Child Abuse

GUIDELINES FOR HEALTH SERVICES

June 1992

Department of Health
TE TARI ORA

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1. BACKGROUND

The Area Health Boards Act 1983 gave area health boards a mandate to address child abuse. Under "functions, duties and powers of the Boards" the Act clearly states boards were:

(a) *Generally to promote and protect the health of the residents of its district, and towards that end, to consult and co-operate with individuals and organisations (including voluntary agencies, private agencies, departments of State, and territorial authorities) concerned with the promotion and maintenance of health.*

To assist area health boards to address the issues surrounding child abuse, the Department of Health published the *Primary Health Care Approach to Child Abuse: Information Package for Health Professionals* in September 1989.

This information package contains specific information on child abuse indicators, staff training, roles and responsibilities of health care purchasers and providers, and other agencies involved in issues of care and protection.

In November 1989 the Children, Young Persons and Their Families Act came into effect. This booklet, *Child Abuse Guidelines for Health Services*, has been developed to help those involved in the purchase and provision of health services for child abuse victims with guidelines on issues to be considered when developing policies, protocols and services within the context of this Act.

These guidelines do not attempt to provide detailed information, but suggest key issues to be considered in the assessment, counselling, therapy and treatment services for child abuse care and protection. The questions included at the end of each section are designed to assist planners to focus on the particular needs within their own area and may prove useful for identifying gaps and needs in local service provision.

Many area health boards have already developed policies and protocols and these guidelines should be seen as an additional, complementary resource to these existing policies and protocols. These guidelines were originally planned for use by area health boards, but are also appropriate for use by regional health authorities and health care providers within the changing health structures.

2. INTRODUCTION

In August 1990 the Minister of Health released a policy statement, *Priorities for Child Health in New Zealand.* The overall goal of this policy was "To improve both the health status of children in New Zealand and to improve the health services provided for children and their whanau/families".

Preventing child abuse was identified in this policy statement as one of ten priority areas for child health. The Department of Health therefore recognises child abuse as one of its ten major health issues, and acknowledges the impact that child abuse can have upon the child, the family and the community: child abuse is a major health problem.

Research, reports and inquiries reflect a glaring inadequacy in the collection of specific data relating to child abuse, and the report from the Ministerial Committee of Inquiry into Violence, March 1987, notes, "Accurate data is urgently required for public information and well planned interventions, but submissions... indicated that the sacrosanct privacy of the family in our societies is a bar to obtaining it". As well as highlighting the need for relevant data and information on child abuse, this statement also introduces a central issue which health service providers will need to address.

There is a small amount of information on the sexual abuse of children. The Ministerial Committee's report records child rape statistics, yet clearly states that, "This data grossly underestimates the extent of child rape". Estimates of the occurrence of child sexual abuse vary and are complicated by the variations in definitions of what constitutes abuse.

Data on other forms of child abuse is extremely limited. A section of the Ministerial Committee's report deals with child assault. It records the following statistics from the Department of Social Welfare on ill treatment and neglect:

Cases investigated by Social Workers where no further action was required (1979-1984)

Total	38,865
Average per year	6,477

Studies that have looked at adult sexual offenders indicate that as many as 80 percent were themselves sexually assaulted as children. In studies that focused upon parents who abused their children, it was revealed that a high percentage of parents who are abusers, were abused as children.

It should therefore follow that support of victims and their families may aid in healing and breaking the cycle of abuse.

3. PARTNERSHIP WITH TANGATA WHENUA

INTRODUCTION

This section deals solely with the needs of Tangata Whenua in developing child abuse policy and services.

The concept of partnership with Tangata Whenua needs to be reflected in child abuse care policy and services. Such partnerships should not preclude the responsibilities that health service providers may have to other ethnic groups within their regions, rather, it acknowledges the special relationship that exists with Tangata Whenua as defined in the Treaty of Waitangi.

The commitment of health service providers to a bicultural approach will be reflected in the level of consultation with Tangata Whenua during the development of policy and provision of services, and in an increase in numbers of Maori health professionals and community health workers in this area.

GENERAL GUIDELINES

1. The Treaty of Waitangi should infuse all policies relating to the development of a partnership between Tangata Whenua and health service providers involved in child abuse counselling, therapy and treatment.

2. Health service providers should consult with Iwi authorities and Maori community-based groups to ensure the needs of Tangata Whenua are met in the areas of assessment, counselling, therapy and treatment of abused children.

3. Health service providers should work with Tangata Whenua to develop appropriate child abuse services.

4. Health service providers should work with Tangata Whenua to develop appropriate training and education programmes that will assist in the care of Maori children and their whanau.

5. When the assistance of Maori community-based services is required, health service providers should contact them as soon as possible.

6. Health service providers should ensure the recruitment, appointment and retention of appropriate Maori staff within their services that deal with child abuse.

7. Since in most instances the Maori community is best aware of who its most appropriate healers are in the field of child abuse, the community should be involved in appointment procedures.

8. Specific protocols for Maori healing processes should be developed as guidelines so that they can be acknowledged for their incorporation of healing for the total child, the abuser and the whanau.

9. In developing child abuse policy and providing child abuse services, health service providers should work with Iwi Authorities and Maori community-based groups that deal specifically with child abuse.

10. When choosing to involve Maori community-based groups, health service providers should consider what resources they can make available to avoid placing undue strain on community-based groups' personnel and financial resources.

Questions to Consider

1. *How has the Treaty of Waitangi been applied? Were there any difficulties? If so, how were they overcome?*
2. *How has partnership with Tangata Whenua been developed and maintained?*
3. *Were there any difficulties with Maori cultural requirements when developing policies on child abuse? If so, how were they addressed and resolved?*
4. *What monitoring procedures have been developed to assess the effectiveness of policies, partnership, and working relationships with Tangata Whenua and Maori community groups?*

4. ASSESSMENT

INTRODUCTION

Assessment of child abuse is an extremely complex area and it can involve three distinct areas:
- family factors
- indicators of abuse
- multidisciplinary team work and community liaison.

Intra-familial abuse encompasses any form of abuse that is imposed upon a child by a member of their family, and extra-familial abuse is any form of abuse that is imposed upon a child by an adult who is unrelated. An understanding of the difference between these types of abuse is essential when supporting and assessing the needs of the victim.

While it is acknowledged that some health service providers have developed policy in the following areas, it may assist those who have not, to consider issues raised in the Department of Health's *Primary Health Care Approach to Child Abuse, Information Package for Health Professionals.*

GENERAL GUIDELINES

1. Good assessment procedures are pivotal to ensuring that effective counselling, therapy and treatment services are provided to victims of child abuse.

2. Underpinning the provision of good assessment services, is the need for health service providers to have a co-ordinated approach to issues of child protection.

3. Interviews must therefore only be carried out by specifically, and verifiably trained staff to ensure that victims are not retraumatised and that information obtained during disclosure interviews can be used in court procedures. Issues of confidentiality should also be observed.

4. Assessment should be conducted in such a way that it is part of the healing process for the child.

5. Health service providers will need to clarify the types of assessment services they currently provide, or may wish to provide in the future.

6. Types of assessment services may include:

a) medical examinations for physical abuse, deprivation and sexual assault
   - diagnosis and documentation
   - treatment of injuries and life threatening medical or surgical conditions
   - diagnosis, prevention, and management of pregnancy where appropriate
   - diagnosis of sexually transmitted diseases.

b) mental health and psychological assessments
c) child protection assessment
d) assessment of whether the family needs support mechanisms.

7. While certain assessment services may be best provided by health service providers, when hospital or specialist clinic facilities are required, health service providers may also negotiate with other agencies as appropriate to the child and the situation.

8. The family should be consulted where the child's safety is not an issue, and involved in the decision process.

Questions to Consider

1. *Are these basic guidelines achievable within current and/or planned services? If not, why?*

2. *What monitoring procedures are currently in place to evaluate the effectiveness of assessment services?*

INTERAGENCY NETWORKING

An essential component to providing an effective child care and protection service is to develop a co-operative working relationship with other statutory and non-statutory agencies. To achieve this, health care providers will need to understand their roles and responsibilities under the Children, Young Persons and Their Families Act 1989. The Department of Health's *Primary Health Care Approach to Child Abuse, Information Package for Health Professionals* may help this process.

To ensure areas such as evidential, diagnostic and psycho-social assessments can be undertaken in a process that has been clearly outlined and agreed on, health service providers, the Police and Department of Social Welfare should draw up mutually agreed protocols and establish interagency liaison and negotiation.

Questions to Consider

1. *Are there, or have there been, difficulties in establishing interagency liaison and co-ordination? If so, how have these been addressed?*

2. *What monitoring procedures need to or have been developed to assess the effectiveness of interagency networking?*

5. COUNSELLING, THERAPY AND TREATMENT

INTRODUCTION

Counselling, therapy and treatment should be parts of a total process that helps to heal victims of child abuse. To ensure a healing process is provided, health service purchasers and providers should consider the psychological, physical, and social aspects of child abuse.

Child abuse services should therefore encompass a spectrum of care and services, including those in the community, and the treatment of choice should match the needs of the children and their families as indicated by the assessment. This does not preclude the need for health services providers to assess how they can best supply a range of services, and some will require flexibility in their provision of services to achieve a spectrum of care.

In areas where suitably qualified, experienced personnel are not available to provide counselling and therapy services to child abuse victims, health services providers may wish to consider seeking assistance from community groups or individuals within government agencies with expertise in this field.

Regardless of how therapy and support services are resourced, health service providers should constantly be aware of the issue of confidentiality during the counselling, therapy and treatment of child abuse victims and their families.

While preserving their distinct and essential role, according to the statutory procedures under the Children, Young Persons and Their Families Act, health services providers should acknowledge and contribute to the child protection process. Resources must therefore be allocated for health professionals to be engaged in consultation processes, case conferences, to be members of Care and Protection Resource Panels and SAT teams, to undertake forensic examinations or be involved in any other appropriate process that is necessary for the care of abused children.

Whatever the circumstances of providers of health services, assessment, counselling, therapy and treatment services should be accessible, effective and appropriate to the needs of child abuse victims, their families and the community. Above all other considerations, they must ensure that the safety of the child is paramount.

GENERAL GUIDELINES

Counselling, therapy and treatment services should:

1. ensure that the needs of the child are the priority at all times

2. uphold the right of child abuse victims and their families to confidentiality

3. promote and provide a healing process and safe environment for the abused child that deals effectively with the abuse and returns the child to as near normal as possible

4. help the non-abusing whanau or family member/s to restore as quickly as possible their capacity to protect and care for the victim

5. provide comprehensive information concerning the treatment involved and the likely effects of non-treatment

6. ensure that the practices of health service providers do not further traumatise the abused child or the family

7. ensure that staff are involved in ongoing review of the safety of child abuse victims

8. acknowledge that receiving counselling and treatment does not automatically mean individuals are safe

9. recognise and ensure that counselling is kept distinctly separate from investigative procedures

10. ensure that victims of abuse are free from coercion from abusers, therapists, counsellors, or support agencies whose practices may invalidate the cultural values of victims and their families.

An effective healing process will:

11. improve how victims feel about themselves

12. aim to change attitudes, behaviour, and associated behavioural patterns of abusers

13. restore appropriate growth and development of the victims and their families

14. aid in restoring physical health through treatment and rehabilitation for injuries and illness.

Question to Consider

1. *Are these basic guidelines achievable within existing services? If not, how can they be achieved?*

CHILDREN, YOUNG PERSONS, AND THEIR FAMILIES ACT 1989

The Children, Young Persons, and Their Families Act 1989, requires health service providers to fulfil specific functions and responsibilities. Health service providers must therefore develop a comprehensive understanding of their responsibilities under the Act through clarifying their

roles and responsibilities, ensuring staff are adequately trained in respect of the Act and knowledgeable about local processes and agencies, and establishing and maintaining boundaries and responsibilities between voluntary and statutory agencies.

Questions to Consider

1. *Have any difficulties arisen in understanding and applying the Act? If so, what have they been and how were they resolved?*
2. *What monitoring mechanisms have been established to assess the application of the Act? If none, what procedures should be developed?*

INTERAGENCY NETWORKING

Due to the multidisciplinary nature of child abuse care and protection services, it is essential to establish liaison, negotiation, co-ordination, and co-operation between the Department of Social Welfare, Police and health service providers. This can be achieved by clarifying the roles, responsibilities, and boundaries of all agencies, and maintaining those boundaries where necessary. Health care providers may wish to consider appointing an advocate for the child to ensure that all the child's requirements for assessment to recovery are met.

Questions to Consider

1. *Did any difficulties arise during the process of interagency networking, and how were they resolved?*
2. *What monitoring procedures are in place to ensure, and assess, the effectiveness of interagency networking?*

COMMUNITY AGENCIES

Health service providers may need to acknowledge that community agencies may be the best service providers in certain areas of the care of child abuse victims, for example counselling. This is particularly relevant to Maori community agencies which should be identified as the primary experts in the field of child abuse affecting Maori whanau. Contracting the services of Maori community groups is only one facet of health service providers meeting their obligations under the Treaty of Waitangi.

Within some health service regions, there are established and effective community-based agencies with skilled and experienced staff working with child abuse victims and their families.

To establish an effective working relationship with these groups, health service providers will need to develop and maintain a close working relationship with community agencies whose services they may need to call upon. Community groups and/or culturally appropriate support people whose assistance is sought by health service providers should be contacted early in the assessment process.

Community Agencies Guidelines

Health care providers should:

1. be familiar with the lists of child abuse agencies included in the Department of Health's *Primary Health Care Approach to Child Abuse, An Information Package for Health Professionals*

2. identify local community agencies with appropriate skills in the area of child abuse

3. develop lists of all local community agencies whose services they are able to use

4. interact with community and statutory agencies when multi-generational abuse has occurred, so victims and families receive optimum care and support.

Questions to Consider

1. *To what extent have community agencies been used?*
2. *Which community agencies have provided support to health services providers?*
3. *Is further information required about community agencies which exist in your health service region?*
4. *Have there been difficulties in establishing and maintaining relationships with community agencies? If so, how have these been resolved?*
5. *What monitoring procedures have been established to assess the effectiveness of community group and health services partnerships, and any services that may have been provided by groups on behalf of the health services?*

STAFF

The safety of the child is paramount. Health service providers must therefore ensure that staff are provided with a basic knowledge and understanding of the indicators of child abuse, and the appropriate reporting procedures to follow. To help **everyone** who has contact with

children to gain this knowledge, health service providers should use the information in the Department of Health's *Primary Health Care Approach to Child Abuse, An Information Package for Health Professionals.*

Staff Guidelines

Health service providers should ensure their staff are:

1. provided with support and training, and given clear procedural guidelines to follow when caring for victims of child abuse

2. given supervisory support when working with child abuse victims. This is inherent in the principle that staff working with victims and families should never work alone

3. required to undergo burn-out assessment after eighteen months. This assessment should also include provision for staff to have relief from such work without risking their employment status

4. able to use the expertise of other agencies, such as the Department of Social Welfare and community groups.

Questions to Consider

1. *What information on indicators of abuse and procedural guidelines is available to all staff who have contact with children? (This includes all children, not only children who are victims of child abuse.)*
2. *What procedural guidelines are available to staff who have direct contact with child abuse victims?*
3. *What problems have occurred in providing and developing procedural guidelines? How have these been resolved?*
4. *What supervisory support is available to staff working with victims of child abuse?*
5. *What are the difficulties in providing supervisory support for staff?*
6. *Has the expertise of Department of Social Welfare staff been used? If so in what areas, and have there been difficulties? If so, what were they, and how were they resolved?*
7. *What monitoring procedures are in place to assess the effectiveness of procedural guidelines, supervision, staff performance, and use of outside personnel? If none exist, how will they be developed?*

STAFF TRAINING

Providers of health services need to ensure that staff who may have contact with abused children and their families are given the opportunity to receive training. Training should focus upon staff being able to recognise and analyse child abuse, understand why the cycle of abuse must be broken, and know how to respond appropriately to it.

Staff Training Guidelines

To ensure the training of their staff is adequate, providers of health services should:

1. ensure staff training includes understanding the short, medium and long-term effects of child abuse on victims

2. consider that such training may need to be part of the working contract of all employees likely to come into contact with child abuse situations

3. ensure staff receive adequate information on the indicators of child abuse, and that when any of the indicators appear they are mentioned in medical and nursing notes in a routine manner

4. consider establishing community and interagency training partnerships, so that the quality and quantity of work in this field is equitably resourced.

Questions to Consider

1. *Are training programmes in place for staff? If so, what provision has been made for the use of outside expert trainers?*
2. *What have been some of the problems in establishing and providing staff training? How were these overcome?*
3. *What monitoring procedures are present to assess the effectiveness of training? If none, what procedures are planned?*

REGISTERS

The primary function of registers should be to protect children who consistently present with unexplained or inadequately explained indicators of abuse. However, there is also an urgent need for information on the extent of child abuse. This information will play a critical role in developing future strategies to effectively and appropriately deal with child abuse.

Registers Guidelines

In establishing registers, health services should:

1. ensure information on the physical, sexual and emotional injuries that brought the child into contact with the health services are specifically recorded

2. develop their own procedures and protocols concerning children who are known by staff to be abused

3. develop policies that clarify how registers are used and kept

4. address issues of informed consent, parental rights, and confidentiality, using the knowledge of staff, ethics committees, and the expertise of those directly involved in child abuse.

Questions to Consider

1. *What difficulties do service providers perceive in developing and establishing registers? How might these be overcome?*
2. *What monitoring mechanisms should exist to assess the effectiveness of registers?*

EMPLOYMENT

It is imperative when ensuring the safety of children that known abusers and people with a criminal record for child abuse are not employed where children might be endangered. While it is acknowledged that gaining information on prospective employees may be difficult, health service providers will need to liaise with other agencies with responsibilities for the care and protection of children and young people, to assess how best this information can be gained and to develop policies and procedures for ensuring abusers are not employed.

Questions to Consider

1. *What policies and procedures have been developed for gaining information on prospective employees? What difficulties have occurred in the application of both policy and procedures? How were these overcome?*
2. *What monitoring procedures should be developed to assess the effectiveness of employment policies and procedures?*

ABUSERS

While it is recognised that health services provide varying degrees of treatment for abusers (for example, mental health services) it is essential to clarify the roles and responsibilities on the issues of assessment, counselling, therapy and treatment of abusers. This is a difficult area for health service providers due to the interface with the Justice Department.

Adolescent abusers are acknowledged as having particular needs for counselling, therapy and treatment to prevent the ongoing cycle of family violence, especially when the adolescent abuser has also been a victim of child abuse.

Abusers Guidelines

Health service providers will need to:

1. develop policies on the types of assistance that will be provided to abusers

2. negotiate and clearly define areas of responsibility for abusers with Police

3. recognise and support community groups which are skilled at counselling abusers. Within certain regions Maori groups have an effective system to monitor and treat offenders of child abuse

4. consider resourcing treatment programmes for abusers where counselling is provided by trained community-based counsellors

5. ensure that abusers and their victims do not attend assessment, counselling, therapy or treatment at the same place and time.

Questions to Consider

1. *What procedures have been developed to deal with known child abusers?*
2. *What type of assistance is offered to abusers?*
3. *What particular difficulties exist when dealing with adolescent abusers? How have these been resolved?*
4. *What monitoring procedures are in place to assess the effectiveness of programmes for abusers?*

RESOURCING CHILD ABUSE SERVICES

Until good monitoring and data collection procedures are established which reflect the short, medium and long-term effects that child abuse has on its victims, their families and the community, health service providers cannot realistically allocate appropriate levels of funding to support the work of healing and prevention. Service providers should therefore:

1. establish data collection and monitoring procedures

2. provide the best possible services within their funding allocations when considering how to provide counselling, therapy, and treatment for child abuse victims, their families and the community

3. be committed to actively addressing the effects of child abuse upon the victims, their families and the wider community.

Questions to Consider

1. *What resources are available to provide child abuse services? Are these adequate? If not, what is required? How can these requirements be met?*

2. *What monitoring procedures are established to ensure that child abuse services are being adequately resourced?*

Appendices

2 Definitions of Family Violence and Child Abuse

The definitions of family violence are taken from the *Family Violence Prevention Co-ordinating Committee statement on Family Violence (1987)*: The definitions of child abuse are taken – with some changes of wording – from the Department of Social Welfare Guidelines on Child Protection.

(1) Family Violence

Is violence that occurs between people connected by relationships (non-strangers), usually in a non-public place.

It includes a conduct that damages physically, emotionally, socially and/or mentally, and it can be of a physical, sexual and/or mental nature.

It involves fear, intimidation, emotional deprivation, assault with or without weapons, and sexual violation.

Such violence is often called 'domestic violence', 'child abuse', 'non-stranger rape', and 'incest/child rape', and it includes all these actions.

It occurs irrespective of age, social status or ethnic group – and it affects a significant number of people in the community.

Males are most often the aggressor, with females and children the predominant targets of this aggression.

It is perpetuated and supported by the abuse of the inherent power that some individuals/groups, institutions/racial groups have over others.

Ko nga raruraru e pa ana ki te tukino tangata, kei waenganui i nga iwi katoa.

He maha nga momo ahuatanga patu i te tangata penei i te kohuru, patu i nga waki katoa o te tinana, ko te tukino wahine, te mahi puremu, te patu me te raweke i te tamariki, te ngaronga ake o te whenua, me te whakaiti tonu i te tangata.

E pa ana tenei raruraru ki nga kaumatua, nga kuia, nga whaea, nga papa, te ranga, nga tamariki me nga mokopuna tahi o nga momo iwi katoa.

Kua kitea, ko nga tane tonu kei te patupatu i nga wahine me nga tamariki a, ki ta matou mohiotanga, he whakaiti tonu tenei i te whare tapu o te tangata me nga pakeke mo te Ao Hou.

E te iwi, me mutu i konei tenei mahi tukino tangata. Ma wai hei mahi? Mau, maku, ma tatou katoa.

(2) Child abuse

Child abuse is a term used to include several different types of abuse – physical, emotional, sexual. Other forms of abuse – such as 'failure to thrive' are described more in terms of a syndrome. Each type of abuse has particular characteristics and may require a different response.

Physical Abuse

The initial identification of the 'battered baby' focused on physical damage – primarily on fractures. However, physical abuse includes bruises, burns, damage from severe shaking, deliberate dunking in scalding water, cigarette burns, lacerations, poisoning and so on. There is usually visible evidence of physical abuse, though the differences between injuries caused by accident, illness or abuse can be slight. A competent medical assessment and report is crucial to establish the match between the injuries and their reported cause, and their likelihood in consideration of the age and competence of the child.

While the injuries may appear minor, they still need to be assessed and recorded, as they can be significant indicators of abuse and may show a pattern of escalation of abuse. There are problems of definition in physical abuse, especially in the area of discipline. The law expressly allows parents to use reasonable force to control children, and teachers may also hit children under certain conditions. It is difficult to define 'reasonable force', however. For example, is it abuse if discipline leaves bruises – or only if there are lacerations? A working definition indicates that bruises are a sufficient indicator of a situation to be investigated.

The study *Attitudes to Family Violence: A Study Across Cultures* (published by the Family Violence Prevention Co-ordinating Committee, Department of Social Welfare, 1988) contains an interesting discussion of these issues in a New Zealand context. Copies are available from the Department of Social Welfare.

Neglect

This is the most commonly alleged form of mistreatment. It is difficult to measure and to define. One definition is:

. . . omissions or commissions by a person having the care of a child which act against the normal development of the child. Examples of neglect include inadequate clothing, inadequate living conditions, failure to thrive without organic cause, lack of supervision, exposure to moral danger, children found wandering or abandoned and so on.

Again, while children need to be protected from the extremes of these omissions it is not clear where the line should be drawn. For example, cultural differences in child-rearing practices have sometimes been labelled as 'neglect'.

Another parental behaviour which can be defined as neglect is failure to obtain medical treatment for a child. Intervention raises difficult moral and ethical issues, especially if the parent's decision is based on religious or other personal beliefs. The debate between the family's right over a child versus society's responsibility is highlighted here.

Failure to Thrive

The syndrome described as failure to thrive can be clearly defined:

. . . a child who has some time in the first three years of life suffered a marked retardation or cessation of growth. (Kempe and Helfer, 1980)

'Failure to thrive' can be readily diagnosed by studying records of growth and development, and – after checking that there are no physical problems – by recording the growth in weight when the child lives somewhere else and is allowed to eat freely.

Every baby or small child – with only rare exceptions – grows steadily in height and weight despite considerable differences in diet, and despite the different levels of parenting skills in those who are bringing them up. When a small child fails to grow, this is an indicator that something is wrong physiologically, or that there may be serious problems between child and parent at home. The parent may be ill-informed about the child's needs, or may be seriously neglecting the child.

Emotional Abuse

As community and professional focus on abuse has sharpened, there has been an extension in the types of behaviour which are included in the label 'child abuse'. New Zealand has followed trends in other countries in moving from the recognition of physical abuse to also recognising the more hidden forms – such as emotional or psychological abuse.

Emotional or psychological abuse exists in all other types of abuse but can also be defined in its own right. It has been defined as:

. . . child abuse which results in impaired psychological growth and development. It frequently occurs as verbal abuse or excessive demands on a child's performance and results in negative self-image on the part of the child and disturbed child behaviour. (Garbarino and Garbarino 1980)

Specific examples of emotional or psychological abuse include: punishing a child for good or normal behaviour such as smiling and exploring; discouraging hugs and affection; and stopping a child from using social skills needed at school and with the peer group. Such examples, however, may be subject to debate because of their mono-cultural bias.

Clear evidence of emotional abuse is often difficult to gather and once gathered is difficult to use to promote change because families are frequently 'locked into' a cycle of (verbal) violence or established negative patterns of behaviour.

Sexual Abuse

Sexual abuse is described broadly as:

. . . the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate the social taboos of family roles. (Marzek and Kempe)

The strong taboo against sexual abuse of children reduces the likelihood of disclosure and admission, so that the whole family (and sometimes the workers) become involved in a powerful 'conspiracy of silence'. Workers have to rely on cues such as: emotional disturbance in the child, (especially sleep disorders, soiling and wetting, and tearfulness), running away from home; unusual sexual knowledge and play; and excessive masturbating. Occasionally there is physical evidence such as trauma to genitals or venereal disease.

Even when there is disclosure of sexual abuse, the social taboo is such that parents and family are motivated to deny any allegation – and it becomes the child's word against the adult. Any investigation into alleged sexual abuse is delicate and uncertain. As well, intervention risks further damage. Repeated telling of the tale – to a trusted friend or relative, then to a social worker, the police, and in the courts – causes further trauma. As well, the family unit is frequently broken up, and the child frequently feels responsible for this loss.

Sexual abuse is one of the most destructive forms of abuse with serious long-term affects on the child if the abuse remains hidden and no treatment is given. With incest the natural parent-child relationship is distorted with the child coerced into keeping the abuse a 'secret'. This leaves the child feeling unable to turn to a parent for help. In a primary-school-age child, the survival response is to appear to adapt. There may be no outward behavioural signs – but the child's ability to trust others may be severely damaged. The need for children to deny their own feelings in order to cope with repeated abuse often destroys their ability to trust themselves. This means the child's sense of reality can become distorted which can lead to later psychological problems if the abuse is not stopped and help given.

For children who speak out first during their adolescence, their repressed rage or depression can become expressed in suicidal self-destructive behaviour or in delinquency, substance abuse, and promiscuity. This often hides the fact that abuse is the underlying cause, decreases the likelihood that they will be believed, and creates major management problems for workers.

In child sexual abuse there is a strong probability – more so than in other forms of child abuse – that one or both of the child's parents will have been sexually abused themselves. For a non-offending parent who has been abused, the emotional effects of their own abuse can make it even harder to act to protect their child. In many cases there is also a pattern of incest across generations within the extended family. This makes it hard to find family resources where the child will be protected.

There is some danger that social panic about sexual abuse can draw attention away from the needs of other abused children. All forms of abuse can be seriously damaging – and a child is frequently subjected to several types of abuse at once.

EXECUTIVE SUMMARY: CHILDREN, YOUNG PERSONS & THEIR FAMILIES ACT

The intention with this paper is to help you gain a sense of the overall direction being taken in the new Act, rather than a detailed section by section explanation.

The General Context

This is an Act which ensures that the final responsibility for the care, protection and control of children and young people rests, through the Courts, with the State. It is also an Act which ensures that the functions and responsibilities of parents, families, whanau and family groups have been honestly and realistically confronted.

Although there is, as mentioned earlier, a clear demarcation of responsibility for the State, this Act also specifically provides for the State's responsibility for ensuring that families, whanau and family groups have been and continue to be involved in the decision making which relates to their own children and young people. At the same time, the duties of the Director General of Social Welfare have been broadened to provide the scope for a more proactive and developmental approach by DSW, as well as the capacity for crisis intervention.

CYP&F Act 1989

The short title is:

The Children, Young Persons and their Families Act (CYPF Act), 1989.

There are two jurisdictions:

* Care and Protection matters will be heard in the Family Court emphasising a welfare approach; and

* Youth Justice matters will be heard in a Youth Court, emphasising a justice approach.

Each jurisdiction has a co-ordinator who will be responsible for ensuring that the statutory intentions (such as diversion and whanau/family decision making) are realised.

OBJECTS

The Objects provide for the establishment of services and facilities which:

1. are <u>culturally appropriate</u>, ie. according to the preferences of different cultural groups;

2. are <u>accessible and easily understood</u>;

3. accept the primacy of family responsibility;

4. minimise disruption to children, young persons and their families, whanau and family groups;

5. assist in preventing harm to children and young people;

6. protect children and young people from harm;

7. encourage children and young people to be accountable for committing offences; and

8. encourage co-operation between agencies/organisations.

PRINCIPLES

The principles which must be accounted for in exercising powers under the Act, are that:

1. families, whanau, family groups must participate in the decision making;

2. families, whanau and family groups should be maintained and strengthened;

3. consideration must be given to the welfare of the child or young person, and of family, whanau, family group stability;

4. appropriate consideration must be given to the wishes of the child or young person;

5. the support of parents or guardians and the child or young person should be obtained where possible; and

6. a child or young person's sense of timing is influential in determining the timing of implementation of decisions.

DUTIES OF THE DIRECTOR GENERAL

The Director General of Social Welfare is charged with the responsibility for ensuring:

1. the attainment of the objects of the Act;

2. consistency with the principles;

3. that policies and issues which impact on children, young people and their families, whanau, or family groups are advised on and monitored;

4. services advance the well-being of children and young people;

5. the adoption of policies which enable the care, protection and development of children and young persons to be preserved;

6. that policies recognise the influence of economic, social and cultural values, as well as the particular values and beliefs of Maori people;

7. support for family, whanau, family group responsibility and keeping children and young people in their family contexts if possible;

8. the establishment of Care and Protection Resource Panels made up of persons from occupations and organisations concerned with the care and protection of children and young persons;

9. regular review of cases;

10. adequacy of training and compliance with appropriate standards;

11. services are monitored and assessed;

<u>In Relation to the Duties of the Court and Others</u>

12. parents and others are informed of decisions;

13. provision of interpreters if required;

14. proceedings are explained;

15. the child or young person is encouraged to participate; and

16. that the distress of medical examinations is minimised.

PART II - CARE AND PROTECTION

CARE AND PROTECTION PRINCIPLES

1. Children and young people are entitled to be free from harm, have their rights upheld and welfare promoted;

2. Primary responsibility for care and protection rests with families, whanau and family groups;

3. Families, whanau, hapu, iwi and family groups should be supported and protected;

4. Only minimal intervention should be used;

5. Family, whanau, hapu, iwi, family group, cultural and social contexts should remain undisturbed;

6. Where possible, care and protection should be sought within the child's family, whanau, hapu, iwi, family group context;

7. A child should not be removed from his/her family, whanau, hapu, iwi or family group unless there is a <u>serious</u> risk of harm;

8. When removal is required, placement priority is given to:

   * other family, whanau, hapu, iwi or family group members;

   * an appropriate family context where the child is in a familiar locality, and where his/her links with family, whanau, family group are maintained and strengthened;

   * a family like environment in which a sense of belonging (personal and cultural) is attainable, as long as the child is safe and free from harm;

9. Where a child cannot be maintained in his/her family, whanau, family group context, priority placement with significant others (such as members of hapu, iwi, or those living in the same locality as the child or young person) is desirable.

<u>DECIDING FACTOR</u>

Where, in relation to care or protection, or in relation to matters involving children and young persons in care, any conflict of principles or interests arise, the welfare and interests of the child or young person is the deciding factor.

<u>DEFINITION OF CHILD OR YOUNG PERSON IN NEED OF CARE OR PROTECTION</u>

A child or young person is in need of care or protection if:

1. he/she is suffering or likely to suffer harm;

2. there is serious impairment or neglect of the child or young person's development or well-being;

3. serious differences between a child or young person and his/her caregivers cause a serious impairment of the child or young person's well-being;

4. a child or young person's behaviour is such that it is or likely to be harmful, and his/her caregivers are either unable or unwilling to control him/her;

5. a child between the age of 10 and 14 has committed an offence which gives rise to serious concern about his/her well-being;

6. the caregivers are unwilling or unable to offer the care and support necessary;

7. the child or young person has been abandoned;

8. serious differences exist between a parent, guardian or other caregiver, and any other person who is caring for the child or young person, such that the differences affect the child or young person's well-being; and

9. the child or young person's ability to develop a significant psychological attachment with a caregiver (who has been charged with the responsibility of maintaining the child or young person apart from his/her family) is seriously impaired.

KEY POINTS AND PROCESSES IN THE CARE AND PROTECTION AREA

The Act supports:

* voluntary notification of suspected abuse, rather than compulsory reporting, although, every report must be investigated if that is necessary or desirable. At the same time, there is no liability incurred by those who report unless the report has been made in bad faith;

* a common process of decision making where there is an established need for care and protection measures. The process revolves around the family group conference which supports family, whanau, family group decision making;

* the establishment of the position of Care and Protection Co-ordinator who will be responsible for convening family group conferences;

* a range of orders by the Court, including:

  a. discharge of the child or young person, or the caregiver;
  b. an order to bring the person back before the Court within 2 years;
  c. an order that the child or young person or caregiver or the abuser receives counselling;
  d. a services order which directs a person or organisation to provide services and assistance as required;
  e. a restraining order (akin to a non-molestation/non-violence order);
  f. a support order;
  g. a custody order for the child or young person to be placed in the custody of the Director General, an Iwi Authority, a Cultural Authority, the Director of a Child and Family Support Service, or any other person;
  h. a guardianship order, in which any of the above named persons or authorities can be appointed guardian, either additional to other guardians, or as sole guardian (except in the case of a Child and Family Support Service); or
  i. an access order.

- provision for temporary or extended care agreements involving the Director General, an Iwi Authority, a Cultural Authority or a Child and Family Support Service;

PART III

PROVISIONS RELATING TO PROCEDURE

Included here, are sections providing for:

- the extension of the appointment of Counsel for the Child and/or lay advocate. Each is seen to be a means of ensuring that the child or young person's best interests are served;

- the calling of a mediation conference upon request where an application is made;

- the Court's obtaining cultural and community reports;

- no time limit on adjournments;

- as far as practicable, applications for a declaration to begin to be heard within 60 days of being filed; and

- new investigative procedures.

PART IV

YOUTH JUSTICE

Introduction

The Offender's age will determine whether proceedings will be conducted by way of civil or criminal jurisdiction:

- proceedings involving 10 - 13 year olds will be heard in the Family Court; and

- proceedings involving 14 - 16 year olds will be heard in the Youth Court.

However, murder and manslaughter by children 10 - 13 years of age will be dealt with by way of criminal proceedings.

YOUTH JUSTICE PRINCIPLES

1. Criminal proceedings should not be instigated against a child or young person if there is another means of dealing with the matter;

2. Proceedings should not be used as a means of providing assistance or services to enhance the welfare of a child, young person, family, whanau or family group;

3. Measures taken for dealing with offending should strengthen families, whanau and family groups, and should foster their ability deal with the offending themselves;

4. A child or young person who commits an offence should, as far as possible, be kept in his/her community;

5. A child or young person's age is a mitigating factor when determining sanctions;

6. Sanctions should still be able to contribute to the ongoing development of the child or young person in his/her family context, and should be the least restrictive;

7. The interests of victims of offences should be accounted for in measures taken to deal with the offending; and

8. The vulnerability of children and young persons entitles them to special protection during investigations.

KEY POINTS AND PROCESSES IN THE YOUTH JUSTICE AREA

- Enforcement Agency powers of arrest are to be similar to those for adults. Therefore, the fact that a child or young person is in need of care and protection will not be a ground for arrest without warrant;

- In recognition of the vulnerability of children and young people during investigations, the Act specifically:

  a. guides the actions of law enforcement agencies;
  b. establishes the rights of the child or young person under investigation; and
  c. establishes rules governing the admissibility of evidence.

- Children and young persons must informed of their rights before being questioned;

- Where an enforcement officer has decided to charge, the child or young person must be informed of his/her rights;

- Statements are not admissible unless the child or young person has been informed of his/her rights, and statements are admissible only if made in the presence of an adult other than the enforcement officer;

- The child or young person is entitled to consult with an adult member of the family, whanau or family group, or with any other adult chosen by him/her. As well, he/she is entitled to consult with a barrister;

* There is a specific set of provisions for establishing the right of parents and/or guardians or caregivers to be informed that their child or young person is being questioned at an enforcement agency office, and that they may visit and consult the child or young person if they wish. Furthermore, no communication during that visit will be admissible as evidence for the prosecution;

* Parents and/or guardians or caregivers are to be notified where any child or young person is arrested and charged with an offence;

* There is a presumption in favour of releasing a child or young person who has been arrested to a person or persons who can care for him/her, pending a court appearance;

* There is, however, provision for a child or young person to be held in DSW or Police custody, although a child or young person cannot be held in custody because he/she is in need of care and protection;

* There is provision for a Family Group Conference (FGC) which is a process which parallels that defined in the Care and Protection part of the Bill. The Conference must be held where:

  a. the Police wish to prosecute a child or young person who has not been arrested;
  b. before a court hears any matter where the young person has been arrested, except where the young person denies the charge after consulting a Barrister or Solicitor;
  c. where the young person has been placed in custody by the court; and
  d. where the charge is found to be proven after a hearing, and a family group conference has not considered ways in which the young person might be dealt with for the offence.

* A Youth Justice Co-ordinator will be appointed for every Social Welfare District, to convene the FGC and to co-ordinate and facilitate its processes;

* Family Group Conferences must occur within certain time limits, with even tighter time limits if the young person is in custody;

* The family, whanau, family group is to be consulted about who should attend the conference, and the date, time and place, as well as the procedure of the conference itself;

* The Family Group Conference consists of officials, the child or young person, the barrister or solicitor (if any), representing the child or young person and the family, whanau or family group itself, but none of the officials (including the barrister or solicitor) may take part in any deliberations made by the family group unless invited to do so;

* The FGC is:

  a. a potential means of avoiding prosecution if possible;
  b. a vehicle of giving advice to the court on how the young person should be dealt with for the offence; and
  c. adviser to the court in relation to the custody of a young person pending any outcome;

* The FGC may recommend:

  a. whether proceedings which have already begun (following arrest) should go ahead or be discontinued;
  b. a Formal Police caution instead of prosecution;
  c. care and protection proceedings; or
  d. appropriate penalties where a charge has been proven;

* The Youth Justice Co-ordinator seeks agreement of all the parties to the decisions, recommendations and plans of the FGC;

* Enforcement agencies and DSW are to comply with the decisions, recommendations and plans of the FGC unless they are clearly impracticable or inconsistent with the principles of the Bill;

* The Youth Court must consider the recommendation of the FGC;

* The Court may adjourn the proceedings and refer a matter to a Care and Protection Co-ordinator;

* A Youth Court cannot make any orders unless the FGC has been held, and it must have regard for the recommendations of the FGC. Furthermore, it cannot make any of the supervision or community work orders for care and protection reasons;

* Orders which can be made, include:

  a. Community Work order;
  b. Supervision order;
  c. Supervision with Activity order, which is an order which can be made in favour of the Director-General, an Iwi or Cultural Authority or any other person or organisation specified in the order; and
  d. Supervision with Residence order, which can only made in favour of the Director-General.

* All Orders are strictly time-limited.

* The person or organisation supervising any Order for the Court, is required to give the Court a written report on the effectiveness of the Order;

* Provision is made for serious matters to be dealt with by the District Court for 15 - 16 year olds.

PART V

PROVISIONS RELATING TO PROCEDURE IN THE YOUTH COURT

- Provision has been made for the appointment of Youth Advocates for a young person during any Youth Court and any subsequent District Court proceedings;

- Provision is also made for a range of people (including a parent, guardian, lay advocate) to make representations to the Court on the young person's behalf, and to obtain cultural or community reports.

PART VII

RELATING TO CHILDREN AND YOUNG PERSONS IN THE CUSTODY OR CARE OF THE DIRECTOR-GENERAL, AN IWI AUTHORITY OR CULTURAL AUTHORITY, OR A CHILD AND FAMILY SUPPORT SERVICE

Includes provision for secure care of children and young persons in Social Welfare residences.

- The grounds for the use of secure care in DSW Institutions are limited to:

    a. where the child or young person has a history of absconding and is likely to abscond unless in a secure care environment, and likely to be harmed if absconds; or

    b. where he/she is at serious risk of harm to himself/herself, or to others;

- DSW's use of secure care is also limited to a 72 hour period, and can only be extended (by Court Order). However, the Order is not an order for a child or young person to be held in secure care necessarily. Rather, it is authority for the child or young person to be held in secure care, ie. in a DSW residence, for up to 2 weeks;

- Where a child or young person is being held in secure care, the family, whanau or family group may make an immediate application to the Court for a review of the placement.

PART VIII

PROVISIONS RELATING TO IWI AUTHORITIES, CULTURAL AUTHORITIES, CHILD AND FAMILY SUPPORT SERVICES AND COMMUNITY SERVICES

These sections relate to the approval, funding and contracting of services for the provision of services.

PART IX

Provides for a Commissioner of Children to be appointed, and sets out the functions and powers of the Commissioner.

PART X

Care and Protection Resource Panels are provided for as advisory bodies appointed by the Director-General.

PART XI

TRANSITIONAL PROVISIONS

Where a hearing has commenced before the new Act becomes effective on 1 November, the Children and Young Persons' Court will complete the matter, and disposition will be under the equivalent provisions of the new Act.

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