WORLD PSYCHIATRIC ASSOCIATION
Position Statement on Safeguarding Children

Steering Group
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INTRODUCTION

Childhood adversity refers to a broad range of events and experiences that can have a negative and lasting impact on the developing child. Childhood adversity is a global problem that creates challenges for governments that are concerned about promoting the welfare of children, protecting them from harm and fostering healthy development into adulthood.

The UK government tried to tackle this problem and, in the process, adopted the term "safeguarding children" to represent the principle of going well beyond "child welfare," and creating a comprehensive view of protecting children from adversity. "Safeguarding" is defined as:

- Protecting children from maltreatment;
- Preventing impairment of children's health or development;
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and,
- Taking action to enable all children to have the best outcomes.[1]

Taken together, this succinctly models an affirmative plan to protect children, their futures, and ours.

This document should be read in conjunction with documents including curriculum prepared for managing Child sexual, physical and emotional abuse.

EVIDENCE

Epidemiology of Childhood Adversity

The concept of childhood adversity seems to be straightforward enough but, perhaps not surprisingly, there is a lack of a global consensus on the how to actually define adversity. In turn, this has made it difficult to acquire data for real estimates of the extent of childhood adversity and its impact on children. One definition about which there appears to be a consensus has come to serve as a proxy for childhood adversity. The World Health Organization (WHO) has developed a definition for child maltreatment:

> "the abuse and neglect of children under 18 years of age. It includes all types of physical and/or emotional maltreatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power."[2]

This is close to the capturing some elements of adversity but fails to incorporate the full nature and scope of the problem. While this definition covers abuse and neglect, it misses other critical aspects of childhood adversity and fails to address different

cultural practices for childrearing. But, this is a starting point for enhancing recognition of the problem so that there can ultimately be improved recognition of the problem, improved measurement of prevalence and consequences, and ultimately, mobilization of resources for intervention and prevention.

Child abuse and neglect are often lumped together for reporting purposes, even though there is evidence to suggest that abuse and neglect may result in different outcomes. While there is a great deal of scientific literature on neglect in early life, the most compelling data come from children raised in institutions. One early study examined British children raised in residential nurseries. While the children had access to adequate material resources, the nursery caregivers were discouraged from forming attachments to the children. The study showed that among the 26 children institutionalized between ages 2 and 4 years, 8 were withdrawn and unresponsive, and 10 were socially indiscriminate and superficial in a manner that is consistent with the current concepts of reactive attachment disorder or disinhibited social engagement disorder.[3,4] Harm resulting from neglect has been verified in numerous other studies.[5,6]

The more recent Bucharest Early Intervention Study provides even more compelling evidence that neglect can lead to long-lasting, devastating effects.[7] This study examined children placed at or around the time of birth in State-run Romanian orphanages; it compared the children who remained in the institutions to those who entered foster care as well as to never institutionalized children. Over the course of a 12-year follow-up, findings showed that children who experienced early adversity and deprivation had deficits in cognition, language, and attachment when compared to children never exposed to institutional rearing.[8] Those receiving foster care showed fewer symptoms at age 12.[9] This work provides important insights into the effects of early deprivation and adversity on developmental outcomes for children and, along with other work, gives credence to significant social and biological consequences of deprivation and adversity.

By any measure, childhood adversity is a problem of staggering proportions. A series of meta-analyses attempting to estimate the global prevalence of child abuse and neglect found that most of the data came from North America or Europe.[10] Among self-report studies there was an overall prevalence of 12.7% for sexual abuse (7.6% among boys, 18.0% among girls), 22.6% for physical abuse, 36.3% for emotional abuse, 16.3% for physical neglect, and 18.4% for emotional neglect.[10] These are surely underestimates especially given the notorious problem of under-reporting. Further, these figures fail to take into account those children who are victims of war, forced migration, abject poverty, lacking in educational opportunity, poor hygiene and much more. In short, childhood adversity is highly prevalent and incredibly devastating to the developing child. This means that child adversity is a major public health problem of tremendous size and scope that demands our fullest attention.

Consequences of Adverse Childhood Experiences (ACEs)

The WHO World Mental Health (WMH) Survey Initiative[11] examined indicators of childhood adversity, including:

- Interpersonal Loss
    - parental death
    - parental divorce
    - other separation from parents
- Parental Maladjustment
    - mental illness
    - substance misuse
    - criminality, violence
- Child Maltreatment
    - physical abuse
    - sexual abuse
    - neglect
- Life-threatening Physical Illness
- Family Economic Adversity

This study found that, across countries with different levels of economic development, these indicators of childhood adversity were highly prevalent and often co-occurring. Nearly 40% of respondents reported experiencing at least one type of adversity. Worldwide, the most common childhood adversities were parental death (12.5%), physical abuse (8.0%), parental divorce (6.6%), and family violence (6.5%).[11]

The scientific literature demonstrates a strong association between childhood adversity and long-term health consequences. The US Centers for Disease Control and Prevention (CDC)-funded the Adverse Childhood Experiences (ACE) Study asked over 17,000 adults in US primary medical care settings about several categories of adverse childhood experiences.[3] These categories were empirically, based on their high prevalence in this largely middle-class population with health insurance as well as data from the childhood trauma literature in the early 90s when the study was planned. Researchers found that following categories of experiences, before age 18, were common: emotional abuse (11%), physical abuse (28%), sexual abuse (28% women, 16% men, 22% overall), physical neglect (10%), emotional neglect (15%), domestic violence (13%), incarcerated household member (6%), household substance abuse (27%), household mental illness (17%), and not raised by both biological parents (23%).[12]

The ACE study calculated cumulative risk by combining ACE exposures into an "ACE Score." The authors found that specific types of adversity rarely occur in isolation. The study authors discovered a dose-dependent relationship between exposure to ACEs and negative mental and physical health measures in adulthood, including depression, substance use, obesity, coronary heart disease, chronic obstructive pulmonary disease, and more.[13-15] Subsequent reports from the ACE Study indicate that corporal punishment contributed to negative outcomes along the same dimensions as physical and emotional child abuse; this was in addition to the harm

from other forms of maltreatment.[16] While 52 countries have now banned all forms of child corporal punishment,[17] attempts to reduce other ACEs have been less productive.

Research linking childhood exposure to adversity with risk for later development of psychopathology has been extended to other population-based samples.[11,18-20] These studies have found that increased numbers of ACEs are associated with a higher risk for negative developmental outcomes. An analysis using data from the WMH Surveys estimates that childhood adversities account for 29.8% of all psychiatric disorders across countries.[11]

The ACE study sets the stage for increased attention to childhood adversities as a public health issue. There have been efforts by 38 US states to implement the US Behavioral Risk Factor Surveillance System.[21] The authors of the ACE study have also worked with the WHO to devise an ACE questionnaire adapted for a global audience. These are important but yet to be completed steps to quantify and characterize ACEs, their consequences, and opportunities for prevention and early intervention.

RECOMMENDATIONS

It is an absolute priority to safeguard children from Adverse Childhood Experiences so that all children have the opportunity for optimal development and developmental outcomes. We suggest the following priority areas:

1. Policy Change
   It now clear that Adverse Childhood Experiences are now a known and established risk for seriously adverse developmental outcomes. Therefore, it is the responsibility of all national governments and their agencies as well as non-governmental organizations to prevent exposure to Adverse Childhood Experiences. This means a concerted commitment of all parties to provide for all children:
   - Healthcare (including maternal care, prenatal care, and vaccines)
   - Clean water and sanitation
   - Appropriate food and nutrition
   - Appropriate shelter
   - Safe communities with protection from violence and fear
   - Education
   - Protection from family separation
   - Protection from forced migration
   - Protection from participation in violence and war

2. **Prevention**

Since the nature and cause of ACEs are well-established, all communities must work to minimize childhood maltreatment.[22] This includes the basic elements of healthcare, housing, food, and safety as well as support for families and communities to provide care for their developing young. By preventing developmental adversity, communities will reduce the burden of disease as well as increase their overall health and prosperity.

3. **Early Intervention and Treatment**
   When adversity cannot be prevented, early intervention and evidence-based treatment is essential to minimize the adverse effects of ACEs. In order to meet this challenge, there must be a commitment to the development of safe and healthy environments as well as appropriately trained medical and mental health workforces that can support children and families, as well as schools and other agencies responsible for the care of children.

4. **Integration**
   Unfortunately, adversity is pervasive. Therefore, it is essential that the resources to identify, prevent, and treat the consequences of exposure to ACEs must be fully integrated into healthcare, social services, education, community services, and law enforcement agencies. This will allow for better information sharing as well as more efficient and effective resource utilization, along with monitoring of epidemiologic trends and allocation of resources.

5. **Research**
   There is still much to be learned about the causes and consequences of exposure to adverse childhood experiences. As a result, it is important to make a commitment to invest in further research on understanding the ways that adverse childhood experiences affect later life outcomes. All forms of research are essential: medical, psychological, biological, epidemiological, etc. With this new understanding comes the opportunity to develop prevention, early intervention, and treatment that can protect children and their families.

REFERENCES

1. Working together to safeguard children: statutory guidance on inter-agency working to safeguard and promote the welfare of children. London: Dept. of Education; 2015.
2. Refugees UNHCf. Refworld | Global Status Report on Violence Prevention 2014. *Refworld*.
3. Tizard B, Rees J. The effect of early institutional rearing on the behaviour problems and affectional relationships of four-year-old children. *J Child Psychol Psychiatry* 1975; **16**(1): 61-73.
4. Tizard B, Hodges J. The effect of early institutional rearing on the development of eight year old children. *J Child Psychol Psychiatry* 1978; **19**(2): 99-118.
5. Gilbert R, Widom CS, Browne K, Fergusson D, Webb E, Janson S. Burden and consequences of child maltreatment in high-income countries. *Lancet* 2009; **373**(9657): 68-81.
6. Lionetti F, Pastore M, Barone L. Attachment in institutionalized children: a review and meta-analysis. *Child Abuse Negl* 2015; **42**: 135-45.
7. Nelson CA, Fox NA, Zeanah CH. Romania's abandoned children : deprivation, brain development, and the struggle for recovery. p. 1 online resource (415 pages).
8. Zeanah CH, Egger HL, Smyke AT, et al. Institutional rearing and psychiatric disorders in Romanian preschool children. *Am J Psychiatry* 2009; **166**(7): 777-85.
9. Humphreys KL, Gleason MM, Drury SS, et al. Effects of institutional rearing and foster care on psychopathology at age 12 years in Romania: follow-up of an open, randomised controlled trial. *Lancet Psychiatry* 2015; **2**(7): 625-34.
10. Stoltenborgh M, Bakermans-Kranenburg MJ, Alink LR, van Ijzendoorn MH. The prevalence of child maltreatment across the globe: Review of a series of meta‐analyses. *Child Abuse Review* 2015; **24**(1): 37-50.
11. Kessler RC, McLaughlin KA, Green JG, et al. Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *Br J Psychiatry* 2010; **197**(5): 378-85.
12. Felitti VJ, Anda RF. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behavior: implications for health care. In: Lanius RA, Vermetten E, Pain C, editors. The impact of early life trauma on health and disease the hidden epidemic. Cambridge: Cambridge University Press,; 2010. p. xvii, 315 p.
13. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med* 1998; **14**(4): 245-58.
14. Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, Anda RF. Adverse childhood experiences and the risk of depressive disorders in adulthood. *J Affect Disord* 2004; **82**(2): 217-25.
15. Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, Anda RF. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics* 2003; **111**(3): 564-72.

16. Afifi TO, Mota N, Sareen J, MacMillan HL. The relationships between harsh physical punishment and child maltreatment in childhood and intimate partner violence in adulthood. *BMC Public Health* 2017; **17**(1): 493.
17. Welcome to the Global Initiative - Global Initiative to End All Corporal Punishment of Children.
18. Green JG, McLaughlin KA, Berglund PA, et al. Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: associations with first onset of DSM-IV disorders. *Arch Gen Psychiatry* 2010; **67**(2): 113-23.
19. McLaughlin KA, Greif Green J, Gruber MJ, Sampson NA, Zaslavsky AM, Kessler RC. Childhood adversities and first onset of psychiatric disorders in a national sample of US adolescents. *Arch Gen Psychiatry* 2012; **69**(11): 1151-60.
20. Bjorkenstam E, Burstrom B, Vinnerljung B, Kosidou K. Childhood adversity and psychiatric disorder in young adulthood: An analysis of 107,704 Swedes. *J Psychiatr Res* 2016; **77**: 67-75.
21. Anda RF, Butchart A, Felitti VJ, Brown DW. Building a framework for global surveillance of the public health implications of adverse childhood experiences. *Am J Prev Med* 2010; **39**(1): 93-8.
22. Mikton C, Butchart A. Child maltreatment prevention: a systematic review of reviews. *Bull World Health Organ* 2009; **87**(5): 353-61.