping to address gaps in services and support.

An evaluation of the FST pilots is to be undertaken. Further information on this should be sought from the Ministry of Justice.

Family Violence Circuit Breaker (Te Rito) – MSD (FACS)

This project has improved co-ordination and alignment of government family violence funding processes. It has also simplified government funding processes and reduced compliance costs for family violence service providers. Fifteen regional Circuit Breaker Teams work with local funders and providers to identify joint funding solutions and service gaps for family violence service providers.

CSRE carried out a real-time formative evaluation to support the development of the initiative. An evaluator collected information from the agency stakeholders and MSD operational personnel involved in the initiative and met with the National Advisory Group to address roll-out issues in a workshop context. A report for internal use was completed in 2005.

New Zealand Family Violence Clearinghouse – MSD (CSRE)

A website has been established as a central access point for the latest information on effective family violence prevention, and has links to current initiatives and events, funding and training opportunities, and research and evaluation news. The Clearinghouse provides bi-monthly reports to MSD.

Further work being undertaken by CSRE

Family Violence Prevention Self-Evaluation Toolkit

CSRE is currently developing a self-evaluation “toolkit” for use by providers of family violence prevention initiatives. The self-evaluation toolkit will contain resources including evaluation tools, guides and instructive examples. Providers can use these tools to evaluate and improve the effectiveness of their own services. A draft toolkit was produced in June 2006, and has been supplied to a number of providers for trial and comment. A final version of the toolkit is expected to be available by June 2007.

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