THE CONTRIBUTION OF VOLUNTEERS TO EARLY INTERVENTION SERVICES IN A COMMUNITY-BASED CHILD PROTECTION PROGRAMME AT A SELECTED NON-GOVERNMENTAL ORGANISATION

By

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Thesis presented in fulfilment of the requirements

for the degree of

Master of Social Work

in the

Faculty of Arts and Social Science

at

Stellenbosch University

Supervisor: Prof Sulina Green

March 2017

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DECLARATION

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ABSTRACT

Child maltreatment in South Africa is a pervasive social problem. South African child protection services follow the family preservation approach, where services strive to keep the child safely in the home, addressing the causes of the maltreatment while working with the family as active participants.

Family preservation services are rendered within a continuum of care, which consists of prevention services, early intervention services, and statutory services. Prevention services are aimed at broader population groups in order to prevent child maltreatment through raising general awareness of the issue and the community resources available to address it. Early intervention services include developmental and therapeutic interventions aimed at specific families who are at risk of statutory intervention because maltreatment has already occurred. Statutory intervention (when a child is placed in foster care, for instance) occurs only once the other two service levels have proved unsuccessful in ensuring the child's safety.

The type of service (prevention, early intervention or statutory) rendered is determined by the degree of risk of maltreatment. Much international research has been conducted to identify risk factors associated with child maltreatment by utilising the ecological model. Maltreatment is viewed as a result of risk factors occurring at the micro-, meso- and macro-levels of the ecological model. Thus, the practice assumption is that family preservation services should address risk factors on various ecological levels to prevent maltreatment.

Child Welfare South Africa is a child protection agency that implements a family preservation programme named the Isolabantwana project: community-based volunteers render early intervention services to specific families at risk of having their children removed. This project shares several characteristics with established American family preservation programmes but was designed to fit the unique needs of South African communities. The Isolabantwana project is implemented nationally in more than 200 communities.

This study was undertaken because there is a lack of research regarding such early intervention services rendered by volunteers in South Africa. The aim of this study was to gain a better understanding of the contribution of volunteers to early intervention services in a community-based child protection programme at a selected child welfare organisation. Since this is a relatively new field of study, a qualitative approach and a descriptive and exploratory

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research design were utilised. This study first presented international research findings of risk factors for child maltreatment from an ecological perspective, and an overview of early intervention services and its function within the continuum of care of the family preservation approach. Guided by this theoretical context, the researcher conducted semi-structured interviews with fourteen Isolabantwana volunteers who were selected by means of a purposive sampling method.

Empirical findings showed that volunteer workload (how many families they worked with at any one time, how often they saw families, the length of visitations as well as overall service duration) was considerably more flexible than workloads of Western family preservation models. This can be viewed as a positive adaptation of a family preservation model that is community-based and addresses problems specific to South African communities.

Volunteers dealt with families facing stressors identified in the literature as maltreatment risk factors. Volunteers addressed several of these crucial risk factors. Obstacles to service delivery, such as a lack of referral resources, or an under-utilisation of volunteer potential, were identified.

A major part of volunteers' services, is to remove a child from a home (for a maximum of 48 hours) when the child is at high risk of maltreatment. The way in which participants assess risk in order to decide whether or not to remove a child, was explored. It emerged that, although participants for the most part removed a child from a high risk situation where serious physical harm was likely to occur, there were certain circumstances where the child was left in a high risk situations due to mitigating factors.

Based on these findings, several recommendations for practice and further research were made.

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OPSOMMING

Kindermishandeling in Suid-Afrika is 'n ernstige sosiale kwessie. Suid-Afrikaanse kinderbeskermingsorganisasies volg die gesinsinstandhoudingsbenadering en lewer dienste wat poog om die kind veilig binne sy of haar gesin te hou, terwyl die oorsake van mishandeling aangespreek word en die gesin aktief by die proses betrek word.

Gesinsinstandhoudingsdienste word gelewer binne 'n diens-kontinuum wat voorkomende dienste, vroeë intervensiedienste, en statutêre intervensiedienste insluit. Voorkomende dienste is gemik op breë teikengroepe en sluit in algemene dienste om kindermishandeling te voorkom deur bewusmaking van die probleem en hulpbronne om dit aan te spreek. Vroeë intervensiedienste is ontwikkelingsgerig en terapeuties van aard, en gemik op spesifieke hoë-risiko gesinne waar kindermishandeling reeds plaasgevind het. Statutêre intervensie (soos, byvoorbeeld, as 'n kind in pleegsorg geplaas word) vind slegs plaas wanneer dienslewering op die ander twee vlakke nie daarin slaag om die kind te beskerm nie.

Die tipe diens (voorkomende dienste, vroeë intervensiedienste, of statutêre intervensiedienste) wat gelewer word, word bepaal deur die graad van risiko van mishandeling waarin die kind verkeer. Heelwat internasionale studies is uitgevoer om risikofaktore wat met kindermishandeling geassosieer word, te identifiseer. Risikofaktore word oor die algemeen binne die ekologiese model nagevors, en mishandeling word gesien as die resultaat van verskeie risikofaktore wat op die mikro-, meso-, en makro-vlakke van die ekologiese model geleë is. Die aanname is dus dat gesinsinstandhoudingsdienste risikofaktore op verskeie ekologiese vlakke sal moet aanspreek.

Child Welfare South Africa is 'n kinderbeskermingsorganisasie wat gedeeltelik gesinsinstandhoudingsdienste deur die Isolabantwana projek lewer. Hierdie projek is gemeenskapsgebaseerd, omdat vrywilligers binne hul eie gemeenskappe aan gesinne vroeë intervensiedienste lewer. Die projek deel sekere eienskappe met Amerikaanse gesinsinstandhoudingsprogramme, maar is deur die organisasie ontwerp om spesifiek die behoeftes van Suid-Afrikaanse gemeenskappe aan te spreek. Die projek word op nasionale vlak geïmplementeer en is in meer as 200 gemeenskappe gevestig.

Hierdie studie is onderneem omdat daar 'n tekort aan navorsing is oor vroeë intervensiedienste wat deur vrywilligers gelewer word aan Suid-Afrikaanse gesinne waar kinders mishandel

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word. Die doel van die studie was om die bydraes van vrywilligers tot vroeë intervensiedienste in 'n gemeenskapsgebaseerde kinderbeskermingsprogram by 'n geselekteerde nie-regeringsorganisasie, te ondersoek. Aangesien hierdie 'n relatief nuwe studieveld is, is die kwalitatiewe benadering, asook 'n verkennende en beskrywende navorsingsontwerp gebruik.

Die studie het eerstens internasionale navorsingsbevindinge oor risikofaktore vir kindermishandeling vanuit die ekologiese perspektief, beskryf. Daarna is 'n oorsig van vroeë intervensiedienste en die funksie van sulke dienste binne die kontinuum van gesinsinstandhoudingsdienste, bespreek. Hierdie teoretiese konteks is gebruik om die navorser te lei om semi-gestruktureerde onderhoude met 14 Isolabantwana vrywilligers te voer wat deur 'n selektiewe steekproef geselekteer is.

Daar is bevind dat vrywilligers se werkslading (hoe baie gesinne hulle mee werk, hoe dikwels hulle gesinne sien, hoe lank hulle intervensiesessies met gesinne duur, en hoe lank die gesinne deel bly van hulle gevalleladings) baie meer aanpasbaar is as die werskladin van Westerse modelle van gesinsinstandhouding. Dit kan as 'n positiewe aanpassing van Westerse gesinsinstandhoudingsmodelle gesien word, omdat dit die unieke behoeftes van Suid-Afrikaanse gemeenskappe aanspreek.

Vrywilligers werk met gesinne wat stressors wat as risikofaktore vir kindermishandeling beskou word, ervaar. Daar is bevind dat vrywilligers heelwat van hierdie risikofaktore deur hul dienslewering aanspreek, alhoewel dienslewering beperk word deur faktore soos 'n tekort aan hulpbronne om gesinne na te verwys, asook die onderbenutting van die vrywilligers se potensiaal.

'n Hooffokus van vrywilligerdienste, is om 'n kind uit 'n huis te verwyder (vir 'n maksimum tydperk van 48 uur) wanneer die kind 'n hoë risiko loop om ernstig mishandel te word. Die manier hoe vrywilligers risiko assesseer om sodoende te besluit om 'n kind te verwyder of nie, is ondersoek. Dis bevind dat, alhoewel vrywilligers meestal kinders uit hoë-risiko omstandighede verwyder, hulle onder sekere omstandighede steeds besluit om 'n kind binne 'n potensiële hoë-risiko situasie te los.

Verskeie aanbevelings is gemaak vir die praktyk en vir verdere navorsing, gebasseer op die voorafgaande bevindinge.

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ACKNOWLEDGEMENTS

I would like to express my heartfelt gratitude to the following people.

My promoter and supervisor, Professor Sulina Green: Prof, if ever there was a personification of patience, it must surely be you. I can never thank you enough. Bitter baie dankie, Prof.

The Isolabantwana volunteers: Baie dankie vir julle tyd en moeite. Sonder julle sou hierdie studie nie moontlik gewees het nie. Dit was 'n groot voorreg om met julle te kon gesels. Julle werk is uiters waardevol. Dankie vir alles wat julle doen.

Child Welfare South Africa: Thank you for allowing me the opportunity to research this wonderful community project and to talk to the remarkable people who make such an invaluable contribution to our children's wellbeing.

Mrs Rochelle Williams, for your constant (or should I rather say chronic) encouragement and for the endless entertainment. What can I say, Boss Lady? You've got the best smile in the business.

The Department of Social Work, Stellenbosch University: Toe ek amper 15 jaar gelede by julle aangeland het, het ek boggerall geweet. Danksy julle vriendelikheid, hulp, ondersteuning, beskuit, geduld en bowenal jul liefde, het ek uiteindelik in die regte rigting begin invaar. Ek is baie dankbaar.

Mev Connie Park: Connie, sonder jou hulp was ek en my tesis bokveld toe. Baie, baie dankie vir al die geduld en moeite.

My ouers: Mamma en Pappa, baie, baie dankie vir alles. Dis al wat ek kan sê. Ek sou nooit klaargemaak het as julle my nie die geleentheid en ondersteuning gegee het nie. Julle het my gemaak maar darem nie so laat staan nie. Daarvoor is ek ewig dankbaar. Ek is baie lief vir julle. (Ek hoop Pa het al die unicorns op die ark gekry.)

My geliefde vriendin, Ilse Jordaan: Baie dankie vir al jou ondersteuning. (Dit sluit nou in die gesels, die gesamentlike geween en gekners van tande, die Mini Magnums, die Melting Moments en jou hulp met die bibliografie.)

Last, but not least, my broers: Johan, Charl en Joe. Weereens dankie vir die twee gebrande chocolate chip koekies. Ek sal dit nooit vergeet nie.

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CHAPTER 1

INTRODUCTION

1.1 MOTIVATION FOR STUDY

Child maltreatment and violence against children is recognised globally as an urgent matter that has significant negative consequences for both affected individuals and society (International Society for the Prevention of Child Abuse and Neglect [ISPCAN], 2012:2; United Nations, 2006:6). The problem is widespread, with the World Health Organisation estimating that 25% to 50% of children worldwide are physically abused, and about 20% of girls and five to 10% of boys being sexually abused (ISPCAN, 2012:5).

Trauma resulting from maltreatment during childhood can have significant consequences for individual development. According to Perry (2001:4; 8) brain development in a child can be altered as a result of experiencing chronic fear in an abusive situation, which in turn will lead to changes in emotional, behavioural, cognitive, physiological and social functioning. Children may suffer dissociative disorders, somatoform disorder, anxiety disorders, major depression, aggression, impulsiveness, post-traumatic stress disorder, attention deficit hyperactivity disorder, and conduct disorder.

Furthermore, childhood experiences of rape, abuse, neglect, and witnessing intimate partner violence are all risk factors for South Africa's most pervasive, critical health dilemmas, such as HIV and AIDS, sexually transmitted diseases, substance misuse, and mental disorders like post-traumatic stress disorder, depression and suicidality (Seedat, Van Niekerk, Jewkes, Suffla & Ratele, 2009:1013).

Personal consequences for child victims of abuse and neglect are not the only negative effect of their experiences. Being abused as a child also appears to contribute to a more violent society in the long term. According to Seedat et al. (2009:1013) child abuse, along with poverty, unemployment, and widespread alcohol abuse, is also a social factor that supports further violence in society. According to Perry (2001:11), children who do not receive sufficient attention or education, and suffer exposure to violence, become adults who 'create … a violent society'.

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Child abuse and neglect also have financial implications for the public. Health care, the justice system, and other governmental institutions that investigate child maltreatment and bear the responsibility for putting children into alternative care all have to be funded by the state (DSD, DWCPD & UNICEF, 2012:44). Furthermore, non-governmental organisations and communities that support maltreated children and their families bear additional financial costs. In the long term, society pays the price as children who suffered violence potentially grow up to be employees who are less productive (DSD, DWCPD & UNICEF, 2012:44).

As in the rest of the world, child neglect, abuse and maltreatment are considered a serious social issue in South Africa.

The White Paper for Social Welfare (Republic of South Africa, 1997:61) identified child abuse and neglect as "a serious and growing problem", citing the statistics from the South African Police Services' Child Protection Unit in 1994. At the time, 22 911 cases of child abuse had been reported to police, which was 36% higher than the number of reports in 1993.

In 2013, national crime statistics from the South African Police Services indicated that the police received a total of 48 718 complaints of crimes against children (persons younger than 18 years). There were 827 murders complaints, 870 attempted murder complaints, 11 809 complaints of common assault, 9 766 complaints of assault with intent to inflict grievous bodily harm, and 25 446 complaints of sexual offences against children (Institute for Security Studies, 2013).

Researchers believe that child abuse in South Africa is all-pervasive, with beatings (using sticks, belts or other objects) occurring on a daily basis. Injuries from such assaults are widespread. On average, boys are beaten more often than girls, and with greater severity. Research has shown that children are exposed to emotional violence and neglect, with one study finding that between 35% and 45% of children had seen their mothers being beaten. Fifteen percent of the children in the study said that one or both of their parents were too intoxicated to take care of them. About 39% of girls have experienced some form of sexual abuse, including rape and exploitation by adult males (Seedat et al., 2009:1013).

The South African government has, at the level of legislation and policy, responded with several measures.

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The country has ratified the United Nations Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, and the International Labour Organisation's Worst Forms of Child Labour Convention of 1999. The South African Constitution, particularly section 28 (known as the Children's Bill), makes provision for a range of children's rights that the government is legally obliged to protect and uphold. Child protection legislation, which legally binds the government to uphold children's rights, include the Children's Act 38 of 2005 along with the Children's Amendment Act 41 of 2007, the Child Justice Act 75 of 2008, the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, as well as the Domestic Violence Act 116 of 1998. These legal instruments place the state under legal obligation to deliver certain services and take specific action regarding child maltreatment (DSD, DWCPD & UNICEF, 2012:37; 47; 59; 57).

The Children's Act 38 of 2005 and the Children's Amendment Act 41 of 2007 give effect to the Declaration of the Rights of the Child as stipulated in the United Nations Convention on the Rights of the Child, the Geneva Declaration of the Rights of the Child, the United Nations Universal Declaration of Human Rights (as it pertains to children), and the African Charter on the Rights and Welfare of the Child.

The Children's Act also gives effect to the various rights of children as enshrined in the South African Constitution, including 'protection from maltreatment, abuse, neglect or degradation' (Republic of South Africa, 2005).

The national and provincial government departments of social development take the lead in the implementation of the Children's Act 38 of 2005, as amended (Act 41 of 2007), and with it the delivery of child protection services.

The framework for the implementation of these protection services is found in the Integrated Service Delivery Model for Developmental Welfare Services (ISDM) of 2006. This model was generated to give effect to the White Paper of Social Welfare of 1997, and the "constitutional, legal and international obligations that inform the mandate of the Department in the provision of services" (Department of Social Development, 2006:5).

Within this legal and policy framework, child protection services take a social development approach. The South African government adopted the social development paradigm to social welfare in 1997 – as outlined in the White Paper for Social Welfare of 1997 – because the apartheid welfare system was viewed as paternalistic, residual, racially discriminating, too

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specialised, fragmented, rehabilitative, and reliant on institutional care. According to the White Paper for Social Welfare (1997), the developmental approach called for an emphasis on development and prevention in order to create a welfare system that would meet the needs of all South African people (Patel, 2005:1; Republic of South Africa, 1997:5). There was a shift in focus - from the rehabilitation of individuals to the empowerment of individuals, families, groups and communities to allow them to deal with their own relationships, social issues and needs, while at the same time harnessing their strengths (Kirst-Ashman & Hull, 2002:7-8, in Patel, 2005:160).

The Integrated Service Delivery Model for Developmental Welfare Services (2006) classifies developmental social welfare services according to different levels of intervention. These levels include prevention, early intervention, statutory intervention/residential/alternative care, as well as aftercare or reconstruction. These four levels are viewed as a continuum of services that a client can access at any of the levels. Prevention is viewed as the primary aim of service delivery, and is focused on strengthening the capacities of clients who are judged to have the potential to engage in risk-behaviour. Early intervention includes developmental and therapeutic interventions to clients who are at risk of imminent statutory intervention. Statutory intervention occurs once a person can no longer function within the normal social setting and legal measures are required, such as when a child is removed from the home to a place of safety. Reconstruction is aimed at reintegrating a person who was removed from a home or community as a result of a statutory intervention, into their home or community. Within this context, the placement of a child in alternative safe care would be viewed as a temporary measure, with the ultimate aim being to reunite the child with the family (Department of Social Development, 2006:18-19).

However, despite these policies and the emphasis on prevention and early intervention programmes to ensure that more children at risk are reached and that child protection services become sustainable, child protection services are still primarily focused on statutory interventions – in other words, removing children at risk from the home and placing them in alternative care. This could be viewed as a result of a lack of human resources – specifically social workers; there are not enough social workers to deal with high caseloads and ever-increasing poverty (HSRC, 2012:3; 7; Department of Social Development, 2006:8). South Africa needs 66 329 social workers to implement the Children's Act 38 of 2005, as amended (Act 41 of 2007). Yet, by 2012, there were only 16 164 social workers registered with the

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South African Council for Social Services Professions (Parliamentary Monitoring Group, 2013).

In the face of such personnel shortages, volunteers are viewed as an integral part of delivering developmental welfare services – including child protection services. The Department of Social Development recognises the need for volunteers as part of the human resource base needed to support the implementation of its developmentally orientated Integrated Service Delivery Model for Developmental Welfare Services (Department of Social Development, 2006:33-34). The White Paper for Social Welfare (1997) identifies the need for the development of volunteer programmes in order to make provision for the additional human resources required to deliver developmental social welfare services and volunteers are viewed as 'critical' to service implementation. More specifically, it states that there is "an overreliance on professional social workers", and that human resources need to be expanded through employing other types of 'social service personnel'. These could include community development workers, child and youth care workers, as well as volunteers (Republic of South Africa, 1997:15; 31; 36).

To address child abuse and neglect in South Africa in the face of the inadequate number of social workers, some non-profit organisations have embarked on community-based projects to include more volunteers in the delivery of child protection services. On example, is that of Child Welfare South Africa (CWSA). CWSA is a non-profit organisation rendering child protection services. The organisation started a project by the name of 'Isolabantwana: Eye on the Children', in 1997 (NPA & UNICEF, 2008:62; Open Society Foundation, 2005:28). The Isolabantwana programme offers a 24-hour protection service to children, and services are rendered by community volunteers who are trained by CWSA. These volunteers have the statutory powers required to remove a child from their home and place them in short-term alternative care, after which a social worker intervenes. Thus, the volunteers intervene with high risk families where the removal of the child through statutory action is highly likely, and therefore deliver early intervention services (Department of Social Development, 2006:18-19).

Despite the widespread involvement of volunteers in early intervention services that promote child protection in South Africa, not much research is available about the contribution of volunteers rendering these services. Although a search of various academic research databases (such as EBSCOHOST and Science Direct) yielded international research results, no South

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African peer-reviewed articles could be located, barring one study evaluating a volunteer-driven, community-based child protection programme in the North West province. However, this study focused on volunteer motivation to remain in the programme, and not on the role that they played in delivering early intervention services (Reynecke, Steyn & Rankin, 2007).

Because there is a lack of research about volunteer involvement in early intervention services, this study was conducted to contribute to a better understanding of this topic within the South African context.

1.2 PROBLEM STATEMENT

According to Rubin and Babbie (1997:92), for problem formulation to occur, "a difficulty is recognised for which more knowledge is needed". A research question is then formulated and refined to ensure increased relevance to practice. During this process, the feasibility of research implementation should also be considered.

The problem that was identified in this case was the lack of research about the contribution that volunteers make to early intervention in child protection services within community-based programmes in South Africa. Because the scope of this research was limited by time and financial constraints, the study focussed on one community-based child protection programme at a single organisation.

The research question was therefore: "How do volunteers contribute to early intervention services in a community-based child protection programme at a selected non-governmental organisation?"

1.3 AIMS AND OBJECTIVES

The aim of this research was to gain a better understanding of the contribution of volunteers to early intervention services in a community-based child protection programme at a selected child welfare organisation.

In order to reach this aim, the following research objectives were set:

- To profile the various risk factors relating to child maltreatment, according to the levels of the ecological model.

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- To provide, in terms of the relevant literature, policies and legislation, an overview of the nature and content of early intervention services within the context of the continuum of care of family preservation.
- To describe how volunteers contribute to early intervention services in a selected community-based child protection programme.
- To make recommendations regarding how volunteers in community-based child protection programmes can further contribute to early intervention services with regard to the maltreatment of children.
- To make recommendations for further studies.

1.4 KEY CONCEPTS

Child

For the purpose of this study, the legal definition of a child was utilised. The Children's Act 38 of 2005 defines a child as "a person under the age of 18 years".

Child maltreatment

In 1999, the World Health Consultation on Child Abuse Prevention defined child maltreatment as follows:

> "All forms of physical or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting 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" (WHO, 2002:59).

This definition is also used by the National Department of Social Development (DSD, DWCPD & UNICEF, 2012:5). This is also the definition that was used in this study.

Child protection services

For the purpose of this study, the definition of child protection services as stipulated in the Integrated Service Delivery Model for Developmental Welfare Services (2006) was used. The policy document defines child protection services as services aimed at preventing child abuse, neglect and abandonment and protecting and promoting the well-being of children, especially those in difficult circumstances (Department of Social Development, 2006:22).

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Early Intervention services

For the purposes of this study, early intervention services were defined as services that target specific families where child removal into alternative care is imminent due to serious maltreatment, or where there is a possibility of removal because the child is at risk of maltreatment, but removal is not imminent (Integrated Service Delivery Model, 2006:19; Strydom, 2012:438).

Community-based development programmes:

For the purpose of this study, the definition of a community-based development programme was drawn from the Integrated Service Delivery Model (2006). Therefore, a community-based development programme was defined as a people-driven programme that focuses on community development, where such development is seen as "the process and method aimed at enhancing the capacity of communities to respond to their own needs, and at improving their capacity for development, through community mobilisation, strength-based approaches and empowerment programmes" (Department of Social Development, 2006:13; 16).

Volunteer

For the purposes of this study, the definition of the term "volunteer" was taken from the White Paper for Social Welfare (1997) as well as the Integrated Service Delivery Model (2006). Thus, a volunteer was defined as a person who provides a service to a welfare or developmental organisation, usually without re-imbursement, and who forms an important section of the human resource corps required to implement the developmental social welfare approach (Republic of South Africa, 1997; 2006:33-34).

1.5 RESEARCH METHODOLOGY

1.5.1 Research approach

The choice between a qualitative and quantitative research approach is dependent on the aim of the study. Qualitative approaches can be more useful than quantitative methods when studying a phenomenon of which little is known. Qualitative research seeks to gain a detailed understanding of personal experiences, and yield data not readily reduced to numbers (Rubin & Babbie, 1997:26-27).

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The quantitative research paradigm, on the other hand, is an inquiry into social issues that focuses on quantifying constructs, and quantitatively measuring the properties of social phenomena being studied (Babbie & Mouton, 2001:646). Quantitative research methods aim to establish findings that are generalisable to the general study population (Rubin & Babbie, 1997:G-7).

This study took a qualitative approach, since it aimed to create new knowledge about a new research area, namely the contribution of volunteers to early intervention services in a community-based child protection programme.

1.5.2 Research design

Research in social work most commonly aims to explore, describe or explain a phenomenon, and a single study can have one or a combination of these purposes. A great deal of social work research aims to explore an issue of which little is known. An exploratory study is also used when a researcher needs to establish how feasible it would be to embark on a more careful study (Rubin & Babbie, 1997:108-109).

According to De Vos, Strydom, Fouché and Delport (2011:95), exploratory research is typically undertaken when there is insufficient basic information regarding a new research area. The authors support the notion that exploratory research is aimed at developing an understanding of a situation, phenomenon, community or individual.

Because this study sought to gain information about a phenomenon about which there is a lack of South African literature – namely volunteers' contribution to early intervention services in community-based child protection programmes – an exploratory research design was utilised.

This study was also descriptive in nature. Whereas exploratory studies are more concerned with establishing the "basic facts" and "a general picture of conditions", descriptive research seeks to describe a phenomenon more accurately (De Vos et al., 2011:96).

According to Rubin and Babbie (1997:110), descriptive qualitative data contains a "thicker examination of phenomena". Because this study aimed to accurately describe volunteers' contribution to early intervention services to address child maltreatment, it was also descriptive in nature.

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1.5.3 Research method

1.5.3.1 Literature Study

According to De Vos et al. (2011:302) the literature review in a qualitative study serves the purpose of placing the research topic within a theoretical framework. Reviewing the literature also allows the researcher to locate the research topic within a wider body of related research. In addition, the literature review should show that the researcher has a comprehensive knowledge of research related to the study. It also demonstrates that a research gap exists and that there is a need for the new study.

Rubin and Babbie (1997:106) state that, without a literature review, one cannot establish whether the research question has already been addressed. The literature review should also look at what research has been completed that is related to the research problem, what the conflicts and similarities between different studies are, what existing theories say about the issue, and how the research study will relate to existing studies (Rubin & Babbie, 1997:97).

A literature review should also provide a theoretical framework within which observations will be made. According to Grinnell (1988:48), theory should guide observations, and observations have no meaning unless they are viewed in a theoretical context. Theory also guides the direction of inquiry, and narrows its focus, since variables relevant to the study are determined by theory.

Family preservation theory was used to establish a theoretical context in this study. This was because early intervention services as a form of child protection services can be seen within the service continuum of the family preservation approach. Strydom (2012:437), discusses a model of family preservation services prescribed by the Child Welfare League of America in their Standards for Service to Strengthen and Preserve Families with Children (1989), and argues that this model is supported by relevant literature on family preservation.

The model classifies child protection services according to three service levels, devised according to the degree of risk that exists for out-of-home placement of a vulnerable child. At each level, the nature of services differs.

The first level of the model is comprised of family support services which are the primary, widest-reaching service band within the family preservation services group. These services – usually community-based – are available to all families in the general population of a

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community where that community displays risk factors for child maltreatment. The programmes are therefore broad and target the general population (Strydom, 2012:437-438).

The second level of service delivery, as conceptualised by the model, is comprised of family-centred services. At this level, there is a possibility that a child may have to be removed, but the child is not yet in danger (Strydom, 2012:438). Therefore, at this level, a specific family has been identified as displaying dysfunction, and service providers have targeted that family.

The third level of service delivery is referred to as intensive family preservation services. At this level, families are in crisis and the removal of a child to a place of safety is imminent (Strydom, 2012:438).

Strydom (2012:437-439) argues that the three levels within this theoretical framework of family preservation services are consistent with service delivery prescriptions contained in the Integrated Service Delivery Model for Developmental Welfare Services (2006), which are also supported by the White Paper for Social Welfare (1997), and the Children's Act 38 of 2005, as amended (Act 41 of 2007).

Specifically, prevention services, the first level of service delivery defined in the Integrated Service Delivery Model (2006:18) and also operationalised in chapter 8 of the Children's Act 38 of 2005, as amended (Act 41 of 2007), corresponds to what the Child Welfare League of America views as family-support services. The second level within the continuum of services prescribed by the Integrated Service Delivery Model (2006:19), known as early intervention services and operationalised in chapter 8 of the Children's Act 38 of 2005, as amended (Act 41 of 2007), corresponds to the second and third levels identified by the Child Welfare League of America, namely family-centred services and intensive family preservation services, respectively (Strydom, 2012:438-439).

In this study, these conceptualisations of services within the continuum of care served as a theoretical context for understanding volunteer contributions to early intervention services.

1.5.3.2 Population and sampling

Gravetter and Forzano (2003:465, in De Vos et al., 2011:223) draw a distinction between a research population and a universe. A research universe, they argue, includes all potential subjects who have the characteristics which the researcher wants to study. A research

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population refers to individuals, or study units, in the universe possessing specific characteristics.

In this study, the universe was therefore all volunteers involved early intervention services in community-based child protection programmes in South Africa. However, since this study looked at one organisation, the population included only those volunteers who were involved in early intervention services in the selected organisation.

The unit of analysis in this study was a programme, since the research investigated the contribution of volunteers to the programme, and the ultimate aim of the study was to gather information about the programme (Babbie & Mouton, 2001:84).

For the purpose of this study, purposive sampling was used. Various factors were considered in choosing a sampling method for this study. Qualitative sampling methods differ from quantitative methods in that large representative samples are usually not required to attain qualitative research goals. Purposive samples are commonly used in exploratory studies aiming to generate new knowledge, since such research often focuses actively on groups of people with characteristics typical to that group. In purposive sampling, criteria of the sampling unit are predetermined (Staller, 2010; Hussey, 2010). Rubin and Babbie (1997:385) state that purposive sampling means selecting a sample that the researcher believes will render the most complete understanding of the research problem.

This study focused on a group of volunteers at one welfare organisation. Since all volunteers met the criteria for this study – namely that they were trained volunteers who worked in a child protection agency and rendered early intervention services within a child protection programme – they were all assumed suitable study participants.

The size of the sample was to be determined by data saturation, in other words, new participants were to be selected until no new data emerged, and themes started to repeat themselves. Adequate sample size typically relies on the notion of "saturation," or the point at which no new information or themes are obtained from the data (Hussey, 2010). During the actual study, only 14 volunteers were available to participate. However, after the tenth interview, no new data or themes emerged, and thus data saturation had been reached.

The researcher initially made contact with these 14 participants by first contacting the welfare organisation to gain permission to conduct the interviews. The organisation then placed the

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researcher in contact with the social worker overseeing the specific project. The social worker invited the researcher to attend the volunteers' monthly meeting at which they normally discuss their work and future plans for the project. The researcher attended this meeting, and was introduced to a group of about 30 volunteers. The researcher explained the purpose and nature of the research to those present, emphasised that participation was voluntary, and obtained the contact numbers of those who were willing to participate in the research. After this, the researcher contacted the individuals to arrange interviews.

1.5.3.3 Data collection

Since this was a qualitative study seeking to explore and describe volunteers' contribution to early intervention services, it was decided that basic individual interviewing would be used to collect data. Within the qualitative paradigm, basic individual interviewing is one of the data collection methods most often used (Babbie & Mouton, 2001:289). The study utilised a semi-structured interview schedule based on the literature review contained in chapters two and three. A semi-structured interview schedule is used to obtain a rich and comprehensive description of the the participant's experience. The interview schedule served to guide the researcher's questions, allowing flexibility in the interview so that themes can emerge (De Vos et al. (2011:351-352).

Primarily open-ended questions were used in the interviews, since they allowed the participants to provide their own answers, without having to select specific answers provided by the researcher, as is the case with closed-ended questions (Babbie & Mouton, 2001:233). Since open-ended questions did not always yield clear answers, probing questions, or follow-up questions, were used to gain more detail and clarity (Grinnell, 1988:283). The interview schedule is contained in Addendum A.

Interviews were digitally recorded, since it provided an exact rendition of what was said by participants and helped to avoid the distractions that can occur when the interviewer takes notes by hand. The participants' informed consent was obtained prior to recording each interview (Grinnell, 1988:297).

Recorded interviews were copied to a computer hard drive, and transcribed as soon as possible after the interview in order to ensure that no information was lost.

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1.5.3.4 Data analysis, presentation and discussion

The data was transcribed in Afrikaans, exactly as it was recorded. (Interviews were conducted in Afrikaans, the participants' first language, in order to allow them to speak freely, and to maximise their contribution to the study.) The transcribed text was translated from Afrikaans to English, since the thesis is presented in English. (To avoid excessive length of the presentation of this study, the transcribed Afrikaans narratives have not been included in the final data presentation. However, the Afrikaans transcriptions are available upon request.) The transcribed text was carefully analysed to identify themes as they arose. Data was organised and presented according to these themes. Themes were compared to literature discussed in the literature review in order to place the findings within the context of the relevant theoretical framework as well as existing research findings (Grinnell, 1988:454; De Vos et al., 2011:402-403).

1.5.3.5 Ethical considerations

Research in human sciences brings very specific ethical issues, since data cannot be obtained if people will be harmed. The helping professions, such as social work, are increasingly recognising the importance of this principal (De Vos et al., 2011:113-114).

De Vos et al. (2011:115) specify a number of ethical concerns in social research. These include the avoidance of harm, voluntary participation and informed consent, the deception of respondents, the violation of privacy, anonymity or confidentiality, as well as compensation.

According to Babbie (2001:522) research should never cause harm to those participating in the study, be it physical or psychological. Divulging certain information to a researcher may cause psychological distress to the respondent for various reasons; he or she may be embarrassed, or feel that talking about certain issues could endanger their lives, families, friendships, and employment, for example. Although it is impossible to guarantee that no harm will come to participants, the researcher must be sensitive to this issue, and safe guard against harming participants. In this study volunteers were interviewed in a safe environment, namely their homes, and any information divulged was kept confidential. Fortunately, none of the participants required counselling or debriefing following the interviews.

Voluntary participation and informed consent (according to Rubin & Babbie, 1997:60) refers to the principle that no respondent should be pressured into participating in a study, must be

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made aware that they are a part of a study, and must be supplied with all information of any consequences the study may have. In this research study, participants were fully informed of the nature, purpose and processes of the study, and could choose whether or not to participate. It was made clear to them by the researcher that not participating would have no negative consequences whatsoever. Participants were also asked to sign an agreement to participate (Addendum B).

The welfare organisation also granted permission for the study (Addendum C).

The deception of respondents can include not revealing that you are a researcher, or not informing respondents of the purpose of the research. Deceiving study participants is considered unethical and, if subjects are deceived, there has to be a valid reason for this, whether for scientific purposes or due to administrative issues (Rubin & Babbie, 1997:62). Respondents were made fully aware of the nature, purpose and processes of this study.

Research participants have a right to privacy, anonymity and confidentiality. Whereas privacy recognises a right to keep personal information, attitudes, beliefs and feelings private, confidentiality refers to protecting the anonymity of the participant (De Vos et al., 2011:120). Participants' rights to confidentiality and privacy were protected: their names were not published in the study, and all records of interviews were kept in a secure place to which only the researcher had access.

Compensation to participate in a research study – either financial or in another form of aid, such as a food parcel – is acceptable, as long as it does not become the sole reason for a person's participation in the study. If someone is wholly motivated by a reward, that person may not provide accurate information (Royse, 2004:59, in De Vos et al., 2011:121). In this study, participants were not compensated. This was made clear to participants prior to the study.

The research proposal for this study was scrutinised by the Stellenbosch University's Departmental Ethics Screening Committee (DESC), and approved (Addendum D). The research complied with the DESC's requirements of posing a minimal risk to participants. The researcher was also registered with the South African Council for Social Service Professionals, and as such was bound by the ethical code of this body.

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1.5.3.6 Limitations of the study

Qualitative studies are limited, since their findings are not generalisable to the wider population. Although a qualitative inquiry can help one establish a very detailed understanding of a phenomenon, one cannot say that those details apply to the population at large (Rubin & Babbie, 1997:414). This particular qualitative study did not yield findings that were generalisable to the wider population, since sampling was purposive, and measurements were not standardised.

Another possible limitation, is that only 14 volunteers were available to participate in the study. However, after the tenth interview, no new themes emerged, and thus data saturation had been reached.

1.6 PRESENTATION

This study consists of five chapters. Chapter one served as an introduction to the study. Chapter two explores various risk factors relating to child maltreatment, according to the levels of the ecological model. Chapter three provides, in terms of the relevant literature, policies and legislation, an overview of the nature and content of early intervention services within the context of the continuum of care of family preservation. Chapter five contains recommendations regarding how volunteers in community-based child protection programmes can further contribute to early intervention services with regard to the maltreatment of children. Recommendations for further studies are also made in this chapter.

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CHAPTER 2

THE RISK FACTORS FOR CHILD MALTREATMENT: AN THE ECOLOGICAL MODEL

2.1 INTRODUCTION

To identify and assess the risk of child maltreatment and to develop effective intervention programmes, it is necessary to understand factors that put children at risk of being abused or neglected (Prilleltensky, Nelson & Peirson, 2001:41; World Health Organisation, 2002:13; Dubowitz, Jeongeun, Black, Weisbart, Semiatin & Magder, 2011:100; Slack, Berger, Du Mont, Yang, Kim, Ehrhard-Dietzel & Holl, 2011:1354).

However, there is no one risk factor that can be pinpointed as the sole cause of child maltreatment in its various forms. Much of the research about child maltreatment has been conducted from the perspective that different factors combine to increase the likelihood of child maltreatment and several authors have advocated the use of the ecological model to conceptualise the etiology of child abuse. The ecological model, as proposed by Bronfenbrenner (1977), has been widely used as a framework to conceptualise the causes of child maltreatment. Within an ecological framework, child maltreatment is viewed as a result of the interaction of multiple risk factors at the macro- (society), exo- (community), and micro- (family, child or individual) level (Belsky, 1993:413; Lee & Goerge, 1999:758; Prilleltensky et al., 2001:11; 58; World Health Organisation, 2002:12; WHO, 2006:13; Browne, Hanks, Stratton & Hamilton, 2002:xviii; 23; NPA & UNICEF, 2008:31-32; Chaffin, Kelleher & Hollenberg, 1996:192; Dubowitz et al., 2011:100; MacKenzie, Kotch & Lee, 2011).

This chapter will fulfil the first objective of the study, which is to explore the various risk factors relating to child maltreatment, according to the levels of the ecological model.

2.2 DEFINING CHILD MALTREATMENT

The definition of child maltreatment is not cast in stone: it may vary depending on cultural perceptions of what constitutes acceptable treatment of children. However, although no

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universally accepted definition exists, there have been attempts to establish a comprehensive definition of this complex concept (World Health Organisation, 2002:59). The World Health Consultation on Child Abuse Prevention of 1999 conceptualised the term "child maltreatment" to encompass a wide variety of behaviours towards children and defined it as follows:

> "All forms of physical or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting 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" (World Health Organisation, 2002:59).

This definition is in agreement with two international declarations to which South Africa is a signatory, and to which the South African Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) aims to give effect. The United Nations Convention on the Rights of the Child of 1989, in particular article 19, which views "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, exploitation and sexual abuse" as forms of child maltreatment (United Nations, 1990:7). The African Charter on the Rights and Welfare of the Child of 1999 recognises the various forms of child maltreatment in Article 16, including "all forms of torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment, including sexual abuse" (African Union, 1999).

In accordance with the prescriptions of these two international policy documents, the South African Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007), although not specifically defining maltreatment, defines child abuse as "any form of harm or ill-treatment deliberately inflicted on a child". As part of this definition, the Act includes the deliberate assault of or infliction of injury upon the child, sexual abuse of the child (whether perpetrating it or allowing it to occur), bullying by another child, labour exploitation – including child prostitution, and exposing a child to any behaviour that may psychologically or emotionally harm him or her. The Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) provides for a separate definition of child neglect, defining it as the failure on the part of the parent to fulfil the "child's basic physical, intellectual, emotional or social needs" (Republic of South Africa, 2005).

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Child maltreatment, therefore, includes a wide range of behaviours that are broadly classified according to the nature of the abuse to include physical, sexual, mental, and emotional abuse as well as neglect.

2.2.1 Physical abuse

Physical abuse against a child may result in actual mental or physical harm to the child, or the potential thereof. This type of maltreatment may include punching, kicking, hitting, burning, scalding with hot fluids, striking a child repeatedly with an object, attempted drowning or suffocation, as well as shaking, throwing, or poisoning the child (Creighton in Browne et al., 2002:7; World Health Organisation, 2002:59; Prilleltensky et al., 2001:11).

2.2.2 Sexual abuse

Sexual abuse can be defined as any acts where a child is sexually exploited by an adult, or where an adult allows a child to be sexually exploited by other adults. It entails forcing, or coaxing a child to participate in or witness sexual acts, whether penetrative or not, irrespective of whether the child is willing to commit the act or not. It can also involve "grooming" children to participate in sexual acts, exposing children to pornography, or forcing or enticing a child to participate in the production of pornography. Consumption of child pornography, or benefitting financially or in any other way from child pornography is also considered a sexual offence. Acts of sexual violation may also include compelling a child to perform sexual acts on him or herself (such as masturbation), or compelling a child to perform a sexual act with another person or child (Republic of South Africa, 2007; World Health Organisation, 2002:59; Creighton in Browne et al., 2002:7).

2.2.3 Mental, emotional and psychological abuse

Emotional abuse occurs when a parent or caregiver fails to create a supportive and nurturing environment for a child's mental development. It includes any actions that impede the child's psychological development and has negative effects on the child's mental health, such as belittling or insulting the child, threatening or intimidating him or her, or rejecting the child. It can also include communicating to the child that he or she is not worthy of being loved, or that he or she is only deemed valuable if they can contribute to the needs of others. A child who is emotionally abused may often feel afraid and unsafe. Emotional abuse is often

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persistent and can occur on its own, but is usually accompanied by other forms of abuse (World Health Organisation, 2002:59; Creighton in Browne et al., 2002:7).

2.2.4 Neglect

According to Creighton (in Browne et al., 2002:7) neglect occurs when a caregiver consistently fails to meet a child's fundamental emotional and physical needs, and can result in mental or physical harm to the child and have adverse effects on the child's development. It can include failure to provide a child with medical care, schooling, shelter, nutrition, clothing, or exposing the child to physical dangers. Emotional neglect occurs when a caregiver ignores a child's basic emotional needs.

However, according to the World Health Organisation (2002:59) poverty is not synonymous with neglect, since behaviour can only be defined as the latter where parents have access to adequate resources. This corresponds with the Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) which defines neglect as "a failure in the exercise of parental responsibilities to provide for the child's basic physical, intellectual, emotional or social needs", but for an act to be deemed maltreatment and entered into the Child Protection Register, it must be proved to have been deliberate (Republic of South Africa, 2005).

2.3 THE ECOLOGICAL MODEL AND CHILD MALTREATMENT

Within the ecological model of human development, first proposed by Urie Bronfenbrenner in 1974, human development is viewed as a life-long process that occurs within a constantly changing environment, with which a person continuously interacts. The environment is conceived as existing of a micro-, meso-, exo-, and macrosystem, and all of these levels impact on an individual's development and social functioning (Bronfenbrenner, 1977:514-515).

The microsystem consists of interactions between an individual and the "immediate setting" in which the child is living. This may include the individual's family, school, or friends. The relationships between these various settings in which a child is developing, constitutes the mesosytem. According to Bronfenbrenner (1977), it can be considered a "system of microsystems". The exosystem includes larger social entities that, although the individual does not directly interact with them, impact upon the person's immediate setting, such as the family or school, affecting the micro- and mesosystems in such a way that the individual is

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also affected. Such social entities can include government bodies, the media, infrastructure, and social networks. The macrosystem, Bronfenbrenner (1977) argues, differs fundamentally from the other three systems, since it does not necessarily refer to particular settings or institutions, but rather to the ideology or "blueprint" of which the micro-, meso-, and exosystems are "concrete manifestations". The macrosystem includes abstract factors that affect the concrete systems, such as cultural values, practices and beliefs that govern and influence the "economic, social, educational, legal and political systems" which give rise to the micro-, meso-, and exosystems. Thus, in terms of child maltreatment prevention, the manner in which an individual and families are treated according to the culture within a particular macro-system will impact on how that person is treated by role-players within the micro-, meso-, and exo-systems (Bronfenbrenner, 1977:514-515).

Prevention strategies should therefore not only be targeted at attributes of individuals; programmes need to take into account the various ecological levels at which risk factors occur, and address them at the appropriate level, and interventions should aim to reduce risk factors (Belsky, 1993:413; Prilleltensky et al., 2001:58; NPA & UNICEF, 2008:38). In addition to risk factors that increase the likelihood of maltreatment, protective factors also need to be considered when estimating the likelihood of maltreatment. Preventative measures should therefore not only address risk factors, but should also aim to promote protective factors in order to decrease the likelihood of child maltreatment occurring (Belsky, 1993:413; Prilleltensky et al., 2001:58).

Prilleltensky et al. (2001:11) have adapted Bronfenbrenner's (1977) ecological model to construct levels that can be used to identify risk factors and develop appropriate interventions to target those risk factors.

These levels include the child (This includes characteristics specific to the child, such as mental health, life skills and personality factors.); the parent and family (These factors include the characteristics of the parents, such as mental functioning, education level and personality factors. It also includes family characteristics, which include intimate partner violence and spousal conflict or the number of children in the family.); the community level (This includes factors such as neighbourhood poverty and violence, and a lack of resources within a community.); the societal level (This refers to factors outside of the family and individual's control that place stress on that individual and family and can therefore potentially increase

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the risk of maltreatment. This includes socio-economic conditions, social values, norms, and beliefs.) (Prilleltensky et al., 2001:64-65; 72-74; 81-82; 94-95).

Because this model has adapted Bronfenbrenner's (1977) original ecological model to make it specifically applicable to risk factors that predict child maltreatment, it will be utilised as part of the theoretical framework for this study. The following sections will discuss risk factors for child maltreatment according to the ecological levels on which they occur, namely the societal, community, family and parent, and child level.

2.4 RISK FACTORS AT THE SOCIETAL LEVEL

According to Kotch et al. (1995:1119) families are "embedded in a social structure that not only dictates standard of living but also may determine what health and safety, educational, developmental, and recreational options are available to parents and children". The authors refer to this as the social domain, while Prilletensky et al. (2001:64; 65) has named it the societal level – a dimension in which social and economic circumstances that the child and family cannot control contribute to the increased probability of child maltreatment. Examples of risk factors at the this level include poverty and low income, unemployment, immigration, tolerance of violence, extremes in family privacy, devaluing caregivers, and gender stereotyping.

Thus, at the societal level, broad characteristics or traits of society – both economic and social – are hypothesised to influence the likelihood of child maltreatment. This next section discusses societal level risk factors for child maltreatment.

2.4.1 Poverty and low income

Several studies conducted in the United States over the past two decades have found that poverty and low income are risk factors for child maltreatment.

Schumacher, Slep and Heyman (2001:231) state that limited socioeconomic resources are the most consistently documented risk factor for neglect. According to Richter and Dawes (2008:86), "poverty is regarded as the primary distal cause of high levels of child abuse". Slack et al. (2011:1362) showed that economic hardships (which included a family being unable to afford a doctor, struggling to pay rent, having water and electricity cut off, as well as the primary caregiver reducing size and frequency of meals), to be consistently associated

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with child neglect. Pelton (in Melton & Barry, 1994:131) asserts that poverty and low income is the most documented risk factor for child abuse and neglect.

Kotch et al. (1995:1115; 1119) found that low-income households (as indicated by their receipt of government sponsored medical insurance) was a significant predictor that mothers would maltreat infants in their first year of life. Goerge et al. (1993, in Lee & Goerge, 1999:756) also found that families receiving state medical assistance (most often poor families) are more likely to be reported for abuse or neglect via hotlines than families that do not. They argue that this may be due to the fact that these families are subject to increased scrutiny from child protection services, which explains higher rates of reports of maltreatment. However, Drake, Lee and Jonson-Reid (2009:314) argue that the "conventional wisdom" that closer monitoring of poor families results in higher rates of maltreatment reports, has yet to be demonstrated empirically.

Li, Godinet and Arnsberger (2011:142) found that in low-income families (identified by their receipt of government sponsored nutritional support and health insurance) mothers were highly likely to be reported to social services for child abuse. Palusci (2011:1376) found that maltreatment prevalence was significantly higher in families who had problems in securing adequate housing, as well as in families who had financial difficulties.

However, Wolock and Magura (1996:1186; 1190) found that parents in families receiving a government grant as their only source of income were only marginally more likely to be be re-reported for child maltreatment. Chaffin et al. (1996:199-200), found that poverty was of small significance in predicting child maltreatment. According to the authors, although this could be due to limitations in the study methodology, it may also support the argument that child maltreatment "cuts across social class far more evenly" than is widely believed, and that poorer parents and members of minority groups are disproportionately reported.

Drake and Pandey (1996:1011) conducted a study of close to 500 000 families to examine the correlation between family income and child physical and sexual abuse and neglect. The annual income of families in neighbourhoods with low poverty levels ranged from $47 974 to $124 492, $29 812 to $43 313 in the neighbourhoods with moderate poverty levels, and $12 390 to $22 890 in those with high poverty levels. The study showed that for physical and sexual abuse, as well as neglect, neighbourhoods with low poverty levels had the lowest number of reports and substantiated reports. Sexual abuse was twice as likely to occur in high

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poverty neighbourhoods than in moderate poverty neighbourhoods, and four times more likely to occur in high poverty neighbourhoods than in low poverty neighbourhoods. Reports of physical abuse were seven times more likely to occur in high poverty than in low poverty areas, and three times more likely to occur in high poverty areas than in moderate poverty areas. Poverty clearly correlated with reports of neglect. The number of reports of neglect in high poverty neighbourhoods were five times that of moderate poverty neighbourhoods and 18 times that of low poverty neighbourhoods.

These findings of the study by Drake and Pandey (1996:1011) offer some explanation as to why poverty is correlated with child maltreatment, and demonstrates the co-occurrence of risk factors in maltreatment cases. The study also found that, in low poverty and moderate poverty neighbourhoods, two-parent homes were far more common than in high poverty neighbourhoods. Within high poverty neighbourhoods, only 16.57% to 42.77% of households had two parents. Within moderate poverty neighbourhoods, this figure ranged from 72.70% and 88.03%, and for low poverty neighbourhoods, this figure ranged from 78.97% to 96.41%. Single parent households have been repeatedly shown to be at higher risk of maltreatment (Chaffin et al., 1996:199; Li et al., 2011:143; 145).

Drake and Pandey (1996:1011) also found that far more adults in low poverty neighbourhoods had completed high school than in poorer neighbourhoods. While 2.16% to 14.21% of adults in low poverty neighbourhoods had not finished high school, this increased to 17.34% to 42.77% for moderate poverty neighbourhoods, and 34.71% to 59.99% for high poverty neighbourhoods. A parent who has not completed high school has been shown to strongly predict maltreatment (Dubowitz et al., 2011:98; Kotch et al., 1995:1122-1123; Li et al., 2011:143).

2.4.2 Unemployment

Professionals in the field of child protection have consistently asserted that there is a relationship between unemployment and child physical abuse. Krugman, Lenherr, Betz and Fryer's (1986:418) longitudinal study of this relationship (which spanned 20 years and was conducted in Colorado in the United States) confirmed this relationship. There has been speculation about explanatory factors: increased mental stress, an increase in the time that the abusive adult spends with the child since the adult does not leave home for work, or the lack of finances to send a child to day care (which also results in increased time spent with a child)

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have all been postulated as possible risk exacerbating factors. Because alcoholism and substance abuse are associated with unemployment and child abuse, these are also confounding factors. However, research has shown that establishing definite causal relationships is near impossible (Krugman et al., 1986:418-418).

These findings have since been supported by other studies. Gillham, Tanner, Cheyne, Freeman, Rooney and Lambie (1998:84) found that in communities where there were high male unemployment rates, there was also a significantly higher number of reports of child maltreatment, in particular physical abuse. A study about children's calls to a helpline in the Netherlands by Van Dolen, Weinberg and Ma (2013:136; 176) found a very significant correlation between the rise in community unemployment rates and an increase in calls about violence.

Taitz, King Nicholson and Kessel's (1987:1074-1075) offer some explanation for the association between unemployment and child maltreatment. In a longitudinal study (spanning 10 years and conducted in Sheffield in the United Kingdom) it was found that, if a family was otherwise functioning in a stable manner, neither sudden loss of employment nor long-term unemployment of the resident male increased the likelihood of maltreatment. The authors surmised that the loss of employment might point to family or individual dysfunction (such as psychological issues that led a man to lose his position or caused him never to be able to keep a steady job, or social problems within the family itself) that was already present prior to the individual losing his job.

2.4.3 Race and ethnicity

Research has yielded mixed findings regarding the association between ethnicity and child maltreatment.

Chaffin et al. (1996:199) found parents of colour (ethnicity was not specified) to be more likely to neglect their children, but not to abuse them, whereas Wolock and Magura (1996:1186; 1190) found that race was not a predictor of maltreatment. Li et al. (2011:142-143) found that a child's ethinicity (Black, White, Hispanic, Asian, Native American and mixed race) did not predict child maltreatment. Drake et al. (2009:314) found that black parents were more likely to be reported for child maltreatment in areas which displayed poverty, but not extreme poverty, whereas white parents were more likely to be reported than black parents in areas with more extreme poverty. Palusci (2011:1375) found that white

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families were at significantly higher risk of maltreating their children than Asian, Black, Hawaiian, Native American or Hispanic families. By contrast, Lee and Goerge (1999:761; 776) found that black parents were more likely than white or Hispanic parents to be reported to social services for maltreating their children, and that this was especially true for neglect, but warn that bias towards black parents when reporting maltreatment could be the cause of this difference.

Palusci (2011:1381) states that while race or ethnicity does not cause child maltreatment, certain race and ethnic groups are disproportionately exposed to other factors (such as poverty) that are risk factors for child maltreatment. For example, Drake and Pandey (1996:1011) found high poverty levels to be a significant risk factor for child maltreatment, and these high poverty neighbourhoods in which the most child maltreatment occurred were occupied predominantly by black people. By contrast, low-poverty neighbourhoods where the least maltreatment occurred, were primarily occupied by white people.

Putnam-Hornstein, Needell, King and Johnson-Motoyama (2013:33; 44) found that black children were twice as likely to be reported to child protection services for child maltreatment and to be placed in foster care before they were five years old, when compared to white children. However, in their study, there were vast disparities between racial groups as far as socioeconomic circumstances and health issues (both of which were strongly associated with child maltreatment) were concerned. When, statistically, these factors were taken into account, it was found that black children in low socioeconomic circumstances had a lower risk of being referred to child protection services and entering foster care than did white children in similar socioeconomic circumstances. The authors concluded that the correlation between race and child maltreatment prevalence is significantly confounded by socioeconomic differences between races, and that studies ignoring these confounding variables are incomplete. They recommend that interventions address socioeconomic factors while guarding against racial bias.

2.4.4 Cultural, values, beliefs and norms

The norms, values, culture and traditions of a society can influence the probability of child maltreatment. This section will discuss some of these aspects of society, including cultural practices, patriarchy and its accompanying gender stereotypes as well as beliefs about corporal punishment.

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2.4.4.1 Familism

Familism can be defined as a cultural value that emphasises the individual's reliance on family members, the importance of the family as a unit, and a responsibility of family members to care for each other, and to care for children in particular. This cultural value places the needs of the family above that of the individual. Respect for the elderly is also highly valued (Zayas, 1992, in Ferrari, 2002:794; Ulibarri, Ulloa & Camacho, 2009:408). Ferrari (2002:807) found that fathers who attached a low value to familism were significantly more likely to use physical punishment to discipline their children when compared to fathers who attached a high value to familism. Physical punishment, in turn, is often considered a form of child abuse in itself, and is a risk factor for further child maltreatment (Gracia & Herrero, 2008:1061; Crouch & Behl, 2001:417-418).

Ferrari (2002:808) also investigated to what extent the value placed on children by their parents affected parents' perception of how serious maltreatment was. As predicted, parents who valued children more highly showed less tolerance for parental drug use, as well as emotional, physical and sexual abuse of children than parents who attached a lower value to children.

2.4.4.2 Cultural practices

Certain cultural prescriptions can act as protective factors that prevent child maltreatment, whereas others increase the risk thereof.

For example, in a Kenyan study exploring the opinions of professionals working with child sexual abuse, Plummer and Njuguna (2009) identified cultural factors that professionals viewed as child sexual abuse risk and protective factors.

The authors identified several protective factors. One such practice is gender separation. In the Masaai tribe, a girl is separated from the males in her family and sent to live in an environment where there are only women in the home. It is also forbidden for girls to serve any males in the home – including their fathers – with food. This was a cultural practice instated specifically to protect girls from sexual abuse. Another protective factor was the existence of strict traditional laws prescribing harsh punishment for child sexual abusers (such as being stoned or forced to leave a community). Religious beliefs were also viewed as a protective factor. Cultural practices that promoted adult guidance and supervision were

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viewed as a protective factor (for example, where it is cultural practice for a mother to be a homemaker, girls are under constant supervision and thus kept safe), as were strong family values (as seen in the practice of extended families taking in children who were orphaned through the AIDS-related deaths of their parents). Cultural beliefs that children are valued and important to the future of the community were also seen as risk-reducing (Plummer & Njuguna, 2009:528).

An important risk factor is a "culture of silence" in which there are social norms that encourage families not to discuss sex or abuse in the open. Traditional roles assigned to children can also pose a risk. For example, the traditional practice for children to walk long distances when herding cattle, or when fetching water or firewood, make children more vulnerable, since it leaves them unsupervised. Thus they become targets for sexual abuse, particularly girls. Other cultural risk factors included the belief that children have an inferior social status, children being forbidden to speak, children not being seen as valuable to the community, and children being powerless (Plummer & Njuguna, 2009:529-530).

2.4.4.3 Patriarchy and gender stereotypes

Patriarchy, gender roles and sexual norms have also been repeatedly identified as risk factors for child abuse.

These factors include beliefs that a man may marry young girls, the encouragement of girls to have sex after they have undergone female genital mutilation (which in itself is a form of physical and sexual abuse) or the belief that men have the right to dominate women (Plummer & Njuguna, 2009:529-530).

Socially entrenched patriarchal values that promote a form of masculinity where men exert power over women and children, are widely recognised as increasing children's vulnerability to maltreatment. According to Lalor (2008:94) values associated with masculinity, such as the view that men should have multiple sexual partners and exert power over women and girls, plays a strong role in forcing girls to participate in sexual activities.

Morris (2009:414) proposes the concept of an "abusive household gender regime", characterised by maternal alienation – a process during which the perpetrator of violence undermines relationships between mother and child. Thus, the perpetrator enforces gender stereotypes to disempower women and to shift power in the household to the abusive male.

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Within the abusive household gender regime, resistance to the idea that fathers can actually harm their children is enforced, and men's role in family violence and other forms of violence in society is trivialised or denied altogether.

Social welfare practitioners are also not immune to enforcing gender stereotypes that shift the responsibility for child safety away from men. According to a study by Scourfield (2014:976; 980) child care workers viewed women as being primarily responsible for changes to be made in the family, especially where the domestic violence was perpetrated by a man. It was seen as the mother's responsibility to "choose her children's safety over living with a violent man". On the other hand, workers expected very little from men. Throughout the world, the stereotyped assumption that men are the breadwinners and that women should be full-time mothers, places the burden of child welfare squarely on the shoulders of women, meaning that child welfare workers do not usually consider involving men in abuse prevention as a priority.

It is not only workers as individuals who overlook the importance of fathers in child protection. Welfare organisations and child protection services in general have a tendency to be driven by the notion that child protection is the business of the mother, which has dire practice implications. The child protection agency also has a responsibility towards fathers: social workers require the support and training from organisations to build up relationships with the fathers of maltreated children in order to involve them in interventions (Scourfield, 2014:980). This notion is enforced by Osborne (2014:994), who argues that without the support of the organisation, social workers will not succeed in engaging fathers in child protection, since staff require essential training, capacity and support to work with men who may be "aggressive, violent, abusive, reluctant or evasive".

2.4.4.4 Corporal punishment

Apart from being defined as a form of abuse in and of itself in certain countries, a belief in the benefits of using corporal punishment to discipline children has been identified as a risk factor for more severe forms child abuse and maltreatment.

In a study of the Spanish population (using a representative sample) Gracia and Herrero (2008:1061) found that there was an association between what the parents believed to be proper parenting practice and the public perception of what constitutes physical abuse of children. They found that, when compared to adults who found corporal punishment unacceptable, adults who saw child corporal punishment as appropriate believed that there

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was a lower prevalence of child physical abuse in Spanish families. Their explanation for this phenomenon is that those who support spanking and slapping as appropriate forms of physical punishment will have a narrower definition of child abuse than those who do not, meaning that they will only view more extreme cases of violence as child abuse. Accordingly, persons who are of the view that children should never be hit, would have a broader definition of what comprises physical abuse.

Li et al. (2011:142) found that mothers who believed that corporal punishment was not an acceptable form of discipline were significantly less likely to be reported to child protective services for child abuse and neglect.

Crouch and Behl (2001:417-418) found that, in two groups of parents that were highly stressed, those who strongly believed in corporal punishment as an appropriate form of discipline were approximately twice as likely to physically abuse their children compared to those who did not strongly believe in corporal punishment. In fact, in cases where parents did not strongly believe in the value of corporal punishment, high stress levels were not significantly associated with the likelihood of physical abuse.

Zolotor, Theodore, Chang, Berkoff and Runyan (2008:364; 366; 367) found that mothers who reported spanking their children 12 months prior to the research interview were 2.7 times more likely to physically abuse (kick, beat, burn, shaking a child under the age of two years, and hitting the child with an object on the body – excluding the buttocks) their children than mothers who did not spank their children. The more a mother spanked her child, the higher the risk of physical abuse. For every extra incident of spanking reported, a parent was 3% more likely to physically abuse their child. Parents who spanked their children with an object were much more likely to physically abuse them than parents who spanked not using an object.

2.5 RISK FACTORS AT THE COMMUNITY LEVEL

At the community level, risk factors include characteristics of the neighbourhood within which the child and his or her family reside. Examples of such characteristics commonly associated with child maltreatment, include impoverishment, lack of family resources, inadequate or unaffordable housing, community violence, and a lack of social cohesion (Prilleltensky et al., 2001:73-74).

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The following sections give an account of various studies exploring such risk factors.

2.5.1 Impoverished communities

Research has firmly established that child maltreatment tends to be concentrated in disadvantaged communities. However, research explaining these patterns are lacking and it is not known exactly how community influences affect child maltreatment (Coulton, Crampton, Irwin, Spilsbury & Korbin, 2007:1118; Drake & Pandey, 1996:1016).

For instance, Lee and Goerge (1999:768) found community poverty to be a very strong risk factor for child abuse and neglect. In high poverty communities (those where 40% or more children lived below the poverty line, as measured by income level) children were three times more likely to suffer sexual and physical abuse and six times more likely to be neglected (as opposed to children in low poverty communities in which fewer than 10% of children lived in poverty). The study also examined annual trends in specific forms of maltreatment (sexual, physical, and neglect). Yearly increases in reports of neglect were found to be primarily restricted to high poverty communities, whereas annual increases in reports of physical and sexual abuse were found to be similar in all communities regardless of poverty status.

2.5.2 Community safety, cohesion and housing quality

Magura and Wolock (1996:1186; 1188; 1190) investigated the relationship between parents' perceptions of their neighbourhood one the one hand, and child abuse and neglect on the other. They used the Quality of Neigbourhood Scale to examine parents' perception of three aspects of their neighbourhood, namely safety of the neighbourhood (crime levels), physical condition of the neighbourhood (condition of houses) and neighbourhood cohesiveness (neighbours supporting each other in troubled times). A lower score indicated a lower quality of neighbourhood. Results showed that a lower score on the Quality of Neighbourhood Scale was a risk factor for parents being re-reported (once or more) to child protection services for child maltreatment. They also found that a lower measurement on the Quality of Neighbourhood Scale negatively affected family functioning, which in turn increased the likelihood of re-reports of maltreatment.

Similarly, Li et al. (2011:142) examined the role of community or neighbourhood quality in predicting a report of child abuse and neglect to social services. They assessed community quality by looking at mothers' perceptions of the degree of social support, neighbourhood

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safety and neighbourhood pride and morale. The study found that perception of a lower quality neighbourhood was a very strong predictor of child abuse and neglect reports, while perception of high neigbourhood quality was a protective factor.

A study by Guterman, Lee, Taylor and Rathouz (2009) aimed to provide some insight into how neighbourhood conditions can create a high-risk environment for child maltreatment. Their research examined how mothers' perception of their neighbourhood affected risk of child abuse and neglect, and went a step further to examine how these perceptions influenced mothers' stress levels and sense of control. Then, the degree to which mothers experienced stress as well as perceived their own levels of personal control over their lives were measured. After this, associations between different variables were made.

Specifically, the research measured mothers' perception of their neighbourhoods using three scales. The first, the social disorder scale, examined how often mothers saw drug dealers and intoxicated persons on the streets in their neighbourhood, the level of gang activity as well as groups of teenagers loitering in the neighbourhood. The second construct measured was that of informal social control. Mothers were asked about their perceptions of the degree to which adults in the neighbourhood would intervene in different neighbourhood issues, such as children showing disrespect for adults. The third construct was social cohesion. Mothers were asked about the extent to which they trusted those living in their neighbourhoods, and how willing neighbours would be to help each other (Guterman et al., 2009:899).

The study determined parental stress level by asking mothers questions about the extent to which having a child prevents them from taking part in activities that they enjoy or results in them making personal sacrifices. Mothers' levels of personal control were measured by asking them about the extent to which they felt they had control over things that happen to them, or their power to change important aspects of their lives (Guterman et al., 2009:900).

The extent of maltreatment by mothers was measured by investigating the extent of psychological abuse (This included actions such as yelling, screaming, cursing or threatening a child in a way that may result in the child experiencing emotional pain or fear.), physical aggression of mothers towards children (such as the number of times a mother shook or pinched the child, or slapped the child on the head, face or ears, or on the buttocks with a hard object) as well as neglecting the child. This included leaving the child at home alone, being so

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embroiled in her own problems that she was unable to demonstrate love towards the child, or not being able to provide a child with the necessary nutrition (Guterman et al., 2009:900).

Study results showed that mothers' negative perception of their neighbourhood was a mild predictor of child physical and psychological abuse and neglect. However, a mothers' negative perception of her neighbourhood was a strong risk factor for mothers' lower sense of personal control, and this in turn was a strong risk factor for mothers' high personal stress levels. Parenting stress was a strong predictor of mothers' abusing their children physically and psychologically, and of neglecting them. In addition, a lower sense of personal control was found on its own to be a direct and significant predictor of child neglect, but not of child physical and psychological abuse. The above findings did not vary across racial groups (blacks, whites or Hispanics) (Guterman et al., 2009:904).

Coulton et al. (2007:1118-1119) recommend that greater understanding of how neighbourhood factors act as stressors (risk factors) that increase the potential for child maltreatment is necessary to direct more targeted interventions. Guterman et al. (2009:905) suggest that parents' sense of control as well parental stress (as impacted by their neighbourhood circumstances) be the focus of intervention programmes.

2.6 FAMILY AND PARENT LEVEL

This domain includes the child's interactions with his or her immediate environment (the family and the child's parents or caregivers). Research has identified various risk factors found in families. Examples include the number of family members, stress levels within the family, intimate partner violence, teenage parents, a lack of parenting skills, low levels of education, personality factors, poor mental health, and substance abuse (Prilleltensky et al., 2001:81-82; Kotch et al., 1995:1118).

The following section will discuss risk factors for child maltreatment found at this level.

2.6.1 Household size and structure

Larger households have been found to be a risk factor for child neglect (Chaffin et al., 1996:196), although a relatively weak predictor. A study by Dubowitz et al. (2011:98) supported these results when it found that the more children there were in a family, the more likely it was for child maltreatment to occur. Kotch et al. (1995:1123) found that if the mother

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of an infant had other children in the household, she was more likely to abuse or neglect that infant within the first year of its life.

In a study of 104 infants who were victims of fatal child abuse, Schloesser, Pierpont and Poertner (1992:6) found that in 31.8% of cases babies who were killed were first born, whereas in 66% of cases they were born after the first child. Lee and Goerge (1999:770) found that birth order was a risk factor for abuse, with children born after the first-born child being 1.7 times more likely to be neglected than first-born children. Both Schloesser et al. (1992:6) as well as Lee and Goerge (1999:770) hypothesise that more children in a family causes increased stress levels for parents who are already faced with limited resources, which in turn may trigger abusive behaviour.

Single-parent households have also been found to influence the likelihood of child maltreatment. Chaffin et al. (1996:199) found an unmarried parent to be more likely to neglect their children, but not to abuse them. Li et al. (2011:143; 145) found that married mothers were far less likely (0.19 times as likely) to be reported for child abuse and neglect than mothers who were single, divorced or separated. The authors sought to explain this by pointing to the likelihood that two-parent households may have access to better resources than single-parent households, and recommend further studies be undertaken to establish what resources occurring in two-parent households could also assist single parent households. Li et al. (2011:146) recommend that programmes strengthening marital relationships will reduce the likelihood of child maltreatment, particularly in cases where families live in poverty and are negatively affected by a high number of life events.

2.6.2 Family functioning and conflict

Wolock and Magura (1996:1186; 1187; 1190; 1191) found that poorer family functioning (a concept which was measured in their study with the following variables: parent's affective state; social isolation; family conflict; behavioural problems of children; parental difficulties; and financial difficulties) was a predictor of re-reports of child maltreatment cases to child welfare services.

Children witnessing intimate partner violence is widely recognised as child maltreatment in itself, negatively impacting the child in similar ways as other kinds of abuse and neglect. Added to this, the abuse of women and children very often co-occur in the same household. Men's severe violence towards their intimate partners most often occur in the presence of

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other types of family violence, including aggression of the mother or her partner towards the child, as well as women perpetrating intimate partner violence against men (MacMillan, Wathen & Varcoe, 2013:1186; Holmes, 2013:520; Morris, 2009:414; McDonald, Jouriles, Tart & Minze, 2009:94; Casanueva, Martin & Runyan, 2009:84).

Violence in the family is a significant risk factor for child maltreatment. Casanueva et al. (2009:84) found that mothers who experienced physical abuse by their partner during the 12 months preceding the study were twice as likely to be re-reported to child protections services for child maltreatment than mothers who were not abused by partners. Furthermore, violence against women is associated with parenting problems and lower levels of maternal warmth. Being physically abused also negatively impacts mothers' mental health. All of these are risk factors for child maltreatment. Chan (2011:532) found that children experiencing intimate partner violence were much more likely to be neglected and be subjected to corporal punishment and severe physical maltreatment than children who did not experience intimate partner violence.

The co-occurrence of intimate partner violence, violence in the family, and child maltreatment has definite practice implications. Casanueva et al. (2009:84) recommend that child maltreatment prevention programmes make assessments to establish if intimate partner violence is present, and to ensure interventions address this type of violence. Holmes (2013:520) recommends that interventions should assist mothers in coping with mental health problems co-occurring with intimate partner violence in order to curb further negative impacts of abuse and witnessing intimate partner violence on children.

2.6.3 Family stressors and support

In study of a sample of poor, young, single mothers, those with more social support (having more close friends and relatives, having a close intimate relationship, membership of a church or group memberships) and fewer stressful life events (whether positive, like getting married, or negative, for example, being evicted) were at the least risk of being reported for child abuse or neglect within the first year of their child's life. It was found that with increased social support came a decrease in risk of being reported for child maltreatment in the infant's first year of life. However, stressful life events, whether positive or negative, can increase this risk. The absence of social support and the extent to which stressful events occur in a parent's life

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should each be considered a risk factor, both separately and when they occur together (Kotch et al., 1995:1119-1121; 1126).

In support of the findings of Kotch et al. (1995) pertaining to stressful life events, Li et al. (2011:142-145) found that an increased number of life events, positive or negative, greatly increased the risk of child abuse and neglect. Mothers with a high number of life events in the preceding year were 2.68 more likely to be reported than mothers with a low number of life events. (In the study, the number of life events was classified as either high or low. Families in the lowest tertile were classified as having a low number of life events, and those within the top two tertiles as having a high number of life events.)

Li et al. (2011:141; 144) also explored social support as a protective factor, and measured it according to confidant support (having someone to talk to or receive advice from), affective support (receiving love and affection), and instrumental support (assistance with transportation, cooking, household tasks and childcare) (Lopez & Cooper, 2011:22). Their study found that a high level of social support was a strong protective factor against child maltreatment. Mothers with high social support levels much were less likely (0.29 times as likely) to receive reports of child abuse and neglect when compared to mothers with low support levels. Social support was also a protective factor against child maltreatment in cases where mothers had a low level of education.

Kotch et al. (1995:1126) recommend that screening tools be utilised to assess the extent of stress a parent experiences, as well as the degree of social support, in order to establish to what extent a child is at risk of maltreatment. Community-based programmes that increase supportive resources for poor mothers are also recommended. Li et al. (2011:146) endorse this finding, recommending that screening procedures be developed to assess families with greater life stress and life events. For families with little social support, they recommend interventions that increase parents' informal support networks. They also suggest that government sponsored programmes run by social service agencies that provide economic assistance and home-visiting programmes be developed.

2.6.4 Parental substance abuse and dependence

Several studies have found parental substance abuse to be a very significant and leading predictor of child abuse (including child sexual and physical abuse), and neglect (Murphy, Jellinek, Quinn, Smith, Poitrast & Goshko, 1991:197; Famularo, Kinscherff & Fenton,

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1992:475; Magura & Laudet, 1993:193; Dinwiddie & Bucholz, 1993:656; Dore, Dorris & Wright, 1995:531; Chaffin et al., 1996:191; Wolock & Magura, 1996:1183; Walsh, MacMillan & Jamieson, 2003:1409; Dubowitz et al., 2011:96; Li et al., 2011:142).

Chaffin et al. (1996:199-200) found substance abuse to be strong predictor for child abuse and neglect. Their results indicated that substance-abusing parents were rated by court investigators as posing a high risk to children, and were significantly more likely than non-substance abusing parents to reject court-ordered services and to have their children removed. The results support an earlier study by Murphy et al. (1991:197) which found that in 50% of serious child abuse and neglect cases one or both parents were alleged to have abused alcohol, cocaine or heroin. Dinwiddie and Bucholz (1993:465) demonstrated similar findings with parents abusing alcohol being significantly more likely to abuse their children. Walsh et al. (2003:1410) found that parents who abuse alcohol or drugs were twice as likely to sexually or physically abuse their children.

Wolock and Magura (1996:1190) showed parental substance abuse to be a very significant predictor of first reports and re-reports of child maltreatment (including physical abuse, neglect, sexual abuse, and emotional abuse) to child welfare services. They also found that when alcohol and other drugs were combined, the likelihood of re-reporting was especially high. It was found that substance abuse also strongly predicted that family functioning would diminish, which in turn was demonstrated to be a risk factor for child maltreatment, especially when both alcohol and drugs were abused.

Dore et al. (1995:531; 540) warn that while substance abuse has been found to be a significant risk factor, "minimal attention" is usually given to this issue during the training of social workers in child protective services. The authors recommend strongly that child welfare workers be appropriately equipped in this regard to allow them to intervene successfully.

2.6.5 Personality factors and mental health

Depression and major depression in parents, as well as maternal depression, have been found to be a strong risk factor for abuse and neglect. Parents diagnosed with obsessive compulsive disorder, antisocial personality disorder, and a high level of psychosomatic syndrome were found to be associated with abuse and neglect, although obsessive compulsive disorder was found to be a weak predictor (Chaffin et al., 1996:197; 199; Dubowitz et al., 2011:98; Kotch et al., 1995:115; Dinwiddie & Bucholz, 1993:471-475; Li et al., 2011).

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Dinwiddie and Bucholz (1993:471-475) found a strong association between child abuse and parents with antisocial personality disorder. Parents who had a history of antisocial behaviour as children (running away from home, being truant, suspended or expelled from school and stealing or destroying property) were also more likely to abuse their children. However, the authors found that these were weak predictors of child abuse. On the other hand, adult antisocial behaviour was found to be a stronger predictor of child abuse. Adults who displayed sexual promiscuity, marital infidelity, violent behaviour, poor family relationships, and poor control of aggression were more likely to have abused their children. This was particularly true in cases where intimate partner violence was found. According to the authors, the study's findings supported previous research which found that adults displaying these behaviours would be significantly more likely to maltreat children.

Chaffin et al. (1996:197; 199) concluded that their study findings supported etiological models in which social stressors activate parental disposition to psychological disorders. This then predisposes the parent to becoming abusive of neglectful towards the child. This is to an extent supported by Shumacher et al. (2001:231) who conclude that behavioural and psychological characteristics may be the best predictors of neglect, even though limited socioeconomic resources are the risk factors most consistently documented. Slack et al. (2011:1360) however, state that economic stressors as a predictor of child neglect was not substantially mediated by other risk factors among parents. The authors question the tendency of preventative programmes to focus on parental risk factors while not addressing economic pressures and material hardships adequately.

Dinwiddie and Bucholz (1993:474) recommend that behaviours that are associated with child abuse be used to identify parents at high risk of abusing their children before abuse actually occurs so that prevention programmes can be implemented timeously.

2.6.6 Parenting skills

A study about teenage mothers' potential for abusing their children by Dukewich, Borkowski and Whitman (1996:1036; 1042) found that mothers who do not have a good understanding of children's developmental phases and the behaviours and abilities they can expect of their child within these phases, are a "critical" risk factor for child maltreatment. The study also showed that mothers' who understood their parental responsibility (in other words, placing the child's needs before their own and accepting that they are responsible for the child's care, and

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that the child cannot take on developmentally inappropriate tasks) were significantly less likely to abuse their children. Thus, lacking an understanding and skill to raise a child in accordance with his or her developmental phase may lead to a mother punishing a child because she perceives his or her behaviour as unruly, when in fact she has unrealistic expectations of the child.

Dukewich et al. (1996:1042) further argue that a young, inexperienced mother's inaccurate perception that a child is "difficult", may increase the likelihood of her becoming more rigid and unhappy, which in turn sets the stage for a hightened risk of abuse. MacKenzie, Nicklas, Brooks-Gunn and Waldfogel (2011:1371) conclude that parents who perceive infant temperament as "difficult" should be targeted by preventative services, and contend that less experienced parents may be at greater risk of spanking an infant because they do not have adequate knowledge about alternatives to spanking. Strickland and Samp (2013:1014) found that when parents have the ability to plan how to handle a child's unwanted behaviour, the risk for child maltreatment decreases.

2.6.7 Young parents

Lee and Goerge (1999:769; 772; 775-775) found that there was a far greater possibility that children born to mothers aged 19 years and younger would become victims of sexual abuse, neglect, and other forms of abuse. In cases of mothers aged 17 years and younger, children were 3.5 times more likely to be sexually or physically abused and neglected before they reached five years of age when compared to children born to mothers 22 years and older. The authors also found that young maternal age combined with poverty places a child at a much higher risk of being neglected or abused than when the two risk factors occur separately. The authors recommend policy and programme interventions that address both teenage parenthood and poverty simultaneously, such as programmes alleviating young mothers' financial stress while also equipping them with parenting skills.

Chaffin et al. (1996:196; 200) found that young parents were at greater risk of neglecting their children, although not significantly so. However, the authors warned that this finding might have been due to methodological limitations. Bartlett and Easterbrooks (2012:2167) found that a quarter of mothers in their study sample who were aged younger than 17 years neglected their children. Li et al. (2011:142) also found that young mothers (those under 20 years of age) were significantly more likely to be reported to child protection services for

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abuse and neglect. This affirms a study by Schloesser et al. (1992:6) in which 73% of mothers of babies fatally abused were younger than 20 years of age.

2.6.8 Gender of parent

Both men and women abuse children, although studies have found that the type of abuse perpetrated differs for the two genders. Schloesser et al. (1992:6) found that 57% of perpetrators of fatal child abuse were male (including fathers, stepfathers and live-in boyfriends), and that a child was more likely to die from head or abdominal injuries when men were the perpetrators. In 36.7%, mothers were the perpetrators, and they were more likely to strangle, asphyxiate, drown or neglect the child. Turla, Cihad Dündar, Çağlar Özkanli (2010:1298) found that mothers were more likely to physically abuse their daughters than their sons, while for fathers the opposite was true.

2.6.9 Parent education level

Dubowitz et al. (2011:98) found that mothers who were less educated (did not complete high school) were more likely to be reported to child protection services. This finding supports that of Kotch et al. (1995:1122-1123) who concluded that low maternal education (not completing high school) was a significant predictor of child maltreatment being reported to child protection services within the first year of the child's life. Supporting these findings, Li et al. (2011:143) found that mothers who had received 12 or more years of education were less likely (0.09 times as likely) to receive reports of child maltreatment when compared to mothers with less than 12 years of schooling.

2.6.10 Parents abused or neglected when young

Kotch et al. (1995:1123) found that if a mother of a young infant had been separated from her own mother before or at age 14, she was significantly more likely to abuse that infant within the first year of its life. The authors also found that mothers who had been witness to violence in their families while growing up, were significantly more likely to maltreat their children.

In their study involving adolescent mothers (aged below 17 years) Bartlett and Easterbrooks (2012:2167) found that mothers who neglected their children were four times more likely to have experienced abuse in their childhood than mothers who did not: the vast majority of mothers in their study sample who neglected their children were physically abused during childhood. According to the authors, this confirms the outcomes of multiple studies that

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physical abuse in childhood increases the likelihood of a mother maltreating her child. The authors suggest that a parental history of childhood abuse is a leading risk factor for neglect, and that this may be particularly pertinent among adolescent mothers.

Li et al. (2011:142-143) found that mothers with a history of being abused or neglected during childhood or adulthood were highly likely to be reported to child protective services for abusing or neglecting their own children. They were 2.26 times more likely to be reported than mothers who did not experience abuse and neglect during childhood.

According to Bartlett and Easterbrooks (2012:2167), very little research has been conducted to establish how mothers abused in childhood can break the cycle of abuse. However, authors state that their research confirmed the majority previous research findings that young mothers who were abused as children but who also received positive care from their own mothers were less likely to neglect their children. Their findings showed that this was the case even when the abuser was the same person who provided the positive care.

The authors suggest that prevention programmes that focus on young mothers should gather maternal histories of trauma when determining risk for neglect. At the same time they suggest that, following a strengths-based approach, it is equally important that the positive aspects of mothers' relationships with their caregivers be assessed, and that mothers' current protective relationships with support systems (social networks, family, and community) which may serve as a buffer to child maltreatment, be identified and supported through interventions. Programmes should also focus on building on mothers' personal strengths to diminish the risk of maltreatment (Bartlett & Easterbrooks, 2012:2167).

2.7 RISK FACTORS RELATED TO CHILDREN

A number of factors related to the characteristics of a child have been found to be associated with child maltreatment. Examples include a low birth weight, poor physical health, poor mental health, difficult behaviour, gender and age (Prilleltensky et al., 2001:95). These risk factors will be discussed in this section.

2.7.1 Low birth weight

Low birth weight has been shown to be a risk factor for child abuse. Schloesser et al. (1992:5) found that babies with a low birth weight (under 5.5 pound) were twice as likely to die as a

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result of fatal child abuse than babies who did not have a low birth weight. Windham, Rosenberg, Fuddy, McFarlane, Sia and Duggan (2004:655) support this finding. Their study showed that children who weighed in below the normal weight-for-gestational age infants were six times more likely to be victims of physical assault than children of normal weight.

2.7.2 Child development and behavior

A large body of research has shown that children who are mentally, physically, developmentally or behaviourally challenged, are at an increased risk of child maltreatment (Stalker & McArthur, 2012:24; Helton & Cross, 2011:126; Sobsey, 2002:29).

In a study sample of 4 503 disabled and non-disabled children and adolescents, Sullivan and Knutson (2000:1257; 1260; 1265-1266) found that children with disabilities were significantly more likely to be abused than non-disabled children. The disabilities examined in their research included autism, behaviour disorders, deaf-blindness, hearing disabilities, mental disabilities (ranging from mild to severe), multiple disabilities, orthopaedic impairments, health impairments (for example, asthma or rheumatoid juvenile arthritis) traumatic brain injury and visual impairments. The types of maltreatment examined included neglect as well as physical, sexual and emotional abuse. Looking at an overall measure of disability (consisting of a composite of all the above-mentioned types of disability), the study showed that disabled children were 3.4 times more likely to experience some form of maltreatment than non-disabled children.

More specifically, disabled children were more likely to experience every type of maltreatment when compared to non-disabled children. They were 3.76 times more likely to experience neglect, 3.79 times more likely to suffer physical abuse, 3.14 times more likely to suffer sexual abuse, and 3.88 times more likely to experience emotional abuse (Sullivan & Knutson, 2000:1266-1265).

Disabled children were also significantly more likely to experience multiple incidents of abuse and neglect rather than a single incident. A total of 71% of children with disabilities experienced the former, and 29% the latter. By contrast, non-disabled children are far less likely to experience either multiple or single instances of abuse – 60.6% and 39.4% respectively (Sullivan & Knutson, 2000:1261-1262).

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The risk to children with specific types of disabilities was also compared to that of children with no disability. Results showed that children who were visually impaired had a 1.5 times greater chance of experiencing neglect, were twice as likely to experience emotional abuse, and 1.2 times as likely to suffer sexual abuse. Children with hearing disabilities were 2.3 times more likely to be neglected, 3.8 times more likely to experience physical abuse, twice as likely to experience emotional abuse, and 1.2 times as likely to have been sexually abused. Children with speech or language impairments were 4.7 times as likely to be neglected and physically abused, 6.6 times as likely to be emotionally abused, and 2.9 times more likely to experience sexual abuse. Mentally disabled children were 3.7 times more likely to be neglected, 3.8 times more likely to experience physical abuse and emotional abuse, and four times more likely to be sexually abused (Sullivan & Knutson, 2000:1266-1265).

Children with behaviour disorders were the most likely to experience all forms of abuse. They were 6.7 times more likely to be neglected, 7.3 times more likely to have been physically abused, seven times more likely to have suffered emotional abuse, and 5.5 times more likely to be sexually abused (Sullivan & Knutson, 2000:1266-1265).

Children with learning disabilities were twice as likely to suffer neglect, physical or emotional abuse, and 1.8 times more likely to be sexually abused. Children with a health impairment were 3.4 times more likely to be neglected or emotionally abused, 3.3 times more likely to experience physical abuse, and twice as likely to be sexually abused. Children with autism were slightly more likely to experience neglect (1.3 times), but were at no increased risk for other forms of maltreatment. Children with physical disabilities were 1.8 times more likely to be neglected, 1.2 times more likely to be physically abused, 1.5 times more likely to be emotionally abused, and twice as likely to experience sexual abuse (Sullivan & Knutson, 2000:1266).

Even if a child is not disabled, below-average development can still be a risk factor for abuse. For example, Dubowitz et al. (2011:101) found that parents of children who were younger than three-and-a-half years and who scored low on a standardised assessment of mental development (although they were not developmentally delayed) were more likely to be reported to authorities for child maltreatment than children with normal scores. The authors theorise that children with more normative development are easier to rear and therefore not as likely to be maltreated, and that there could be a higher probability that children develop normally because they live in environments where their healthy development is nurtured.

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They recommend that children's development be monitored, and that that developmental delays serve as possible indicators of families at higher risk of abusing a child.

A study by Helton and Cross (2011:126) that included 1 675 maltreated children between the ages of three and 10 years showed similar findings to that of Dubowitz et al. The research found that children with minor disabilities were at higher risk than children who were severely disabled or who functioned superiorly.

In the study, parental physical assault was classified as severe or minor. Behaviours included in the operationalised definition of minor physical assault included shaking a child, hitting the child on the buttocks with a hard object, spanking a child with the bare hand, slapping the child on the leg, arm or hand, or pinching the child. Severe physical assault included hitting the child with the fist, kicking the child hard, grabbing the child around the neck and chocking him or her, repeatedly hitting the child hard, purposely burning or scalding the child, striking the child with a hard object anywhere other than the buttocks, threatening the child with a weapon (knife or gun), throwing the child, knocking the child to the ground, and slapping the child on the face, head or ears (Helton & Cross, 2011:128).

Results showed that children with increased behavioural dysfunction (measured by indicators such as somatic complaints, anxiety, depression, delinquency and aggressive behaviour) were at a significantly higher risk of both severe physical assault and minor physical assault. Children with average and below-average social skills functioning (indicators included the child's level of co-operation with the parent, degree of assertiveness, ability to assume responsibility and to maintain self-control) were significantly more likely to suffer minor assault than children who functioned at an above average to superior level (Helton & Cross, 2011:128; 132-133).

Possessing superior daily living skills (measured by indicators such as the child's ability to feed and dress him- or herself, maintain personal hygiene, and perform domestic tasks) was found to be a protective factor for severe physical assault, whereas children with average daily living skills were only at slightly lower risk of severe assault than children with below-average daily living skills (Helton & Cross, 2011:128; 132-133).

Where linguistic ability was concerned, children with mild language disability were at a higher risk of minor assault than children with a more severe disability. This, according to the authors, corresponds to several studies that have found children who are mildly disabled to be

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at greater risk than children with severe disabilities. (Helton & Cross, 2011:133). This also echoes the findings of Dubowitz et al. (2011:101) that non-disabled children with below average functioning are more at risk than children who are severely disabled.

2.7.3 Child gender

Research has shown that boys and girls are prone to varying degrees of risk for different types of abuse. In particular, boys appear to be at greater risk for physical abuse, whereas girls seem to be at higher risk of sexual abuse.

Lee and Goerge (1999:770) found girls younger than five years to be three times more likely to be reported as sexual abuse victims than boys in the same age group. In a Finnish study of 4 561 men and 8 361 women, Laaksonen, Sariola, Johansson, Jern, Varjonen, Von der Pahlen, Sandnabba and Santtila (2011:480; 485) found that women were more likely to have experienced sexual abuse during childhood than men. A total of 9.3% of women in the sample had experienced being touched in a sexual manner, compared to 4.3% of men, and 6.3% of women indicated that they were forced to perform or watch a sexual act, compared to 4.6% of men.

In a study that took place in the United States, findings by MacMillan, Tanaka, Duku, Vaillancourt and Boyle (2013:15), supported those of Laaksonen et al. (2011). In their study of childhood abuse experiences that included 1 928 men and women, females were at a significantly greater risk of experiencing sexual abuse. A total of 22.1% of females in the sample reported sexual abuse, compared to 8.3% of males. Boney-McCoy and Finkelhor found that girls in their study were three times more likely than boys to be victims of sexual abuse (1995:1409).

However, it is possible that the number of male children who are sexually abused are underestimated and under-reported. According to Easton, survivors of such abuse are "stigmatised, under-studied, and marginalised". In a study examining a sample of 487 men (aged 19 to 84 years) who had experienced child sexual abuse, Easton found that it took men an average of 21 years before disclosing the abuse to anyone. In only 15% of these cases was the crime reported to authorities, with a spouse, partner, or mental health professional being the most likely persons to whom disclosure occurred (2013:344; 348).

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With regard to physical abuse, studies have shown that boys could be at greater risk than girls. MacMillan et al. (2013:15-16) found that 33.7% of boys had experienced physical abuse, compared to 28.2% of females. (In this study, physical abuse included: being slapped in the face, head or ears; being spanked with a hard object; being pushed, grabbed, shoved, kicked, bitten, punched, choked, burnt or physically attacked in any other manner.)

A Turkish study of the self-reported childhood physical abuse experiences of 988 university students, found that men were 1.5 times more likely to have been physically abused as children when compared to women: 64% of men and 41.6% of women reported abuse (Turla et al., 2010:1298).

2.7.4 Age of the child

Studies have repeatedly shown that the type of child maltreatment that children suffer varies according to their developmental stage (Belsky, 1993:419). However, research has yielded mixed results regarding the predictability of the various forms of maltreatment based on a child's age, and research limitations may lead to underestimation of prevalence for certain age groups.

For example, a study by Egley (1991:889) demonstrated that child physical abuse and neglect are most common between ages three and eight. However, Belsky (1993) warns that this result may be due to the fact that the abuse of children younger than three does not come to the attention of child protection services as often because the abuse is more likely to occur "behind closed doors". In addition, according to Belsky, these findings do not necessarily indicate that adolescents are abused less frequently than young children, since adolescent abuse is often not considered abuse, or is less likely to be reported (Belsky, 1993:419).

Research has shown that no age group is immune to the various types of maltreatment. This was demonstrated by a large scale study in the Unites States that examined 1 297 400 cases of confirmed child abuse. In the age groups naught to five years, five to nine years, and 10 to 14 years, the total number for all forms of child abuse stood at 508 223 (152 068 were infants younger than one year), 457 988 and 228 432 respectively. For adolescents aged 15 to 18 years, the total number of confirmed reports was 97 982 (Palusci, 2011:1376).

A total of 26.6% of adolescents aged 15 to 18 years were victims of physical abuse compared to 13.6% of naught to five year olds, followed by five to nine year olds (13.5%) and 21.6% of

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10 to 14 year olds. Sixty percent of children in the naught to five year group were neglected, as opposed to 40.7%, 45%, and 39% for five to nine year olds, 10 to 14 year olds, and 15 to 18 year olds, respectively. Medical neglect was experienced by 54.6% of naught to five year olds, compared to 31.9%, 40.2% and 34.5% of five to nine year olds, 10 to 14 year olds, and 15 to 18 year olds, respectively. In the 15 to 18 year group, 3.3% suffered sexual abuse, followed by the 10 to 14 year group at 2.8%, and the five to nine year group at 2.7%. The figure for naught to five year olds stood at 1.8%. As far as psychological abuse is concerned, 3.7% of naugth to five year olds were victims, followed by 3.8% of five to nine year olds, 5.9% of 10 to 14 year olds, and 5.3% of 15 to 18 year olds. As far as experiencing multiple forms of abuse is concerned, 65.5% of naught to five year olds were victims, compared to 52.8% of five to nine year olds, followed by 55.1% of 10 to 14 year olds, and 51.1% of 15 to 18 year olds (Palusci, 2011:1376).

Although it should be borne in mind that, should absolute numbers be taken into account, children aged naught to five years old are far more likely to receive a confirmed report for all types of child maltreatment, Belsky's warning that older children are less likely to be perceived as being maltreated possibly offers some degree of explanation for the large discrepancy of reports between the youngest and the oldest cohort of children. Despite such research limitations, this large-scale study gives an indication that children of all ages are vulnerable to all forms of child maltreatment (Belsky, 1993:419).

Research findings of the extent of maltreatment of children falling into a smaller age range are also not consistent.

For instance, Schloesser et al. (1992:5) found that 85% of the 104 children (all of whom were four years or younger) in their study who were abused and fatally injured, were younger than two years, and 65% of them were younger than one year. Between the ages of two and three years, there was a distinct decrease in fatalities. By contrast, Windham et al. (2004:651; 655) found in their study (which included 595 mothers of newborns deemed to be at risk of maltreatment) that children of certain ages were at greater risk of physical assault as well as "assault on the child's self-esteem". The latter was measured using a variety of behaviours considered to have a negative impact on the development of a child's sense of self-worth. These behaviours included slapping the child in the face or on the head or ears, calling the child dumb or lazy, threatening to leave the child, or cursing at the child. However, their findings differed from Schloesser et al.'s in that they found one-year olds to be the least likely

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to be victims of either types of abuse. A total of 10% of one-year olds suffered self-esteem assault, and 1% suffered physical assault, whereas there was an increase in these figures for two-year olds, with 21% suffering assault to their self-esteem, and 4% having been physically assaulted. A total of 26% of three year-olds had suffered self-esteem assault, whereas the figure for physical assault for this group stood at 3%.

With regard to sexual abuse, although girls are more likely to be abused than boys, all age groups for both genders are at risk of this form of maltreatment. A Brazilian study that included 1 936 respondents that looked at sexual abuse for male and female children, found that 80% of all first experiences of sexual abuse occurred before age 19. A total of 63% occurred before the age of 15 years, 49% before age 13 years, and 27% before age eight years. In 6% of cases abuse occurred before the child reached four years of age (Bassani, Palazzo, Béria, Gigante, Figueiredo, Aerts & Raymann, 2009:3).

Similarly, Boney-McCoy and Finkelhor (1995:1410), found that older children (aged over 12 years) were at a greater risk of experiencing sexual abuse. This is supported by Glaser (2005:54) who states that adolescent girls are more likely to be abused than younger children, although young girls and boys do experience sexual abuse.

2.8 CONCLUSION

This chapter aimed to fulfil the first objective of the study, which is to explore the various risk factors relating to child maltreatment, according to the levels of the ecological model. Risk factors were discussed in in terms of the ecological levels on which they occur, namely the societal, community, family and parent, and child level. The next chapter will provide, in terms of the relevant literature, policies and legislation, an overview of the nature and content of early intervention services within the context of the continuum of care of family preservation.

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CHAPTER 3

EARLY INTERVENTION WITHIN THE CONTINUUM OF CARE OF FAMILY PRESERVATION

3.1 INTRODUCTION

Various social work approaches to child protection have been developed in response to the pervasive issue of child maltreatment. Family preservation services constitute one such approach (Schuerman, Rzepnicki & Littell, 1994:19-20). This chapter will provide, in terms of the relevant literature, policies and legislation, an overview of the nature and content of early intervention services within the context of the continuum of care of family preservation. The basic principles underlying family preservation services will be discussed. Examples of three different family preservation programmes that have been implemented in the United States will be discussed, after which a description of the South African programme that is the focus of this study will be provided.

3.2 THE EXTENT OF CHILD MALTREATMENT

Globally, child maltreatment is thought to be widespread. According to the World Health Organisation, estimates of the problem are not exact, because many countries do not conduct prevalence studies. However, the organisation reviewed the results of studies by the United Nations Children's Fund (UNICEF), the United States Centers for Disease Control and Prevention, as well as those of national government research conducted in southern and eastern African countries, and estimated the global prevalence of child maltreatment based on these findings. They concluded that, where girls are concerned, 25% to 73% percent experience physical abuse, 28% to 33% experience sexual abuse, and 24% to 30% are emotionally abused. In the case of boys, 61% to 73% percent are physically abused, 9% to 18% are sexually abused, while 28% to 29% of boys are emotionally abused (ISPCAN, 2012:5). Worldwide, fewer investigations have been conducted into the prevalence of child neglect, but a meta-analysis of studies from various countries suggest a prevalence of 16.3%

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for physical neglect and 18.4% for emotional neglect (World Health Organisation, 2013:viii; 9; 15; 17).

Research about child maltreatment prevalence in Sub-Saharan Africa is lacking and incomparable to studies conducted in developed nations (Lalor, 2008:95), and determining the true extent of the child abuse, neglect, and maltreatment in South Africa is problematic. South Africa is no exception. The White Paper for Social Welfare (Republic of South Africa, 1997:61) states that the true prevalence of the abuse and neglect of children in South Africa is not known, for reasons such as under-reporting, inconsistent research, uncoordinated record-keeping, and the absence of a central register of cases. According to the Human Science Research Council (2012:6) due to the ineffective implementation a child protection register in South Africa, there is no reliable surveillance data about child maltreatment.

Reports of violence against women and children tend to be far lower than other crimes, because it is considered an intimate crime. Child abuse, as with other forms of domestic violence, is often seen as a personal matter not to be talked about outside the home. Fear of stigmatisation by the community is a contributing factor to sexual abuse of girls remaining unreported (DSD, DWCPD & UNICEF, 2012:8).

In a study by Jewkes, Dunkle, Nduna, Jama and Puren (2010:834) involving 1 367 male and 1 415 female volunteers from 70 rural villages, respondents were asked to provide information about their experiences of maltreatment before they had reached 18 years of age. Results showed that 89.3% of women and 94.4% of men had been physically punished, while 54.7% of women and 56.4% of men had been subject to emotional abuse. Indicators of emotional abuse included a child seeing or hearing his or her mother beaten by her husband or boyfriend, a child being told that he or she was lazy, stupid, or ugly by someone in their family, or a child being insulted or humiliated by someone in their family. A total of 41.6% of women and 39.6% of men had been emotionally neglected. Emotional neglect included a child being passed from household to household, spending time outside the home while none of the adults in the home knew the whereabouts of the child, or one or both parents being too drunk to care for the child. A total of 15% of the entire sample (including men and women) indicated that either their mother, or father or both parents had been too drunk to care for them on at least one occasion (Jewkes et al., 2010:837).

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A total of 39.1% of women and 16.7% of men had been sexually abused before age 18. Sexual abuse included being touched on the thighs, buttocks, breasts or genitals, being touched in a sexual manner by someone other than a boyfriend or girlfriend because he or she was threatened, frightened or forced, and a girl being forced to have sex against her will with a boyfriend (Jewkes et al., 2010:837).

Physical hardship (indicators included a child not being washed, having to wear very dirty clothing, frequently not being warm enough, and not having enough to eat) was experienced by 65.8% of girls and 46.8% of boys (Jewkes et al., 2010:837).

Physical punishment was experienced by 89.3% of girls and 94.4% of boys. Indicators for physical punishement included being beaten, being beaten daily or weekly, being beaten at home with a belt, stick or whip or any other hard object, and being beaten so hard that the child was bruised or scarred (Jewkes et al., 2010:837).

A study conducted in 38 medico-legal laboratories by Mathews, Abrahams, Jewkes, Martin and Lombard (2013:562) describing age- and sex-specific rates of child homicide in South Africa, found that approximately 1 018 children had been murdered in 2009 – a rate of 5.5 homicides per 100 000 children in the national population under 18 years. The study also found that this rate was significantly higher in boys, at 6.9 per 100 000. The rate stood at 3.9 per 100 000 for girls. In 44.5% of all homicides, child maltreatment, including abuse and neglect, preceded the homicide. Girls were maltreated prior to their murder three times more often than boys. The study concluded that the rate of child homicide in South Africa was double that of the global average.

Childline South Africa (2008) reported that, of the crisis calls they received during 2008, a total of 3 428 were reports of physical abuse (up from 1 175 in 2006), 4 827 of emotional abuse (up from 2 065 in 2006) and 3 883 were reports of neglect (as opposed to 2 109 reports in 2006). Therefore the number of reports for each category had almost doubled from 2006 to 2008.

The family preservation approach has been adopted in South Africa to address the risk factors for child maltreatment. The next section aims to provide, in terms of the relevant literature, policies and legislation, an overview of the nature and content of early intervention services within the context of the continuum of care of family preservation.

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3.3 THE NATURE OF FAMILY PRESERVATION SERVICES

Family preservation services (also referred to as home-based services, family-centred services, family-based services and in-home services) have their roots in the ideology that families are the best place in which to raise a child, and the belief that families should be assisted to rear their own children before that child is considered for placement in foster or institutional care. It is therefore the primary goal of all family preservation services to prevent a child from being placed in out-of-home care. This approach to child maltreatment within families is based on the principle that the family has the strengths and potential to function adequately, even in cases where severe child abuse and neglect have already occurred. The practice implication of these assumptions, is that social workers include families as active participants in interventions aimed at improving their social functioning while keeping the child safe within the home (Nelson & Landsman, 1992:3; Kaplan & Girard, 1994:5; Schuerman et al., 1994:18-19).

According to Schuerman et al. (1994:19) family preservation services have specific characteristics. Firstly, services should not only focus on the child, but should strive to improve family functioning so that the child can remain in the home. Secondly, services should be home-based, in other words, delivered in the family home, as opposed to the welfare agency offices. Services should also be community orientated in that the family should be linked to community resources. Linked to this aspect is the fourth characteristic: the use of case management to make sure that each family is connected to resources. Another characteristic of family preservation services is the use of the crisis situation to bring about change. This is based on the belief that, during times of crisis, families will be more motivated to make a change. This also means that services should be short-term, intensive, and available at all hours. These factors will also necessitate a small caseload. Finally, social workers are encouraged to empower families so that they can learn how to use their own strengths to solve their problems independently.

Family preservation services commonly follow an ecological approach by acknowledging that interaction occurs between the family and the community, and by targeting all family members, as opposed to focusing on individual members only. As such, these services include linking families to external support systems, improving the relations between family members, addressing crises within the family, developing families' abilities to cope in the

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world, and facilitating family reunification in cases where out-of-home placement did occur. (Nelson & Landsman, 1992:3; Kaplan & Girard, 1995:5).

The premise that the family is the best environment in which to raise a child, and that families should be assisted so that children are only removed into alternative care as a last resort, is also reflected in international and South African policies and legislation pertaining to children's rights.

The United Nations Universal Declaration of Human Rights, adopted by United Nations General Assembly in 1948, is the first international declaration on human rights to make specific mention of the right of children and families to protection by the state and society. In particular, article 16 recognises the family as the basis of society, stating that it is the "natural and fundamental group unit of society and is entitled to protection by society and the state". Article 23 makes provision for the family's right to social protection (United Nations, 1948).

The United Nations Declaration on the Rights of the Child of 1959 explicitly enforces the principle that an attempt must be made to keep a child within the family environment. Principle six establishes the child's parents as the preferred parties to take primary responsibility for a child's development and states that, only in extraordinary circumstances, a young child should be removed from the care of his or her mother.

Adopted by the United Nations in 1989, the Convention on the Rights of the Child is an expansion of the preceding declarations. Specifically, the roles of civil society, the courts, and governments in child protection is expanded upon, and there is an increased emphasis on parental and family responsibility for child protection. Article three also makes it clear that the state is obliged to ensure that children are protected and cared for while at the same time acknowledging the rights and responsibilities of a child's parents or legal guardians to care for and protect their children. The state is obligated to take "legislative and administrative measures" to ensure that the person legally responsible for a child fulfils this duty.

In accordance with international policy, South African legislation pertaining to child protection supports the basic premise of family preservation that families are the best environment in which to raise a child, and that the child should only be removed from the family as a last resort.

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Section 28 of Chapter two of the South African Constitution, also known as the Children's Bill, speaks specifically to the rights of children. Section 28 emphasises the importance of the family environment, stating that it is every child's right to be cared for by a family or parent, and to be placed in adequate alternative care if the child is removed from the family. (Republic of South Africa, 1996:1225). In accordance with the Children's Bill, Article 31 of Chapter 2 of the White Paper for Social Welfare of 1997 recognises the importance of the family as "the basic unit of society". It also states that families should be strengthened and supported through "family orientated policies and programmes" (Republic of South Africa, 1997:13).

Although sharing common characteristics and being based on the fundamental principle that the family is the best environment in which to raise a child, not all family preservations programmes are similar with regard to content and their manner of implementation. The manner in which services are delivered, whom they target, and what their content is, may differ significantly from programme to programme. Programmes may, for example, focus on different client target groups, ranging from children at risk of maltreatment, children and youth with disabilities or mental disorders, or children and youth in conflict with the law. Services may also be shaped by the setting (urban or rural) in which they are rendered, as well as the specific needs of target groups. Programmes also differ in terms of the duration of services, the frequency of contacts between the helper and the family, the number of clients assigned to a helper, and the theoretical approach to intervention. Services may be rendered by different disciplines, professionals, or paraprofessionals (Kaplan & Girard, 1995:5).

Another potential difference between programmes is the stage at which they are introduced to the client system. The point at which intervention occurs – be it when the family is in crisis and removal of the child is imminent, when a child is at risk but removal is not yet deemed necessary, or when reunifying the child with the family – may vary both between programmes and within a specific programme (Kaplan & Girard, 1995:5). As such, services have been classified according to a continuum of care, depending on when an agency starts its intervention.

3.4 RISK AND THE CONTINUUM OF CARE

Different types of family preservation services can be delivered depending on the extent to which a child is judged to be at risk of being maltreated. For example, intervention can occur

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when a child is at risk of maltreatment, but placement is not yet deemed necessary, or when a child is at such risk of maltreatment that placement is imminent. Intervention can also occur when a child is to be reunited with his or her family after spending time in out-of-home care (Kaplan & Girard, 1995:5). In each instance, the type of intervention utilised may vary, depending on whether the family is in crisis, or whether they are functioning adequately.

This classification of service delivery, according to which interventions are classified in terms of risk of child maltreatment, has been conceptualised as a "continuum of care", a categorisation that is internationally recognised, and also utilised in South Africa (Thompson, 1995:12-13; Gardner, 2003:144; Department of Social Development, 2006:5; 18-19; Strydom, 2012:438-439).

This internationally accepted concept of the continuum of care centres around the concept of risk, since the extent to which a child is deemed at risk of maltreatment determines at which point that child enters the continuum of care. The next section will discuss the concept of risk and its influence on shaping the continuum of care, as well as the different levels of the continuum of care.

3.4.1 Risk of child maltreatment

A child's risk of being maltreated can direct the course of intervention. The type of risk factors involved (as classified according to the ecological model), as well as the degree to which a child is deemed to be at risk, can direct the nature of intervention and consequently determine where such intervention can be placed on the continuum of care. Thus, the concept of risk is fundamentally linked to prevention strategies (Prilleltensky et al., 2001:11; 41; Welbourne, 2013:138).

Welbourne (2012:120; 126; 135) identifies two components by which risk can be measured. Firstly, risk assessment is a prediction of the likelihood that maltreatment will occur. Secondly, it is a forecast of how severe the consequences of that maltreatment will be. Thus, even if maltreatment is unlikely to occur, but the consequences should it occur are expected to severely harm the child, that child should be considered to be a high-risk case. Conversely, if the harm expected to result from the caretaker's actions is deemed negligible, but the maltreatment is deemed highly likely to occur, that child will be judged as a low-risk candidate.

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According to Welbourne (2012:148), risk assessment has several components, including rational, evidence-based information gathering directed by theories about development, legislation and policies, and the social worker's beliefs and values pertaining to risk. Thus, assessing risk is not entirely objective: the professional's own perceptions, personal feelings, and experience may also play a role.

Risk assessment should ideally not only take into account risk factors associated with maltreatment, but also protective factors – factors that are associated with a reduced risk of child maltreatment, such as good parenting skills or a child that is securely attached to the parent (Browne et al., 2002:49; Prilleltensky et al., 2001:20). Furthermore, risk factors to be addressed through preventative strategies must be modifiable – in other words they must have a realistic potential to change through means of intervention. Thus, addressing parental skills development can be seen as a more realistic risk factor to address than structural poverty, over which neither the family nor the service provider has control (Welbourne, 2012:139).

Risk prediction is, however, by its very nature, not infallible, since the concept of risk by definition implies that it is not possible to accurately predict that a child will be maltreated. Risk assessment is at best an estimation of the degree to which a child is in danger of being maltreated, and many researchers persistently argue that most at-risk children are, in fact, never maltreated. In addition, risk assessment tools, such as checklists, have been found to yield high numbers of false positives, in other words, children who were deemed at-risk but were ultimately never maltreated. (Welbourne, 2012:126; Prilleltensky et al., 2001:63; Browne et al., 2002:44)

Shuerman et al. (1994:23; 234) contend that, since it is not possible to precisely determine risk of maltreatment, a programme in which children are left in a home which is unsafe instead of being removed to alternative care will inevitably put more children at risk of serious harm and even death. The authors are also critical of the term "imminent risk" of harm or placement. They argue that the term can be interpreted in a number of ways. The word "imminent" suggests a crisis situation, but it does not specify a time frame. Thus, just how "imminent" the risk is remains open to the interpretation of the social worker. The term "risk" is also, as stated previously, lacking in specificity; it is an attempt to predict future human behaviour that in itself is fluid and difficult to determine.

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Enrolling families in family preservation programmes unnecessarily can also have negative consequences should risk be exaggerated. According to Browne et al. (2002:45; 49) risk assessments yielding false positives can result in a waste of resources in cases where families are wrongly identified as requiring family preservation services. Schuerman et al. (1994:215) suggest that, to counter the problem of inaccurate targeting of service recipients that leads to the unnecessary participation of families in family preservation services, it is necessary to understand how social workers decide to place children in alternative care, or to enrol a family in a family preservation programme.

Despite obvious shortcomings in risk assessment, it non-the-less directs the course of intervention by determining where a child enters the continuum of care. This next section will discuss this continuum.

3.4.2 The continuum of care

South African policy and legislation provides a clear framework for the continuum of care.

According to the Integrated Service Delivery Model (Department of Social Development, 2006:18-19), services for children and families in South Africa are to be rendered according to a continuum of care, determined by the degree to which the child is deemed to be at risk of being maltreated. The Integrated Service Delivery Model (2006) suggests the following levels of service delivery: prevention, early intervention (non-statutory services); statutory intervention services as well as reconstruction and after-care services. However, the boundaries between these levels of service delivery are not always clear. The Service Delivery Model (2006) acknowledges this, stating that "a client may enter the system at any of the levels, and the levels may overlap in practice" (Department of Social Development, 2006:18).

Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007), distinguishes more clearly between the levels of service delivery. The Act's introduction of prevention and early intervention services marked an important change in South Africa's approach to combating child maltreatment. The Child Care Act 74 of 1983 made scant provision for prevention and early intervention services, with its emphasis almost entirely on statutory services. The shift made in the Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) towards the stronger focus on prevention and early intervention is a significant change in child protection legislation.

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By implication, the introduction of prevention and early intervention services in child protection in South Africa brought about a shift in groups targeted for service delivery. The next section will discuss the target groups of prevention and early intervention services.

3.4.3 Target groups of prevention services

The White Paper for Social Welfare of 1997 refers to this broad-based approach as primary prevention services which target the broader community before families start exhibiting dysfunction (Republic of South Africa, 1997). In line with this policy, the Integrated Service Delivery Model (2006) stipulates that prevention services should be the primary focus of service delivery. Programmes must focus on empowering families who are not dysfunctional, but may display traits that place them in the at-risk category for maltreatment in the future. These services are aimed at the broader population and community in order to assist people to improve their social functioning and wellbeing, particularly persons affected by poverty. The ecological approach is employed here, since these services are directed by "individual, environmental and societal" problems that may contribute to an increased risk to the child. Services are also developmental in nature, and are often delivered to the target population via community development services (Department of Social Development, 2006:18-20).

Strydom (2012:437) discusses the model of family preservation services advocated by the Child Welfare League of America in their Standards for Service to Strengthen and Preserve Families with Children (1989). As is the case with the Integrated Service Delivery Model (2006) services are divided into three levels, depending on the degree of risk that exists for out-of-home placement, and different types of services are rendered at each level. Strydom (2012:437-439) argues that the three levels within this framework of family preservation services are consistent with service delivery prescriptions contained in the Integrated Service Delivery Model (2006).

To this end, the author contends that prevention services, the first level of service delivery defined in the Integrated Service Delivery Model (2006:18) corresponds to what the Child Welfare League of America classifies as family-support services (Strydom, 2012:438-439). Services at this level are usually community-based and the entire community that displays risk factors for child maltreatment is targeted (Strydom, 2012:437-438).

In their discussion of the Child Welfare League of America in their Standards for Service to Strengthen and Preserve Families with Children (1989), Fraser, Pecora and Haapala (1991:7)

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refer to this first level in broader terms, namely family resource, support and education services. They describe services at this level to include community-based services accessible to all families with children without any criteria for participation that may lead to parents being labelled or stigmatised.

Prilleltensky et al. (2001:8; 12; 25) view prevention services as "proactive" programmes directed not only at preventing child maltreatment, but also at promoting child wellbeing at the various ecological levels. The authors define wellness as an environment in which all the family's needs – material, psychological, and emotional – are met. These services are universal and aimed at the population as a whole, and are meant to promote the wellness of families who are functioning effectively.

However, according to Prilleltensky et al. (2001:12-14), prevention services should also target high-risk families before a harmful event occurs. This means that risk indicators should be utilised to identify specific families where maltreatment is highly likely to occur, instead of relying on actual maltreatment occurring before addressing risk factors. The authors refer to these services specifically as "proactive, high-risk approaches". This view is supported by Browne et al. (2002:44-45) who argue that universal services are not sufficient; targeted prevention services to specific individuals and families should be delivered before the child is harmed.

3.4.4 Target groups of early intervention services

Early intervention programmes, which constitute the second level of service delivery, must, according to the Integrated Service Delivery Model (2006), include services rendered when a child is at risk of being subjected to statutory intervention, such as being placed in alternative care. These services aim to prevent such an intervention, and are developmental and therapeutic in nature (Department of Social Development, 2006:19). However, the Integrated Service Delivery Model (2006) does not clearly state whether children falling into this target groups have already experienced some form of maltreatment, and there are no clear criteria provided for risk assessment at this level of the continuum of care.

The White Paper for Social Welfare of 1997 uses the terms 'secondary prevention' and 'early intervention' interchangably. It states that this level of service delivery focusses on identifying persons or families that are at risk, but do not yet find themselves in a "critical situation" (Republic of South Africa, 1997:glossary). Thus, at this level of intervention, services target

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specific families and individuals, as opposed to all families and individuals as is the case in primary prevention. However, similar to the Integrated Service Delivery Model (2006), the White Paper for Social Welfare (1997) does not clearly state whether children targeted at this service level have been maltreated or whether placement of the child is imminent, since the term "critical situation" is not clearly defined.

Where the South African Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) is concerned, Section 143 defines early intervention services as those delivered "to families where there are children identified as being vulnerable to or at risk of harm or removal into alternative care". Notably, section 46(1) and sections 155(8) of the South African Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) makes provision for the children's court to order a family to participate in an early intervention programme, should the court find (after an investigation has been carried out by a social worker) that the child is not in need of immediate care and protection. In terms of this provision, one can argue that the second and third level of the continuum of services as prescribed by the Integrated Service Delivery Model (2006) overlaps, since statutory intervention is possible at both levels.

Welbourne (2012:139) refers to the second level of the continuum of service delivery as "secondary prevention". These services are put in place after a "potentially harmful event" has occurred, and are also aimed at "mitigating harm". The term "mitigating harm" suggests that harm has already occurred. Thompson (1995:13) also refers to this level of service delivery as secondary prevention, and concurs with Welbourne (2012) that at this level, abuse has already occurred, or is likely to occur. The target population is smaller than that of primary prevention services, with specific groups identified as service recipients based on risk assessment, such as families with teenage mothers.

However, Prilleltensky et al. (2001:12-13) view any type of services delivered after the child has been maltreated as reactive, irrespective of the level of risk the child faces. Based on this, the authors view such services as being a part of the third level of the service continuum, grouping it with statutory interventions (even if no statutory action has yet been taken).

The content and nature of early intervention programmes vary according to the target group. The next section will illustrate this variation.

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3.4.5 Programme content of early intervention services

South African Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) indicates the type of programmes that must be included in early intervention services. However, these programmes are mentioned under the banner of both prevention and early intervention services, and it is not stipulated which programmes and services are particular to which level of the continuum of care (Republic of South Africa, 2008:54; 56).

Several programmes are listed, including those that develop parental skills and parents' and caregivers' ability to act in the best interest of their children, which also includes using non-violent measures of discipline. Programmes must also promote healthy family relationships, and psychological, rehabilitative and therapeutic programmes targeting children must be made available. The family's failure to provide an environment that provides for children's needs has to be prevented, and programmes must assist families to gain access to resources that meet their most basic needs, and improve families' abilities to meet their own basic needs without outside assistance. This includes informing families about how they should access services, and how they can assist children to reach their full potential. Prevention and early Intervention must involve families, parents, caregivers and children in identifying and finding solutions.

Thus, within the context of the family preservation service paradigm, early intervention services entail a range of programmes and strategies. These can include services aimed at parents, such as parental childcare skills development courses, or programs that focus on social support that builds the capacity of communities to provide resources like child care services, community centres, the inclusion of subjects in a school curriculum teaching adolescents parental skills, as well as programmes that provide support for young parents (Thompson, 1995:13). The Integrated Service Delivery Model (2006) lists a few examples of such services, including early childhood development, child wellness promotion programmes, life skills programmes and parenting skills programmes (Department of Social Development, 2006:22).

As mentioned, Strydom (2012:437-439) argues that the Child Welfare League of America's 1989 classification of family preservation services corresponds to that of the Integrated Model for Social Service Delivery (2006). Family-centred services comprise the second level of the Child Welfare League of America's classification. At this level there is a possibility that a

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child may have to be removed, but the child is not yet at risk of imminent removal (Strydom, 2012:438; Fraser et al., 1991:7). Therefore, at this level, a specific family receives services. The third level of service delivery is referred to as intensive family preservation services. At this level, families are in crisis and the removal of a child to a place of safety is imminent, or the child has returned to the home after placement (Strydom, 2012:438; Fraser et al., 1991:7).

Strydom argues that the early intervention, as prescribed by the Integrated Service Delivery Model (2006:19) and operationalised in chapter 8 of the Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007), corresponds to the second and third levels identified by the Child Welfare League of America, namely family-centred services and intensive family preservation services, respectively (Strydom, 2012:438-439).

Fraser et al. (1991:7) describes the nature of the programmes offered at these two service levels. Family-centred services may include counselling services, therapeutic services, educational programmes, skills development, providing concrete services, or advocating on the family's behalf. The programmes aim to prevent a family from becoming dysfunctional and entering a crisis situation.

Intensive family-centred crisis services differ from family-centred services in that they are more intense: caseloads are smaller, and more time is spent with the family. Ideally, a worker should be assigned a caseload of two to six families, and should visit the families for a total period of approximately eight to 10 hours a week, with the entire intervention process spanning four to 12 weeks. Intensive counselling is a primary component of early intervention, as well as concrete support (Fraser et al., 1991:7).

According to Fraser et al. (1991:8-9) a hallmark of intensive family-centred crisis services are that they are provided in the family home, since a worker can better understand the family's functioning when rendering services within the home environment. By contrast, family-centred services can be either home- or office-based.

Various early intervention programmes have been implemented with the aim of preserving families and preventing placement. The next section will discuss four such programmes, three of which were developed in the United States, and one which was developed in South Africa.

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3.4.5.1 The Homebuilders model

The Homebuilders model, which first commenced in 1974, is one of the most established family preservation programmes in the United States. It targets families with multiple issues through a crisis intervention model, with a focus on developing life skills to enable families to deal with their problems independently, and enabling families to access a variety of services to prevent placement. Based on the crisis intervention model, the Homebuilders model operates on the principle that a family will be most likely to make changes when experiencing a crisis, and services are usually rendered when removal of a child is imminent because the child is not receiving adequate care, or because a parent can no longer control the child. If removal is not imminent and if at least one family member is not willing to co-operate, the case is not considered appropriate to the Homebuilders model (Fraser et al., 1991:2; Nelson & Landsman, 1992:10; Kinney, Hapaala & Booth, 1991:13).

The crisis intervention model allows the family experiencing the crisis to have a counselling session within 24 hours of referral by the worker. A minimum of one family member must be willing to participate in the programme for a four-week period. Ideally, the entire family should participate, but the programme is initiated based on the principle that change in one person can initiate change within the entire family. In some cases a child may already have been placed, in which case the counsellor and the parents must plan to return the child to the home within seven days after the case was referred in order for the counsellor to work with the whole family (Kinney et al., 1991:13).

Counsellor availability at all times is a salient characteristic of this programme. The family can contact the counsellor 24 hours a day, seven days a week, and efforts are made to ensure that the counsellor is always contactable. This includes holidays. Counsellors also spend about eight to ten hours weekly with families, and this is tapered as the programme continues and family function improves. Services are home-based, in other words, the counsellor works with the family in the family home at all times, at a time that suits the family. This increases the chances of the family being available for programme participation, and allows the counsellor to understand the family better since he or she can gain first-hand experience of the family's environment, as opposed to being limited to observation in an office environment (Kinney et al., 1991:23-25).

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Another characteristic of the Homebuilders model is that it offers a variety of services, and intervention is tailor-made for each family, depending on their values, life-style and skills. Services focus on behaviour, cognition and environmental change. For example, concrete assistance is offered, such as assisting a family to obtain housing, advocacy, referral to other services, accessing informal support services, and managing personal finances. Clinical services offered may include parental skills training, managing emotions, and interpersonal skills. Furthermore, counselling can occur when all or some family members are present, or with individual family members (Kinney et al., 1991:28-31).

3.4.5.2 The Family First programme

The Family First programme was initiated in the United States in the state of Illinois in 1988 (Schuerman et al., 1994:27). This programme was influenced strongly by the Homebuilders model, and shares many of its characteristics. Families are seen by a caseworker in their home, within 24 hours of referral, and thereafter workers are available 24 hours a day, every day.

The programme takes a multisystems approach, and as such a wide range of services are offered. The types of services are similar to those rendered by the Homebuilders programme, ranging from concrete assistance to interpersonal skills development, and linking the family with community resources (Schuerman et al., 1994:25).

Families targeted for service include those in which a child aged 12 or younger is involved in reports of abuse or neglect and the removal of that child is imminent (in other words, the family is in crisis). In addition, services are only rendered if a child is not deemed to be in danger while the programme is in progress, and the family had to have been subjected to at least one investigation in which it was confirmed that the child was harmed. Families are served for a period of three months, and a follow-up plan is put in place if necessary (Schuerman et al., 1994:25).

3.4.5.3 The Family Treatment model

Nelson and Landsman (1992:15-16) discuss the Family Treatment model as an example of family preservation services. Unlike the Homebuilders model and the Family First programme, the Family Treatment model is less intensive, focuses primarily on therapeutic

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services, and plays a lesser role in providing the family with concrete support services. The service is rendered either in the family home or at the service provider's office.

An example of the Family Treatment model is the Intensive Family Service Programme first implemented in the state of Oregon in the United States in 1980. As is the case with the other two models, this model initiates services once the removal of a child is imminent. The intervention usually spans an average of three months (Nelson & Landsman, 1992:15).

Services are less intensive: about 11 families are assigned to one counsellor at any given time, the initial contact is intensive and usually takes place between the family and two to four therapists. A session can last several hours, after which shorter weekly follow-up meetings with a therapist take place. In most cases, a family will have two therapists assigned to them (Nelson & Landsman, 1992:15).

Services are based on family systems theory and, as is the case with the Homebuilders and the Family First models, rest on the premise that change in one family member affects change in another. However, unlike the Homebuilders model, which offers counselling for individual family members, the Intensive Family Service Programme utilises family therapy sessions (Nelson & Landsman, 1992:15).

Finally, therapeutic sessions focus on improving family relations through building communication skills. Considerably less emphasis is placed on concrete services, while skills programmes like parental training may be added to the list of services. However, the main emphasis of the programme is therapy (Nelson & Landsman, 1992:15-16).

3.4.5.3 The Isolobantwana ("Eye on the Child") project

The Cape Town Child Welfare Society in South Africa initiated the Isolobantwana project, also known as the Eye on the Child Project, in 1997. The first projects commenced in two socio-economically challenged communities within the Cape Town metropolis, namely Ottery and Khayelitsha Site C. In 2003, the Child Welfare Movement officially recognised the Isolabantwana project as a National Child Protection Programme (Child Welfare South Africa, 2013:7). The project has expanded nationally to include 200 project sites, and the number is increasing.

As is the case with the Homebuilders, Family First and Family Treatment models, the Isolabantwana programme aims to preserve families and operates on the premises that

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families must be supported to prevent placement: a child should be removed from the home as a last resort, since it is possible for families and communities to take ownership of the safety of their children. Similar to the Homebuilders and Family First models, Isolabantwana volunteers are available 24 hours a day, every day of the week. Families are actively involved in the process; for example volunteers are able to facilitate personal skills training to prevent parents or carers from maltreating children, and children also undergo life-skills training to empower them to protect themselves. In addition, certain homes within the community are selected as safe homes in which a volunteer can place a child for a maximum of 48 hours (Child Welfare South Africa, 2013:7-9).

However, the Isolabantwana project differs substantially from the American models for family preservation in that it is community-based. Instead of professional counsellors or therapists entering the community as outsiders, volunteers who undertake home visits are from the community and are trained by Child Welfare South Africa to deliver specific child protection services in that community. Each case handled by volunteers is supervised by a social worker. In addition, the project strives to gain community cooperation in child protection by emphasising the importance of the community's responsibility for children's safety. The volunteers engage the community by networking and partnering with schools, religious bodies, law enforcement, municipalities and other organisations to promote children's rights and more effective child protection. They also provide families with a referral service to community resources. Thus, the police and child protection services are not seen as the only agencies responsible for preventing child maltreatment (Child Welfare South Africa, 2013:7; 9).

Volunteers act as monitors who, because they reside in the community, are consistently present within the community to detect child abuse and neglect, and act to ensure children's safety in crisis situations by taking them to a temporary place of safety if they are at risk of maltreatment. Volunteers pay unexpected visits to families who have been reported for maltreatment in order to monitor the situation in the home. If necessary, volunteers can remove the child to a community safehouse for 48 hours (Child Welfare South Africa, 2013:7; 9).

Initially, under section 12 of the Children's Act 38 of 2005, volunteers were legally authorised by the Commissioner of Child Welfare to issue an order to temporarily remove children from their homes and to place them in a place of safety. However, this was changed by the

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Children's Amendment Act 41 of 2007, and volunteers can no longer issue such a form. They now require the services of a police officer or social worker before they can remove a child (Republic of South Africa, 2005; Republic of South Africa, 2007).

Furthermore, teams of volunteers work in shifts, and there is a team on duty within the community at all times. When a case is reported, volunteers are obliged to visit the home immediately, and to make an assessment of the circumstances. In addition, volunteers have to inform parents or guardians as to the purpose of the project – to keep families together – and that volunteers are always available to support the family to prevent long-term placement of the child in alternative care. When the volunteer carries out an investigation immediately after a case is reported, he or she must prioritise ensuring the safety of the child. Volunteers may address a parent or guardian in an attempt to resolve the issue, but should they be of the opinion that the child is in danger, they must facilitate the removal of the child to a temporary place of safety. The volunteer must report the case to the social worker in charge of the project within 24 hours. If a child has been removed from the home by a volunteer through the issuing of a form 36 on three occasions, the child will be removed into foster care or another form of long-term alternative care (Child Welfare South Africa, 2013:8).

The training received by volunteers prior to their enrolment in the Isolabantwana programme provides a further indication of the nature of the services they are meant to deliver.

Volunteers are trained about the nature of the various forms of maltreatment, and to identify the signs of different forms of maltreatment through assessing the child, the parent or guardian, and the home circumstances. For instance, volunteers learn that sexually transmitted diseases or pregnancy in a child are possible indicators of sexual abuse. They also learn how to identify risk factors for various forms of maltreatment; for example, single-parent households and parents with a history of depression are identified as risk factors for emotional abuse (Child Welfare South Africa, 2013:25-29).

Furthermore, volunteers are trained in managing the situation if a child maltreatment report has been confirmed. For instance, they are taught how to question the child in a sensitive manner through, for example, listening attentively, believing the child's account of events, and not badgering the child with too many questions. Volunteers also learn how to follow official procedures if a child has been maltreated, such as reporting the matter to the police

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and receiving a case number, taking the child to the district surgeon, and reporting the case to a social worker (Child Welfare South Africa, 2013:30).

Volunteers learn a variety of other skills that will allow them to support a family, including how to handle incidents of family violence and to assist victims of such violence; how to address and prevent alcohol and drug abuse; how to support families affected by HIV and AIDS; how to impart parental skills; the hosting of family meetings as well as supporting families in to cope with trauma and loss (Child Welfare South Africa, 2013:34; 40; 49; 59; 71; 72; 74; 99).

3.5 CONCLUSION

This chapter provided, in terms of the relevant literature, policies and legislation, an overview of the nature and content of early intervention services within the context of the continuum of care of family preservation. The basic principles underlying family preservation services were set out. Examples of three different family preservation programmes that have been implemented in the United States were discussed, as well as one example of the South African family preservation programme, which was the focus of this study. The next chapter will investigate how volunteers contribute to early intervention services in a selected South African community-based child protection programme that follows the family preservation approach. The findings of the study will be presented.

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CHAPTER 4

THE CONTRIBUTION OF VOLUNTEERS TO EARLY INTERVENTION SERVICES IN A COMMUNITY-BASED CHILD PROTECTION PROGRAMME AT A SELECTED NON-GOVERNMENTAL ORGANISATION

4.1 INTRODUCTION

This chapter will fulfil objective four of this qualitative exploratory research study, which is to explore how volunteers contribute to early intervention services in a selected community-based child protection programme. It sets out the empirical findings of this study. Study participants' narratives of their experiences will be analysed in terms of the theory presented in the literature review contained in chapters two and three. The narratives will be organised in tables according to themes, subthemes, and categories. Each table will be followed by a discussion of the findings in terms of literature review.

4.2 RESEARCH DESIGN

A qualitative approach, and a research design that was both exploratory and descriptive in nature, were utilised to investigate volunteers' contribution to early intervention services in a selected community-based child protection programme. This approach and design were utilised since, although internationally there is a vast body of research available pertaining to the subject, the literature review conducted in this study revealed that research specific to this widely implemented South African programme is lacking (De Vos et al., 2011:95-96; Rubin & Babbie, 1997:26-27; 108-109).

4.3 THE DEVELOPMENT OF THE INTERVIEW SCHEDULE

Since this was a qualitative exploratory and descriptive study to investigate volunteer contributions to early intervention services, it was decided that individual interviews would be used to collect data. Within the qualitative approach, individual interviewing is one of the data collection methods most often used (Babbie & Mouton, 2001:289).

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The semi-structured interview schedule (see Addendum A) was based on the literature review contained in chapters two and three, as prescribed by De Vos et al. (2011:352). Primarily open-ended questions were used in the interviews. Open-ended questions were formulated, based on the literature review, to guide participants. Open questions allow particpants to provide their own answers, without having to select specific answers provided by the researcher, as is the case with closed-ended questions (Babbie & Mouton, 2001:233). Closed questions were only utilised to provide specific identifying details of participants. Since open-ended questions may not always yield clear answers, probing questions, or follow-up questions, were used to gain more detail and clarity (Grinnell, 1988:283).

4.4 ETHICAL CONSIDERATIONS

Research in human sciences carries with it serveral ethical issues, since data cannot be obtained if people will be harmed. The helping professions, such as social work, are increasingly recognising the importance of this principle (De Vos et al., 2011:113-114). Therefore, ethical considerations as described in chapter one of this study were all taken into account during the research.

De Vos et al. (2011:115) specify a number of ethical concerns in social research. These include the avoidance of harm, voluntary participation and informed consent, the deception of participants, the violation of privacy, anonymity or confidentiality, as well as compensation. According to Babbie and Mouton (2001:522) research should never cause harm to those participating in the study, be it physical or psychological. Divulging certain information to a researcher may cause psychological distress to the participant for various reasons; they may be embarrassed, or feel that talking about certain issues could endanger their lives, families, friendships, and employment, for example.

Permission for the research was obtained from the organisation managing the participants, and the organisation acted as a link between the researcher and participants (See Addendum B).

Participant consent was obtained prior to each interview (See Addendum C). All participants were informed of the nature of the interview and the aim of the study. They were also told that they were not obliged to answer any questions they did not want to answer. In addition, they were assured that their information would be kept confidential. Participants were

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interviewed in a safe environment, namely their homes. Participants' names were not published in the study, and all records of interviews were kept in a secure place to which only the researcher had access.

Ethical clearance was obtained from the Stellenbosch University's Departmental Ethics Screening Committee (See Addendum D).

4.5 PILOT STUDY

De Vos et al. (2011:240) states that a pilot study is necessary to ensure that interview schedules are adequate. Two volunteers were interviewed, and the interview schedule yielded the necessary information to reach the objectives of this study. This is largely due to the open-ended nature of questions coupled with broad guidelines of what needed to be explored and described (as identified in the literature review), as well as the use of probing questions and follow-up questions to ensure answers yielded sufficient information (Grinnell, 1988:283).

4.6 SAMPLE

For the purpose of this study, purposive sampling was used. Qualitative sampling methods differ from quantitative methods in that large representative samples are usually not required to attain qualitative research goals. Purposive samples are commonly used in exploratory studies aiming to generate new knowledge, since such research often focuses actively on groups of people with characteristics typical to that group. In purposive sampling, criteria of the sampling unit are predetermined (Hussey, 2010; Staller, 2010). Rubin and Babbie (1997:385) state that purposive sampling means selecting a sample that the researcher believes will render the most complete understanding of the research problem.

This study focused on a group of volunteers at one welfare organisation. All volunteers met the criteria for this study: they were trained volunteers who worked in a child protection agency and rendered early intervention services within a community-based child protection programme, according to the family preservation approach. Because there were only fourteen volunteers who met the criteria for inclusion who were available for interviews at the time, the sample was restricted to this size.

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4.7 THE ANALYSIS AND INTERPRETATION OF THE DATA

The qualitative data was analysed according to the themes, subthemes, and categories emerging from this study. The data was transcribed exactly as it was recorded. It was then analysed and organised according to these themes, subthemes and categories. These were in turn discussed and analysed in terms of the literature review in chapters two and three, thereby placing the findings within the context of the relevant theoretical framework (De Vos et al., 2011:402-403; Grinnell, 1988:454).

4.8 RESULTS OF THE INVESTIGATION

The findings of this study are set out in two sections. Section A provides identifying details of the participants. Section B is a presentation of the empirical results analysed in terms of the literature review.

SECTION A: OVERVIEW OF PARTICIPANTS

4.8.1 Identifying details

Participants were requested to indicate certain identifying details. These included their gender, age, education level, how long they had been a part of the project, and the area where they resided.

4.8.1.1 Gender of participants

All participants were female. This is reflective of the wider trend in South Africa where women are more likely to do volunteer work than men. In 2014, 90% of the country's 2.2 million volunteers were active in the community and social services industry. Of the 2.2 million, 60.7% were women, and women constituted the majority in all volunteering activities (Statistics South Africa, 2014:iii; 4). The fact that the volunteers in the Isolabantwana project are all female possibly reflects the stereotypical notion that the primary responsibility for children's safety rests with the mother, not the father, and, by extension, with women and not with men (Scourfield, 2014:976; 980).

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4.8.1.2 Age of participants

Hewstone, Fincham and Foster (2005:208) broadly distinguish three phases of adulthood. These include early adulthood (18 to 40 years), middle adulthood (41 to 65 years), and late adulthood (66 years and older). Four participants were in the phase of early adulthood, and the remainder of the participants was in the phase of middle adulthood. Erik Erikson contended that persons in middle adulthood are conflicted by a choice between generativity and stagnation. Generativity refers to a person's desire to contribute to the improvement of future generations, whereas stagnation refers to a sense of having nothing significant to contribute to society's future. It is therefore not unexpected that most participants were in this life stage (Hewstone et al., 2005:214).

4.1.8.3 Area of residence of participants

Participants were also asked whether or not they volunteered in the same area where they lived. All participants said that they did. This demonstrates the community-based nature of the project. Volunteers act as monitors who, because they reside in the community, are consistently present within the community to detect child abuse and neglect, and act to ensure children's safety in crisis situations by taking them to a place of safety if they are at risk of maltreatment (Child Welfare South Africa, 2013:7; 9).

4.1.8.4 Qualification levels of participants

One participant had some primary school education, one participant had completed primary school education, nine participants had some high school education, one participant had completed high school, and two participants had a tertiary qualification. Thus, the majority of participants had not completed their school education.

This finding is in contrast to those of the 2014 Statistics South Africa Volunteer Activity Survey, which found that South Africans with a tertiary level education were the most likely to volunteer, followed by those who had completed high school (Statistics South Africa, 2014:6). However, the findings do reflect the educational demographics for the selected area in which the participants live. In this area, 8.8% of residents had partially completed primary school, 5.2% had completed primary school, 34% had completed high school, and 43.3% of people had partially completed high school. Only 7.4% of the population in the area had a tertiary education (Statistics South Africa, 2011).

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4.1.8.5 Number of years participating in the project

Participants were asked how long they had been participating in the project. Six answered that they had been participating between one and five years. Four participants said that they had been working in the project between six and 10 years. One participant said that she had been a part of the project for six months. Two participants said that they have worked for the project for over 10 years. With most participants being involved in the project for at least a year, and a further six stating that they had been part of the project for over five years, it appears that volunteer retention in the project has been fairly successful. The fact that most of the participants are experienced in volunteering for the project should contribute to the validity of the study.

SECTION B: EMPIRICAL RESULTS

The third objective of this study was to investigate how volunteers contribute to early intervention services in a selected community-based child protection programme. Several themes were identified, explored and described in order to reach this objective. The first part of this section deals with findings about themes related to characteristics and principles specific to the family preservation approach upon which the Isolabantwana project is based. The second part of this section presents findings with regard to stressors that families experience at the various levels of the ecological model and which may increase the risk of child maltreatment. The stressors faced by families and the manner in which participants address these stressors in an attempt to reduce their impact on child maltreatment risk, are discussed and analysed in terms of the literature review. The last part of this section discusses and analyses the factors influencing the decision of participants to remove a child to a temporary place of safety.

4.8.2 Workload

The workload carried by social workers delivering family preservation services has distinct characteristics identified in the literature. For example, in the United States, Fraser et al. (1991:7) distinguish between two types of family preservation services, namely intensive family-centred crisis services and family-centred services. There are distinct differences between these two programmes, because they target families that differ in terms of the degree of child maltreatment risk.

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Family-centred services aim to prevent a family from becoming dysfunctional and entering a crisis situation where removal of the child is imminent. Intensive family-centred crisis services, on the other hand, target a family that is already in crisis, with removal of the child being imminent. As such, intensive family-centred crisis services are, as the name suggests, more intensive than family-centred services, which means that caseloads are smaller, and more time is spent with the family as compared to family-centred services. Ideally, with intensive family centred services, a worker should be assigned a caseload of two to six families, and should visit the families for a total period of approximately eight to 10 hours a week, with the entire intervention process spanning four to 12 weeks. Intensive counselling is a primary component of early intervention (Fraser et al., 1991:7).

Guided by the above theoretical knowledge contained in the literature review of chapter three, the researcher asked participants to describe their workload. The categories that emerged from their narratives described the following subthemes: *'caseload allocation', 'contact frequency', 'contact duration'* and *'service duration'*.

This section presents the findings pertaining to participants' workloads, accompanied by a literature control.

4.8.2.1 Subtheme: Caseload Allocation

Table 4.1 below contains the responses of participants to the question: "How are cases allocated to you?" Two categories emerged from participant responses. They included *'social worker instructions'* and *'community need'*. Some participants indicated that their caseload was determined by both of these factors.

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Table 4.1: Caseload allocation

Theme: Workload		
Subtheme	**Category**	**Narrative**
Caseload allocation	Social worker instruction	"*When we're* ***on duty, we're told (by the social worker) there's a case****. If there's only one case, we do only that one.*" "***They (the social workers) give about three cases*** *to a team of four.*" "***We get divided into groups, so this month, let's say, there are five of us working. If there is a case in that time, they (the social workers) let us know.*** *We visit the house, assess the circumstances, and give feedback (to the social worker).* ***And only if you are told to go back, then you can go back****.*"
	Community need	"When the ***police contact us*** …" "***One of the community members will say*** there is a house we have to go to …" "***They (parents) come to me for advice****, solutions. Mostly weekends …*" "*Sometimes* it's five, six a day who ***come to the house to ask for advice****.* ***The times that it's at its worst, is on All Pay days****, when parents receive children's grant money.* ***Then it's drinking, drugs, everything*** *…*"

a) Category: Social worker instruction

About a third of participants indicated that they relied on instructions from the social worker prior to taking on a case. These narratives demonstrate this:

> "*When we're* ***on duty, we're told (by the social worker) there's a case****. If there's only one case, we do only that one.*"
>
> "***They (the social workers) give about three cases*** *to a team of four.*"

Such formal case allocation is a characteristic of Western models of family preservation, in which social workers are assigned specific cases and are limited to working with families who are part of their formal caseload (Kinney et al., 1991:23-25).

Participants indicating that this is how their caseload allocation was determined described working strictly within the structure of the Isolabantwana project. This is demonstrated by the following volunteer's statement:

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"***We get divided into groups, so this month, let's say, there are five of us working*. *If there is a case in that time, they (the social workers) let us know.*** *We visit the house, assess the circumstances, and give feedback (to the social worker).* ***And only if you are told to go back, then you can go back*.**"

This description is in accordance with the Isolabantwana project's structure. Volunteers follow a schedule and work in shifts, with a team of volunteers being assigned cases for one month by the social worker. These volunteers routinely monitor certain families for that month, since there is maltreatment risk. They aim to ensure the child remains safe and cared for appropriately. Volunteers then relay information about the family's situation to the social worker. In the next month, another team takes over the work (Child Welfare South Africa, 2013:8-9).

b) Category: Community need

The majority of the participants said that they responded to community needs as they arose ("*When the* ***police contact us*** *...*"). Participants' availability to provide services as the need arises, irrespective of whether or not instructions have been received from the social worker to do so, demonstrates how the Isolabantwana project is an implementation of the community-based development approach as described in the Integrated Service Delivery Model (2006). According to the model, community-based development programmes are people-driven programmes that focus on community development, where such development is seen as "the process and method aimed at enhancing the capacity of communities to respond to their own needs" (Department of Social Development, 2006:13; 16). Participants' narratives indicated that the Isolabantwana project has empowered them with the capacity to assist their own community in the absence of a social worker, and that other community members not volunteering in the programme are also actively involved in addressing child maltreatment. This is illustrated by the following participant's statement:

"***One of the community members will say*** there is a house we have to go to …"

The fact that volunteers use their own judgement to take on cases, instead of waiting for instructions from the social worker, not only testifies to the community-based nature of the programme; it also illustrates a significant difference between the Isolabantwana project and Western models of family preservation (such as the Homebuilders model) in which cases are first allocated to the social worker before the social worker becomes available to deal with

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child maltreatment on a 24-hour basis (Kinney et al., 1991:13). Volunteers deal with new cases, based on their own judgement, irrespective of whether these cases are part of their formally assigned caseload, as is demonstrated by this participant's statement:

> "*Sometimes* it's five, six a day who ***come to the house to ask for advice***. ***The times that it's at its worst, is on All Pay days***, *when parents receive children's grant money*. ***Then it's drinking, drugs, everything*** ..."

Western models, like the Homebuilders model, the Family Treatment model, and the Family First programme, prescribe that cases are only taken on when the removal of the child is imminent or when there is a crisis in the family. Similarly, the Isolabantwana project also offers early intervention services by intervening when removal of a child is highly likely. However, it differs from the Western models of family preservation in that volunteers will assist families even when removal is not imminent, as demonstrated by this participant's statement:

> "***They (parents) come to me for advice, solutions*** ... *Mostly weekends*".

This, according to Prilleltensky et al. (2001:12-14) and Hamilton and Browne (2002:44-45), can be viewed as a preventative service, since volunteers are in the position to target high-risk families before a harmful event occurs. The fact that the project is community-based, allows volunteers to provide such targeted prevention services. This is an aspect that differs significantly from Western models and illustrates a unique adaptation of the family preservation approach to serve the needs of South African communities.

4.8.2.2 Subtheme: Contact frequency

Participants were asked to talk about how often they made contact with their clients. Findings show that there was no pre-determined frequency of client contact, and that the frequency was determined either by the *'family's need for follow-up monitoring visits',* or the '*need to respond to immediate problems'*. Table 4.2 contains the findings.

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Table 4.2: Contact frequency

Theme: Workload		
Subtheme	**Category**	**Narrative**
Contact frequency	Family's need for follow-up monitoring visits	"*It often varies. Sometimes you see a family* ***twice a month.*** *If it's* ***serious you monitor every week***." "*They (the social workers) give us* ***follow-up*** *work.* ***If it's not such a serious case ... once or twice a month*** *...*" "*I've got to do* ***follow-up*** *work with a specific girl. I see her often,* ***almost every day****, since* ***she has two children and she uses (drugs)***."
	Need to respond to immediate problems	"***People will come in the night*** *to my house, and then I get up ...* ***especially weekends*** *... then they come and call me and say the child is with so and so.*" "*Someone will come and* ***call me in the night, and say 'She's under the influence of alcohol'****. I've had to go out* ***two weekends in a row ... the child's life is in danger. She's not allowed to sleep outside with the child***."

a) Category: Family's need for follow-up monitoring visits

Two thirds of the participants explained how the frequency with which they visited clients was determined by the family's need for follow-up monitoring visits. There was no set number of follow-up visitations per month, as can be seen from the following participants' statements:

> "*It often varies. Sometimes you see a family* ***twice a month.*** *If it's* ***serious you monitor every week***."

> "*They (the social workers) give us* ***follow-up*** *work.* ***If it's not such a serious case ... once or twice a month*** *...*"

Western family preservation models traditionally prescribe a specific frequency for client contact. For example, with the Homebuilders model, counsellors spend about eight to 10 hours weekly with families. The number of visits is then tapered as family functioning improves (Kinney et al., 1991:23-25).

In one sense, findings demonstrate that the Isolabantwana project differs from a typical family preservation model, such as the Homebuilders model, since the frequency of follow-ups are

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not constant, but adapted to client need for monitoring, which can be very intensive. This is demonstrated by this participant's statement:

> "*I've got to do **follow-up** work with a specific girl. I see her often, **almost every day**, since **she has two children and she uses (drugs)**.*"

However, since the Homebuilder's model also tapers visitation frequency as family functioning improves, the two programmes are similar in that the Isolabantwana project also utilises family functioning as a gauge to determine the frequency of visits. Flexibility to monitor the family's situation allows volunteers to fulfil a central objective of family preservation services, namely to keep the child safe within the home while the family participates in the programme (Nelson & Landsman, 1992:3).

b) Category: Need to respond to immediate problems

A third of participants said that the frequency with which they visited families was not predetermined, since they at times had to respond to immediate problems that the family was experiencing. This can be seen in the following statement:

> "***People will come in the night** to my house, and then I get up ... **especially weekends** ... then they come and call me and say the child is with so and so.*"

Responding to cases spontaneously and as frequently as required by families, irrespective of the time of day, allows the Isolabantwana project to utilise a crisis situation to start initiating change in a family system, as is typical of the family preservation approach (Schuerman et al., 1994:19).

Responding to immediate needs is also in line with the Isolabantwana project's aim to make child protection services available on a 24-hour basis to children at risk of maltreatment and families in crisis (Child Welfare South Africa, 2013:7-8), in order to ensure a child's safety in the case of an emergency. This is illustrated by this participant's statement:

> "*Someone will come and **call me in the night, and say 'She's under the influence of alcohol'**. I've had to go out **two weekends in a row ... the child's life is in danger. She's not allowed to sleep outside with the child**.*"

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This is similar to the prescription of the Homebuilders model as well as the Family First programme that the social worker should be available to families 24 hours a day, seven days a week (Kinney et al., 1991:23-25; Schuerman et al., 1994:27). In addition, as was the case with the family's needs for follow-up visits, this flexibility in frequency of visitation allows volunteers to ensure children's safety, which is a priority of family preservation services (Nelson & Landsman, 1992:3).

4.8.2.3 Subtheme: Contact duration

Participants were asked to discuss the factors that determined the duration of their contact sessions with clients. It was revealed that the duration of contacts varied depending on three factors, which also form the categories for the subtheme *'contact duration'*. These categories include *'monitoring', 'monitoring with additional support', and 'child removal'*. Table 4.3 contains the findings.

Table 4.3: Contact duration

Theme: Workload		
Subtheme	**Category**	**Narrative**
Contact duration	Monitoring	"*Maybe* ***30 minutes*** *that we talk, see* ***if there is food, how the kids are, is the mom ok****?*" "*About* ***20 minutes****, we talk with the people,* ***make sure we get all the things on those forms. Does the child go to school? Do they get SASSA All Pay?***"
	Monitoring with additional support	"*It* ***usually takes two hours. Sometimes you just want to go in and out quickly, but that elicits a reaction.*** *They'll say 'It's going well, under the circumstances'.*" "*But when* ***she comes to me then she has a problem.*** *Then she talks a lot, because* ***it gets emotional. Then it takes long.***"
	Child removal	"*If we see the child has to be removed, we call the police. If it's an emergency,* ***you spend a lot of time.*** *You* ***have to write a whole report*** *...* ***when you have to remove a child; you need to get the police in. You sometimes wait long for the police.***" "*If we get* ***an emergency*** *...* ***We might sit with it all day*** *... For example, a small boy we had to* ***remove*** *about four, five months ago ...* ***at the police station we probably sat for three hours.***"

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a) Category: Monitoring

The majority of participants described routine monitoring contacts in which they visited clients for 20 to 30 minutes. This time was normally used for ensuring that the child was safe and that his or her basic needs were being met, and to establish the wellbeing of the parent and whether or not they could fulfil the child's basic needs. This can be seen in these participants' narratives:

> "*About* ***20 minutes****, we talk with the people,* ***make sure we get all the things on those forms. Does the child go to school? Do they get SASSA All Pay?***"

> "*Maybe* ***30 minutes*** *that we talk, see* ***if there is food, how the kids are, is the mom ok****?*"

Family preservation services strive to keep the family intact without compromising the safety of the child. Volunteer monitoring demonstrates this principle (Nelson & Landsman, 1992:3).

b) Category: Monitoring with additional support

Two participants said that client contacts sometimes unexpectedly became counselling sessions that could last up to two hours, because clients expressed the need to talk about their problems. The following statements demonstrate this:

> "*It* ***usually takes two hours. Sometimes you just want to go in and out quickly, but that elicits a reaction.*** *They'll say 'It's going well, under the circumstances'.*"

> "*But when* ***she comes to me then she has a problem.*** *Then she talks a lot, because* ***it gets emotional. Then it takes long.***"

Providing counselling is desirable in terms of the family preservation approach. The availability of volunteers to counsel clients when the client is in need, can form an integral part of family-centred services aimed at preventing crises within a family (Fraser et al., 1991:7). Family preservation tends to be crisis-orientated by nature because they rely on the assumption that a crisis situation is a catalyst for change in a dysfunctional family (Schuerman et al., 1994:19). Participants' utilisation of opportunities to assist clients who reach out for help, is potentially a way to take advantage of a crisis to affect change.

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c) Category: Child removal

A small portion of participants described how removing a child from the home could take up to a full working day, since certain legal procedures had to be followed. These participants' narratives demonstrate this:

> "*If we see the child has to be removed, we call the police. If it's an emergency,* ***you spend a lot of time.*** *You* ***have to write a whole report*** *...* ***when you have to remove a child; you need to get the police in. You sometimes wait long for the police***."

> "*If we get* ***an emergency*** *...* ***We might sit with it all day*** *... For example, a small boy we had to* ***remove*** *about four, five months ago ...* ***at the police station we probably sat for three hours.***"

In the past, in terms of section 12 of the Children's Act 38 of 2005, volunteers were legally authorised by the Commissioner of Child Welfare to issue a temporary detainment order, known as form 36, and to temporarily remove children from their homes and to place them in a place of safety. However, the Children's Act 38 of 2005 was amended by the Children's Amendment Act 41 of 2007, and volunteers are no longer authorised to remove children in an emergency situation. They are obliged to wait for a police officer to remove a child. Slow response times from police may compromise a child's safety, which in turn defeats the purpose of family preservation services, which is to preserve the family while the child remains safely in the home (Nelson & Landsman, 1992:3).

4.8.2.3 Subtheme: Service duration

Participants were asked to talk about how long a client was normally assigned to their caseload. Their narratives showed that there was no set period for service duration. Service duration varied from one month to indefinite periods. The two categories that emerged were therefore *'limited service period'* and *'unlimited service period'*. The results are presented in table 4.4 below.

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Table 4.4: Service duration

Theme: Workload		
Subtheme	**Category**	**Narrative**
Service duration	Limited service period	*"I usually work with the family for* ***about two months. Until I feel, 'Ok, you're mature enough. You can go on on your own****."* *"We usually do* ***a three month period, to see if there is an improvement or change****. If there isn't, then the social worker takes it further."*
	Unlimited service period	*"****Until I see you're standing on your feet*** *... but that doesn't mean we won't worry about you anymore.* ***We'll maybe swing by your house to see how it's going****.* ***They stay in our programme.****"* *"****They stay in our programme.*** *Because that person has to be carefully* ***monitored.****"*

a) Category: Limited service period

Half of the participants indicated that there was a time limit to their services, ranging from one to three months. It appeared that participants in some cases stopped providing services once the family was functioning adequately. This is demonstrated by this participant's statement:

> *"We usually do* ***a three month period****, to see* ***if there is an improvement*** *or change. If there isn't, then the social worker takes it further."*

In many western family preservation programmes, a time limit is placed on services and the duration of service delivery is predetermined. For instance, the Homebuilders model calls for the family to be a part of the programme for a four-week period (Kinney et al., 1991:13). In the Family First programme, families are served for a period of three months, and a follow-up plan is put in place if necessary (Schuerman et al., 1994:25).

It is argued that the advantage of working with a family for a limited period creates a sense of responsibility with the family to improve their situation within that limited space of time, and thus increases the family's motivation (Schuerman et al., 1994:21-22).

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In the case of the Isolabantwana project, the approach varies somewhat; although service periods are limited, the true determinant of when to terminate services is the family's level of functioning. This is demonstrated by the following participant's statement:

> "*I usually work with the family for* ***about two months. Until I feel, 'Ok, you're mature enough. You can go on on your own***."

b) Category: Unlimited service period

Half of the participants indicated that there was no time limit to the service duration, since a family requires continuous support, even if the family appears to be functioning adequately and the child appears to no longer be a risk of maltreatment. This is apparent from the following participant's narrative:

> "***Until I see you're standing on your feet*** *... but that doesn't mean we won't worry about you anymore.* ***We'll maybe swing by your house to see how it's going. They stay in our programme.***"

Such indefinite service delivery to a family is not in keeping with the approach in Western family preservation models that prescribe a definite time limit for intervention (Kinney et al., 1991:13; Schuerman et al., 1994:25). However, Schuerman et al. (1994:21-22) also question the effectiveness of short-term services. Short-term services are linked to crisis intervention, an approach underpinning many models in family preservation. The authors argue that families are also reported for maltreatment when they are not necessarily in a crisis, and that the maltreatment as well as the factors leading to it, have been present for an extended period. Participant responses show that cases are often viewed as requiring attention in the long-term, as is demonstrated by this participant's narrative:

> "***They stay on our programme.*** *Because that person has to be carefully* ***monitored***."

Again, as was the case with the caseload allocation, this can be viewed as targeted prevention services, since the child continues to be considered at risk and the family is kept in the programme, even if they are only monitored to ensure the child's well-being (Prilleltensky et al., 2001:12-14; Hamilton & Browne, 2002:44-45).

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4.8.3 Stressors that are risk factors for child maltreatment

Family preservation services commonly follow an ecological approach. This approach, as described by Bronfenbrenner (1977), has been widely used to research the causes of child maltreatment. Within an ecological approach, child maltreatment is viewed as a result of the interaction of multiple risk factors at the macro- (society), exo- (community), and micro- (family, child or individual) levels (Belsky, 1993:413; Lee & Goerge, 1999:758; Prilleltensky et al., 2001:11; 58; World Health Organisation, 2002:12; World Health Organisation, 2006:13; Kotch et al., 2002:xviii; 23; NPA & UNICEF, 2008:31-32; Chaffin et al., 1996:192; Dubowitz et al., 2011:100; MacKenzie et al., 2011).

Proponents of the ecological approach towards family preservation argue that strategies should not only be targeted at attributes of individuals; programmes need to take into account the various ecological levels at which risk factors occur, and address them at the appropriate level. Interventions should aim to reduce risk factors (Belsky, 1993:413; Prilleltensky et al., 2001:58; NPA & UNICEF, 2008:38; Kotch et al., 2002:24).

Prilleltensky et al. (2001:11) have adapted Bronfenbrenner's ecological approach to construct levels that can be used to identify risk factors and develop appropriate interventions to target those risk factors. These levels include the child level (characteristics specific to the child, such as mental health, life skills and personality); the parent and family level (the characteristics of the parents, such as mental functioning, education level and personality; family characteristics, like intimate partner violence, spousal conflict, and the number of children in the family); the community level (for example, neighbourhood poverty and violence, and a lack of resources within a community); the societal level, which includes factors outside of the family and individual's control that place stress on that individual and family and can therefore potentially increase the risk of maltreatment. Examples include socio-economic conditions, and social values, norms, and beliefs (Prilleltensky et al., 2001:64-65; 72-74; 81-82; 94-95). The model of Prilleltensky et al. (2001:11) has been utilised as a guideline to explore the risk factors that participants address in the families with whom they work, and participants were asked to discuss these risk factors risk factors.

Section 4.8.3.1 deals with findings about certain characteristics of the families to whom participants render services. Section 4.8.3.2 sets out findings about the manner in which participants assist families to deal with specific stressors. Section 4.8.3.3 shows the findings

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on how participants assess risk in order to decide whether or not to remove a child from the home.

4.8.3.1 Family characteristics

Participants were asked to describe the characteristics of families that are risk factors for child maltreatment, in order to gain insight into the characteristics of families with whom they worked. The subthemes that emerged included '*large families*', '*unmarried parent*', '*teenage parent*', and '*children younger than six years*'. Naturally, these risk factors all occur at the parent and family level, as well as the child level.

a) Subtheme: Large families

The majority of participants indicated that they had encountered large families. This can be seen in these narratives:

> "*… Six children* ***in a bungalow****.*"

> "*She has* ***seven children****. She has* ***another baby*** *now. And all her children have been taken away.*"

These findings are consistent with research that shows that large families are associated with child maltreatment. Dubowitz et al. (2011:96) found that more children in the home increased the likelihood of a family being reported to social services for maltreatment. Sedlak, Mettenburg, Basena, Petta, McPherson, Greene and Li (2010:13) found that the risk of child maltreatment was the highest for families with more than four children. However, having three children was also a risk factor, although to a lesser extent. Kotch et al. (1995:1123) found that a greater number of children in the home was a significant predictor of a higher number of child maltreatment reports for a family.

b) Subtheme: Unmarried parent

Nearly all participants described working with maltreated children whose parent was unmarried. This is evident from the following statements from participants:

> "*We deal with mothers who have six children. Many of them are* ***unmarried****.*"

> "*... It's* ***seldom a married couple*** *...*"

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"*They're* ***usually not (married)*** *...* ***In most cases not.***"

These findings echo existing research showing that households where the parent is unmarried are strongly associated with child maltreatment. Chaffin et al. (1996:196) found an unmarried parent to be more likely to neglect their children, but not to abuse them. Li et al. (2011:145) found that married mothers were far less likely (0.19 times as likely) to be reported for child maltreatment than unmarried mothers. The authors sought to explain this by pointing to the likelihood that households where parents are married may have access to better resources than households headed by one parent who is unmarried. Li et al. (2011:146) recommend that programmes strengthening marital relationships will reduce the likelihood of child maltreatment, particularly in cases where families live in poverty and are negatively affected by several stressful life events.

c) Subtheme: Teenage parent

Most of the participant said that they encountered teenage parents in the families with whom they worked. Participants stated that teenage parents who maltreated their children were also usually substance abusers:

"Yes, ***there are many of them (teenagers)*** *who sit at the shebeens, and then the child is alone at home.*"

"***Some of them (parents) are (teenagers)****. Most of them* ***abuse alcohol.***"

Young maternal age is associated with maltreatment. Schloesser et al. (1992:6) found that 73% of 104 mothers whose babies were fatally wounded through abuse were younger than 20 years of age. Lee and Goerge (1999:768) found that children of mothers who were under 20 years of age (when the child was born) were more likely to be reported for all types of child maltreatment than older mothers. When a woman was 17 years or younger at the time of birth, her child was approximately 3.5 times more likely to be maltreated as compared to children whose mothers were 22 years or older when they gave birth. The authors recommend that teenage mothers be assisted through approaches focusing on improving their parental skills and decreasing financial stress (Lee & Goerge, 1999:776).

Participant statements reflect that teenage parents who maltreat their children also tend to abuse alcohol, thus revealing two concurrent risk factors. Several studies have found parental substance abuse to be a leading predictor of child abuse (including child sexual and physical

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abuse), and neglect (Murphy et al., 1991:197; Famularo et al., 1992:475; Magura & Laudet, 1993:193; Dinwiddie & Bucholz, 1993:656; Dore et al., 1995:531; Chaffin et al., 1996:191; Wolock & Magura, 1996:1183; Walsh et al., 2003:1409; Dubowitz et al., 2011:96; Li et al., 2011:142).

d) Subtheme: Child is younger than six years

All participants indicated that they worked with families where maltreated children were younger than six years. Participant statements supported research findings that younger children were more vulnerable to abuse:

> "***Children who can't help themselves***. *Who can't pour themselves water or take a piece of bread.* ***About four, five, six***. ***Many babies get maltreated*** ... *children who are* ***sexually abused when they are still babies.***"

> "*These are children that get taken from the shebeens and placed with us –* ***babies, a month old. Three months. One is nine months.***"

These findings are in keeping with literature that has shown young children to be more vulnerable to maltreatment (Palusci, 2011:1376; Belsky, 1993:419). Palusci (2011:1376) found that, in a sample of 1 297 400 children with at least one report for maltreatment between 2003 and 2007, 508 223 were younger than five years. Of these children, 152 068 were younger than one year. A total of 152 068 were infants less than one year old. These children were most likely to be medically or physically neglected. A total of 457 988 maltreated children were aged five to nine years (Palusci, 2011:1376; Belsky, 1993:419).

4.8.3.2 Early intervention services and stressors that are risk factors for child maltreatment

This section presents the findings regarding the various types of early intervention services implemented by the volunteers of the Isolabantwana project to address stressors that are risk factors for child maltreatment.

Families where children are maltreated often experience medical, social and economic stressors that are associated with such maltreatment. Various research studies have demonstrated that child maltreatment is more likely to occur in families that are exposed to

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increased, acute stressors, especially when environmental support is lacking during such times (Prilleltensky et al., 2001:84-85).

Participants were asked to describe how they addressed certain stressors that are risk factors for child maltreatment. Questions were guided by the literature review of chapter two. Three broad subthemes emerged, namely social, economic, and medical stressors.

Subtheme: Economic stressors

According to Kotch et al. (1995:1119) families are "embedded in a social structure that not only dictates standards of living but also may determine what health and safety, educational, developmental, and recreational options are available to parents and children". The authors refer to this as the social domain, while Prilleltensky et al. (2001:64-65) have named it the societal level – a dimension in which social and economic circumstances that the child and family cannot control contribute to the increased probability of child maltreatment. Examples of risk factors at this level include poverty, low-income and unemployment. Prilleltensky et al. (2001:73-74) also describe economic stressors present at the community level. Risk factors at this level include characteristics of the neighbourhood within which the child and his or her family reside. Examples of such characteristics commonly associated with child maltreatment include impoverishment, lack of family resources, and inadequate or unaffordable housing.

The following section explores economic stressors that increase the risk of child maltreatment, and would have to be addressed by the volunteers of the Isolabantwana project in order to reduce the risk of maltreatment. The findings are presented in table 4.5.

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Table 4.5: Early intervention services and economic stressors

Theme: Early intervention services and stressors that are risk factors for child maltreatment		
Subtheme	**Category**	**Narrative**
Economic Stressors	Services related to housing	"*We **refer people to the municipal housing office**. Many people struggle with housing. **They are on the waiting list and wait for houses for years**.*" "*At the community hall here at the school, because **I know a reliable source there, I always tell people "Go to that person, and say that I sent you, he'll give you more information about housing**. Then you don't have to go to the municipality.*" "***We help them to place them on the waiting list (at the municipality) for a home … The houses are badly built**. It's not a three-bedroom home. It's just an open space and a toilet. The children sleep with the parents. There is no privacy. **The parents will sit right there and drink, and the little children just come in. They see everything the parents do.***"
	Services related to obtaining government grants	"*When it's All Pay and Mr. K is here from SASSA, **often I refer them** and say they must go on such a date when he is here. Then **we help them to fill in the form and get all the stuff ready**. But many times the community impoverishes itself. Because the **state makes provision for children with grants, but many parents misuse it** (by buying alcohol). They don't get enough of an income.*" "*If the child doesn't have, and I can see they are suffering, sometimes people wait and **the child is already six months old** and they still haven't gone. Then **I'll tell them that the child is suffering because of this, they must go (to SASSA).***"
	Services addressing unemployment	"*They **also go for training to work in the community** – sometimes FAMSA offers a course, or Mosaic. **I slot them in there.***" "***The skills development courses that the government offers** … it doesn't mean they go there, but **we tell them there is a place to go.***" "*The one's father didn't work. And the other one's mom. They do piecework. **So for a month they work, then they lay off again, until there is work again**. The one couple I worked with – the man doesn't work, the woman doesn't work. **So I told the woman that at the (Child Welfare) office they offer various courses.***"
	Access to resources addressing food shortage	"***I often tell them**: 'If you don't have food, **there are people who hand out food**.'*" "***I send them to the soup kitchens**.*"

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Theme: Early intervention services and stressors that are risk factors for child maltreatment		
Subtheme	**Category**	**Narrative**
		"***I'll always make food and take the food***. *But I don't take raw food, because they sell it. So I always take a pot of food.*" "***Food shortage is a big problem. We've asked for one (a soup kitchen) here, so that we can feed the children.***"
	Services related to accessing childcare services	"***There is afterschool care … we do refer them***. ***I've told people often***." "***Often we'll ask people***, *'Look, this girl is going to look for work.* ***Won't you just look after her child just for the day*** *while she is looking?'*" "***We often fight with the schools. We'll go to them (the schools) if we know your child must be in preschool***. *Then we ask, 'How is it possible that the child applied for preschool last year, yet the child's name isn't on the list?' We really do support the parents with that.*" "*They* ***can't get into crèches, because there's no money***. *Many of the children are at home. They don't go because they don't have shoes,* ***they have nothing***." "*There are crèches here, but the* ***parent doesn't want to pay R800 a month***. *All the crèches here, you have to pay.*" "*But because the* ***majority of the young girls – they don't work***. *They just get the state grant, the child support grant, and that money is only R340.* ***They can't afford crèches***. ***And their (drug) habits cause them to not see their way to paying that money, because they still have to feed their habits***."

a) Category: Services related to housing

The narratives of all but one participant demonstrated how they assisted families of maltreated children to access improved housing, as illustrated by this participant's narrative:

> "*At the community hall here at the school, because* ***I know a reliable source there, I always tell people 'Go to that person, and say that I sent you***, ***he'll give you more information about housing***.*'*

According to Prilleltensky et al. (2001:73-74) inadequate or unaffordable housing has been associated with increased risk of child maltreatment. Palusci (2011:1374) found that families who had problems securing adequate housing were more likely to have a second confirmed report of child maltreatment. Thus, participants' narratives are in line with existing research.

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However, participants' responses showed that they could only offer families very limited services in this regard. Participants indicated that a shortage of quality housing was a widespread problem in their community. One participant explained that this was due to the slow delivery of houses by the local municipality:

> "*We **refer people to the municipal housing office**. Many people struggle with housing. **They are on the waiting list and wait for houses for years**.*"

Another participant said that she assisted persons to add their names to the municipal waiting list for housing, but described a situation in which municipal housing structures could lead directly to child maltreatment:

> "***We help them to place them on the waiting list (at the municipality) for a home ... the houses are badly built**. It's not a three-bedroom home. It's just an open space and a toilet. The children sleep with the parents. There is no privacy. **The parents will sit right there and drink, and the little children just come in. They see everything the parents do.***"

Participants assisting families to improve their housing conditions address a significant risk factor for child maltreatment. Inappropriate housing is considered to be a community-level risk factor. However, municipal housing is targeted at persons who cannot afford adequate housing, and this in turn is linked to economic factors at the societal level (Prilleltensky et al., 2001:64-65; 72-74). It is therefore not surprising that the above narratives from participants show that addressing this risk factor is largely beyond their control.

b) Category: Services related to accessing government grants

Pelton (in Melton & Barry, 1994:131) asserts that poverty and low income is the most documented risk factor for child abuse and neglect. It therefore was not unexpected that all participants described how the families that they worked with usually did not have enough money to afford their living expenses, and that they advised the families to obtain government grants to relieve poverty.

One participant described the role she played in making families aware of the need to apply for grants in order to prevent neglect:

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> "*If the child doesn't have, and I can see they are suffering, sometimes people wait and* ***the child is already six months old*** *and they still haven't gone. Then* ***I'll tell them that the child is suffering because of this, they must go to SASSA.***"

This statement echoes the findings of Kotch et al. (1995:1115; 1119) that low-income households were a significant predictor that mothers would maltreat infants in their first year of life.

Another participant who assisted families with the administrative tasks related to obtaining such grants, explained that the grant system was not always effective since parents misspent grant money:

> "*When it's All Pay and Mr. K is here from SASSA,* ***often I refer them*** *and say they must go on such a date when he is here. Then* ***we help them to fill in the form and get all the stuff ready****. But many times the community impoverishes itself. Because* ***the state makes provision for children with grants, but many parents misuse it*** *(by buying alcohol). They don't get enough of an income.*"

Thus, even if a volunteer is able to assist a family to secure a government grant, the potential of the grant to reduce poverty and thus address maltreatment risk is diminished due to parental substance abuse, which is in turn a leading risk factor for child maltreatment (Li et al., 2011:142; Chaffin et al., 1996:199-200).

Presumably, assisting families to obtain government grants can bring some relief to families enduring such hardships. However, it appears that parental misuse of government grants, as well as a lack of awareness of the availability of grants, can prevent this resource from reaching the child.

c) Category: Services addressing unemployment

Professionals in the field of child protection have consistently asserted that there is a relationship between unemployment and child maltreatment. Krugman et al.'s (1986:418) longitudinal study of this relationship (which spanned 20 years and was conducted in Colorado in the United States) confirmed this. Increased mental stress as well as an increase in the time that the abusive adult spends with the child have been postulated as possible risk exacerbating factors (Krugman et al., 1986:418-418). In accordance with this research, all of the participants described how they assisted parents of maltreated children who were

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unemployed (primarily by referring them to services to enhance their skills in order to increase their chances of finding employment). This is demonstrated by the following participants' narratives:

> "*They* ***also go for training to work in the community*** *– sometimes FAMSA offers a course, or Mosaic.* ***I slot them in there.***"

> "***The skills development courses that the government offers*** *... it doesn't mean they go there, but* ***we tell them there is a place to go.***"

Another participant explained how unemployment was not only caused by parents' lack of skills, but also depended on societal level risk factors:

> "*The one's (child's) father didn't work. And the other one's mom. They do piecework.* ***So for a month they work, then they lay off again, until there is work again****. The one couple I worked with – the man doesn't work, the woman doesn't work.* ***So I told the woman that at the (Child Welfare) office they offer various courses.***"

This statement is indicative of how problems at the societal level can contribute to an increased risk to child maltreatment. Unemployment is a widespread problem in South Africa: In 1994, the official unemployment rate was 22%. By 2014, that figure had increased to 25% (Statistics South Africa, 2014). Unemployment is therefore another societal level risk factor over which volunteers in all probability have a very limited influence.

d) Category: Access to resources addressing food shortage

Research has demonstrated that the risk of child maltreatment occurring increases when families do not have enough food. For instance, Slack et al. (2011:1362) found that when a primary caregiver reduced the size and frequency of meals, the risk of child neglect increased. Accordingly, two thirds of participants provided narratives that illustrated how they addressed food shortages in the home.

These participants' narratives demonstrate that participants act as a referral service to community resources:

> "*I often tell them: 'If you don't have food,* ***there are people who hand out food'***."

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"*Yes, **I send them to the soup kitchens***."

One participant's narrative illustrates the widespread nature of food shortages, as well as the lack of resources to address it:

"***Food shortage is a big problem. We've asked for one (a soup kitchen) here, so that we can feed the children.***"

In the face of a lack of resources to address food shortages, another participant addressed the problem through her own efforts:

"***I'll always make food and take the food**. But I don't take raw food, because they sell it. So I always take a pot of food.*"

Food insecurity in the community where the participants work, appears to be part of a larger societal problem. A study found that 80% of households were food-insecure within the metropolitan area where the community is located (Frayne, Battersby-Lennard, Fincham & Haysom, 2009:13). Thus, this is another stressor that volunteers have a limited capacity to address, since it is related to the broader economic context at the macro-level.

e) Category: Services related to accessing childcare services

Research has shown that a lack of access to childcare facilities is associated with a higher risk of child maltreatment. Accordingly, all except one participant described how they attempted to link families to childcare facilities during the course of their services.

Participants described acting as links between parents and formal or informal childcare services, as can be seen from the following narratives:

"***There is afterschool care** ... **we do refer them**. **I've told people often***."

"***Often we'll ask people**, 'Look, this girl is going to look for work. **Won't you just look after her child just for the day** while she is looking?'*"

One participant described advocating on parents' behalf to assist them to gain access to services, as is demonstrated in this narrative:

"***We often fight with the schools. We'll go to them (the schools) if we know your child must be in preschool**. Then we ask, 'How is it possible that the child applied*

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for preschool last year, yet the child's name isn't on the list?' We really do support the parents with that."

Assisting parents in such a manner actively deals with a significant risk factor for child abuse. According to Prilleltensky et al. (2001:73-74) a lack of childcare resources has been identified as a risk factor for child maltreatment. Li et al. (2011:141; 144) found that social support (including assistance with child care) was a protective factor against child maltreatment.

However, participants' narratives showed that, despite their attempts to assist parents to access childcare, financial constraints were an obstacle:

"*They* ***can't get in (to crèches), because there's no money****. Many of the children are at home. They don't go because they don't have shoes,* ***they have nothing****.*"

"*There are crèches here, but the* ***parent doesn't want to pay R800 a month****. All the crèches here, you have to pay.*"

The following narrative from a participant describes a situation in which various risk factors for child maltreatment were present, and illustrates how some risk factors exacerbate others. She explained how unemployment and substance abuse lead to low income, which in turn meant that childcare facilities became inaccessible:

"*But most of the young girls don't work. They only get the child support grant and that's just R340. They can't afford crèches. And* ***their (drug) habits cause them not to have a way to pay****, because they have to feed their habits too.*"

This statement is reflective of research findings about concurrent risk factors for child maltreatment. According to Krugman et al. (1986:418), trends in unemployment is a risk factor for child physical abuse, and the authors state that one explanation for this may be that a lack of finances to send a child to day care results in the unemployed adult spending more time with the child, thus increasing the chances of abuse. The authors also identified alcoholism and substance abuse as being associated with unemployment and child physical abuse.

Subtheme: Medical stressors

Research has shown that certain medical stressors are associated with child maltreatment. Medical stressors occur at the parental and child level. In accordance with the literature

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discussed in chapter two, the categories of medical stressors that emerged from participant narratives included poor parental mental health, parental substance abuse and child physical and mental disabilities (Prilleltensky et al., 2001:81-82; Kotch et al., 1995:1118; Stalker & McArthur, 2012:24; Helton & Cross, 2011:126; Sobsey, 2002:29). The findings are contained in Table 4.6.

Table 4.6: Early intervention services and medical stressors

Theme: Early intervention services and stressors that are risk factors for child maltreatment		
Subtheme	**Category**	**Narrative**
Medical stressors	Services for parental substance abuse	"***Many of them have drug problems. We get many calls.*** *Say the girl is on drugs. She has a child. Now she leaves the child at home, locks the child up in the house, and walks off with her mates.*" "***We ask if they want to be helped.*** *And they will say yes, but then they will go two, three times (to a substance abuse support group).* ***With one in three people we see a difference.***" "***We give them the advantages and disadvantages of going to rehabilitation.*** *We ask them if they want to go. We tell them there are places they can go to.* ***But we cannot force anyone. Everything has to be their own free will.***" "***We work through the trauma room at the Victim Empowerment Programme.*** *There are forms for places (substance abuse rehabilitation facilities) where the parents can go.* ***We can't force them. Only the court can.***" "***We tell them there is help,*** *but if there's a child involved,* ***we don't give the child back before they've gone to rehabilitation. They have to go to rehab. That is one of the conditions.***" "***But if the mom uses drugs seriously, then we don't have a choice but to remove the child.***" "*The people who use drugs, it's not always that they agree to be helped. It's very rare. So if the mom uses drugs, we do a report and send it to the social worker, and* ***then we'll monitor, because it's not nice to keep taking the child a way from the mother.***"
	Services for children with mental or physical disabilities	"***We refer the child and parent to the social worker. The social worker will approach the school or psychologist*** *and the* ***child can be placed in a school.*** *It's (schools like) Dorothea, Rusthof, Astra, Bethal. All those schools.*" "***Usually we work with them (disabled children) ourselves.***"

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Theme: Early intervention services and stressors that are risk factors for child maltreatment		
Subtheme	**Category**	**Narrative**
		*"There are **many disabilities**. Like **paralysis, blindness**... You get a bit of everything. **Alcohol syndrome babies**. We just had a baby whose mother was on tik. That child has **cerebral palsy**. He doesn't know anything of anything. **There isn't a place like that (for disabled children) here**."* *"The one girl here, her child is disabled. So **we are still struggling to get her into school. She's ten already**."*
	Services for parental mental health	*"If they've got **problems that they cannot solve**, or if **they are emotional**, then we tell them they can go to **the clinic**."* *"We **refer them to the pastors for counselling**."* *"We **refer them to the sister at the day hospital. She refers them to Stikland, Lentegeur, or Valkenburg** with the help of the social worker ... we're like a chain with different links."*

a) Category: Services for parental substance abuse

A nationally representative study found that of all the South African provinces, the Western Cape had the highest lifetime prevalence of substance use disorders at 20.6% (Herman, Stein, Seedat, Heeringa, Moomal & Williams, 2009:341). This is also the province where the selected Isolabantwana project is being implemented. In addition, a large body of research has shown parental substance abuse to be a leading predictor of child abuse (sexual and physical), and neglect (Murphy et al., 1991:197; Famularo et al., 1992:475; Magura & Laudet, 1993:193; Dinwiddie & Bucholz, 1993:656; Dore et al., 1995:531; Chaffin et al., 1996:191; Wolock & Magura, 1996:1183; Walsh et al., 2003:1409; Dubowitz et al., 2011:96; Li et al., 2011:142).

It is therefore not suprising that all participants described parental substance abuse as a significant problem in the families with whom they worked, as demonstrated by this participant's narrative:

> *"**Many of them have drug problems**. **We get many calls.** Say the girl is on drugs. She has a child. Now she leaves the child at home, locks the child up in the house, and walks off with her mates."*

All participants said that they frequently referred parents of maltreated children to alcohol and drug rehabilitation services, although intervention was seldom successful. Participants saw the

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recovery from substance abuse as largely dependent on the parent's willingness to address the issue, as demonstrated by these narratives:

> "***We ask if they want to be helped.*** *And they will say yes, but then they will go two, three times (to a substance abuse support group).* ***With one in three people we see a difference.***"

> "***We give them the advantages and disadvantages of going to rehabilitation.*** *We ask them if they want to go. We tell them there are places they can go to.* ***But we cannot force anyone. Everything has to be their own free will.***"

> "***We work through the trauma room at the Victim Empowerment Programme.*** *There are forms for places (substance abuse rehabilitation facilities) where the parents can go.* ***We can't force them. Only the court can.***"

This approach to the problem is in accordance with the principle of family preservation that calls for the social worker to work in partnership with the family, based on the assumption that social workers should include families as active and willing participants in interventions (Nelson & Landsman, 1992:3; Kaplan & Girard, 1994:5; Schuerman et al., 1994:18-19). However, as shown by the narratives, parents were unlikely to participate willingly.

Other participants saw recovery from alcoholism and drug abuse as a prerequisite for returning a child to the home:

> ***We tell them there is help,*** *but if there's a child involved,* ***we don't give the child back before they've gone to rehabilitation. They have to go to rehab. That is one of the conditions.***

> "***But if the mom uses drugs seriously, then we don't have a choice but to remove the child.***"

However, participants' narratives also revealed that they would consider leaving the child in the home, despite the parents' unwillingness to stop abusing substances. This is evident from the following statement:

> "*The people who use drugs, it's not always that they agree to be helped. It's very rare. So if the mom uses drugs, we do a report and send it to the social worker,*

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> *and* ***then we'll monitor, because it's not nice to keep taking the child a way from the mother.***"

Participants' narratives illustrate a clear obstacle to implementing the family preservation approach: substance abuse is prominent in many families where child maltreatment occurs, and parents are not always willing to co-operate with the social worker (or in the case of the Isolabantwana project, the volunteer).

This lack of cooperation from the parent arguably renders the family preservation approach inappropriate in cases where parents persistently abuse substances. This is because the parents' active and willing participation in the early intervention process is considered key in the family preservation approach. Persisting with the family preservation approach in cases where parents are unwilling to stop abusing substances, means that the child stays in the home and remains at risk. This is in itself contrary to the principle in family preservation that a child should be safe while remaining at home.

Despite these contradictions, Kinney et al. (1991:22) argue that it is possible to teach families mechanisms to cope with substance abuse even if the addicted family member remains in the home with the child. This situation may be unavoidable because of a lack of options for child placement. The situation, Kinney et al. (1991:22) state, results in "moral dilemmas. We don't have the answers for them".

b) Category: Services for children with mental or physical disabilities

A large body of research has shown that children who are mentally, physically, developmentally or behaviourally challenged, are at an increased risk of child maltreatment (Stalker & McArthur, 2012:24; Helton & Cross, 2011:126; Sobsey, 2002:29). In line with this research, it emerged from a third of participants' narratives that they dealt with this risk factor.

One participant addressed this risk factor via the social worker at their organisation:

> "***We refer the child and parent to the social worker. The social worker will approach the school or psychologist*** *and the* ***child can be placed in a school****. It's (schools like) Dorothea, Rusthof, Astra, Bethal. All those schools.*"
>
> *Another participant stated that volunteers worked with the children:* "***Usually we work with them ourselves***."

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These findings show that some participants do address this important risk factor for child maltreatment by acting as a referral service to formal resources (such as special needs schools), as well as by taking it upon themselves to deliver community-based services. Still, participants' narratives revealed that there are few informal, community-based services for children with disabilities. In addition, there is a lack of access to formal institutions for disabled children. This is clearly demonstrated by the following participants' narratives:

> "*There are* ***many disabilities****. Like* ***paralysis, blindness*** *... You get a bit of everything.* ***Alcohol syndrome babies****. We just had a baby whose mother was on tik. That child has* ***cerebral palsy****. He doesn't know anything of anything.* ***There isn't a place like that (for disabled children) here****.*"

> "*The one girl here, her child is disabled. So* ***we are still struggling to get her into school. She's ten already****.*"

Thus, even though participants described attempting to assist families to gain access to services for disabled children, the lack of resources appears to be an obstacle to service delivery. Community-based development programmes described in the Integrated Service Delivery Model (2006), call for programmes that are people-driven and aim to enhance the capacity of communities to respond to their own needs (Department of Social Development, 2006:13; 16). The lack of availability of such community-based programmes would appear to be an obstacle to participants' capacity to address this risk factor. The same is true for the lack of formal institutional resources (such as schools and special homes) who deliver expert, specialised and professional care and education for children with special needs.

One participant's mentioning of fetal alcohol syndrome being widespread in the community is of particular concern. All participants previously described frequently dealing with parents who refuse or are unable to cease their substance abuse practices. In addition, South Africa (particularly the Western Cape where this Isolabantwana project is being implemented) has repeatedly been shown to have a high prevalence of fetal alcohol syndrome (Centers for Disease Control and Prevention, 2003:661; May, Brooke, Gossage, Adnams, Jones, Robinson & Viljoen, 2000:1905; May, Gossage, Brooke, Snell, Marais, Hendricks, Croxford & Viljoen, 2005:1190; Urban, Chersich, Fourie, Chetty, Olivier & Viljoen, 2008:887).

Arguably, the prevalence of fetal alcohol syndrome in this particular community is very likely to be high, and could play a significant role in the increased risk of child maltreatment.

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Furthermore, fetal alcohol syndrome is preventable (De Vries & Green, 2013:383; Floyd, Ebrahim, Tsai, O'Connor & Sokol, 2006:151). Considering this, it is concerning that so few participants spoke about addressing foetal alcohol syndrome, or, for that matter, the disabilities in children caused by the use of other drugs during pregnancy.

c) Category: Services related to parental mental health

Depression and major depression in parents, as well as maternal depression, have been found to be a strong risk factor for child abuse and neglect. Parental diagnoses of obsessive compulsive disorder, antisocial personality disorder, and a high level of psychosomatic syndrome have a all been found to be associated with abuse and neglect, although obsessive compulsive disorder was found to be a weak predictor (Chaffin et al., 1996:197-199; Dubowitz et al., 2011:98; Kotch et al., 1995:115; Dinwiddie & Bucholz, 1993:471-475; Li et al., 2011:142). Chaffin et al. (1996:197; 199) concluded that their study findings supported etiological models in which social stressors activate parental disposition to psychological disorder that then predisposes the parent to becoming abusive or neglectful towards the child.

Not surprisingly then, all participants described assisting parents to access services to address their mental health problems. Although participants are not qualified to diagnose mental illnesses, they are aware of community resources to which they can refer clients should they suspect that a person might need assistance in this area. The following narratives demonstrate this:

> "*If they've got **problems that they cannot solve**, or if **they are emotional**, then we tell them they can go to **the clinic**.*"

> "*We **refer them to the pastors for counselling**.*"

Such referral illustrates an important principle in the family preservation approach of linking families to community resources (Schuerman et al., 1994:19).

One participant's statement clearly illustrates that Isolabantwana volunteers' presence within the community – in other words, the community-based nature of the programme – can assist families to access resources outside their communities:

With 30.3% of South Africans experiencing some form of mental disorder in their lifetime (Herman et al., 2009:339), and with the treatment of such disorders requiring specialist

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services, volunteers can fulfill an important role in ensuring that parents have access to such services.

d) Social stressors

Research has shown that various social stressors are risk factors for child maltreatment. Participant narratives described various social stressors and how they assisted families to manage these. Results are contained in table 4.7 below.

Table 4.7: Early intervention services and social stressors

Theme: Early intervention services and stressors that are risk factors for child maltreatment		
Subtheme	**Category**	**Narrative**
Social Stressors	Services addressing a lack of parenting skills	"***I'll recommend it*** *(parenting skills workshop), if it's necessary.*" "***Yes, we send them*** *(to parenting skills training).* ***That's the social worker's department.***" "*I asked them to* ***be part of the ECP so that they can learn how to work with children****. At the (Child Welfare South Africa) office,* ***they have various courses, like parenting skills.***" "*Often the parents come here to my house. Now, the bit that I learnt in the training, I'll share that with them.* ***We speak to them, give them information and guidance****.*" "*There's* ***definitely a shortage (of parenting skills).*** *Definitely. Because* ***every second person is a parent*** *...*" "***They don't know how to talk to their children****. They don't have the training. They just have the children and they don't have a way to talk to the children.*"
	Services addressing intimate partner violence	"*If we see that the child must be removed,* ***we phone the police****. We're on the scene.* ***They come and they fill the form (form 36) in for us****. We take the child to the safety house.*" "*The child has to be* ***placed in foster care.***" "*The child is removed and the* ***person causing the violence is offered help. We ask if he wants to go to rehab****, or whatever.*" "***Couples counselling is a big focus for us****, because unhealthy parents give a child an unhealthy upbringing. Because a mom and a dad that are both sick and fight every day, that child grows up with the idea, 'I must fight, because my mother and father fight'.*"

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Theme: Early intervention services and stressors that are risk factors for child maltreatment		
Subtheme	**Category**	**Narrative**
	Services addressing a lack of informal social support	"***Usually we ask the family or friends to support*** *them.*" "***We do that*** *(run a support group)* ***ourselves***". "**I don't know about anything like** that (a community-based support group). And they ***usually don't feel comfortable to speak to their own family***." "*I was involved with a family – I never want to get involved like that again. The mother was HIV positive, and the son.* ***She didn't want to tell her family and I was her only support. That drained me. Sometimes you support, but the clients weigh heavily on you.***"

a) Category: Services addressing a lack of parenting skills

Research has shown that a lack of parental skills contributes to an increased risk for child maltreatment. In accordance with this, all but two of the participants described how they assisted parents to address this issue. Participants either acted as a referral service, or imparted parental skills to parents themselves.

> "***I'll recommend it*** *(parenting skills workshop), if it's necessary.*"

> "***Yes, we send them*** *(to parenting skills training).* ***That's the social worker's department.***"

> "*I ask them to* ***be part of the ECP so that they can learn how to work with children****. At the (Child Welfare South Africa) office,* ***they have various courses, like parenting skills***."

> "*Often the parents come here to my house. Now, the bit that I learnt in the training, I'll share that with them.* ***We speak to them, give them information and guidance***."

The lack of parenting skills encountered by participants also reflects research findings that parents who are unprepared to have children and lack basic parenting skills are more likely to maltreat their children. This is demonstrated by the following narratives:

> "*There's* ***definitely a shortage (of parenting skills).*** *Definitely. Because* ***every second person is a parent*** *...*"

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> "***They don't know how to talk to their children***. *They don't have the training. They just have the children and they don't have a way to talk to the children*."

According to MacKenzie et al. (2011:1371) parents who are unprepared for parenthood may perceive an infant's temperament as "difficult", and such parents should be the target of services. Not knowing what to expect of children during certain developmental phases are a very significant risk factor for maltreatment (Dukewich et al., 1996:1036; 1042), and one way to address this, would be to provide parents with the skills to plan how to handle a child's unwanted behaviour (Strickland & Samp, 2013:1014).

b) Category: Services addressing intimate partner violence

Children witnessing intimate partner violence is recognised as child maltreatment, and negatively impacts the child in similar ways as other kinds of abuse and neglect. Added to this, the abuse of women and children very often co-occur in the same household. Men's severe violence towards their intimate partners most often occur in the presence of other types of family violence, including aggression of the mother or her partner towards the child, as well as women perpetrating intimate partner violence against men (MacMillan et al., 2013:1186; Holmes, 2013:520; Morris, 2009:414; McDonald et al., 2009:94; Casanueva et al., 2009:84).

In accordance with this research, the majority of participants said that they encountered this risk factor, and explained that violence usually required immediate removal of the child. The child could then be placed in a temporary safe house, or a long-term removal like foster care could be considered. This is demonstrated by the following narratives:

> "*If we see that the child must be removed,* ***we phone the police***. *We're on the scene.* ***They come and they fill the form (form 36) in for us***. *We take the child to the safety house.*"

> "*The child has to be* ***placed in foster care.***"

This is in line with the principle of family preservation that the safety of the child is paramount, and that services can only continue once the child's safety is assured. A primary function of the Isolabantwana project is to ensure children's safety in crisis situations by taking them to a place of safety if they are at risk of maltreatment (Child Welfare South Africa, 2013:7; 9). Participants clearly indicated that they perform this duty.

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However, participants also said that they worked with the family to address the their problems, not only focusing on the child. This is demonstrated by the following narratives:

> "*The* ***child is removed and the person causing the violence is offered help. We ask if he wants to go to rehab****, or whatever.*"

> "***Couples counselling is a big focus for us****, because unhealthy parents give a child an unhealthy upbringing. Because a mom and a dad that are both sick and fight every day, that child grows up with the idea, "I must fight, because my mother and father fight.*"

This is in accordance with Schuerman et al. (1994:19) who state that family preservations services should not only focus on the child, but should strive to improve family functioning so that the child can remain in the home.

c) Category: Services addressing a lack of social support

According to Kotch et al. (1995:1119-1121; 1126) the absence of social support and the extent to which stressful events occur in a parent's life should each be considered a risk factor, both separately and when they occur together. About half of the participants described attempting to link parents to some form of social support. This included advising parents to speak to family members and hosting their own informal support group. This is demonstrated by the following narratives from participants:

> "***Usually we ask the family or friends to support*** *them.*"

> "***We do that*** *(run a support group)* ***ourselves.***"

If participants can successfully link parents to social support structures, it should reduce the risk for child maltreatment. Li et al. (2011:141; 144) explored social support as a protective factor against child maltreatment, and measured it according to confidant support (having someone to talk to or receive advice from), affective support (receiving love and affection), and instrumental support (assistance with transportation, cooking, household tasks and child care). Their study found that a high level of social support was a strong protective factor against child maltreatment. Mothers with high social support levels were less likely (0.29 times as likely) to receive reports of child abuse and neglect when compared to mothers with

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low support levels. Social support was also a protective factor against child maltreatment in cases where mothers had a low level of education.

Still, it should be noted that only half of the participants sought to connect families with informal social support networks. This may be due to a shortage of such informal support groups, or mistrust of a parent in family members, as illustrated by this participant's statement:

> "***I don't know about anything like that*** *(a neighbourhood support group). And they usually* ***don't feel comfortable to speak to their own family***."

This lack of informal support can have the result that the role of providing social support falls to the volunteer, which may be overwhelming for him or her. This is demonstrated by the following participant's narrative:

> "*I was involved with a family – I never want to get involved like that again. The mother was HIV positive, and the son ...* ***I was her only support. That drained me. Sometimes you support, but the clients weigh heavily on you***."

Informal support from family, friends, and community groups is a significant protective factor against child maltreatment risk, is community-based, and does not require a service fee. It was therefore surprising that only half of the participants mentioned this as part of their services.

4.8.3.3 Factors influencing the decision to remove a child from home

Volunteers are available 24 hours a day to respond to emergencies involving child maltreatment. If the risk of maltreatment is sufficient, volunteers are obliged to remove a child from the home on a temporary basis (Child Welfare South Africa, 2013:7-9). This means that volunteers must have the ability to judge whether or not a child is at imminent risk of maltreatment and whether or not the risk warrants removal of the child.

In order to gain an understanding of how volunteers assessed risk of maltreatment, participants were asked to describe the factors that would influence their decision to remove a child from the home in an emergency situation. Two subthemes emerged, namely '*high risk to a child's physical safety*' and the '*family's reaction to intervention*'.

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A) Subtheme: High risk to child's safety

Table 4.8 displays participants' descriptions of what they deemed to be risk situations in which they would remove a child. These descriptions could further be divided into three categories: *'violence in the home', 'alleged sexual abuse', 'inadequate supervision' and 'a parent or other person in the home is intoxicated'*.

Table 4.8: High risk to child's safety

Theme: Factors influencing the decision to remove a child from home		
Subtheme	**Category**	**Narrative**
High risk to a child's physical safety	Violence in the home	"*If the* ***child really needs help now****. The* ***child's life is in danger*** *...*" "*When it comes to* ***physical abuse*** *you can of course see, we must make a plan here because* ***the child has to get out of here****.*" "*We* ***remove the child based on the fact that the child's life is in danger****, because many times you see the father fought with the mother and there is blood ...*" "*If you get to the house and* ***there is violence****, then we have to* ***remove the child from those circumstances immediately****.*"
	Sexual abuse	"*The child has to be* ***removed immediately*** *... then* ***go for tests to see if it is so that the child was sexually abused.***" "*With* ***sexual abuse we must remove the child immediately****. He's already traumatised, and now* ***needs psychological treatment****.*" "*We have to* ***remove the child immediately (sexual abuse)****! We always remove the child.*" "*We wouldn't easily go that far so as to remove the child. We'll check it out first our way.* ***We can't just act if we're not sure****. We'll look at the child's demeanour and body language.*"
	Inadequate supervision	"*That's why they finally removed him, because he was* ***without supervision and close to the train tracks****. But he wasn't abused or neglected. He was just dirty like a normal child who is sitting and playing. He didn't have wounds or marks. They just were homeless.*" "*The child is left alone at home. The parents went out and* ***the child is without supervision****.*"
	A parent or other person in the home is intoxicated	"***The mother is so drunk, she doesn't even know about herself****. I'll easily take the child ... and* ***there are men smoking dagga or drugs, then I'll remove the child****.* "

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Theme: Factors influencing the decision to remove a child from home		
Subtheme	**Category**	**Narrative**
		"*Often we get to homes where there is* ***an aggressive father, aggressive teenager on drugs*** *...* ***we remove the child.***" "*I said to them we couldn't leave the child alone with the mother, because she is* ***under the influence of alcohol*** *and the people already said that* ***the boyfriend came and looked for the mom with a hockey stick***."

a) Category: Violent situations

All of the participants described how they would immediately remove a child from the home if they suspected that the violent situation in the home would lead to abuse with severe consequences for the child. The following statements from participants illustrate this:

> "*If the* ***child really needs help now. The child's life is in danger*** *...*"

> "*When it comes to* ***physical abuse*** *you can of course see, we must make a plan here because* ***the child has to get out of here***."

> "*We* ***remove the child based on the fact that the child's life is in danger****, because many times you see the father fought with the mother and there is blood ...*"

> "*If you get to the house and* ***there is violence****, then we have to* ***remove the child from those circumstances immediately***."

Participants' decision to remove a child when there are signs of violence that places the child at risk of serious physical harm, is in keeping with research that shows violence in the home to be an extremely strong predictor of child maltreatment. Apart from children witnessing intimate partner violence being widely recognised as child maltreatment in itself, the abuse of women and children very often co-occur in the same household. Men's severe violence towards their intimate partners most often occur in the presence of other types of family violence, including aggression of the mother or her partner towards the child (MacMillan et al., 2013:1186; Holmes, 2013:520; Morris, 2009:414; McDonald, et al., 2009:94; Casanueva et al., 2009:84).

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b) Category: Sexual abuse

Where sexual abuse was concerned, more than two thirds of participants explained that they would immediately remove a child. This is clearly illustrated by these participants' narratives:

> "*With* ***sexual abuse we must remove the child immediately****. He's already traumatised, and now* ***needs psychological treatment****.*"

> "*We have to* ***remove the child immediately (with sexual abuse)****! We always remove the child.*"

One participant's response showed that she considered removal necessary even if sexual abuse was only alleged, as can be seen in this narrative:

> "*The child has to be* ***removed immediately*** *... then* ***go for tests to see if it is so that the child was sexually abused.***"

Sexual abuse cannot be officially confirmed without a medical examination conducted by a state-appointed district surgeon. Participants deciding to remove a child based on the suspicion that a child has been abused, is in accordance with Welbourne's (2012:120; 126; 135) conceptualisation of risk assessment which states that the likelihood of abuse as well as the seriousness of the consequences of abuse weigh heavily in deciding to remove a child. The risk of maltreatment is considered high if the consequences are serious, even if it is unlikely that it will occur. However, if it is likely that abuse will occur, but the consequences thereof are not considered serious, the risk is deemed low. Participants clearly regarded the consequences of sexual abuse as being extremely serious, and thus suspicion thereof was a strong enough motivator for removal.

The following narrative is one example of how participants made the decision that the likelihood of sexual abuse was high enough to remove the child:

> "*We wouldn't easily go that far so as to remove the child. We'll check it out first our way.* ***We can't just act if we're not sure****. We'll look at the child's demeanour and body language.*"

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On the one hand, assessment of risk in the case of sexual abuse allegations may be necessary, but, on the other hand, if that assessment is inaccurate, children are potentially left in high-risk situations.

c) Category: Inadequate supervision

A third of participants said that they would remove a child in situations where inadequate child supervision posed a risk to the child's safety. The following participants' statements demonstrate this, and the second statement shows that inadequate supervision was a strong motivational factor for removing the child in the absence of all other signs of maltreatment:

> "*The child is* ***left alone at home. The parents went out and the child is without supervision***."

> "*That's why they finally removed him, because he was* ***without supervision and close to the train tracks***. ***But he wasn't abused or neglected.*** *He was just dirty like a normal child who is sitting and playing. He didn't have wounds or marks.*"

It is not surprising that participants viewed an unsupervised child as being at risk. In a Kenyan study, Plummer and Njuguna (2009:528) found that adult supervision was a protective factor against child maltreatment. In addition, a lack of child supervision can itself be considered a form of child maltreatment, since it can potentially lead to a child being harmed (WHO, 2002:59).

d) Category: A parent or other person in the home is intoxicated

The majority of participants explained that they would remove a child from a home where the parent or other adults in the home were intoxicated to the extent that it threatened the child's safety. The narratives from these two participants demonstrates this:

> "***The mother is so drunk, she doesn't even know about herself***. *I'll easily take the child ... and* ***there are men smoking dagga or drugs, then I'll remove the child***. "

> "*Often we get to homes where there is* ***an aggressive father, aggressive teenager on drugs*** *...* ***we remove the child***."

Another participant described situations where parental alcohol or drug abuse co-occurred with violence in the home:

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> "*I said to them we couldn't leave the child alone with the mother, because she is **under the influence of alcohol** and the people already said that **the boyfriend came and looked for the mom with a hockey stick**.*"

Participants' views of alcohol and substance abuse as a risk factor for child maltreatment largely influenced their decision to remove a child. This is in line with several studies that have found parental substance abuse to be a very significant and leading predictor of child abuse (including child sexual and physical abuse), and neglect (Murphy et al., 1991:197; Famularo et al., 1992:475; Magura & Laudet, 1993:193; Dinwiddie & Bucholz, 1993:656; Dore et al., 1995:531; Chaffin et al., 1996:191; Wolock & Magura, 1996:1183; Walsh et al., 2003:1409; Dubowitz et al., 2011:96; Li et al., 2011:142).

B) Subtheme: Family's reaction to intervention

The family's response to the early intervention services offered by participants played a significant role in the decision to remove a child. Two categories emerged in this subtheme, namely the '*child's verbal and non-verbal communication'*, as well as the *'parent's level of cooperation'.* Table 4.9 displays the findings.

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Table 4.9: Family's reaction to early intervention

Theme: Factors influencing the decision to remove a child from home		
Subtheme	**Subtheme**	**Subtheme**
Family's reaction to early intervention services	Child's verbal and non-verbal communication	*"Many of the* ***children who can talk, they will say****, 'uncle so and so made me sore'."* *"Then* ***we'll talk to the child and ask, 'Has mommy assaulted you?' or 'What did Mommy do?'*** *And then we'll put it on black and white and go back to the mom."* *"If the child is very traumatised, even if it is just the parents swearing and yelling, but* ***we see the child's nerves can't take it, the child is scared, then we remove the child****, even if it's just for one night so that the child can sleep."* *"Often we remove the child for good reasons based on the child being abused by parents. When we get to a house* ***we can see a child is being abused: that child is anxious, the child just wants to go away with you, or the child clings to you****."*
	Parent's level of cooperation	*"****If the child has marks and the parent handles the situation, gives her co-operation, then we leave the child and tell her to be at the office on Monday morning****. But if she's aggressive, and you can see there are no rules in that house, then we remove the child if the child has marks from being hit."* *"****Maybe if they are poor*** *or don't have a home. They maybe don't have food every day; they're dependent on disability and have no other income.* ***But they try and bring relief****."* *"****If the mother cries with the child, if she regrets what she did*** *... but some of them are completely rude and hard. They don't care."*

a) Category: Child's verbal and non-verbal communication

Half of the participants described how the child's verbal or non-verbal communications played a part in their decision to remove the child. Referring to removal in the case of sexual abuse, one participant stated:

> *"Many of the* ***children who can talk, they will say****, 'Uncle so and so made me sore'."*

Another participant also emphasised the importance of the child's testimony in the decision to remove the child:

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> "*Then we'll* ***talk to the child and ask, 'Has mommy assaulted you?' or 'What did Mommy do?'*** *And then we'll put it on black and white and go back to the mom.*"

Participants' assessment of the degree of risk of maltreatment, based on the child's testimony, be it verbal or non-verbal, is in accordance with the Children's Act 38 of 2005 which states that "Every child that is at such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration" (Republic of South Africa, 2005).

Participants also assessed risk based on the child's non-verbal behaviour. One participant's response showed that the child's non-verbal response to verbal abuse might be considered enough reason to remove a child:

> "*If the child is very traumatised, even if it is just parents swearing and yelling, but* ***we see the child's nerves can't take it****, the child is scared, then we remove the child, even if it's just for one night so that the child can sleep.*"

Another participant viewed non-verbal behaviour as a sign that some form of physical abuse had most likely already occurred, and saw this as enough reason to remove the child:

> "*Often we remove the child for good reasons based on the child being abused by parents. When we get to a house* ***we can see a child is being abused: that child is anxious, the child just wants to go away with you, or the child clings to you****.*"

Participants' tendency to take into account a child's verbal and non-verbal communication in order to assess risk is in accordance with the training they receive from Child Welfare South Africa. Volunteers are trained to believe the child's testimony, and to identify non-verbal signs of anxiety and nervousness in a child as a potential sign of violence occurring in the home as well as the child suffering trauma (Child Welfare South Africa, 2013:30; 37; 100).

b) Parent's level of cooperation

Nearly all participants explained that the parent's level of cooperation with them would influence their decision to remove a child. In some cases, a parent's willingness to work with social services to end maltreatment, motivated participants to leave the child in the home, despite confirmed abuse. One participant's statement clearly shows this:

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> "***If the child has marks and the parent handles the situation, gives her co-operation, then we leave the child and tell her to be at the office on Monday morning***. *But if she's aggressive, and you can see there are no rules in that house, then we remove the child if the child has marks from being hit.*"

Another participant explained that a parent's willingness to care for a child would motivate them to leave the child with the parent, despite the parents' inability to meet basic needs, like shelter and nutrition:

> "***Maybe if they are poor*** *or don't have a home. They maybe don't have food every day; they're dependent on disability and have no other income.* ***But they try and bring relief***."

A third participant's narrative demonstrates that a parent showing remorse could also act as a motivator to let the child remain in the home:

> "***If the mother cries with the child, if she regrets what she did*** *... but some of them are completely rude and hard. They don't care.*"

Allowing the child to remain in the home if the parent co-operates, despite the fact that abuse or neglect has already occurred, is in line with the basic principle of family preservation that states that the family has the strengths and potential to function adequately, even in cases where severe child abuse and neglect have already occurred. It also underscores the practice implication of this assumption, namely that families should be active participants in interventions aimed at improving their social functioning while keeping the child safe within the home (Nelson & Landsman, 1992:3; Kaplan & Girard, 1994:5; Schuerman et al., 1994:18-19).

However, findings also imply that a child may be left in a high-risk situation if a parent is willing to cooperate with social services. In this sense, participants' approach to family preservation can be seen as a contradiction to the primary aim of ensuring the child's safety within the home. The family preservation approach has been criticised for leading to practice that in fact fails to remove a child from a high-risk situation. Shuerman et al. (1994:23; 234) contend that, since it is not possible to precisely determine the risk of maltreatment, a programme in which children are left in a home which is unsafe instead of being removed to alternative care will inevitably put more children at risk of serious harm and even death.

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Ultimately, the burden falls on the volunteer to determine if the maltreatment risk is high enough to warrant removal. It would appear that a parent's level of cooperation and the child's behaviour and verbal communications gave participants an indication that the child was no longer at high risk of maltreatment. In other words, participants saw parents who cooperate as a protective factor. This is in accordance with the view that risk assessment should ideally not only take into account risk factors associated with maltreatment, but also protective factors such as good parenting skills or a child that is securely attached to the parent (Hamilton & Browne, 2002:49; Prilleltensky et al., 2001:20).

4.9 CONCLUSION

This chapter set out the empirical findings of this exploratory and descriptive study about how volunteers contribute to early intervention services in a selected community-based child protection programme that follows the family preservation approach. A total of fourteen participants were selected through purposive sampling. The interview schedule was based on the literature review contained in chapters two and three of this study. Tables were used to present data, and the data was analysed, interpreted and contextualised in terms of the literature review. In chapter five, the findings of the study presented in this chapter will be utilised to produce conclusions and recommendations for early intervention services delivered as part of community-based child protection programmes according to the family preservation approach.

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CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The aim of the study was to explore the contribution of volunteers to early intervention services in a community-based child protection programme at a selected non-governmental organisation. Chapter four presented the empirical findings of the study, and this chapter will set out the recommendations and conclusions based on the findings.

This chapter therefore will fulfil objectives four and five of this study. These objectives were the following:

Objective 4:

- To make recommendations regarding how volunteers in community-based child protection programmes can further contribute to early intervention services with regard to the maltreatment of children.

Objective 5:

- To make recommendations for further studies.

These objectives were achieved through the implementation of the other objectives of this study, which were dealt with in the second, third and fourth chapters. These included the following:

Objective 1:

To explore various risk factors relating to child maltreatment, according to the levels of the ecological model.

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Objective 2:

- To provide, in terms of the relevant literature, policies and legislation, an overview of the nature and content of early intervention services within the context of the continuum of care of family preservation

Objective 3:

- To investigate how volunteers contribute to early intervention services in a selected community-based child protection programme

5.2 CONCLUSIONS AND RECOMMENDATIONS

This section will set out the conclusions and recommendations of the study, based on the empirical findings presented in chapter four. Findings providing an overview of participant characteristics will be presented. Following this, various findings regarding the themes which were explored in the study will be discussed. These themes included *'workload'*, *'family characteristics', 'early intervention services and stressors that are risk factors for child maltreatment', and 'factors influencing the volunteer's decision to remove a child from the home'*. The recommendations are aimed at the improvement of early intervention services delivered as part of community-based child protection programmes according to the family preservation approach.

5.2.1 Overview of participants

Participants provided certain identifying details to sketch an overview of their general characteristics. These included their gender, age, education level, how long they had been a part of the project, and the area where they resided.

5.2.1.1 Gender of participants

All participants were female.

Conclusion

The fact that all participants are female possibly reflects the wider trend in South Africa where women are more likely to do volunteer work than men, and the stereotypical notion

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that the primary responsibility for children's safety rests with the mother, not the father, and, by extension, with women and not with men.

Recommendation

- Men in the community should be actively recruited by the organisation and existing volunteers to become volunteers in the Isolabantwana project.

5.2.1.2 Age of participants

The majority of the participants were in the phase of middle adulthood, a life stage in which Erik Erikson contends people either start to contribute to the wellbeing of future generations, or fail to contribute.

Conclusion

People in middle adulthood may be more suited to do volunteer work for the Isolabantwana project, owing to their motivation due to their life stage, as well as their life experience. However, it is important to continually recruit young members into the project, since child safety concerns the entire community, and since the sooner the person can join the project, the more experience they can build in the long-run, which in turn will become increasingly valuable to the project.

Recommendation

- Young people in the community should be actively recruited by the organisation and existing volunteers to become volunteers in the Isolabantwana project.

5.2.1.3 Area of residence of participants

All volunteers said that they did their volunteer work in the community where they lived.

Conclusions

The fact that volunteers are permanently present in the community where they work, demonstrates the community-based nature of the project. Volunteers can identify with community members, know the local culture, and can assist the community in emergencies. They are also more accessible to community members than the social worker, since they are located in the community.

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Recommendation

- The organisation should maintain the status quo of letting volunteers implement the programme where they live. Preferably, they should live within walking distance of the client base that they are meant to serve.

5.2.1.4 Qualification levels of participants

The majority of volunteers had not completed their school education.

Conclusion

Volunteers not having completed formal schooling is to be expected, since it is reflective of the broader educational trends within the area.

Recommendation

- The organisation should maintain the status quo of not letting formal qualifications be a prerequisite for joining the project, since this may considerably limit their potential volunteer base.

5.2.1.5 Number of years participating in the project

Volunteers had spent periods ranging from 6 months to over 10 years with the project. At least half of the volunteers had been with the programme for several years.

Conclusion

Volunteer retention within the programme appears to be very successful.

Recommendation

- The organisation should continue to implement practices that boost volunteer retention, since training new volunteers is costly, and losing the knowledge of experienced volunteers is potentially damaging to the project.

5.2.2 Theme: Workload

This section of the study sought to explore the nature of the workload of volunteers within the framework of the family preservation approach.

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The workload carried by social workers delivering family preservation services has distinct facets identified in the literature. Since this research explored a family preservation programme unique to South Africa, the study determined various unique characteristics thereof.

5.2.2.1 Subtheme: Caseload Allocation

Within this subtheme, two primary categories became apparent from the findings of the study, the first being '*social worker instruction'*, and the second '*community need'*. A small minority of participants indicated relying strictly on social worker instruction before taking on a new client. The majority of participants, however, described taking on cases when the need within the community arose, such as when they were notified of child maltreatment by the police or a community member. In other words, these participants not only worked strictly with clients allocated by the social worker, but showed a great degree of flexibility with regards to responding to community needs as and when they arose. However, a small minority of participants did not appear to adhere to this approach, and preferred to strictly work upon social worker instruction, not fully utilising their potential to address child maltreatment.

Conclusion

A formal, predetermined number of cases allocated to volunteers, based strictly on the social worker's instructions, is a characteristic of the most widely recognised Western family preservation models, such as the Homebuilder's model. Volunteers taking on cases when the need within the community arises, is an approach that distinguishes this South African family preservation programme from Western models. This approach indicates that the programme has been adjusted to respond to community and client needs within a specific South African context. This is in line with the community-based approach prescribed in government policy.

Recommendations

- Volunteers who do not feel at ease working independently of the social worker's instructions, should be encouraged and empowered by the social worker to do so in order to take full advantage of their presence within the community.
- Those volunteers who only take on new cases based on social worker instruction, should be paired with volunteers who are more independent in their response to

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community needs. This will assist them to gain experience and confidence to broaden the ambit of their service.

5.2.2.2 Subtheme: Contact frequency

Unlike Western models of family preservations, the findings of this study indicated that there was no predetermined frequency of client contact, and that the frequency was determined either by the *'family's need for follow-up visits',* or the *'need to respond to immediate problems'*. Two thirds of participants described assessing the situation within a family to determine how often follow-up visits should be made to ensure that the family environment remains stable and safe for the child. A third of the respondents said that they would respond to families' needs on an ad hoc basis and visit the family whenever there was a need to do so, at any hour of the day.

Conclusion

The flexibility of volunteers in terms of frequency of family visits, reflects a unique adaptation of the family preservation approach used in the West: The Isolabantwana programme is community-based and volunteers live in the community. This differs from Western models because these models still employ social workers who are outsiders to a community.

However, volunteers possibly face a heavy burden since there is no limit to the contact frequency. This is of particular concern when volunteers are available to assist families after hours, and community members can easily access volunteers. Although this is an asset to the project and specific to the project's design, it may be taxing on volunteers in the long-run, and lead to burnout.

Recommendations

- Volunteers should be carefully monitored by social workers to ensure that the work does not tax them to the extent that their social functioning becomes impaired.
- Special measures should be put in place by the organisation to ensure that volunteers do not reach a stage of burnout. Such measures could include occasional removal from the community to an environment where volunteers can rest, and where debriefing can occur.

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- Social workers should regularly debrief volunteers on an individual basis in order to address trauma they may have experienced during the course of their work.
- Social workers should facilitate therapeutic group sessions to allow volunteers to share their experiences and address trauma that they may have experienced during the course of their work.

5.2.2.3 Subtheme: Contact duration

Findings demonstrated that contact duration varied greatly depending on the purpose of the session. Three categories determining contact frequency emerged. Routine home visits to monitor that the child was not at risk, tended to last 30 minutes. Findings also showed that a routine monitoring session could develop into a lengthy session when a client required additional support or counselling, meaning the session could last for more than an hour. In addition, findings revealed that contact duration was the longest (at times lasting several hours) when a volunteer had to remove a child from a home to a place of safety. This is largely because volunteers must rely on police to arrive at the scene and legally authorise the removal of the child. However, police often do not respond to volunteers' calls for assistance immediately.

Conclusions

The flexibility of contact duration is advantageous because it allows volunteers to utilise a crisis situation to promote change. This is desirable on the one hand, because it lends a family the immediate support that social workers often cannot provide due to their heavy caseloads. On the other hand, providing long, intensive counselling sessions can be emotionally taxing, and is not necessarily in the best interest of the volunteer's mental health and social functioning.

In addition, the fact that volunteers are no longer legally authorised to remove a child temporarily slows down service delivery. This is taxing on the volunteer in terms of time spent processing the case. In the past, section 12 of the Children's Act 38 of 2005 authorised volunteers to issue a temporary detainment order (known as form 36) and to remove children from their homes to a place of safety (Republic of South Africa, 2005). However, the Children's Act was amended by the Children's Amendment Act 41 of 2007, and volunteers are no longer authorised to remove children in an emergency situation (Republic of South Africa,

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2007). The result is that the child's safety may be placed at risk because service response is slowed down. This situation hampers efficient emergency service delivery, which is one of the main focuses of the project.

Recommendations

- Volunteers who provide lengthy counselling sessions for clients, should have specific consultation sessions with social workers in order to assist them to deal with complex client issues, and to prevent burnout. This can also be achieved during group sessions for volunteers, facilitated by the social worker.
- The organisation should lobby to amend the law in order to grant volunteers the authority to issue a section 36 form. Volunteers need to regain the legal authority to remove children to a place of safety without the assistance of a police officer or social worker. This will prevent the delay in service provision that could put the child's safety in jeopardy. It would also relieve the volunteer's burden of investing a large amount of personal time and effort.

5.2.2.4 Subtheme: Service duration

Findings showed that there was no set period for service duration. Half of the participants described situations in which the service period was unlimited. In these cases, families where children were once maltreated were still sporadically monitored by volunteers (based on the volunteers' own initiative). The other half of the participants indicated that they worked with clients until they judged them to be adequately functional, or until they passed the case on to the social worker for further service delivery because they could not see a change in the family's behaviour.

Conclusions

The Western approach to family preservation draws heavily on the crisis intervention model, which prescribes a set period of service delivery in order to motivate the family to change their behaviour. In other words, families are urged to work towards a deadline. However, with the Isolabantwana project, volunteers consider children who were once maltreated to be at a higher risk of future maltreatment. Since many families face chronic and persistent problems at the societal, community, family and child level (such as poverty, unemployment, and chronic and persistent health problems like alcohol and drug addiction) it stands to reason that

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such families remain at risk and should be monitored in the long-run. Within the context of the community where this project is implemented, as well as the chronic nature of these problems, the crisis intervention model's prescription for time limits on services may not necessarily be fitting.

Recommendations

- The organisation should maintain an open-door policy with regards to clients who have maltreated their children, since the risk factors present prior to the maltreatment will likely remain in the family despite volunteer intervention.
- Social workers should play an active role in ensuring that long-term monitoring continues, and such monitoring should be part of the project's formal structure. Long-term monitoring should not solely rely on volunteer initiative.

5.2.3 Theme: Family characteristics

Findings showed that most of the volunteers were faced with family characteristics that were risk factors for child maltreatment. These included '*large families*', '*unmarried parent*', '*teenage parent*', and '*children younger than six years*'.

Conclusions

At best, volunteers can assist families with coping mechanisms for the existing circumstances, or focus on preventing certain family characteristics from developing in the first place (such as large families).

Recommendations

- In the case of large families, volunteers should focus on family planning counselling and community awareness programmes about the benefits of having fewer children. When working with large families, volunteers should address the specific stressors experienced by parents, particularly as far as material assistance and parental skills are concerned.
- The organisation should arrange for volunteers to receive training in couple's counselling. Volunteers should also receive special training in addressing the specific childcare needs of an unmarried parent.

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- Volunteers should liaise with other community organisations (and schools in particular) to raise awareness to prevent teenage pregnancies.
- The organisation should arrange for volunteers to receive training to assist them to address the special parenting needs of teenage parents.
- Volunteers should make parents with children younger than six years acutely aware of what behaviour they can expect of their children during specific developmental phases. Volunteers should teach such parents the skills needed to deal with the child's behaviour. To this end, the organisation should ensure that volunteers are trained appropriately.
- Volunteers should make the parents of young children aware of the signs of maltreatment in order to allow them to identify if the child has been maltreated by a third party.
- Volunteers should make parents aware that young children are particularly vulnerable, often cannot speak for themselves, and therefore require special supervision to protect them from maltreatment.

5.2.4 Theme: Early intervention services and stressors that are risk factors for child maltreatment

Findings showed that various types of early intervention services were implemented by the volunteers to address stressors that are risk factors for child maltreatment. The three subthemes of stressors addressed as such included medical, social and economic stressors. Various categories emerged within each subtheme.

5.2.4.1 Subtheme: Economic stressors

Findings demonstrated that volunteers delivered early intervention services to address various economic stressors associated with child maltreatment. The categories of services that emerged included: '*services related to housing', 'services related to obtaining government grants', 'services addressing unemployment', access to resources addressing food shortage', and 'services related to accessing childcare services'.*

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a) Category: Services related to housing

Findings showed that volunteers frequently assisted families to obtain better housing conditions, by, for example, referring them to the local municipality so that they can be placed on a waiting list to receive a government sponsored home. However, findings also revealed that families were likely to wait for several years before obtaining homes. When families did receive homes, the quality of housing was usually poor.

Conclusions

Volunteers' ability to address this risk factor is limited since it occurs at the societal level – a level over which volunteers have little control. In addition, even if families did obtain government housing, the housing was of such poor quality that it led to situations that amounted to child maltreatment. For example, children witnessed adults becoming intoxicated because there was no privacy within the government-built home.

Recommendations

- Volunteers should make parents aware that certain behaviours performed in front of children (such as becoming intoxicated or having sex) can negatively affect a child's development and amount to maltreatment.
- Volunteers should assist parents to arrange their homes in a manner that affords them some degree of privacy, such as temporary partitions to fashion makeshift rooms.

b) Category: Services related to accessing government grants

Findings indicated that volunteers usually worked with families who did not have enough money to afford their living expenses. To address this, volunteers advised these families to obtain government grants. Findings also showed that families were not always making use of the grant system; despite being eligble for grants, they failed to apply. It also emerged that some families who obtained grants misspent them on alcohol and drugs, instead of tending to the child's needs.

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Conclusions

Even in cases where volunteers are able to assist a family to secure a government grant, the potential of the grant to reduce poverty and thus address the maltreatment risk is diminished due to alcohol and substance abuse.

Recommendations

- Volunteers should report cases of misspending of grants to the social worker, since they are ideally placed to observe whether or not parents mismanage their grants.
- The social worker should devise specific interventions to ensure that the grant money is spent in the child's best interest. This could include taking the grant money away from the parent and administering it on their behalf. Volunteers should play a key role in this strategy.
- The social worker should facilitate long-term removal (such as foster care) of a child from a home where two high-risk factors – poverty and substance abuse – persist.

c) Category: Services addressing unemployment

Findings showed that most volunteers assisted the unemployed parents of maltreated children to find work. Volunteers did this primarily by referring parents to services to enhance their skills in order to increase their chances of being employed. Howevever, findings also revealed that volunteers' ability to successfully reduce this risk factor was hampered by factors at a societal and community level. For instance, some parents were temporarily employed, but since their work was largely dependent on seasonal availability, little could be done by volunteers to address the problem.

Conclusions

Unemployment is another societal and community level risk factor over which volunteers in all probability have a very limited influence. A lack of employment opportunities means that even if volunteers referred parents to skills workshops, this did not necessarily secure parents' chances of finding steady employment. However, it is possible to create additional resources on a community level that may address this risk factor.

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Recommendations

- The welfare organisation should construct a database containing information about employment opportunities for parents.
- The social worker should actively engage volunteers so that volunteers can assist in expanding and updating the database of employment opportunities.
- Volunteers should utilise this information source to refer parents to vacant jobs.

d) Category: Access to resources addressing food shortage

Findings showed that the families with whom volunteers worked suffered food shortages and that they frequently assisted families in accessing food, either by referring them to a community resource (for example, a soup kitchen) or by purchasing food for families from their own pockets. Findings also indicated that there was a lack of resources to which volunteers could refer hungry families.

Conclusions

Food shortages in families are, arguably, a problem linked to the societal level, in this case structural poverty. Therefore, volunteers have limited capabilities to deal with this issue. However, as was clear from findings, there are not enough soup kitchens in the community, despite the fact that this is a resource that can be created within the community, irrespective of structural poverty.

This lack of community resources contributes to volunteers taking it upon themselves to feed families in need. This goes beyond the ambit of volunteers' duties and taxes their own limited resources. In the long-run, this is not sustainable and creates a stressor for the volunteer.

Recommendations

- Additional resources addressing food shortages in families, such as soup kitchens, should be created by social workers and volunteers (in partnership with schools and other organisations, if need be). This will allow volunteers the opportunity to refer clients, instead of spending their own resources on families.

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d) Category: Services related to accessing childcare services

Findings showed that volunteers referred parents of maltreated children to childcare services, such as preprimary schools, crèches, afterschool care, and informal care (for example, advising a parent to ask a friend to take care of a child). Volunteers therefore harnessed formal resources and informal resources. Volunteers also advocated on behalf of parents in cases where a child was denied access to preschool. However, despite the availability of resources, some participants cited the unaffordability of childcare services, as well as parents' unwillingness to pay for childcare services, as obstacles to access. Findings also showed that unemployment and substance abuse led to reduced finances which prevented parents from placing children in childcare.

Conclusions

The primary obstacles to accessing childcare services, appears to be other risk factors for child maltreatment, namely substance abuse, unemployment and poverty. Additional emphasis needs to be placed on addressing these risk factors.

Recommendations

- Social workers and volunteers should prioritise addressing substance abuse, unemployment and poverty, since these risk factors seem to be an obstacle to placing children in childcare services.
- Volunteers should work with other community organisations and community members to establish additional informal, community-based childcare services. These childcare services, if correctly designed, could allow parents with little financial resources to place their child in a safe environment when they cannot supervise the child, and can also create employment for persons operating such services.

5.2.4.2 Subtheme: Medical stressors

Medical stressors that are risk factors for child maltreatment were explored, and several categories emerged. These included '*services addressing parental substance abuse'*, *'services for children with mental or physical disabilities'*, and finally '*services related to parental mental health'*.

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a) Category: Services addressing parental substance abuse

Findings indicated that substance abuse was a problem common in families where children were maltreated, and that volunteers frequently referred parents to services related thereto. Findings demonstrated that volunteers left the final decision to go for rehabilitation to the parent. This is in accordance with the family preservation approach that calls for the volunteer to work in partnership with the family, based on the assumption that families should be active participants in interventions. Findings also made it clear that parents were often unwilling to receive help, or could not successfully rehabilitate. Many volunteers saw removal of the child into foster care as an unavoidable consequence of this.

Conclusions

Parents who are unwilling or unable to rehabilitate, place a child at continual high risk of maltreatment. Therefore, in cases where parents are addicts who do not rehabilitate, the family preservation approach cannot fulfil its primary aim of keeping the family together *while keeping the child safe*. In short: it is an inadequate approach to ensuring the child's best interest, and a clear demonstration that the widely accepted assumption that it is in the child's best interest to remain with his or her family, should be scrutinised anew.

Although the assumption is internationally supported, the question should be raised as to whether or not it serves as an excuse for government entities to evade their responsibility to ensure a child's wellbeing. Because alcohol is such a widespread issue, it is also quite possible that both the government and social welfare organisations have grown complacent in accepting a status quo that seems insurmountable.

To boot, there would be financial implications for an increase in foster care services, or to avail more alcohol rehabilitation service. In other words, increased statutory interventions will increase service delivery costs. This move would be contradictory to existing social development policy in South Africa. It would also not be in line with the principle that families should stay together. These factors may serve to discourage government and social services from ensuring a child's safety.

However, leaving a child in a home where substance abuse is a problem (which has been repeatedly shown by research to constitute a high-risk situation for the child) is decidedly not in the best interest of the child.

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Recommendations

- Social workers should place a child in foster care until such time as a parent addicted to substances is rehabilitated. If the parent fails to rehabilitate, foster care should continue or adoption should occur.
- Social workers should challenge the assumption in government policy that family preservation is in the best interest of the child, particularly in cases where the child maltreatment is consistently accompanied by parental substance abuse.
- Social work organisations should lobby for a policy adjustment to adequately deal with children who become victims of child maltreatment because their parents abuse substances.
- Research should be carried out (in a joint effort between academic institutions, the government, and social welfare organisations) to establish the extent to which the family preservation approach has been successful in promoting the child's best interest in cases where substance abuse is concerned.

b) Category: Services for children with mental or physical disabilities

Findings revealed that only a small minority of volunteers had attempted to assist parents to access services for children with mental or physical disabilities. This may be an indicator that child disability is not a significant problem in the community. However, this is unlikely: foetal alcohol syndrome is probably common in the community where volunteers work. This is suggested by findings from this study that alcohol and drug abuse is common in the community where volunteers work, and in the families with whom they work. In addition, research has shown that substance abuse and foetal alcohol syndrome is a widespread problem in the whole of South Africa, particularly in the Western Cape.

Findings also showed that volunteers struggled to place disabled children in such special care. Thus, it appears there are not sufficient resources to assist children with disabilities.

Conclusions

Although creating more community-based resources to address the issue of child disability is an option for volunteers, very specific professional care is required to work with such children. Volunteers may be trained to assist parents to understand and deal with the special

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needs of such children, but this may not offer protection from maltreatment since such children are particularly vulnerable, and other family members or acquaintances may take advantage of such children.

Utilising the community-based approach to address the special needs of disabled children is advocated by government, their motivation being that expensive institutionalised care should be avoided. However, a strong case can be made that, in the case of children with such special needs, this approach is not advisable, and the community-based approach is not suited to adequately address this stressor, due to the need for specific care and professional knowledge to work with such children. Arguably, the government has failed in its legal and constitutional duty to ensure the wellbeing of these children.

Recommendations

- Volunteers should assist parents to care for disabled children, and should receive additional training from the welfare organisation to do this.
- Volunteers should strongly focus on prevention campaigns that highlight the fact that children who are disabled are particularly vulnerable to maltreatment, and require supervision at all times.
- Volunteers should also drive prevention campaigns informing parents of the dangers of alcohol consumption to the development of the unborn child.
- Social workers and welfare organisations should lobby for the increased availability of specialised institutional facilities to care for children with special needs.

c) Category: Services related to parental mental health

Findings showed that volunteers frequently referred parents to services to address their mental health problems. These services included community-based sources, such as a local day hospital. Volunteers also acted as a link between the social worker and parent. The volunteer would refer the parent to the social worker, who in turn referred the parents to formal mental health institutions.

Conclusions

Since volunteers are not qualified to diagnose mental illness, and since this stressor requires specialist medical intervention, it is important that volunteers limit their intervention in this

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area to a referral service. However, since they are, by the nature of the Isolabantwana project, accessible to parents who potentially suffer from mental illness, it is crucial that volunteers are equipped to identify parents who require mental health services.

Recommendation

- The organisation should arrange for volunteers to receive special training to identify signs of mental illnesses, in order to ensure that referral to specialised services occurs timeously.

5.2.4.3 Subtheme: Social stressors

Research has shown that various social stressors are risk factors for child maltreatment. Findings from this study showed that volunteers addressed primarily three social stressors, namely a *'lack of parental skills', 'intimate partner violence'*, as well as a *'lack of social support'*.

a) Category: Services addressing a lack of parenting skills

Findings show that volunteers frequently referred parents of maltreated children to parental skills courses or counselled the parents themselves.

Conclusion

The lack of parenting skills encountered by volunteers is a stressor occurring at the parental level, and volunteers are ideally placed to work with parents in improving their parental skills, teaching them how to communicate with children, and informing them about what they should expect at various stages of the child's development. Although parental skills workshops are available at the office of the welfare organisation, the role that volunteers can play by delivering parental skills training within the home environment should not be underestimated, since it is a way to ensure that this high-risk factor is directly addressed: parents may not always be willing to make the effort to travel to a service provider office to attend a parenting skills course.

Recommendations

- The organisation should provide volunteers with regular training related to parental skills development.

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- The social worker should encourage volunteers to impart parental skills as often as possible, on a more formal basis, in the family's home environment. Imparting parental skills should be a standard part of volunteers' follow-up monitoring visits.

b) Category: Services addressing intimate partner violence

Findings of this study revealed that intimate partner violence was a risk factor frequently present in homes where children were abused. Intimate partner violence often required, at the very least, immediate temporary removal of the child to a place of safety, or placement in foster care. Police assistance was usually required to deal with immediate violent situations. Volunteers also offered parents assistance (in the form of counselling or referral to drug rehabilitation services) to end continuous intimate partner violence. During such a time, the child was kept in a place of safety.

Notably, findings did not demonstrate extensive efforts by volunteers to assist women, who are usually the victims of intimate partner violence, to exit such harmful relationships.

Conclusions

Removal of a child from a home where intimate partner violence occurs, ensures the safety of the child in the face of such a critical risk factor for maltreatment. Removal is the prudent course of action to take in the face this risk factor. However, assistance to the other victims of violence in the home, such as the mother, could eliminate that violence altogether, and enable family preservation.

Recommendations

- Volunteers should focus on empowering women to leave relationships where intimate partner violence occurs. This can be done by assisting the woman to apply for an interdict against the perpetrator, or by referring the woman to a service provider who will assist her with such an interdict, or with laying criminal charges against the perpetrator. Volunteers are ideally placed to empower women in this manner.

c) Category: Services addressing a lack of social support

Findings revealed that volunteers frequently did not address a lack of social support for families where children were maltreated. Volunteers did in some cases attempt to link parents

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with social support structures (such as their families, or informal support groups within the community). However, due to a lack of community-based support groups, or because parents did not trust their families enough to seek support, volunteers often did not address this risk factor. The findings also suggest that a lack of social support resources in the community could lead to volunteers becoming the sole source of social support for parents. This can create a tremendous stressor for the volunteer.

Conclusion

A lack of social support structures is a risk factor that volunteers are very well placed to address, at no cost to the organisation. Yet it appears that existing resources are not harnessed, new resources are not being created, and mistrust among family members are not being adequately addressed. Social support is one of the few services that can be addressed free of charge, yet this services is not maximally exploited. It appears that the value of social support structures in mitigating the risk for child maltreatment is undervalued within the context of this specific project.

Recommendations

- Social workers should place renewed emphasis on the provision of social support to parents of maltreated children. To this end, community resources, such as informal support groups, should be established. Volunteers should assist in this process.
- Volunteers should receive training in setting up social support groups within a community, with the aim of such groups operating autonomously.
- Volunteers should liaise with other community organisations to create support groups where they do not exist.
- Social workers should offer assistance to volunteers in cases where parents do not trust family members, in order to empower volunteers to facilitate family meetings to enable family members to trust and support each other.

5.2.5 Theme: Factors influencing the decision to remove a child from home

A primary function of Isolabantwana volunteers is to deliver early intervention services to address child maltreatment when the social worker is not on duty. To this end, volunteers must be able to assess the extent to which the child is at risk of maltreatment, in order to

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decide whether or not to remove a child to a place of safety. Findings yielded two subthemes that would influence volunteers' decision to remove a child. These included '*high risk to the child's physical safety'*, and the '*family's reaction to intervention'*.

5.2.5.1 Subtheme: High risk to the child's physical safety

The first subtheme to emerge from findings was that a decision to remove a child from a home was based on the extent to which the child's immediate physical safety was at judged to be at risk. There were several categories that emerged within this subtheme, namely '*violent circumstances', 'alleged sexual abuse', 'inadequate supervision, and 'a parent or other person in the home being intoxicated'*.

a) Category: Violence in the home

Violence in the home is a critical risk factor for child maltreatment, since it can cause serious injury, or death, and is an immediate threat. Volunteers, as a matter of course, removed a child when they judged the child's physical safety or life to be in danger due to violence in the home.

Conclusions

Violence in the home is a primary reason for immediate removal of the child. Immediate removal of the child to a place of safety during incidents of extreme domestic violence is desirable in terms of the family preservation approach, since the approach places the safety of the child first.

Recommendations

- Volunteers should assist in violence prevention through awareness campaigns, and by assisting adult victims of violence in the home to seek assistance to escape violent situations.
- Volunteers should assess whether parents or family members are willing to address the underlying causes of violence in the home, such as alcohol abuse, in order to address the root of the problem and make a home safe for a child in the long run.

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- Volunteers should assist victims to lay criminal charges against perpetrators of domestic violence, or to obtain interdicts against perpetrators, since perpetrators of domestic violence need to be held accountable for their actions.

b) Category: Sexual abuse

Findings indicated that it was the norm for volunteers to remove children immediately in cases of sexual abuse. Volunteers judged a child to be at high risk of maltreatment due to the serious nature of such abuse. However, findings also indicated that an allegation of sexual abuse was not always a motivator for a volunteer to remove a child immediately, and that volunteers may opt for conducting their own investigation before recommending that the child go for a medical examination or questioning the child separately, in a safe environment where the alleged perpetrator is not present. This potentially leaves the child in an extremely high-risk situation.

Conclusion

The only way to assess whether child sexual abuse has occurred or not, is through a medical examination. Volunteers are not qualified to make the decision to remove a child in a case of alleged sexual abuse, and if they do decide to leave a child in the home despite such allegations, the child is potentially placed in a high-risk situation.

Recommendation

Volunteers should, under no circumstances, leave a child in a home where child sexual abuse has allegedly occurred. Thus, the standard procedure should be to temporarily remove a child until alleged abuse has been confirmed or disproved.

b) Category: Inadequate supervision

Findings showed that volunteers would remove a child when the inadequate supervision of that child placed him or her at risk of maltreatment, or physical injury or death.

Conclusions

Child supervision is a basic parenting skill and leaving a young child unsupervised constitutes neglect in and of itself. Adequate supervision is a protective factor that volunteers could promote at the parental and family level.

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Recommendations

- Volunteers should, while working with parents, emphasise the importance of child supervision. Volunteers should make parents aware that a lack of supervision can amount to child neglect, and may lead to injury, death or the removal of a child.
- Volunteers should engage the wider community in awareness about the need for adequate supervision of children, and they should encourage community members to be aware of children's presence in the community, their safety, and whether or not they require assistance or supervision. The community as a whole should take responsibility for the safety of children.

d) Category: Parent or other person in the home is intoxicated

Findings showed that when a parent was intoxicated to the extent that it placed the child in immediate physical danger, volunteers felt they had no choice but to remove a child. Participants stated that violence often accompanied intoxication of parents or other persons in the home. This finding is not unexpected, since earlier findings of this study showed that substance abuse was a major motivator for removing a child. Findings also revealed that intoxication was frequently accompanied by domestic violence, creating high-risk situations for children.

Conclusions

The combination of substance abuse and violence pose a major threat to children's safety in many of the cases encountered by volunteers. Volunteers recognise these risk factors, and it is standard practice for them to remove the child immediately. This is desirable since it secures the child's safety.

Recommendations

- Volunteers should focus their services on prevention campaigns to make parents aware of the dangers of substance abuse, its association with violence, and the risk these two factors pose to children's safety.
- Volunteers should continually encourage community members to contact them should they suspect that violence may escalate in a home where adults and teenagers are intoxicated in the presence of a child.

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- Volunteers should continue to operate on a 'zero tolerance' principle and retain a standard procedure of immediately removing a child in the presence of these two major risk factors.

5.2.5.2 Subtheme: Family's reaction to intervention

Findings revealed that the family's response to volunteers' intervention played a significant role in the decision to remove a child. Two categories emerged in this subtheme, namely the '*child's verbal and non-verbal communication'*, as well as the '*parent's level of cooperation'*.

a) Category: child's verbal and non-verbal communication

A child's verbal and non-verbal communication emerged as a strong factor influencing a volunteer's decision to remove a child from the home.

Conclusions

Volunteer training in giving importance to the testimony of the child appears to have made a positive impact on their approach to assessing whether a child has been maltreated. However, a child may not feel safe speaking to volunteers when the perpetrator of maltreatment is present. For this reason, a child's reaction is not necessarily an accurate gauge of the extent of the risk that the child faces. Even if a child appears not to be traumatised, or seems willing to remain with a parent, this does not mean that the child is not at risk of maltreatment. Thus, a child may be left in a high-risk situation.

Recommendations

- Volunteers should, despite an absence of verbal and non-verbal signs that the child wants to be removed from the home, ensure that the child is questioned in a safe environment where he or she can speak freely without a potential perpetrator present. Volunteers should therefore temporarily remove the child for questioning and observation if needed, or at the very least interview the child in a private space. This will potentially allow the volunteer to make a better assessment of the maltreatment a child may have experienced.

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b) Category: Parent's level of cooperation

Findings showed that the extent to which a parent was willing to work with volunteers to address child maltreatment played a major role in volunteers' decision to remove a child from the home. In most cases, a child would be left at home if the parent were willing to co-operate with the volunteers, should the child's life not be in immediate danger. However, findings also revealed that volunteers would at times leave a child in a parents' care despite the fact that abuse, and in some cases serious abuse (such as physical injury to the child) has occurred, simply because the parent was willing to co-operate wit them. Volunteers automatically considered a child to be at considerably lower risk should the parent show remorse or a willingness to cooperate.

Conclusions

Leaving a child who has already been maltreated in the care of a parent simply because the parent shows initial willingness to work with the volunteer, constitutes a blind adherence to the family preservation principle that families should be active participants in the intervention process. Leaving a child in the home based on the parent's reaction, which may well lack integrity, means that a child can potentially remain in a high-risks situation.

Recommendations

- Volunteers should be strictly instructed by social workers to temporarily remove a child from a potentially high-risk situation, irrespective of the parent's willingness to co-operate. Parents' willingness to participate in a programme, or their show of remorse for committing maltreatment, should not be considered a factor when deciding to remove a child where obvious signs of serious abuse is already present.

5.3 RECOMMENDATIONS FOR FURTHER RESEARCH

This small-scale study was exploratory and descriptive in nature and, based on the literature research, only the second study conducted with regards to this South African community-based project. Since this is a nationally implemented project, there is much room for further exploration and description of the project, particularly in terms of qualitative studies, since it is necessary to gain a detailed understanding of how volunteers deliver early intervention services. It must also be borne in mind that this study only focused on one project at a specific

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organisation. However, the project is implemented in several different geographic areas, which all have unique characteristics in terms of communities and local culture.

The following areas should be investigated in further research:

- The manner in which volunteers assess the degree of risk of maltreatment, and the manner in which their actions are influenced by these assessments.
- The extent to which children remain in high-risk situations in this community-based project, and the reasons why this occurs.
- The extent to which unique community culture influences the manner in which volunteers render early intervention services and assess the risk of child maltreatment.
- The differences in risk factors volunteers must address in the various communities.
- Best practices regarding the development of low-cost community resources in order to allow volunteers to develop resources themselves.
- The effect that a lack of community resources have on the success of service delivery by volunteers.
- The extent to which the programme is successful in ensuring that families are preserved while a child is kept safe in the house.
- Possible further adaptations of this project to suit the unique needs of each community.

5.4 CONCLUSION

This chapter achieved the final objective of the study. Based on the empirical findings, conclusions were drawn and recommendations were made pertaining to volunteers' contribution to early intervention services in a community-based child protection programme at a selected non-governmental organisation. This chapter also presented discussions of the conclusions and recommendations, based on the themes, subthemes, and categories that emerged in the previous chapters.

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ADDENDUM A:

SEMI-STRUCTURED INTERVIEW SCHEDULE

STELLENBOSCH UNIVERSITY

DEPARTMENT OF SOCIAL WORK

THE CONTRIBUTION OF VOLUNTEERS TO EARLY INTERVENTION SERVICES IN A COMMUNITY-BASED CHILD PROTECTION PROGRAMME AT A SELECTED NON-GOVERNMENTAL ORGANISATION

Interviewer: Heidi Swart

Please note:

- All the information recorded in this interview schedule will be regarded as confidential.
- The names of interview participants will be kept confidential.

Instructions:

- Please answer the following questions.
- Please be as honest as possible.
- You may choose not to answer any of the questions.

Date of interview: .... Participant number: ....

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1. Identifying details

1.1 Gender

1.2 Age

1.3 Do you live in the same community where you work as a volunteer?

1.4 What is the highest level of education you have reached? (Please use the table to answer the question.)

1.5 How long have you been a volunteer in the Isolabantwana project?

2. Work load

2.1 How are cases allocated to you?

2.2 What determines how often you visit a family?

2.3 What determines how long you visit a family?

2.4 How long does a family stay part of your case load?

3. Family characteristics

What characteristics do you see in families with whom you work? (For example: How big are these families? How old are the children usually?)

4. Early intervention services and stressors that are risk factors for child maltreatment

4.1 What do you as volunteer do to address economic stressors (for instance poverty or unemployment) in a family?

4.2 What do you as volunteer do to address medical stressors (for instance chronic illnesses or disabilities) in a family?

4.3 What do you as volunteer do to address social stressors (for instance conflict within a family, or a parent who does not know how to communicate with a child) in a family?

5. Factors influencing the decision to remove a child from home to a place of safety

Describe what influences your decision to remove a child from home to a temporary place of safety, like a community safe house.

6. Conclusion

Thank you for participating in this study.

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Universiteit van Stellenbosch

Departement Maatskaplike Werk

Semi-gestruktureerde onderhoudskedule

DIE BYDRAES VAN VRYWILLIGERS TOT VROEË INTERVENSIE DIENSTE IN 'N GEMEENSKAPSGEBASEERDE KINDERBESKERMINGSPROGRAM BY 'N GESELEKTEERDE NIE-REGERINGSORGANISASIE

Navorser: Heidi Swart

Let asseblief:

- Alle inligting wat tydens die onderhoud ingesamel word, word beskou as streng konfidensieel.
- Die name van die persone met wie onderhoude gevoer is, sal nie bekend gemaak word nie.

Instruksies:

- Beantwoord asseblief die volgende vrae.
- Wees asseblief so eerlik as moontlik.
- U kan die keuse uitoefen om nie 'n vraag te beantwoord nie.

Datum van onderhoud: .... Deelnemer nommer: ....

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1. Identifiserende besonderhede

1.1 Geslag

1.2 Ouderdom

1.3 Bly u in dieselfde gemeenskap as waar u werk as vrywilliger?

1.4 Wat is die hoogste vlak van onderrig wat u bereik het? (Gebruik asseblief die onderstaande tabel om die vraag te beantwoord.)

1.5 Hoe lank werk u al as 'n vrywilliger in die Isolabantwana projek?

2. Wersklading

2.1 Hoe word gevalle aan u toegewys?

2.2 Wat bepaal hoe dikwels u 'n gesin besoek?

2.3 Wanneer u 'n gesin besoek, wat bepaal hoeveel tyd u gewoonlik met hulle spandeer?

2.4 Hoe lank bly 'n gesin deel is van u werkslading?

3. Eienskappe van gesinne

Watter eienskappe sien u onder gesinne met wie u werk? (Byvoorbeeld: Hoe groot is die gesinne gewoonlik? Hoe oud is die kinders in die gesin gewoonlik?)

4. Vroeë intervensie dienste en stressors wat risiko faktore is vir kindermishandeling

4.1 Wat doen u as vrywilliger om 'n gesin se ekonomiese stressors (byvoorbeeld armoede of werkloosheid) te hanteer?

4.2 Wat doen u as vrywilliger om 'n gesin se mediese stressors (byvoorbeeld kroniese siektes of gestremdhede) te hanteer?

4.3 Wat doen u as vrywilliger om 'n gesin se sosiale stressors (soos byvoorbeeld 'n ouer wat nie met sy of haar kind kan kommunikeer nie, of konflik binne die gesin) te hanteer?

5. Faktore wat die besluit om 'n kind na tydelike plek van veiligheid (veiligheidshuis) neem

Watter faktore het 'n invloed op u besluit om 'n kind na 'n tydelike plek van veiligheid (veiligheidshuis) te neem?

6. Afsluiting

Dankie vir u deelname aan die onderhoud.

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ADDENDUM B:

CONSENT FORM TO PARTICIPATE IN RESEARCH

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT FORM TO PARTICIPATE IN RESEARCH

The contribution of volunteers to early intervention services in a community-based child protection programme at a selected non-governmental organisation

You are hereby kindly requested to participate in a research study that is to be conducted under the auspices of the Department of Social Work at the University of Stellenbosch. This research will be undertaken by Ms. Heidi Swart in order to fulfil the requirements of a master's degree in social work. The results of this study will be published in a research report. You were identified as a potential participant in this study because you are a volunteer who contributes to early intervention services in a community-based child protection programme.

1. PURPOSE OF THE STUDY

The aim of this research is to gain a better understanding of the contribution of volunteers to early intervention in a community-based child protection programme.

2. PROCEDURES

Should you choose to become a part of this research study, you will be requested to participate in an unstructured interview. All information gathered during this interview will remain strictly confidential. You will be under no obligation to indicate your name or any particulars on the interview schedule. All interviews will be conducted by the master's student mentioned above.

3. POTENTIAL RISKS AND DISCOMFORTS

You are encouraged to discuss any uncertainties you may harbour about with the interview schedule or process with the researcher at any time.

4. POTENTIAL BENEFITS TO SUBJECTS AND / OR TO SOCIETY

The results of this study will provide welfare organisations with a better understanding of how volunteers contribute to early intervention services in a community-based child protection programme. This information could be used by welfare organisations for further planning in service delivery, in order to improve services to clients.

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5. PAYMENT FOR PARTICIPATION

Participants will not receive any form of payment for their participation in this study.

6. CONFIDENTIALITY

Any information obtained during the course of this research will remain confidential and will be disclosed only with your permission or as required by law. All questionnaires will be managed, analysed and processed by the researcher and will be stored in a secure location.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether or not to participate in this study. Should you volunteer to be a participant in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer, and still remain a participant in the study. The researcher may withdraw you from this research if circumstances arise which warrant doing so (for example, if you should influence other participants in the completion of their questionnaires).

8. IDENTIFICATION OF STUDENT-RESEARCHER

If you have any questions or concerns about the research, please feel free to contact the study supervisor, Professor Sulina Green, at the Department of Social Work at the University of Stellenbosch. Her contact details are as follows:

Telephone: 021-808 2069

Email: sgreen@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation in this study without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, please feel free to contact Ms Maléne Fouché of the Stellenbosch University's Division for Research Development. Her contact details are as follows:

Telephone: 021 808 4622

Email: mfouche@sun.ac.za

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SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

I, the participant, ____, hereby declare that all of the information contained in this document, as well as any other information relevant to me as a participant in this study, was clearly and comprehensively communicated to me by the researcher, Ms. Heidi Swart. I declare that I am satisfied with and fully comprehend said information. I declare that I was afforded the opportunity to ask any and all questions about the study that I deemed necessary, and that these questions were answered to my satisfaction.

I hereby voluntarily consent to participate in this study.

____

Name of Participant

______________________________________ ______________________________

Signature of Participant **Date**

SIGNATURE OF RESEARCHER

I, the researcher, Heidi Swart, hereby declare that I clearly and comprehensively communicated to the participant, ______________________________, all of the information contained in this document, as well as any other information relevant to the participant in this study. I declare that, to the best of my knowledge, the participant fully comprehends said information. I declare that I afforded the participant the opportunity to ask any and all questions about the study that he or she deemed necessary, and that, to the best of my knowledge, these questions were answered to his or her satisfaction.

This communication with the participant will take place in English or Afrikaans, as requested by the participant, and no translator will be used.

______________________________________ ______________________________

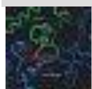
Signature of Researcher **Date**

Stellenbosch University https://scholar.sun.ac.za

ADDENDUM C:

CONSENT FROM ISOLO PROJECT

Inbox x



Heidi Swart <swart.heidi@gmail.com> 5/19/15

to Kantoorhoof

Hello [redacted]

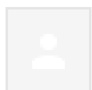
Ek is nou op 'n punt waar ek graag die onderhoude met die Isolobantwana vrywilligers in [redacted] wil begin. Watter prodedure moet ek volg om die onderhoude te reel? Kan ek direk met jullie mense daar gesels, of moet ek deur jou werk?

Nog 'n vraag: Dink jy ek sou 15 volunteers kan kry om mee te gesels? Hulle hoef nie noodwendig steeds by die program betrokke te wees nie. Hulle moet net die werk reeds gedoen het.

Baie dankie vir jou ondersteuning.

Groete,

Heidi



Kantoorhoof 5/19/15

to [redacted], [redacted], me

Afrikaans

English

Translate message

Stellenbosch University https://scholar.sun.ac.za

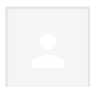
Turn off for: Afrikaans

Dagse Heidi,

Ek stuur hierdie aan en . Lg is die skakel tussen die kantoor en die Isolo's. , kan jy en hierdie bespreek en sommer direk aan Heidi terugvoering gee?

Dankie aan almal.

From: Heidi Swart [mailto:swart.heidi@gmail.com]
Sent: 19 May 2015 10:44
To: Kantoorhoof
Subject: Onderhoude vir Isolo projek



cwsa_ @mweb.co.za 5/19/15

to me

Afrikaans

English

Translate message

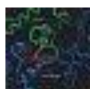
Turn off for: Afrikaans

Hello Heidi

is vandag in . Ek sien haar eers weer môre. Ek sal dit met haar bespreek en dan terugvoer gee aan jou.

Groete

From: Kantoorhoof [mailto:]
Sent: 19 May 2015 11:25 AM
To: 'Heidi Swart'
Cc:
Subject: FW: Onderhoude vir Isolo projek



Heidi Swart <swart.heidi@gmail.com> 5/19

Stellenbosch University https://scholar.sun.ac.za

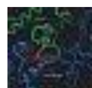
/15

Hello ,

Baie baie dankie!

Groete,

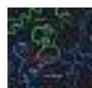
Heidi



Heidi Swart <swart.heidi@gmail.com> 5/19 /15

to Kantoorhoof

Baie dankie



Heidi Swart <swart.heidi@gmail.com> 5/21 /15

Hello ,

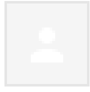
Ek hoop dit gaan goed.

Kon jy al met gesels? Ek wou ook byse: Ek kan enige tyd die interviews kom doen - wat ook al die gemaklikste is vir julle en die vrywilligers. Ek sal omtrent 45 minute met elkeen benodig, minimum 'n halfuur.

Groete,

Heidi

Stellenbosch University https://scholar.sun.ac.za



[redacted] <[redacted]1@[redacted].co.za> 5/22/15

to me

Afrikaans

English

Translate message

Turn off for: Afrikaans

Middag Heidi

Ek is [redacted], betrokke by die ECP-program.

Ons het op Maandag, 25/05/2015 `n vergadering waar al die ECP-lede vergader.

Wil jy hulle almal sien of verkies jy `n ander datum.

Vriendelike groete!

Stellenbosch University https://scholar.sun.ac.za

ADDENDUM D:

APPROVAL LETTER FROM THE STELLENBOSCH UNIVERSITY'S DEPARTMENTAL ETHICS SCREENING COMMITTEE (DESC)

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice
New Application

02-Jul-2014
SWART, Heidi

Proposal #: **DESC/Swart/June2014/20**

Title: **The contribution of volunteers to prevention and early intervention services in a community-based child protection programme at a selected non-governmental organisation.**

Dear Miss Heidi SWART,

Your **New Application** received on **05-Jun-2014**, was reviewed
Please note the following information about your approved research proposal:

Proposal Approval Period: **26-Jun-2014 -25-Jun-2015**

Please take note of the general Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

Please remember to use your **proposal number** (**DESC/Swart/June2014/20**) on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Also note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary).

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) registration number REC-050411-032.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 0218089183.

Sincerely,

Clarissa GRAHAM
REC Coordinator
Research Ethics Committee: Human Research (Humanities)

Stellenbosch University https://scholar.sun.ac.za

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2.Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4.Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch Universtiy Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7.Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8.Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9.Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

10.On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.