2 Individual factors that contribute to child vulnerability

This chapter examines five individual factors contributing to child vulnerability: disability, mental health, immigrant background, maltreatment and being in out-of-home care. It provides evidence on how these factors affect child well-being and later adult outcomes.

Introduction

Individual factors contributing to child vulnerability stem from cognitive, emotional and physical capabilities or personal circumstances, for instance age, disabilities, a child's own disposition or mental health difficulties. They can be invariable, such as belonging to an ethnic minority or having an immigrant background, or situational, such as experiencing maltreatment, being an unaccompanied minor or placed in out-of- home care. This chapter examines five individual factors and how they affect child well-being and later adult outcomes.

Disability

Children with disabilities are a very broad group with varying capabilities and needs whose individual functioning is limited by physical, intellectual, communication and sensory impairments and various chronic conditions. Children with disabilities have more extensive health needs, a greater rate of unmet health, educational and therapeutic needs, and experience higher social and environmental barriers to full participation. In younger children, disability is a delay or deviation in the expected developmental trajectory (Halfon et al., 2012[1]).

OECD countries operationalise different frameworks for measuring childhood disability. Some include long-term impairments only, while others count illnesses that are likely to resolve in time. Ireland, for example, applies the International Classification of Functioning, Disability and Health (ICF) framework, which incorporates the bodily and social dimensions of disability and particularly recognises the susceptibility of people with disabilities to exclusion from everyday life. More aligned definitions of childhood disability among countries would allow meaningful comparisons of prevalence and be a resource for better policy development across the lifecycle.

OECD countries collect data on childhood disability through specialised surveys and/or censuses. Given the level of detail required, under-reporting is more common in censuses (OECD, 2010[2]). The most up-to-date data comes from the 2004 Global Burden of Disease study, which recorded that the prevalence of moderate and severe disabilities among children in the 0-14 age group in high-income countries is nearly 3%, almost half the global rate of over 5%. At the country level, in the United Kingdom, 8% of children and young people between the ages of 0-19 years have a disability based on any physical or mental health condition or illness that lasts or is expected to last for 12 months or more which limits ability to carry out day-to-day activities (DWP, 2018[3]). In Canada, based on parents' responses to a survey on disability, nearly 4% of the 0-14 age group have a physical or mental health condition or health problem that restricts their ability to engage in activities of daily living (HRSD Canada, 2011[4]).

The outlook for children with disabilities has changed considerably over the last few decades. Improvements in health care have allowed them to enjoy a better quality of life. For example, children born with Down syndrome, the most common genetic form of disability, can now expect to live to 60 years of age and in much better health (Glasson et al., 2016[5]). Inclusive education policy has emphasised the need for equal opportunities for students with disabilities or special needs and has reduced segregation in mainstream schools (NCSE, 2010[6]). Access to local schools also facilitates children living at home with their families and integration in the community.

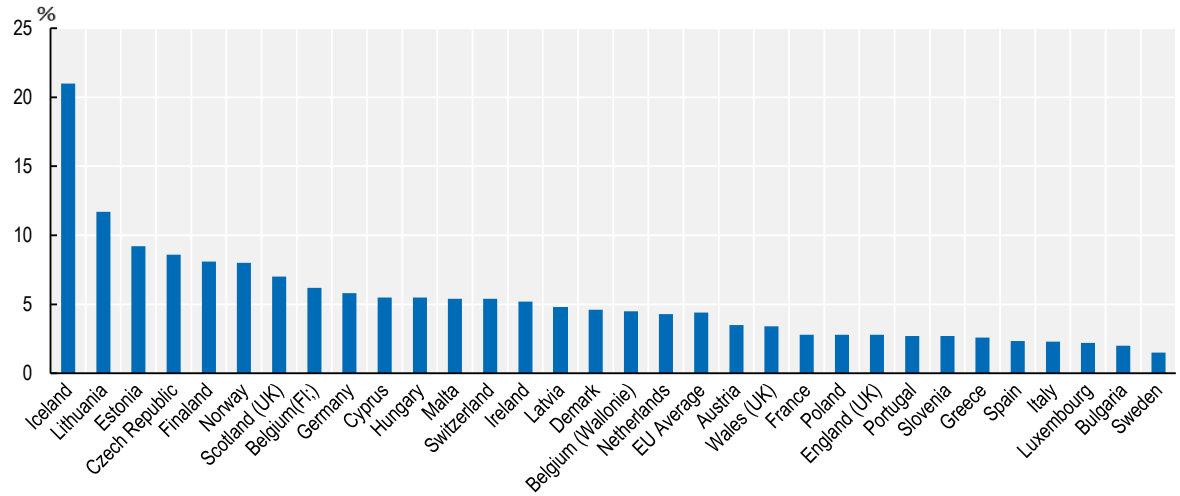
Nonetheless, children with disabilities continue to experience greater adversity and poorer outcomes. They are over-represented in institutional care settings, particularly in transition economies (Opening Doors for Europe's Children, 2017[7]) (Berens and Nelson, 2015[8]). They are more likely to experience maltreatment, particularly neglect (Paquette et al., 2018[9]), and are at higher risk of bullying victimisation (Emerson, 2012[10]) and violence (Jones et al., 2012[11]). They have lower educational attainment, particularly children from lower socio-economic backgrounds (Sentenac et al., 2019[12]).

Children with disabilities are twice as likely to live in low socio-economic households in OECD countries (Spencer, Blackburn and Read, 2015[13]). The reasons for this association are not clear, but one possible explanation is the negative impact of poor social and environmental conditions during pregnancy and early childhood on child development. There is some evidence of an association between Autism Spectrum Disorder (ASD) and low-economic status. Research from Sweden suggests that children from lower-income families and of parents with manual occupations are at higher risk (Rai et al., 2012[14]), while French research found that the rate of children with ASD with an associated intellectual disability is higher in areas with the highest levels of deprivation (Delobel-Ayoub et al., 2015[15]). Moreover, the financial and time resources parents allocate to caring for a child with a disability can worsen economic hardships. Parents also shoulder significant pressures placing them at a heightened risk of poor physical and mental health.

Children with disabilities face particular challenges in succeeding in their education. At the European Union level, over 4% of children are assessed as having a special education need, i.e. a disability or difficulties with learning. There are large variations between countries, from almost 2% in Sweden to around 21% in Iceland (Figure 2.1). Ninety-seven percent of 9 year-olds and almost 99% of 15 year-olds diagnosed with an official special education need attend mainstream education.[1] Boys are twice as likely as girls to have a special educational need. Evidence suggests that boys are more likely to have difficulty coping with mainstream school environments, are more often referred for special needs assessments and receive more support (Rix et al., 2013[16]).

Educational transitions, such as starting school or ageing out of compulsory state schooling, are a critical time for children with disabilities. Children face the risk of educational and social exclusion, and therefore diminished outcomes, when the necessary supports are not in place in the school environment. These include assisted technologies, physical accessibility, extra learning support, trained teachers and investment in labour market insertion for young adults.

Figure 2.1. Percentage of children in the EU with a special educational need, 2016



Note: Percentage of pupils with an official decision of SEN, based on the enrolled school population (%).
Source: European Agency for Agency for Special Needs and Inclusive Education 2016 database.
www.european-agency.org/resources/publications/european-agency-statistics-inclusive-education-2016-dataset-cross-country.

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Mental health difficulties

The WHO defines mental health as "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2004, p. 59[17]). Good mental health means not only the absence of symptoms and disorders, but also positive well-being and the ability to cope with difficulties.

Much of the foundations for well-being are laid during childhood, and efforts should be made to ensure that they are strong and healthy. Poor mental health emerges early: half of all lifetime cases start by the age of 14 years (Kessler et al., 2005[18]) and 75% before 25 years (McGorry et al., 2011[19]). Despite this, treatment usually does not begin until later due to stigma, lack of awareness and other cultural and social factors.

Comparing the prevalence of childhood mental health difficulties between OECD countries is difficult due to differing definitions and related statistical frameworks. Based on a systematic review using 2010 and 2013 Global Burden of Disease study data, the global prevalence of mental health difficulties among children and adolescents aged 5-17 years across a number of disorders (i.e. conduct disorders, attention deficient hyperactivity disorders (ADHD), autism spectrum disorders (ASD), eating disorders, depression and anxiety) was almost 7%. This figure paints an incomplete global picture, as data from low- and middle-income countries is very limited (Erskine et al., 2017[20]). Studies from individual OECD countries show higher prevalence rates: England at almost 13% (NHS Digital, 2018[21]); Poland 9% (ENOC, 2018[22]); and New Zealand 8%[2] (MoH, 2018[23]).

Certain disorders, such as Autism Spectrum Disorder (ASD), fall in between disability and mental health classifications. ASD is considered a neurodevelopmental disorder, as symptoms typically emerge as developmental delays in a child's first two years of life. According to the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5), people with ASD have difficulties – within a wide degree of variation – in communicating and interacting with others, restricted interests and repetitive behaviours, and significant impairments in social, occupational or other important areas of functioning. Some children with ASD have normal levels of intelligence, while others have mild or significant intellectual disabilities or are gifted (Association of American Psychiatrics, 2015[24]). Under-identification of ASD is associated with language barriers, a lack of parental awareness and, in the case of some countries, stigma (OECD, 2017[25]).

Globally, the prevalence of mental health difficulties among children and youth is increasing (Moffitt et al., 2010[26]; West and Sweeting, 2003[27]). For example, at the country level, England (United Kingdom) reports small increases over time: from slightly below 10% in 1999 to just above 10% in 2004, and more than 11% in 2017 (NHS Digital, 2018[21]). Potential factors behind this rise in prevalence are increased interest in and awareness of emotional well-being, and an increase in help-seeking behaviours. There is also better detection, particularly of rare conditions. A systematic review of time trends in the reporting of mental health difficulties across certain OECD and non-OECD countries showed no improvements or changes for toddlers and children, mixed results for adolescent boys and an increase in reporting of internalised difficulties for adolescent girls. Researchers concluded that the increase in readiness to report is unlikely to be a key explanatory factor in the rise in mental health difficulties among adolescent girls and boys (Bor et al., 2014[28]).

Overlapping factors contribute to poor childhood mental health, for example rising wealth and income inequalities, weakening of the family unit and support systems, Internet and social media, perceived inferior social status, poor body image and high academic pressures (Bor et al., 2014[28]). Inequality has been linked with greater psychological distress and poor mental health in adolescents through data from the Health Behaviour of School-aged Children Study (HBSC). A time series analysis of data for 34 countries associated higher national inequality with greater reporting of psychological symptoms and more pronounced differences between socio-economic groups in psychological, physical and subjective

well-being (Elgar et al., 2015[29]). Another study measuring the association between relative affluence (where children rank economically among peers) versus absolute affluence and self-reported psychosomatic symptoms (physical complaints with a psychological and emotional cause) found that relative affluence was a better predictor for psychosomatic symptoms and related to symptoms even when differences in absolute affluence were held constant (Elgar et al., 2013[30]).

Children and adolescents from low socio-economic backgrounds are two to three times more likely to develop mental health difficulties than peers from high socio-economic backgrounds. Furthermore, children from low socio-economic backgrounds are more likely to suffer from more than one disorder. The negative effect of low socio-economic background on mental health is strongest for children under 12. Childhood material deprivation is linked to the onset of mental health problems, though it does not influence disease course or severity. Parents' level of education is a protective factor, as highly educated parents are better able to access timely and specialist support (Reiss, 2013[31]).[3]

The inter-generational transmission of mental health is strongest amongst children in lower socio-economic backgrounds (Reiss, 2013[31]). In particular, poor maternal mental health is associated with children's susceptibility to developing difficulties, as mothers typically take on the larger share of childcare and caregiving tasks, reinforcing environmental transmission (Fitzsimons et al., 2017[32]). Exposure to stressful situations is another important factor: a German study suggests that along with poor parental mental health, experiencing two or more stressful events is significantly associated with the development of child mental health difficulties (Plass-Christl et al., 2017[33]). This finding is concerning, as adverse factors are more frequent in families with a parent with poor mental health. It underlines the relevance of strong parent-child relationships for good mental health, and the use of interventions to improve communication between parents and children.

Box 2.1. Digital technologies and vulnerable children's mental health

The rapid growth in the use of digital technologies brings into focus their effects on children's social and emotional well-being. To date, the literature in this area is not extremely well developed and tends to be inconsistent, but the question is raised of how much digital technology usage is too much for children and how much is too little (the "Goldilocks Hypothesis") (Przybylski and Weinstein, 2017[34]).

Using digital technologies poses a risk to children, but also provides opportunities to foster important skills and enhance well-being through the promotion of protective factors such as the reinforcement of relationships (Burns and Gottschalk, 2019[35]). Digital technologies can compound risks for vulnerable children: for example, adolescents with depression or low self-esteem may prefer to access support and social interactions online, which can contribute to social exclusion and increase self-comparison (El Asam and Katz, 2018[36]). In the case of adolescents who self-harm or are suicidal, the Internet can be constructive in terms of emotional support and reinforcement of positive behaviours, but can also normalise self-harm and provide exposure to suicide and self-harm material (Daine et al., 2013[37]).

The transition of young people from child and adolescent mental health services (CAMHS) to adult services is frequently problematic. Poorly planned transitions can mean discontinuity of care for very vulnerable young people or service provision that is not appropriate or sensitive to need and developmental stage. A 2018 study on the interface between child/adolescent and adult mental health services in EU countries indicated that almost half of young people receiving mental health services have a continuing need for care, yet few countries have transition plans in place to avoid disruptions (Signorini et al., 2018[38]).

The significant association between child mental health and later adult mental health, labour market participation and high economic costs makes reducing the burden of childhood mental health difficulties a priority. Based on 2010 Global Burden of Disease data, the cost of mental illness to the global economy is

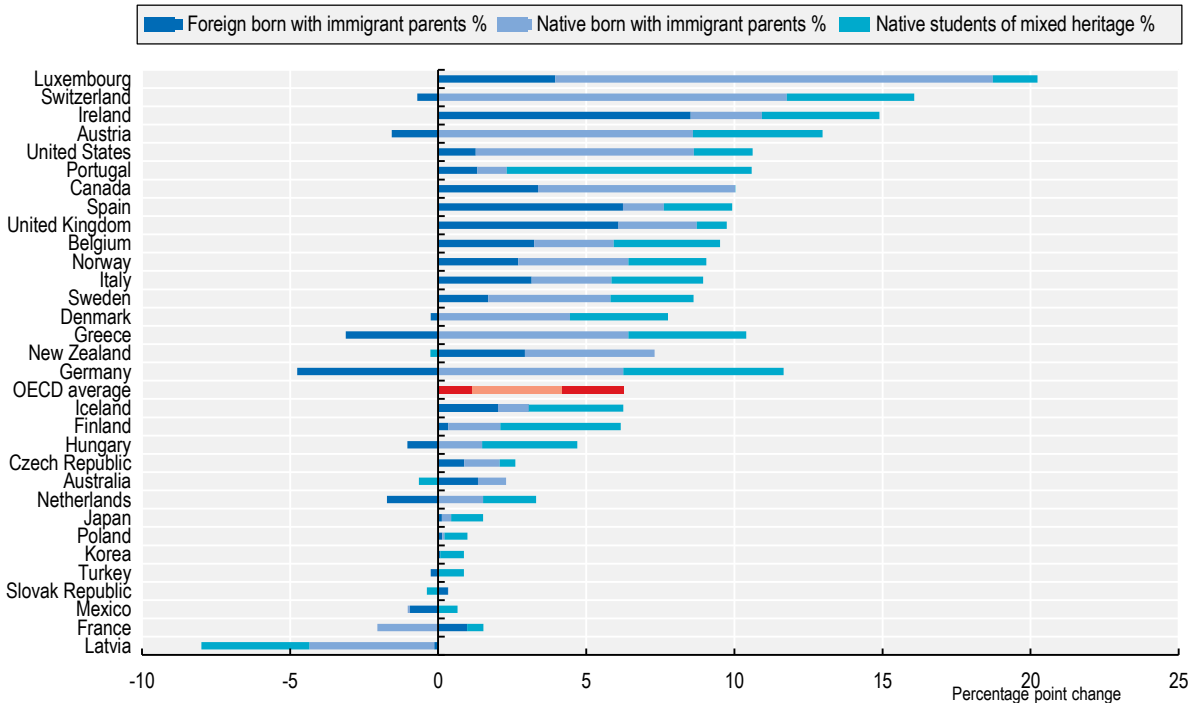
high, though to what degree depends on the analytic approach taken: USD 2.5 trillion by adding direct (e.g. healthcare) and indirect costs (e.g. loss of income and loss of productivity); or USD 8.5 trillion using a willingness-to-pay approach. Mental illness has economic costs comparable to cardiovascular disease and higher costs than other chronic conditions including diabetes and cancer. The economic burden is expected to almost double until 2030 (Trautmann, Rehm and Wittchen, 2016[39]).

Immigrant background

Children with an immigrant background are a large and growing group across OECD countries. As a whole, for the under-15 age cohort these children number around 40 million, or almost 18% of the child population.[4] Broken down across the OECD in 2015, on average 23% of 15 year-old children with an immigrant background were foreign-born with two foreign-born parents; 31% were native-born with two foreign-born parents; 38% were of mixed heritage (native-born with one native-born and one foreign-born parent) and a further 8% were foreign-born with native-born parents (OECD, 2018[40]).

Analysis of the OECD's Programme for International Student Assessment (PISA) data shows that between 2003 and 2015 the share of students aged 15 years who migrated or had a parent who migrated across international borders grew by six percentage points on average across OECD countries (Figure 2.2). The share of foreign-born students (with and without native-born parents) grew by around 1%, native-born students with immigrant parents by 3%, and native-born students with a mixed background by 2% (OECD, 2018[40]).

Figure 2.2. Changes in the percentage of students aged 15 with an immigrant background between 2003 and 2015



Note: 1.Foreign-born students are those who were not born in the country in which they sat the PISA test at the age of 15 and have two foreign-born parents (or one foreign-born parent in the case of students living in single-parent households).
Source: OECD, PISA 2015 Database and PISA 2003 Database.

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The profiles of students with an immigrant background have evolved differently over time and across countries (Figure 2.2). These differences are associated with a child's migration experience along with factors such as personal and family circumstances, relationships with peers and school personnel, and system-level support. In many education systems, students with an immigrant background face multiple sources of disadvantage. They tend to have parents with lower educational attainment working in less prestigious jobs, and fewer economic resources in the household. In the EU, 15% of native-born children with non-EU parents have a mother with no completed formal education, five times the share among children with native-born mothers. In many European OECD countries, native-born children with low-educated immigrant parents have a lower probability of completing secondary school and higher education compared with native-born children whose parents have an equally low level of education but are native-born. In addition, higher levels of parental education do not improve later labour market chances for the children of non-EU immigrants as much as they do for the children of natives.

Children with an immigrant background tend to have fewer social networks established in their host country, speak a language at home that differs from the language of instruction, and tend to be more mobile. As a result, they are more likely to have changed schools, switched curricula and in some cases experienced an interruption in schooling. This can negatively influence academic proficiency and well-being (OECD, 2017[41]).

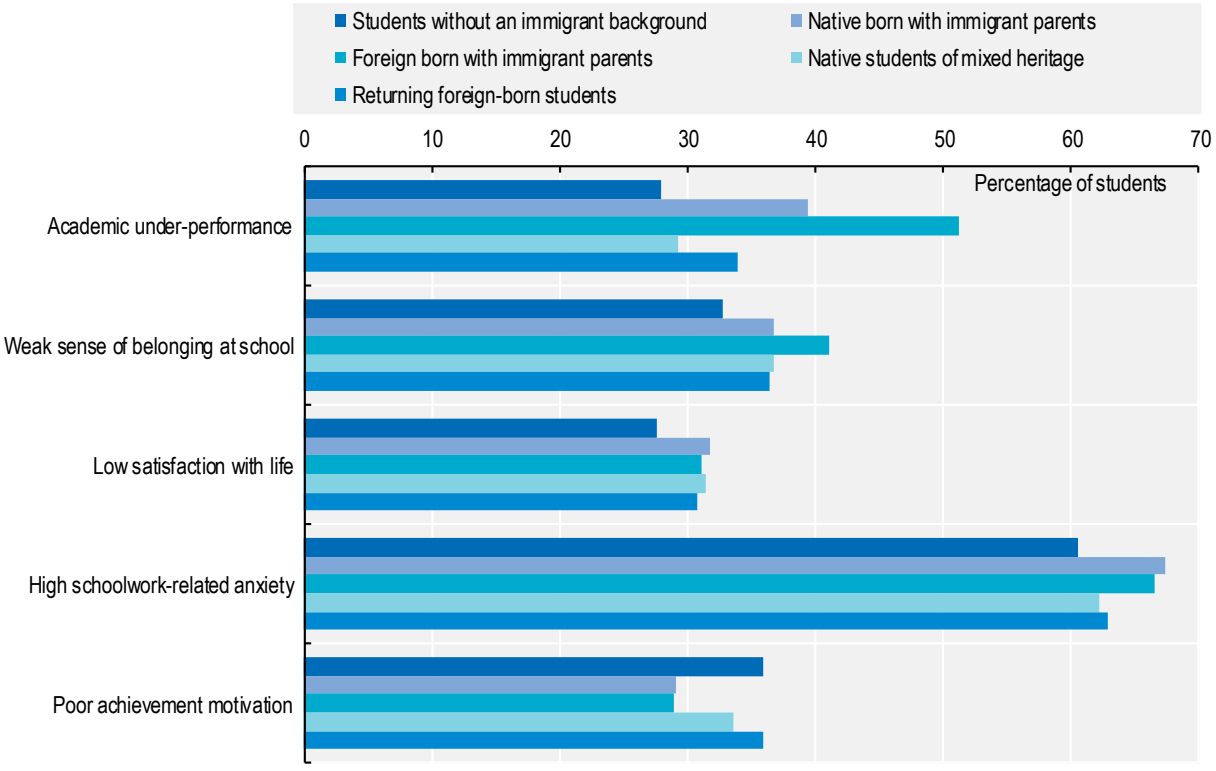
Results from PISA 2015 reveal that on average across OECD countries, as many as 51% of foreign-born students with immigrant parents failed to reach baseline academic proficiency in mathematics, reading and science, compared to only 28% of students without an immigrant background (Figure 2.3). This gap in performance underlines the need for education policies to improve the academic skills of immigrant students. Attaining academic proficiency is an important part of the integration process, as it helps to equip immigrant students with the skills needed to enter the labour market and participate in the economy of their host country.

Disadvantaged socio-economic status and language barriers are other important risk factors. For example, in 25 countries and economies the gap in academic proficiency between native and immigrant students was considerably smaller after socio-economic differences were considered. This means that differences in academic proficiency were at least partly due to immigrant students being more socio-economically disadvantaged. Socio-economic background also influences student well-being, but this correlation is much weaker than that between socio-economic background and academic performance.

In some cases, level of linguistic proficiency can explain the gap in academic achievement. In most countries, immigrant students reporting that the language used to administer the PISA assessment was different than the one they spoke at home had lower scores in reading than both native students and immigrant students who reported speaking the language of assessment at home, after accounting for mathematics scores and socio-economic status. On average across OECD countries, the gap in reading scores between native-speaking and non-native-speaking immigrant students was 16 points, but the difference can be much larger. In the Slovak Republic, the score difference in reading performance between immigrant students who reported that they did not speak the language of assessment at home and native students who reported that they did was 56 points (OECD, 2018[42]).

Age of arrival can also influence the well-being of students with an immigrant background. For example, late-arrival immigrant students in Germany were 45 percentage points less likely to report a sense of belonging at school than those who immigrated before the age of 12. On average across OECD countries, the share of students who reported this sentiment was five percentage points smaller among non-native-speaking immigrant students than among native-speaking immigrant students, and nine percentage points smaller than among native students.

Figure 2.3. Academic and well-being outcomes aged 15, by immigrant background, OECD average



Note: Differences in all outcomes between students without an immigrant background and all categories of students with an immigrant background are statistically significant, except for the difference in the percentage of students with poor achievement motivation between students without an immigrant background and returning foreign-born students. Academic under-performance implies that a student failed to attained at least proficiency Level 2 in all three core PISA subjects: science, reading and mathematics. Low satisfaction with life implies that a student reported a life satisfaction of 6 or less on a 0-10 scale. High school-work related anxiety implies that a student reported that he or she "agrees" or "strongly agrees" with the statements "I often worry that it will be difficult for me taking a test" and "Even if I am well prepared for a test, I feel very anxious". Poor achievement motivation implies that a student "disagrees" or "strongly disagrees" with the statement "I want to be the best, whatever I do".

Source: OECD (2018), "Graph 1.1 - Academic and well-being outcomes, by immigrant background: OECD average", in *The Resilience of Students with an Immigrant Background: Factors that Shape Well-being*, OECD Reviews of Migrant Education, OECD Publishing, Paris, https://doi.org/10.1787/9789264292093-graph1-en.

Major differences exist in self-reported levels of social and emotional well-being between native students and those with an immigrant background (Figure 2.3). A large degree of variation depends on the country in which the student (or their parents) settle, such as cultural or linguistic differences between their country of origin and the host country, but also on the characteristics of the schools students attend and the help they receive in dealing with daily problems of living, learning and communicating. Results from PISA 2015 show that 89% of native-born students with immigrant parents from Iraq who live in Finland reported a sense of belonging at school, while only 63% of those who live in Denmark did so. Similarly, 82% of native-born students with immigrant parents from Somalia who live in Finland reported a sense of belonging at school, while only 63% of those living in Denmark did so.

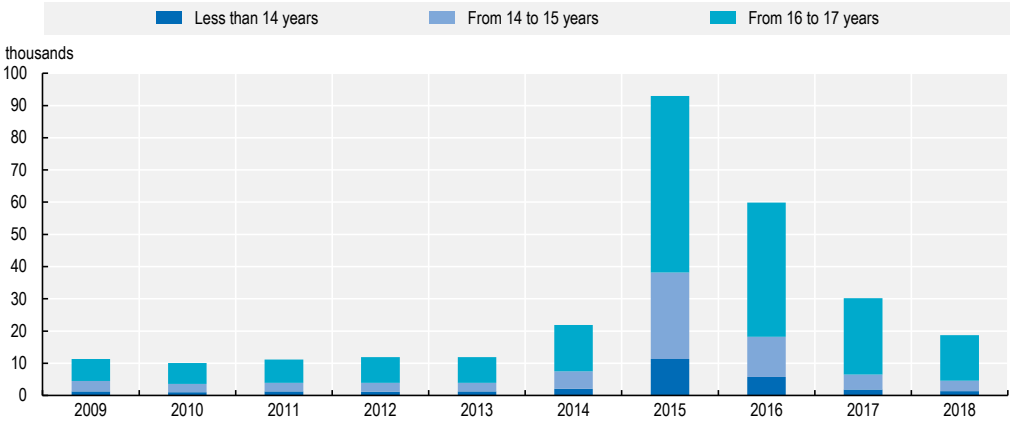
When considering the academic proficiency and well-being of students with an immigrant background, it is crucial to acknowledge not only the challenges they face but also the assets they posess. High motivation is one of the most important assets students with an immigrant background have. It is an ingredient of

achievement both in school and beyond (OECD, 2013[43]). PISA 2015 shows that in 16 out of 30 OECD countries with available data, foreign-born students with immigrant parents were more likely to express high levels of achievement motivation compared to native students (OECD, 2017[44]). Ensuring that education systems can help students with an immigrant background make full use of such protective factors is key to building the resilience of these children.

Unaccompanied minors

Unaccompanied minors are children who migrate without parents or caregivers. The rise in numbers of unaccompanied minors over recent years, including in Austria, Germany, Italy Sweden and the United States, has made providing for their needs a major policy challenge. For example, between 2014 and 2016, European OECD countries received more than 180 000 asylum applications from unaccompanied minors, and the United States reported almost 170 000 border apprehensions of unaccompanied minors. The numbers have decreased since a peak in 2015 in European OECD countries (Figure 2.4) and the United States in 2014. A number of accompanied minors do not submit asylum applications, as some countries grant protection without requiring a direct application.

Figure 2.4. Asylum applications submitted by unaccompanied minors in European OECD countries



Source: Data adapted from Eurostat (2019), *Asylum applicants considered to be unaccompanied minors by citzenship, age and sex. Annual data (rounded)* (database), http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=migr_asyunaa.

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Before arriving in a host country, unaccompanied minors have often travelled for months or years in unhealthy, unsafe and stressful conditions. As a consequence, they are more vulnerable to psychosocial difficulties, behavioural problems, negative role modelling and substance misuse. The typical late age of arrival can further complicate the integration process. Unaccompanied minors do not have the time to catch up with peers and often need urgent and substantial support to find their way through the school system and into the labour market in a meaningful way (OECD, 2019[45]).

The United Nations Convention on the Rights of the Child (UNCRC) stipulates that countries should afford unaccompanied minors the same set of rights as all other children, such as protection and access to education and health care. Notably, expenditure costs associated with unaccompanied minors are higher than that of other refugee groups. Data from Austria and Norway suggest that expenditure on unaccompanied minors is three to five times higher than for adult asylum seekers, particularly in the period prior to settlement (OECD, 2016[46]).

Responsibility for the care of unaccompanied minors generally comes under central governments or local authorities, but there are significant differences in the way OECD countries handle it. In the EU, there is great heterogeneity in procedures, practices and resources. In principle, after authorities have identified unaccompanied minors, child protection authorities should ensure that they are accommodated in special facilities that provide an adequate standard of living and access to education and healthcare (FRA, 2016[47]).

Unaccompanied minors face particular integration challenges, particularly those who do not have a guardian to provide emotional, financial, social and practical support. Most arrive just before or after the age at which schooling is no longer compulsory (14-17 years) but have little or no formal education. Therefore, the main challenge for host-country education systems is to enrol unaccompanied minors in school as quickly as possible. In the EU, member states should enrol asylum-seeking children in education within three months of arrival, but extended periods of time spent in reception centres and on securing a school placement during the academic year delays enrolment (FRA, 2016[47]). Furthermore, unaccompanied minors who have passed the cut-off age for compulsory education may find it particularly difficult to access education and language courses.

Unaccompanied minors are often among the most determined to build a new life in their host country. Job search intensity is high, as many want to start earning soon after arrival in order to remit money back home to their families. While this motivation to be in employment is positive, it can come at the cost of investment in continued education and lead to low-skilled and unstable work. Unaccompanied minors need tailored education and training programmes to help overcome the many obstacles they face. This requires a substantial commitment from training and integration services.

Maltreatment

Child maltreatment is a public health problem requiring co-ordinated responses across multiple government departments and services. Child maltreatment is defined as child abuse (physical, sexual and emotional) and neglect, regardless if harm was intended (Measuring the prevalence of maltreatment across countries is difficult. First, multiple sources of data (e.g. hospital admissions, child protective services referrals and police records) needs to be disaggregated, particularly between substantiated and unfounded maltreatment cases and again by groups at risk. Second, countries operationalise varying definitions of maltreatment across and within countries, obscuring the true extent of the problem. Under-reporting is an issue and is influenced by social stigma, societal acceptance and cultural and political barriers . Third, some countries' national child protection systems are not yet mature, for example Mexico's .

There is no comparative data on the prevalence of child maltreatment in OECD countries. Based on a limited number of country studies, a 2009 systematic review estimated that each year around 4-16% of children are physically abused; one in ten children experiences neglect or emotional abuse; and 5-10% of girls and 1-5% of boys are subjected to penetrative child sexual abuse over the course of childhood . When broader definitions of sexual abuse are applied, prevalence estimates of sexual abuse are much higher. For example, in the United States, under a broader definition approximately 11-17% of girls and 4-5% of boys are sexually abused over the lifetime. The size of these numbers indicates a high demand for child protective services (CPS) and preventative services.

Table 2.1). In the majority of cases children are maltreated by parents or caregivers. Children are also vulnerable to maltreatment by other adults and children, though to a much smaller extent (Hurren et al., 2018[48]). Children are more likely to be maltreated by their mothers, with young maternal age a risk factor (Jonson-Reid et al., 2010[49]). Increasingly, exposure to intimate partner violence is considered a form of child maltreatment (Nixon et al., 2007[50]).

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Table 2.1. Definition of child maltreatment, by type

	Definitions
Physical Abuse	The intentional use of physical force against a child that results in, or has the potential to result in, physical injury. This can include hitting, kicking, punching, beating, stabbing, biting, pushing, shoving, throwing, pulling, dragging, dropping, shaking, strangling/choking, smothering, burning, scalding and poisoning.
Sexual Abuse	Any completed or attempted (non-completed) sexual act, sexual contact with, or exploitation (i.e. noncontact sexual interaction) of a child by a caregiver, adult or older child.
Emotional abuse (psychological abuse)	Intentional caregiver behaviour that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another's needs. Emotional abuse can be continual or episodic. Emotionally abusive behaviours may include blaming, belittling, degrading, intimidating, terrorizing, isolating, restraining, confining, corrupting, exploiting, spurning or otherwise behaving in a manner that is harmful, potentially harmful, or insensitive to the child's developmental needs, or can potentially damage the child psychologically or emotionally.
Neglect	Failure by a caregiver to meet a child's basic physical, emotional, medical/dental, or educational needs, and to ensure a child's safety within and outside the home given the child's emotional and developmental needs.
Exposure to Intimate Partner Violence	Direct and indirect exposure to intimate partner violence, e.g. violence, threatening behaviour and abuse in parental intimate relationships.

Note: * includes caregivers in temporary custodial roles (e.g. relatives, teachers, clergy and coaches).
Source: Adapted from Gilbert, et al (2009), Burden and consequences of child maltreatment in high-income countries, Lancet.

At the regional level, the WHO Regional Office for Europe estimates that the lifetime prevalence of childhood sexual abuse is almost 10% (5.7% of boys, 13.4% of girls), physical abuse almost 23%, and emotional abuse 30%. In addition, almost 15% of children witness intimate partner violence in the home. Differences in cross-country prevalence are partly attributable to levels of inequality within countries and the level of state assistance provided to families exposed to financial hardships (Sethi et al., 2013[54]).

At the country level, in the United States, the National Survey of Children's Exposure to Violence (NatSCEV) 2014 measured the maltreatment exposure rate in the study year among 0-17 year olds and lifetime exposure among older children aged 14-17 years.[5] The survey showed that around 15% of children experienced some form of maltreatment over the previous year, while almost 38% of older children reported experiencing maltreatment over the lifetime. Over 8% of children experienced sexual victimisation over the previous year, while almost 22% of older children experienced sexual victimisation over the

lifetime (Finkelhor et al., 2015[55]). Taking another angle, an Australian study looked at the prevalence of particular maltreatment types by category, using administrative data on CPS contact with maltreatment perpetrators, specifically those born in 1983 and 1984. Neglect was the most common of maltreatment perpetrated (38.5%), followed by emotional abuse (38%), physical abuse (20.9%) and sexual abuse (2.6%). Significantly, maltreatment categories co-occur: 40% of perpetrators had multiple contacts with CPS (Hurren et al., 2018[48]). This highlights that seizing the opportunity to intervene, when it presents, is critical.

Box 2.2. Understanding child sexual abuse

High-profile inquiries into historical (i.e. non-recent) child sexual abuse have raised public awareness of the problem.[6] In general, these inquiries highlight systemic failings by the state and other key institutions to protect children from abuse. In many cases, the subjects of inquiries are large institutions or serial sex offenders. Although provoking high levels of decry, the understanding of child sexual abuse remains limited among the public and other important stakeholders. Media reporting tends to stereotype sex offenders, often negating the diversity of sexual offenders' backgrounds and the different typology of risks posed (Mccartan, Kemshall and Tabachnick, 2015[56]). This contributes to the persistant view that child sex offending is perpetrated in a narrow set of circumstances.

Evidence suggests the under-reporting of child sexual abuse across OECD countries (Gilbert et al., 2009[53]; Alaggia, Collin-Vé Zina and Lateef, 2019[57]). The effects of child sexual abuse are insidious, with disclosures often made on a retrospective basis in adulthood. Therefore, there is a large discrepancy between official figures supplied by child protection services (CPS) and the police, and those counted in prevalence studies, mostly based on North American and European samples. Under-reporting also implies that many children exposed to sexual abuse never come to the attention of CPS and remain at risk of further abuse and longer-term maladjustment.

Child sexual abuse is a global problem affecting children across all ages, genders, ethnicities and socio-economic classes. It demands the same treatment as other public health problems with resources invested in prevalence monitoring, prevention and treatment (WHO, 2006). Childhood sexual abuse contributes to a range of poorer adult developmental outcomes with a small to medium effect size: mental health difficulties, low self-esteem and life satisfaction; social welfare dependency (Fergusson, McLeod and Horwood, 2013[58]); and poor general physical health (Irish, Kobayashi and Delahanty, 2010[59]). Yet compared to other forms of childhood adversity, child sexual abuse and other forms of child maltreatment are a much smaller focus of child policy discussions.

Managing the risk of child sexual abuse requires that key stakeholders in children's lives collaborate well. Child safeguarding procedures need to be better operationalised and child protection systems strengthened. Prevention also includes the provision of monitoring and therapeutic treatment to individuals who pose risks to children.

Not enough is known about the causal pathways that lead to maltreatment. Research has identified factors that place children at risk, but identifying children at actual risk can be difficult, as not all children facing the same risk factors are maltreated. Environmental factors associated with maltreatment include household poverty (Slack et al., 2004[60]), high neighbourhood poverty (Farrell et al., 2017[61]); overcrowded housing (Cant et al., 2019[62]); social isolation (Gracia and Musitu, 2003[63]); intimate partner violence (Zolotor et al., 2007[64]); and parental substance misuse (Kepple, 2018[65]). In addition, parental understanding and ability to respond to children's needs is relevant and is informed by parents' own

experiences of being parented (Howe, 2005[66]). Child factors include disability, behavioural problems and poor child-parent attachment (Maclean et al., 2017[67]; Howe, 2005[66]).

Child maltreatment has a deleterious impact on child development, well-being and later adult outcomes. Articles 19 and 34 of the UNCRC stipulate the duty of countries to protect children all forms of maltreatment while in the care of parents, and from all forms of sexual abuse and exploitation. A systemic review of the long-term effects of childhood physical and emotional abuse and neglect suggest a causal relationship with a range of psychiatric disorders, drug use, sexually transmitted infections and risky sexual behaviours (Norman et al., 2012[68]). Furthermore, child maltreatment prior to 12 years of age has been found to affect adult cognitive functioning, evident in deficits in working memory, executive functioning and emotional processing, in particular sexual abuse on working memory (Gould et al., 2012[69]).

Research suggests that neglect is the most common type of maltreatment, yet less is known about its impact on child development and well-being and on strategies to support vulnerable children and families. Neglect is the failure of parents or caregivers, in the context of available resources, to meet children's health, security and safety needs, as well as their material, emotional, social and educational needs. Parental stress, parental substance misuse, hardships and intimate partner violence are contributing factors (Gardner, 2016[70]). In the short term, neglect is associated with increased internalising and externalising behavioural problems, and delays in cognitive and emotional development (Stoltenborgh, Bakermans-Kranenburg and van IJzendoorn, 2013[71]).

Maltreatment often co-occurs with environmental stressors and deprivations. Poverty, poor parental mental health and parental substance misuse are associated with higher maltreatment reoccurrence (Jonson-Reid et al., 2010[49]). Some of the long-term effects may be explained by these mediating factors (Norman et al., 2012[68]). Nonetheless, some studies have accounted for the maltreatment effect while controlling for these factors and provided evidence of the direct negative effects.

Adults who were maltreated in childhood experience long and enduring economic consequences. They have lower education, earn less and have fewer assets (Currie and Widom, 2010[72]). In all, there is a 14% gap in the probability of employment at middle age, controlling for demographic factors. Experiencing and/or witnessing sexual abuse and physical violence during childhood negatively predicts poor adult mental health and male convictions for non-violent crimes (Ballard et al., 2015[73]). Poor parental mental health has been linked to sexual abuse exposure, suggesting in part that sexual abuse mediates the intergenerational transmission of mental health disorders.

Out-of-home care

Children in out-of-home care are a particularly vulnerable group who face high levels of adversity. Available data from some OECD countries suggests that the overall number of children in out-of-home care is relatively small,[7] but insufficient harmonised data makes meaningful comparisons between countries impossible. At the European level, a 2010 survey across 30 European countries highlighted inconsistent approaches to data collection and lack of shared understanding of what constitutes family-like and institutional-like care (Eurochild, 2010[74]).

Child protection systems in OECD countries operate quite differently, shaping the numbers of children entering and leaving the care system. Multiple factors are linked to these differences, including countries' social, political and cultural contexts, legislative and policy frameworks, CPS resources and constraints, and child protection workers' training and decision-making (Davidson-Arad et al., 2015[75]). The factors informing decisions to place children in care vary across countries and even at the country level, from legal definitions of maltreatment to differences in professional and agency perceptions of risk. More often than not, child protection workers walk a tight line when deciding whether a child's well-being would be less

harmed by removal than remaining in the family home (Keddell and Hyslop, 2018[76]; Davidson-Arad et al., 2015[75]).

The UNCRC and UN Guidelines for the Alternative Care of Children stipulate that countries should support efforts to keep children in the care of their families, and place children in out-of-home care only when measures to prevent family separation have failed. Even then, countries should continue to work on the possibility of family reunification if the risks to children have been resolved or minimised. The UN Guidelines for the Alternative Care of Children also state that countries should provide children care in a family-like environment or, in limited circumstances, a residential setting if "appropriate, necessary and constructive" and "in his/her best interests" (UNGA, 2010[77]).

In the majority of cases, children in out-of-home care reside in family-based foster care (general and kinship care) or residential care (small residential units and larger institutions). The proportion of children in these systems varies across the OECD. Australia, Ireland and New Zealand have high numbers of children in family-based foster care, over 80%.[8] In some eastern European OECD countries, for example Latvia, Lithuania and Poland, a larger proportion of children live in large state institutions. This is because ending the practice of placing of children in large institutions (deinstitutionalisation) is still ongoing. Some European OECD countries, for instance Austria, Belgium and Greece, have responded to the challenge of hosting unaccompanied minors by placing them outside of the foster care system in residential and non-specialised reception centres (Opening Doors for Europe's Children, 2018[78]).[9] In the United States, the majority of children are in family-based foster care (Children's Bureau, 2017[79]), while in Japan, the majority are in residential care (Nakatomi et al., 2018[80]).

Considerable research supports the placement of children in family foster care for more favourable outcomes (Li, Chng and Chu, 2017[81]; Sim, Li and Chu, 2016[82]). The same holds true in promoting foster care for children who have experienced institutionalisation. Evidence from the Bucharest Early Intervention Project, a randomised control trial that assigned children to foster care versus remaining in institutional care, shows the long-term positive effects of family-based care on children's brain electrical activity. Comparing the brain electrical activity of three groups (16 year-olds currently in institutional care, in foster care or never institutionalised), adolescents who had been placed in foster care displayed brain activity comparable to adolesents who were never institutionalised, even if the transition to foster care was made after 24 months of age (Debnath et al., 2019[83]).

Residential care varies greatly across countries in quality and number of children cared for. Some facilities provide children with a family-like environment, and others an institutional-like environment. Institutional environments are characterised by isolation of children from the community, the lack of control/say children have in their daily lives, and prioritisation of the institution's requirements over children's needs (Opening Doors for Europe's Children, 2018[78]). Children with higher needs and those who have experienced many placement breakdowns may be better suited to residential settings that are small in size and staffed with professional caregivers.

The challenges faced by children in out-of-home care can be particularly pronounced when children are separated from their extended family network and neighbourhood of origin, for instance the additional burden of worrying about their parents' well-being. Disruptions such as changes in care placements and family reunification can have deleterious effects. Placement disruptions – e.g. moving homes, changing schools and leaving friends and supportive adults behind – are associated with developing insecure attachments, emotional and behavioural problems, mental health problems, poor educational outcomes, and failed adoption and family reunification (Jedwab et al., 2019[84]). Placement permanency is essential for children to feel safe and secure in their environment.

Young people ageing out of the foster care system are expected to become independent very quickly. This is a big undertaking for young people who lack stable social support to help them through the transition into adulthood. Significantly, ageing out of care has been linked with higher incidences of homelessness

in young adulthood (Fowler et al., 2017[85]). Residential centres can provide intensive support to young people preparing for independence as they age out of the care system (Hart and Valle, 2015[86]).

In general, outcomes for children in out-of-home care – across education, health, adult employment and future earning – are lower than that of the general population (Gypen et al., 2017[87]). Given the high levels of adversity experienced, poorer outcomes are not surprising. Nonetheless, good quality out-of-home care plays a fundamental role in improving outcomes. For example, children in out-of-home care are among the lowest performing groups in terms of educational outcomes internationally, but can catch-up if they have well-supported foster carers with an interest in their educational achievements and aspirations (Sebba et al., 2015[88]).

Research on adult labour market outcomes for children in out-of-home care is not well developed Out of what is known about these children's adult employment outcomes and earnings, educational attainment and the quality of care received around the time of ageing out of the care system are important determinants (Hook and Courtney, 2011[89]).

Children in care have additional health needs, some of which arise as a consequence of difficult family circumstances and the accumulation of disadvantages prior to their reception into care. For example, children in out-of-home care have greater dental needs, a higher prevalence of tooth decay and require more interventions compared to low-income children not in foster care (Morón et al., 2019[90]). Up to half of children in-out-home care have clinical-level mental health difficulties and another 15-25% have difficulties approaching the clinical level (Tarren-Sweeney, 2017[91]). As such, children in out-of-home care should have priority of access to health and specialist care.

The removal of a child from its family is the strongest and most far-reaching intervention a state can undertake. Therefore, mastering successful care placements is a priority for governments. Child protection systems need to enhance the procedures and interventions that build resilience in children by contributing to placement stability (more kinship care and well-supported foster carers), providing children with adequate health and therapeutic support, fewer changes in child protection personnel, and help for birth parents in coping with their problems and loss (Jedwab et al., 2019[84]).

Notes

[1] Calculated as the number of 9 year-olds or 15 year-olds who are enrolled and educated in mainstream classes with their non-disabled peers for at least 80% of the time over the number of 9 year-olds or 15 year-olds enrolled in all formal educational settings.

[2] In New Zealand, 8% of children aged 3-14 years assessed are at high risk of experiencing social, emotional or behavioural difficulties based on a Strengths and Difficulties Questionnaire completed by parents. Children graded in the 'concerning category' are regarded as likely to benefit from a clinical assessment and probably some intervention.

[3] Family socio-economic status was measured by household income, parental education and/or parental occupation.

[4] Among these children under the ages of 15 years, 19 million are native-born with two foreign-born parents (8.2%); a further 13 million are native-born with a mixed background (one parent foreign-born and one parent native-born) (5.7 %), and 8 million are foreign-born (3.3%).

[5] Maltreatment is defined in the NatSREV survey as physical abuse, emotional abuse, neglect and custodial interference, and sexual victimisation as experiencing any sexual offence including sexual assaults and harassment.

[6] National inquiries into child abuse include The Pollard Review 2012 into Jimmy Savile (United Kingdom); Freeh Report 2012 into Gerald A. Sandusky (United States); Independent Commission of Inquiry into Child Sexual Abuse 'Geschichten die Zählen' 2018 (Germany); Royal Commission into Institutional Responses to Child Sexual Abuse 2017 (Australia); The Report of the Commission to Inquire into Child Abuse 2009 (Ireland); and the Final Report of the Wilhelminenberg Commission 2013 (Austria).

[7] The absolute numbers of children in out-of-home care in several OECD countries are as follows: Australia 47 915 (AIFS, 2018[97]); Austria 13 617 (Statistik Austria, 2019[105]); Canada 62 428 (Jones, Sinha and Trocmé, 2015[98]); England (United Kingdom) 75 420 (DfE, 2018[103]); France 164 000 (DREES, 2017[99]); Ireland 6 072 (Tusla, 2018[100]); Japan approximately 30 000 (Nakatomi et al., 2018[80]): Switzerland 18 900 (Seiterle, 2018[104]); New Zealand 6 400 (MSD, 2019[102]); and 442 995 in the United States (Children's Bureau, 2017[79]).

[8] The percentage of family-based placements as a total of out-of-home placements is as follows: Australia 94% (AIFS, 2018[97]); Ireland, 92% (Tusla, 2018[100]); and New Zealand 82% (MSD, 2019[102]).

[9] Information on the use of residential and institutional care in European OECD countries was accessed through Opening Doors individual country fact sheets. <https://www.openingdoors.eu/category/resources/country-factsheets/>

References

AIFS (2018), *Children in care: CFCA Resource Sheet*, Australia Institute for Family Studies, https://aifs.gov.au/cfca/publications/children-care (accessed on 25 July 2019). [97]

Alaggia, R., D. Collin-Vé Zina and R. Lateef (2019), "Facilitators and Barriers to Child Sexual Abuse (CSA) Disclosures: A Research Update (2000-2016)", http://dx.doi.org/10.1177/1524838017697312. [57]

Association of American Psychiatrics (2015), *DSM-5 : manuel diagnostique et statistique des troubles mentaux*, Elsevier Masson. [24]

Ballard, E. et al. (2015), "Latent classes of childhood trauma exposure predict the development of behavioral health outcomes in adolescence and young adulthood", *Psychological Medicine*, Vol. 45/15, pp. 3305-3316, http://dx.doi.org/10.1017/S0033291715001300. [73]

Berens, A. and C. Nelson (2015), "The science of early adversity: is there a role for large institutions in the care of vulnerable children?", *The Lancet*, Vol. 386/9991, pp. 388-398, http://dx.doi.org/10.1016/S0140-6736(14)61131-4. [8]

Bor, W. et al. (2014), "Are child and adolescent mental health problems increasing in the 21st century? A systematic review", *Australian & New Zealand Journal of Psychiatry*, Vol. 48/7, pp. 606-616, http://dx.doi.org/10.1177/0004867414533834. [28]

Burns, T. and F. Gottschalk (eds.) (2019), *Educating 21st Century Children: Emotional Well-Being in the Digital Age*, OECD Publishing. [35]

Cant, R. et al. (2019), "Overcrowded housing: One of a constellation of vulnerabilities for child sexual abuse", *Child Abuse & Neglect*, Vol. 93, pp. 239-248, http://dx.doi.org/10.1016/J.CHIABU.2019.05.010. [62]

Children's Bureau (2017), *The AFCARS Report: Preliminary FY 2017 estimates as of September 24, 2018 - Number 25*, U.S. Department of Health and Human Services, Administration for Children and Families, AdministrationonChildren,YouthandFamilies,Children'sBureau, https://www.acf.hhs.gov/cb (accessed on 25 July 2019). [79]

Currie, J. and C. Widom (2010), "Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being", *Child Maltreatment*, Vol. 15/2, pp. 111-120, http://dx.doi.org/10.1177/1077559509355316. [72]

Daine, K. et al. (2013), "The Power of the Web: A Systematic Review of Studies of the Influence of the Internet on Self-Harm and Suicide in Young People", *PLoS ONE*, Vol. 8/10, p. e77555, http://dx.doi.org/10.1371/journal.pone.0077555. [37]

Davidson-Arad, B. et al. (2015), "Decision making in child protection: An international comparative study on maltreatment substantiation, risk assessment and interventions recommendations, and the role of professionals' child welfare attitudes", *Child Abuse & Neglect*, Vol. 49, pp. 63-75, http://dx.doi.org/10.1016/J.CHIABU.2015.03.015. [75]

Debnath, R. et al. (2019), "The long-term effects of institutional rearing, foster care intervention and disruptions in care on brain electrical activity in adolescence", *Developmental Science*, p. e12872, http://dx.doi.org/10.1111/desc.12872. [83]

Delobel-Ayoub, M. et al. (2015), "Socioeconomic Disparities and Prevalence of Autism Spectrum Disorders and Intellectual Disability", *PLOS ONE*, Vol. 10/11, p. e0141964, http://dx.doi.org/10.1371/journal.pone.0141964. [15]

DfE (2018), *Children looked after in England (including adoption), year ending 31 March 2018*, Department for Education, United Kingdom, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/757922/Children_looked_after_in_England_2018_Text_revised.pdf (accessed on 25 July 2019). [103]

DREES (2017), *Les mineurs et jeunes majeurs accueillis a l'aide sociale a l'enfance*, DREES, Paris, https://drees.solidarites-sante.gouv.fr/IMG/pdf/fiche17-7.pdf (accessed on 2 August 2019). [99]

DWP (2018), *Family Resources Survey 2016/17 United Kingdom*, Department for Work & Pensions, London, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/692771/family-resources-survey-2016-17.pdf (accessed on 3 October 2019). [3]

El Asam, A. and A. Katz (2018), "Vulnerable young people and their experience of online risks", *Human–Computer Interaction*, Vol. 33/4, pp. 281-304, http://dx.doi.org/10.1080/07370024.2018.1437544. [36]

Elgar, F. et al. (2013), "Absolute and relative family affluence and psychosomatic symptoms in adolescents", *Social Science & Medicine*, Vol. 91, pp. 25-31, http://dx.doi.org/10.1016/J.SOCSCIMED.2013.04.030. [30]

Elgar, F. et al. (2015), "Socioeconomic inequalities in adolescent health 2002–2010: a time-series analysis of 34 countries participating in the Health Behaviour in School-aged Children study", *The Lancet*, Vol. 385/9982, pp. 2088-2095, http://dx.doi.org/10.1016/S0140-6736(14)61460-4. [29]

Emerson, E. (2012), "Understanding Disabled Childhoods: What Can We Learn From Population-Based Studies?", *Children & Society*, Vol. 26/3, pp. 214-222, http://dx.doi.org/10.1111/j.1099-0860.2012.00434.x. [10]

ENOC (2018), *Child and Adolescent Mental Health in Europe: Synthesis Report*, European Network of Ombudspersons for Children, Strasbourg, https://www.defenseurdesdroits.fr/sites/default/files/atoms/files/rapport-enoc-gb-num-05.09.18.pdf (accessed on 1 July 2019). [22]

Erskine, H. et al. (2017), "The global coverage of prevalence data for mental disorders in children and adolescents", *Epidemiology and Psychiatric Sciences*, Vol. 26, pp. 395-402, http://dx.doi.org/10.1017/S2045796015001158. [20]

Eurochild (2010), *Children in Alternative Care: National Surveys (2nd Edition)*, Eurochild, Brussels, https://www.eurochild.org/fileadmin/public/05_Library/Thematic_priorities/06_Children_in_Alternative_Care/Eurochild/Eurochild_Publication_-_Children_in_Alternative_Care_-_2nd_Edition_January2010.pdf (accessed on 17 October 2019). [74]

Farrell, C. et al. (2017), "Community Poverty and Child Abuse Fatalities in the United States.", *Pediatrics*, Vol. 139/5, p. e20161616, http://dx.doi.org/10.1542/peds.2016-1616. [61]

Fasquelle, D. and N. Sarles (2018), *Evaluation de la prise en charge de l'autisme*, Comité d'évaluation et de controle des politiques publiques, Assemblée Nationale, http://www2.assemblee-nationale.fr/content/download/68311/695594/version/1/file/Powerpoint+Autisg-g06-06.pdf (accessed on 24 July 2019). [94]

Fergusson, D., G. McLeod and L. Horwood (2013), "Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand", *Child Abuse & Neglect*, Vol. 37/9, pp. 664-674, http://dx.doi.org/10.1016/J.CHIABU.2013.03.013. [58]

Finkelhor, D. et al. (2015), "Prevalence of Childhood Exposure to Violence, Crime, and Abuse", *JAMA Pediatrics*, Vol. 169/8, p. 746, http://dx.doi.org/10.1001/jamapediatrics.2015.0676. [55]

Fitzsimons, E. et al. (2017), "Poverty dynamics and parental mental health: Determinants of childhood mental health in the UK", *Social Science & Medicine*, Vol. 175, pp. 43-51, http://dx.doi.org/10.1016/J.SOCSCIMED.2016.12.040. [32]

Fowler, P. et al. (2017), "Homelessness and aging out of foster care: A national comparison of child welfare-involved adolescents", *Children and Youth Services Review*, Vol. 77, pp. 27-33, http://dx.doi.org/10.1016/J.CHILDYOUTH.2017.03.017. [85]

FRA (2016), *Thematic focus: Children, European Union Agency for Fundamental Rights*, https://fra.europa.eu/en/theme/asylum-migration-borders/overviews/focus-children (accessed on 28 August 2019). [47]

Gardner, R. (ed.) (2016), *Tackling Child Neglect: Research, Policy, and Evidence-based Practice*, Jessica Kingsley Publishers. [70]

Gilbert, R. et al. (2009), "Child Maltreatment 1 Burden and consequences of child maltreatment in high-income countries", *The Lancet*, Vol. 373, pp. 68-81, http://dx.doi.org/10.1016/S0140. [53]

Glasson, E. et al. (2016), "Improved Survival in Down Syndrome over the Last 60 Years and the Impact of Perinatal Factors in Recent Decades", *The Journal of Pediatrics*, pp. 214-220, http://dx.doi.org/10.1016/j.jpeds.2015.10.083. [5]

Gould, F. et al. (2012), "The effects of child abuse and neglect on cognitive functioning in adulthood", *Journal of Psychiatric Research*, http://dx.doi.org/10.1016/j.jpsychires.2012.01.005. [69]

Government of Mexico (2019), *Sistema Nacional de Protección de Niñas, Niños y Adolescentes ¿Qué hacemos? (National System of Protection for Girls, Boys and Adolescents: What we do?)*. [52]

Gracia, E. and G. Musitu (2003), "Social isolation from communities and child maltreatment: a cross-cultural comparison", *Child Abuse & Neglect*, Vol. 27/2, pp. 153-168, http://dx.doi.org/10.1016/S0145-2134(02)00538-0. [63]

Gypen, L. et al. (2017), "Outcomes of children who grew up in foster care: Systematic-review", *Children and Youth Services Review*, Vol. 76, pp. 74-83, http://dx.doi.org/10.1016/J.CHILDYOUTH.2017.02.035. [87]

Halfon, N. et al. (2012), "The Changing Landscape of Disability in Childhood on JSTOR", *The Future of Children*, Vol. 22/1, pp. 13-42, https://www.jstor.org/stable/41475645?seq=1#metadata_info_tab_contents (accessed on 14 June 2019). [1]

Hart, D. and I. Valle (2015), *The place of residential care in the English child welfare system*, University of East London, London, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435694/Residential_care_in_the_English_child_welfare_system.pdf (accessed on 10 July 2019). [86]

Hook, J. and M. Courtney (2011), "Employment outcomes of former foster youth as young adults: The importance of human, personal, and social capital", *Children and Youth Services Review*, Vol. 33/10, pp. 1855-1865, http://dx.doi.org/10.1016/J.CHILDYOUTH.2011.05.004. [89]

Howe, D. (2005), *Child Abuse and Neglect: Attachment, Development and Intervention*, Palgrave MacMillan. [66]

HRSD Canada (2011), *Disability in Canada: A 2006 Profile*, http://publications.gc.ca/collections/collection_2011/rhdcc-hrsdc/HS64-11-2010-eng.pdf (accessed on 9 August 2019). [4]

Hurren, E. et al. (2018), *Who are the Perpetrators of Child Maltreatment?*, Criminology Research Advisory Council, http://crg.aic.gov.au/reports/1718/18-1314-FinalReport.pdf (accessed on 11 July 2019). [48]

Irish, L., I. Kobayashi and D. Delahanty (2010), "Long-term Physical Health Consequences of Childhood Sexual Abuse: A Meta-Analytic Review", *Journal of Pediatric Psychology*, Vol. 35/5, pp. 450-461, http://dx.doi.org/10.1093/jpepsy/jsp118. [59]

Jedwab, M. et al. (2019), "Children and youth in out-of-home care: What can predict an initial change in placement?", *Child Abuse & Neglect*, Vol. 93, pp. 55-65, http://dx.doi.org/10.1016/j.chiabu.2019.04.009. [84]

Jones, A., V. Sinha and N. Trocmé (2015), *Children and Youth in Out-of-Home Care in the Canadian Provinces*, Centre for Research on Children and Families, McGill University., https://cwrp.ca/sites/default/files/publications/en/167e.pdf (accessed on 25 July 2019). [98]

Jones, L. et al. (2012), "Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies", *The Lancet*, Vol. 380/9845, pp. 899-907, http://dx.doi.org/10.1016/S0140-6736(12)60692-8. [11]

Jonson-Reid, M. et al. (2010), "Understanding service use and victim patterns associated with re-reports of alleged maltreatment perpetrators.", *Children and youth services review*, Vol. 32/6, pp. 790-797, http://dx.doi.org/10.1016/j.childyouth.2010.01.013. [49]

Keddell, E. and I. Hyslop (2018), "Role type, risk perceptions and judgements in child welfare: A mixed methods vignette study", *Children and Youth Services Review*, Vol. 87, pp. 130-139, http://dx.doi.org/10.1016/J.CHILDYOUTH.2018.02.017. [76]

Kepple, N. (2018), "Does parental substance use always engender risk for children? Comparing incidence rate ratios of abusive and neglectful behaviors across substance use behavior patterns", *Child Abuse & Neglect*, Vol. 76, pp. 44-55, http://dx.doi.org/10.1016/J.CHIABU.2017.09.015. [65]

Kessler, R. et al. (2005), "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication", *Archives of General Psychiatry*, Vol. 62/6, p. 593, http://dx.doi.org/10.1001/archpsyc.62.6.593. [18]

Leeb, R. and J. Fluke (2015), "Child maltreatment surveillance: enumeration, monitoring, evaluation and insight.", *Health promotion and chronic disease prevention in Canada : research, policy and practice*, Vol. 35/8-9, pp. 138-40, http://www.ncbi.nlm.nih.gov/pubmed/26605561 (accessed on 11 July 2019). [51]

Li, D., G. Chng and C. Chu (2017), "Comparing Long-Term Placement Outcomes of Residential and Family Foster Care: A Meta-Analysis", http://dx.doi.org/10.1177/1524838017726427. [81]

Maclean, M. et al. (2017), "Maltreatment Risk Among Children With Disabilities.", *Pediatrics*, Vol. 139/4, p. e20161817, http://dx.doi.org/10.1542/peds.2016-1817. [67]

Mccartan, K., H. Kemshall and J. Tabachnick (2015), "The construction of community understandings of sexual violence: rethinking public, practitioner and policy discourses", *Journal of Sexual Aggression*, Vol. 21/1, pp. 100-116, http://dx.doi.org/10.1080/13552600.2014.945976. [56]

McGorry, P. et al. (2011), "Age of onset and timing of treatment for mental and substance use disorders: implications for preventive intervention strategies and models of care", *Current Opinion in Psychiatry*, Vol. 24/4, pp. 301-306, http://dx.doi.org/10.1097/YCO.0b013e3283477a09. [19]

Moffitt, T. et al. (2010), "How common are common mental disorders? Evidence that lifetime prevalence rates are doubled by prospective", *Psychological Medicine*, Vol. 40/6, pp. 899-909, http://dx.doi.org/10.1017/S0033291709991036. [26]

MoH (2018), *Social, Emotional and Behavioural Difficulties in New Zealand Children: Summary of findings*, Ministry of Health, Wellington, https://www.health.govt.nz/system/files/documents/publications/social-emotional-behavioural-difficulties-nz-children-summary-findings-jun18-v2.pdf (accessed on 9 August 2019). [23]

Morón, E. et al. (2019), "Dental Status and Treatment Needs of Children in Foster Care.", *Pediatric dentistry*, Vol. 41/3, pp. 206-210, http://www.ncbi.nlm.nih.gov/pubmed/31171072 (accessed on 9 July 2019). [90]

MSD (2019), *Kids in Care*, Ministry of Social Development, https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/cyf/kids-in-care.html (accessed on 25 July 2019). [102]

Nakatomi, T. et al. (2018), "Children and adolescents in institutional care versus traditional families: a quality of life comparison in Japan.", *Health and quality of life outcomes*, Vol. 16/1, p. 151, http://dx.doi.org/10.1186/s12955-018-0980-1. [80]

NCSE (2010), *Literature Review of the Principles and Practices relating to Inclusive Education for Children with Special Educational Needs*, National Council for Special Education, Trim, Co. Meath, https://ncse.ie/wp-content/uploads/2014/10/NCSE_Inclusion.pdf (accessed on 3 October 2019). [6]

NHS Digital (2018), *Mental Health of Children and Young People in England, 2017: Summary of Key Findings*, https://gss.civilservice.gov.uk/wp- (accessed on 1 July 2019). [21]

Nixon, K. et al. (2007), "Do good intentions beget good policy? A review of child protection policies to address intimate partner violence", *Children and Youth Services Review*, Vol. 29/12, pp. 1469-1486, http://dx.doi.org/10.1016/J.CHILDYOUTH.2007.09.007. [50]

Norman, R. et al. (2012), "The Long-Term Health Consequences of Child Physical Abuse, Emotional Abuse, and Neglect: A Systematic Review and Meta-Analysis", *PLoS Medicine*, Vol. 9/11, p. e1001349, http://dx.doi.org/10.1371/journal.pmed.1001349. [68]

OECD (2019), *Ready to Help?: Improving Resilience of Integration Systems for Refugees and other Vulnerable Migrants*, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264311312-en. [45]

OECD (2018), *The Resilience of Students with an Immigrant Background Factors that Shape Well-being*, OECD Publishing. [40]

OECD (2018), *The Resilience of Students with an Immigrant Background: Factors that Shape Well-being*, OECD Reviews of Migrant Education, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264292093-en. [42]

OECD (2017), *How does having immigrant parents affect the outcomes of children in Europe?*, OECD Publishing. [41]

OECD (2017), "Neurodiversity in Education", *Trends Shaping Education Spotlights*, No. 12, OECD Publishing, Paris, https://doi.org/10.1787/23198750-en. [25]

OECD (2017), *PISA 2015 Results (Volume III): Students' Well-Being*, PISA, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264273856-en. [44]

OECD (2016), *Making Integration Work: Refugees and others in need of protection*, Making Integration Work, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264251236-en. [46]

OECD (2013), *PISA 2012 Results: Ready to Learn (Volume III): Students' Engagement, Drive and Self-Beliefs*, PISA, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264201170-en. [43]

OECD (2010), *CO1.9: Child Disability*, OECD, Paris, http://www.oecd.org/social/family/database (accessed on 10 July 2019). [2]

Opening Doors for Europe's Children (2018), *Maintain, Strengthen, Expand: How the EU Can Support the Transition from Institutional to Family-based Care in the Next Multiannual Financial Framework*. [78]

Opening Doors for Europe's Children (2017), *Deinstitutionalisation of Europe's Children Questions and Answers*, Opening Doors, https://www.openingdoors.eu/wp-content/uploads/2017/12/OD_DI_QA_07122017.pdf (accessed on 19 June 2019). [7]

Paquette, G. et al. (2018), "Factors associated with intellectual disabilities in maltreated children according to caseworkers in child protective services", *Children and Youth Services Review*, Vol. 90, pp. 38-45, http://dx.doi.org/10.1016/j.childyouth.2018.05.004. [9]

Plass-Christl, A. et al. (2017), "Parents with mental health problems and their children in a German population based sample: Results of the BELLA study.", *PloS one*, Vol. 12/7, p. e0180410, http://dx.doi.org/10.1371/journal.pone.0180410. [33]

Przybylski, A. and N. Weinstein (2017), "A Large-Scale Test of the Goldilocks Hypothesis", *Psychological Science*, Vol. 28/2, pp. 204-215, http://dx.doi.org/10.1177/0956797616678438. [34]

Rai, D. et al. (2012), "Parental Socioeconomic Status and Risk of Offspring Autism Spectrum Disorders in a Swedish Population-Based Study", *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol. 51/5, pp. 467-476.e6, http://dx.doi.org/10.1016/J.JAAC.2012.02.012. [14]

Ramberg, J., A. Lénárt and A. Watkins (2016), *European Agency Statistics on Inclusive Education: 2016 Dataset Cross-Country Report | European Agency for Special Needs and Inclusive Education*, EASIE, Odense, Denmark, https://www.european-agency.org/resources/publications/european-agency-statistics-inclusive-education-2016-dataset-cross-country (accessed on 10 July 2019). [93]

Reiss, F. (2013), "Socioeconomic inequalities and mental health problems in children and adolescents: A systematic review", *Social Science & Medicine*, Vol. 90, pp. 24-31, http://dx.doi.org/10.1016/j.socscimed.2013.04.026. [31]

Rix, J. et al. (2013), "Exploring provision for children identified with special educational needs: an international review of policy and practice", *European Journal of Special Needs Education*, Vol. 28/4, pp. 375-391, http://dx.doi.org/10.1080/08856257.2013.812403. [16]

Roh, B., E. Jung and H. Hong (2018), "A Comparative Study of Suicide Rates among 10-19-Year-Olds in 29 OECD Countries.", *Psychiatry investigation*, Vol. 15/4, pp. 376-383, http://dx.doi.org/10.30773/pi.2017.08.02. [96]

Sebba, J. et al. (2015), *The Educational Progress of Looked After Children in England: Linking Care and Educational Data*, REES Centre, University of Oxford, University of Bristol, http://www.nuffieldfoundation.org (accessed on 5 September 2019). [88]

Seiterle, N. (2018), *Ergebnisbericht Bestandesaufnahme Pflegekinder Schweiz 2016 (Results report: Inventory of children in out-of-home care Switzerland 2016)*, PACH Pflege- und Adoptivkinder Schweiz, Zürich, http://www.diexperten.ch (accessed on 25 July 2019). [104]

Sentenac, M. et al. (2019), "Education disparities in young people with and without neurodisabilities", *Developmental Medicine & Child Neurology*, Vol. 61/2, pp. 226-231, http://dx.doi.org/10.1111/dmcn.14014. [12]

Sethi, D. et al. (2013), *European report on preventing child maltreatment*, http://www.euro.who.int/pubrequest (accessed on 11 July 2019). [54]

Signorini, G. et al. (2018), "The interface between child/adolescent and adult mental health services: results from a European 28-country survey", *European Child & Adolescent Psychiatry*, Vol. 27/4, pp. 501-511, http://dx.doi.org/10.1007/s00787-018-1112-5. [38]

Sim, F., D. Li and C. Chu (2016), "The moderating effect between strengths and placement on children's needs in out-of-home care: A follow-up study", *Children and Youth Services Review*, Vol. 60, pp. 101-108, http://dx.doi.org/10.1016/J.CHILDYOUTH.2015.11.012. [82]

Slack, K. et al. (2004), "Understanding the Risks of Child Neglect: An Exploration of Poverty and Parenting Characteristics", *Child Maltreatment*, Vol. 9/4, pp. 395-408, http://dx.doi.org/10.1177/1077559504269193. [60]

Spencer, N., C. Blackburn and J. Read (2015), "Disabling chronic conditions in childhood and socioeconomic disadvantage: a systematic review and meta-analyses of observational studies.", *BMJ open*, Vol. 5/9, p. e007062, http://dx.doi.org/10.1136/bmjopen-2014-007062. [13]

Stalker, K. and K. McArthur (2012), "Child abuse, child protection and disabled children: a review of recent research", *Child Abuse Review*, Vol. 21/1, pp. 24-40, http://dx.doi.org/10.1002/car.1154. [92]

Statistik Austria (2019), *Anzahl der in sozialpädagogischen Einrichtungen und bei Pflegepersonen betreuten Kinder und Jugendlichen im Jahr 2017 (Number of children and adolescents cared for in socio-educational institutions and by carers in 2017)*, Statistik Austria, https://www.statistik.at/web_de/statistiken/menschen_und_gesellschaft/soziales/sozialleistungen_auf_landesebene/kinder_und_jugendhilfe/110532.html (accessed on 25 July 2019). [105]

Stoltenborgh, M., M. Bakermans-Kranenburg and M. van IJzendoorn (2013), "The neglect of child neglect: a meta-analytic review of the prevalence of neglect", *Social Psychiatry and Psychiatric Epidemiology*, Vol. 48/3, pp. 345-355, http://dx.doi.org/10.1007/s00127-012-0549-y. [71]

Tarren-Sweeney, M. (2017), "Rates of meaningful change in the mental health of children in long-term out-of-home care: A seven- to nine-year prospective study", *Child Abuse & Neglect*, Vol. 72, pp. 1-9, https://pdf.sciencedirectassets.com/271783/1-s2.0-S0145213417X00094/1-s2.0-S0145213417302570/main.pdf?X-Amz-Date=20191001T172526Z&X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Signature=cadfc21b94a85207c7457dfba8485fb48377e3bd801333b6d98ad99abeb8f21b&X-Amz-Crede (accessed on 1 October 2019). [91]

Trautmann, S., J. Rehm and H. Wittchen (2016), "The economic costs of mental disorders: Do our societies react appropriately to the burden of mental disorders?", *EMBO reports*, Vol. 17/9, pp. 1245-9, http://dx.doi.org/10.15252/embr.201642951. [39]

Tusla (2018), *National Performance and Activity Dashboard*, Tusla, Child and Family Agency, https://www.tusla.ie/uploads/content/National_Performance__Activity_Dashboard_September_2018_Final.pdf (accessed on 25 July 2019). [100]

UNGA (2010), *Guidelines for the Alternative Care of Children*, https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf (accessed on 25 July 2019). [77]

West, P. and H. Sweeting (2003), "Fifteen, female and stressed: changing patterns of psychological distress over time", *Journal of child psychology and psychiatry, and allied disciplines*, Vol. 44/3, pp. 399-411, http://www.ncbi.nlm.nih.gov/pubmed/12635969 (accessed on 24 July 2019). [27]

WHO (2014), *Investing in Children: The European Child Maltreatment Prevention Action Plan 2015-2020*, WHO Regional Office for Europe, Geneva, http://www.euro.who.int/en/who-we-are/governance (accessed on 11 July 2019). [101]

WHO (2014), *Preventing Preventing suicide suicide: A global imperative*, World Health Organisation, Geneva, http://www.who.int (accessed on 2 July 2019). [95]

WHO (2004), *Promoting Mental Health: Concepts, Emerging Evidence, Practice: Summary Report*, World Health Organisation, Geneva, https://apps.who.int/iris/bitstream/handle/10665/42940/9241591595.pdf (accessed on 1 July 2019). [17]

Zolotor, A. et al. (2007), "Intimate partner violence and child maltreatment: overlapping risks", *Brief Treatment and Crisis Intervention*, Vol. 4/7, pp. 305-321, https://pdfs.semanticscholar.org/e573/c80a7a35e9897df94322dd3f23b84180cf05.pdf (accessed on 3 October 2019). [64]

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