



“It’s everyone’s job to make sure
I’m alright”

Literature Review



SCOTTISH EXECUTIVE

Making it work together

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Introduction

This piece of work was not intended to be a systematic review of the literature. The aim was to provide an overview of the ideas and research evidence on child abuse and child protection in order to inform the work of the child protection review team. It is predominantly a review of UK research evidence. In some areas, however, UK evidence was found to be lacking and reference has been made to research from the US, Australia and elsewhere. There is, therefore, variation in the extent to which reference is made to international work. The research evidence is presented in three parts:

- Part I is about definitions and information and includes sections on defining child abuse and child protection; the extent of child abuse; and causes of child abuse.
- Part II is about identification and assessment and includes sections on identifying child abuse; reporting child abuse and investigation and decision making.
- Part III looks at addressing the problem and 'what works'. It includes sections on messages from elsewhere; prevention; messages from reviews and inquiries; and 'what works' in child protection.

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Definitions and Information

Defining child abuse and neglect and child protection

The level and extent of child abuse and neglect

Causes of child abuse and neglect

Conclusions

Defining child abuse and neglect and child protection

Despite vigorous debate over the last two decades little progress has been made in constructing a clear, reliable, valid and agreed definition of child abuse or child protection. There is no standardised definition that has been developed by researchers and accepted and used by practitioners. Definitions of child abuse vary amongst professionals, over time, across cultures and between social and cultural groups. What is viewed as abusive in one society is not necessarily seen as such in another (Brougham 1997; Corby 1993; Parton 1997). This chapter considers some of the debates surrounding definitions.

(i) The World Health Organization (WHO) definition of child abuse

The World Health Organization state that the core elements of a definition of child abuse should refer to:

- the child;
- the abusing agent; and
- indirect harm caused by the abuse.

They provide a general definition of child abuse or maltreatment:

'Child abuse or maltreatment constitutes all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm in the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.'

They also provide definitions of different types of abuse:

- **'Physical abuse'** of a child is that which results in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be a single or repeated incidents.'
- **'Emotional abuse'** includes the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies commensurate with her or his personal potentials and in the context of the society in which the child dwells. There may also be acts towards the child that cause or have a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. These acts must be reasonably within the control of the parent or person in a relationship of responsibility, trust or power. Acts include restriction of movement, patterns of belittling, denigrating, scapegoating, threatening, scaring, discriminating, ridiculing or other non-physical forms of hostile or rejecting treatment.'
- **'Neglect'** is the failure to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible.'
- **'Child sexual abuse'** is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not

developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and another person who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage it in unlawful sexual activity; the exploitative use of child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials.'

- *'Commercial or other exploitation of a child refers to use of the child in work or other activities for the benefit of others. This includes, but is not limited to, child labour and child prostitution. These activities are to the detriment of the child's physical or mental health, education or spiritual, moral or social-emotional development.'*

The WHO state that their definition of child abuse should be adapted to the situations of individual countries. They also point out that one definition of child abuse cannot serve all purposes, for example, a definition that would serve to increase awareness differs from that of service provision and a definition for legal purposes differs from that for research.

(ii) Official definitions of child abuse in Scotland and the UK

A study of child protection registers undertaken in 1987 revealed that more than 20 categories of child abuse were being used by Scottish local authorities. A joint steering group was set up to recommend standard criteria for admission to, and removal from, local registers. The steering group produced a document (Scottish Office Social Work Services Group 1992) which stated that:

'Children may be in need of protection where their basic needs are not being met, in a manner appropriate to their stage of development, and they will be at risk through available acts of commission or omission on the part of their parent(s), sibling(s), or other relative(s), or a carer (i.e. the person(s) while not a parent who has actual custody of a child).'

It outlined five specific categories of child abuse which are those now outlined in national inter-agency guidance on child protection - *Protecting Children A Shared Responsibility*, *Guidance on inter agency co-operation* (Scottish Office 1998):

- **Physical abuse** is defined as *'actual or attempted physical injury to a child under the age of 16 where there is definite knowledge, or reasonable suspicion, that the injury was inflicted or knowingly not prevented'* and may include a serious incident or a series of minor incidents involving bruising, fractures, scratches, burns or scalds; deliberate poisoning, attempted drowning or smothering, Munchausen syndrome by proxy,¹ serious risk of or actual injuries resulting from parental lifestyle prior to birth, for instance substance abuse; physical chastisement deemed to be unreasonable.

¹ Munchausen syndrome by proxy describes a situation where a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child whom they are looking after. The condition has also been termed Fabrication or Induction of Illness in a Child by a Carer and is described in more detail on Page 11.

- *'Any child below the age of 16 may be deemed to have been sexually abused when any person(s) by design or neglect, exploits the child, directly or indirectly, in any activity intended to lead to the sexual arousal or other forms of gratification of that person or any other person(s) including organised networks. This definition holds whether or not there has been genital contact and whether or not the child is said to have initiated the behaviour'.* **Sexual abuse** may include such activities as incest, rape, sodomy or intercourse with children; lewd or libidinous practices or behaviour towards children; homosexual practices towards children; indecent assault of children; taking indecent photographs of children or encouraging them to become prostitutes or witness intercourse or pornographic materials. Activities involving sexual exploitation, particularly between young people, may be indicated by the presence of one or more of the following characteristics - lack of consent; inequalities in terms of chronological age, developmental stage or size, actual or threatened coercion.
- **Non-organic failure to thrive** occurs in *'Children who significantly fail to reach normal growth and developmental milestones (i.e. physical growth, weight, motor, social and intellectual development) where physical and genetic reasons have been medically eliminated and a diagnosis of failure to thrive has been established.'* Factors affecting a diagnosis may include inappropriate relationships between the care giver and child especially at mealtimes, for instance the persistent withholding of food as punishment and the sufficiency and/or suitability of the food for the child. In its chronic form non-organic failure to thrive can result in greater susceptibility to more serious childhood illnesses, reduction in potential stature.
- **Emotional abuse** occurs when there is *'failure to provide for the child's basic emotional needs such as to have a severe effect on the behaviour and development of the child'.* This may include situations where, as a result of persistent behaviour by the parent(s) or care givers, children are rejected, denigrated or scapegoated; inappropriately punished; denied opportunities for exploration, play and socialisation appropriate to their stage of development or encouraged to engage in anti-social behaviour; put in a state of terror or extreme anxiety by the use of threats or practices designed to intimidate them; isolated from normal social experiences, preventing the child from forming friendships. Children who are left alone for long periods, are understimulated or suffer sensory deprivation, especially in infancy; who do not experience adequate nurturing or who are subject to a large number of caregivers may also come into this category. Sustained or repeated abuse of this type is likely in the longer term to result in failures or disruptions of development of personality, inability to form secure relationships and may additionally have an effect on intellectual development and educational attainment.

Physical neglect *'occurs when a child's essential needs are not met and this is likely to cause impairment to physical health and development. Such needs include food, clothing, cleanliness, shelter and warmth. A lack of appropriate care results in persistent or severe*

exposure, through negligence to circumstances which endanger the child'. Physical neglect may also include a failure to secure appropriate medical treatment for the child, or when an adult carer persistently pursues or allows the child to follow a lifestyle inappropriate to the child's developmental needs or which jeopardises the child's health.

The English/Welsh guidance *'Working together to safeguard children'* (Department of Health *et al* 1999) states that:

'Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family, or in an institutional or community setting; by those known to them or, more rarely by a stranger.' The categories of physical abuse, sexual abuse, emotional abuse and neglect are broadly similar to those in the Scottish document. There is no separate category for non organic failure to thrive in the England/ Wales document, it is covered by the category of neglect.

(iii) Recent developments in the understanding of abuse

Over the past 30 years the problem of child abuse has undergone what has been described as considerable 'diagnostic inflation' (Parton 1997). As knowledge of child development and children's needs has increased, the number of situations and experiences which are considered to be abusive has also increased. This section describes some of the more recent developments which have affected our understanding of child abuse.

Organised abuse

The term 'organised abuse' has been widely used but does not have an agreed meaning. La Fontaine (1993; 1994) defines organised abuse as:

'Sexual abuse where there was more than a single abuser and the adults concerned appear to have acted in concert to abuse the children AND/OR where an adult has used an institutional framework or position of authority to recruit children for sexual abuse.'

'Protecting Children a shared responsibility' (Scottish Office 1998) and *'Working together to safeguard children'* (Department of Health *et al* 1999) both provide guidance on organised abuse or abuse involving multiple abusers.

Children abused through prostitution

The prostitution of children may be viewed as a form of organised abuse. The involvement of young people in child prostitution, the sex industry or sexual exploitation has recently drawn increasing attention. It is difficult to estimate the number of children being abused through prostitution since it is to a large extent a hidden problem. Abuse through prostitution can be physical and emotional as well as sexual. It is increasingly becoming accepted that children and young people should not be viewed as prostitutes but as victims of child abuse because they are involved in an abusive or exploitative situation (Barnardos 1998; Palmer

2001). In some police forces, however, the issue is not dealt with by the child protection team but by the serious crime squad and some social workers do not consider it a matter of child protection (Bibby 1996; Doran and Brannan 1996; Stanley 1999).

'Safeguarding children involved in prostitution' (Department of Health 2000b) provides supplementary guidance to the England/Wales document *'Working together to safeguard children'* (Department of Health 1999). It states that children involved in prostitution should be treated primarily as the victims of abuse and as children in need who may be suffering or may be likely to suffer significant harm. Similar guidance for Scotland does not yet exist and children involved in prostitution are mostly dealt with under the children's hearing system which addresses their welfare needs. The Scottish Executive were, however, jointly involved with the Department of Health, Home Office, National Assembly for Wales and Northern Ireland Office in the production of the *'National Plan for Safeguarding Children from Commercial Sexual Exploitation'* (Department of Health 2001) which includes the prostitution of children and young people, the production, sale, marketing and possession of pornographic pictures of children over the internet, trafficking in children and sex tourism involving children.

Child pornography and the internet

The safety of children who use the internet has been raised as a child protection issue in recent years. *'Working Together to Safeguard Children'* (Department of Health *et al* 1999) includes a section on child pornography and the internet which states that Area Child Protection Committees may wish to consider awareness about the safe use of the internet by children. It also states that where somebody is discovered to have placed child pornography on the internet or to have accessed child pornography, the police should normally consider whether that individual may be involved in the active abuse of children. The Scottish guidance does not refer to internet safety but the Scottish Executive has produced a document entitled *'Clickthinking: personal safety on the Internet'* (Scottish Executive 1999).

Ritual abuse

The term 'ritual abuse' is usually reserved for those cases involving overt rituals as found in religious and quasi-religious ceremonies. La Fontaine (1993; 1994) found that allegations of ritual were present in only 8 per cent of cases involving organised abuse which themselves are a minority of all child abuse cases. Confirmed cases in which there was corroborative evidence of ritual were even rarer.

Institutional abuse

Institutional abuse is abuse which takes place in a school or residential setting. The dynamics of institutional settings can lead to a climate in which children are particularly vulnerable to being abused. There is evidence that children with special needs who live in institutions are particularly vulnerable to abuse (Bibby 1996; Doran and Brannan 1996; Stanley 1999).

Barter (1998; 1999; 1999a) found that while boys were as likely to be involved in investigations of organised abuse as girls most of the allegations made by boys concerned physical abuse, allegations made by girls more often concerned sexual abuse. Allegations were more often made against a male member of staff even though the majority of direct care residential work is undertaken by females.

Institutional abuse cannot be subsumed under 'organised abuse' because a large number of abusers in institutions act alone and the abuse is not 'organised'. Barter (1998; 1999; 1999a) found that over half of the investigations involving institutional abuse concerned individual children making allegations against an individual worker.

'Protecting children a shared responsibility' (Scottish office 1998) and *'Working together to safeguard children'* (Department of Health *et al* 1999) both include sections on children living away from home.

Munchausen's by proxy/fabrication or induction of illness in a child by a carer

There is a growing body of medical literature about Munchausen's syndrome by proxy or fabrication or induction of illness in a child by a carer which is '*...when an infant or child is presented to doctors, often repeatedly, with a disability or illness fabricated by an adult, for the benefit of that adult*' (McClure *et al* 1996). There are three main ways in which the carer fabricates or induces illness in the child:

- fabrication of signs and symptoms which may include fabrication of past medical history;
- fabrication of signs and symptoms and falsification of hospital charts and records and specimens of bodily fluids (this may include falsification of letters and documents); and
- induction of illness by a variety of means, for example, by poisoning or suffocation.

The total number of confirmed cases in the UK and the Republic of Ireland between 1 September 1992 and 31 August 1994 of children incurring Munchausen's syndrome by proxy, non-accidental poisoning or non-accidental suffocation (which were notified to the British Paediatric Association Surveillance Unit if a formal case conference had been held for the first time during that period to discuss any of these conditions), was 128. This gives a combined annual incidence of Munchausen's syndrome by proxy, non-accidental poisoning and non-accidental suffocation of 0.5 per 100,000 children aged under 16. More than three-quarters (77%) of cases are aged below 5 years which means that the annual incidence for this age group during the period of study was 1.2 per 100,000 children. For children aged under 1 the annual incidence is 2.8 per 100,000 (McClure *et al* 1996). These calculations are likely to be under estimates, however, since some paediatricians may have been deterred from notifying cases due to legal aspects, maintenance of confidentiality or difficulties of diagnosing such a rare condition (Corby 1993; Department of Health 2001a; McClure *et al* 1996).

The Department of Health (2001a) has produced supplementary guidance to '*Working together to safeguard children*' entitled '*Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities*'. Munchausen's by proxy is not specifically covered in the Scottish guidance.

Domestic abuse

Gibbons *et al* (1995) found that domestic abuse was a factor in 27% of child abuse investigations. The association between domestic abuse appears to be strongest for physical abuse, weaker for sexual abuse and neglect (Rumm *et al* 2000; Tomison 1995).

Domestic abuse is known to have both a direct and indirect impact upon children (Hester *et al* 2000). The personal accounts of women who have experienced violence from a partner, the accounts of children who have spoken out about domestic abuse, the accounts of service providers such as refuge workers, and a growing body of research, all suggest that a high proportion of men who abuse their partners also physically abuse their children or that children and young people are directly abused when they attempt to intervene to prevent abuse to their mothers (McGee 2000; Department of Health 1995). Children are also indirectly abused as a result of suffering emotional abuse through witnessing violence against their mother, whether or not they have themselves been directly abused. Violent men may also emotionally abuse children by using them to manipulate and control their partners, both during a relationship and after separation (Department of Health 1995; Gibbons *et al* 1995; Doyle 1996; O'Hara 1993; Rumm *et al* 2000; Cleaver *et al* 1998; Tomison 1995; Scottish Women's Aid (undated); McGee 2000).

The England and Wales guidance '*Working together to safeguard children*' (Department of Health *et al* 1999) includes a section on domestic abuse which states that where there is evidence of domestic abuse the implications for children in the household should be considered including the possibility that the children may themselves be subject to violence or other harm. The document states that it is good practice for the police to notify the social services department when they have responded to an incident of domestic abuse and it is known that a child is a member of the household. Domestic abuse is not specifically mentioned in the Scottish guidance but the '*National Strategy to address domestic abuse in Scotland*' (Scottish Executive 2000) makes many references to the needs of children and states that services should recognise and understand child protection issues.

Foetal abuse

There has been concern for some time now, particularly in the US about the issue of 'foetal abuse', where a foetus may be damaged in utero by acts of omission or commission. Behaviours on the part of a pregnant mother such as tobacco, alcohol and drug use are perceived as harmful to the unborn child. Men can also physically harm a foetus by physically assaulting the mother and evidence suggests that controlling men may be particularly violent to women when they are pregnant (Hobbs and Hobbs 1999; Albert 2000).

Neither the Scottish nor English/Welsh guidance specifically refers to foetal abuse but the Scottish Executive (2001) consultation paper *'Getting our priorities right'* discusses the issue of problem drug taking in pregnant women.

Children affected by problem drug use

Children, as well as fetuses, may also be affected by the problem drug use of their carers. Estimating the extent of problem drug use in Scotland and its impact upon children is complex as it is estimated that only up to a third of problem drug users may be in touch with specialist services.

- In 1999/2000 11,123 people with drug problems made an initial contact with drugs agencies, and nearly a fifth of these (19%) were living with dependent children.
- The Greater Glasgow Drug Action Team estimate that between 7,000 and 10,000 children are directly affected by their parents' problem drug use in the Greater Glasgow area and a third of problem drug users in touch with local community projects said they had dependent children.
- Information from Glasgow City's child protection register indicates that in 52% of cases on the register, alcohol and/or problem drug use was the underlying factor leading to registration (Scottish Executive 2001).

Links are not always made between adult drug services and child protection services. A mapping exercise carried out by substance misuse services in the London boroughs of Kensington and Chelsea, Westminster, Hammersmith and Fulham and Ealing (2001) found that many staff had no information about the children of their clients and information was only normally recorded about children if they were on the child protection register. Staff were unsure about child protection procedures and unclear when confidentiality could be breached.

Children affected by problem drug use is not covered in the national guidance but *Getting Our Priorities Right* (Scottish Executive 2001) outlines policy and practice guidelines for working with children and families affected by problem drug use.

Children with disabilities

There are a number of experiences that disabled children have that non-disabled children do not. Some of these experiences could be termed abuse, for example:

- discrimination;
- force feeding;
- medical photography - photographing of disabled children in hospitals in insensitive and intrusive ways;
- segregation into special schools;
- physical restraint;

- misuse of medication;
- neglect of medical care; and
- bullying (ABCD Consortium 1993).

Protecting Children A Shared Responsibility (Scottish Office 1998) and *Working Together to Safeguard Children* (Department of Health *et al* 1999) include sections on the abuse of disabled children but the guidance does not suggest that children who are disabled may experience different forms of abuse from children who are not disabled. Instead the guidance provides guidelines on how professionals should work with disabled children who have been abused.

Racial abuse

Child protection procedures and guidance have failed to require agencies to adopt pro-active approaches to challenging racism, including the racial abuse of ethnic minority children and young people. Racial abuse on the whole receives a 'non-reaction' response from professionals, with racial abuse victims receiving very little satisfactory assistance from agencies, particularly the social services department. Racial abuse is not usually viewed as an example of child abuse and the protection of black children from racial abuse has not been seen as a practice issue despite the fact that racial abuse damages children both physically and emotionally (Barter 1999b; Dutt and Phillips 1997).

Dutt and Phillips (1997) point out that it is important to raise the issue of racial attacks and harassment of children and young people with asylum-seeking status as there is evidence to suggest there is a growing problem of racial abuse in asylum-seeking communities. There is evidence that children are being abused by white adults and children and by black young people of Afro Caribbean and Asian descent. Unaccompanied asylum-seeking children are often placed in black-led homes because it is often assumed that such homes will, and should, be able to understand, empathise and be experienced in dealing with these children when this is often not the case. Save the Children Scotland and the Scottish Refugee Council (2000) documented the abuse directed at refugee children who had been dispersed with their families into areas of Glasgow and East Lothian.

'*Working together to protect children*' (Department of Health *et al* 1999) states that while racism is not in itself a category of abuse, the effects of racism need to be considered in order to protect the child. The Scottish guidance makes no reference to racial abuse.

Female Genital Mutilation (FGM)

The Prohibition of Female Circumcision Act 1985 made it an offence to '*excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person*' or '*to aid, abet or procure the performance by another person of any of these acts on that other person's own body*'. A person found guilty of such an offence is liable to a fine or imprisonment of up to five years. Despite the Act it appears that the operation of female circumcision is still being performed illegally, albeit infrequently, in the UK

by medically qualified or unqualified practitioners and children are also being sent abroad to have the operation (Jordan 1994; Black and DeBelle 1995). Many Area Child Protection Committees now regard FGM as a form of child abuse in their child protection guidance but commentators such as Iweriebor (1996) are keen to point out that the issue is misrepresented if it is seen in this way since parents do not intend to harm their daughters. The procedure is carried out with the best intentions for the future welfare of the child, there is no possibility of its repetition and it is approved by sections of the communities in which it is practised. For some cultures it is a component of a rite of passage to socially acceptable adulthood, for others a nuptial necessity. Some parents want their daughters to undergo surgery because they believe it protects them from would-be seducers and rapists.

Working Together to Safeguard Children (Department of Health *et al* 1999) has a section on FGM which states that a local authority may exercise its powers under section 47 of the Children Act 1989 if it has reason to believe that a child is likely to be or has been the subject of FGM. It also states that in local areas where there are communities or individuals who traditionally practice FGM, Area Child Protection Committee policy should focus on a preventative strategy involving community education. FGM is not covered in the Scottish guidance.

There has also been some concern regarding the issue of male circumcision. While there have been suggestions that the medical benefits of circumcision may include a reduced risk of urinary tract infection, penile cancer, HIV and certain other sexually-transmitted diseases (Schoen *et al* 2000; Wiswell 1997), critics argue that the procedure is painful and traumatic to the child and unethical in that normal healthy body parts should not be surgically removed in a child or young person. There is some evidence that while the procedure is generally safe some serious complications have occurred, mostly related to bleeding and infection (Circumcision Resource Center website). The procedure has been banned in Switzerland.

Forced marriage

In August 1999 the Home Office Minister for community relations established a working group to investigate the problem of forced marriage in England and Wales and to make proposals for tackling it effectively. Forced marriage is '*a marriage conducted without the valid consent of both parties, where duress is a factor*'. Young people are often taken overseas on the pretext of a holiday and then expected to get married when they arrive. They may then be kept out of the country until they are 16. Government figures suggest that annually there are 1,000 forced marriages involving UK spouses and probably around 50 cases per year in Scotland. As a result of the report of the working group a joint action plan has been developed to tackle forced marriages. Measures include a project which has developed links between UK police forces and overseas forces, a community liaison unit which has been set up in the foreign office and leaflets and videos which have been produced and distributed to teach young people about their rights in relation to forced

marriage (the report of the working group on forced marriage (undated)). The issue is not covered in national guidance.

Children who need protecting from themselves

That children may need protecting from their own actions is a particularly important issue for staff involved in the care and treatment of individuals with learning disabilities who may need to protect the child from his or her own challenging behaviour which may result in self injury. It appears, however, that the problem may be far wider than this. Meltzer *et al* (2001) found that according to parents, approximately 1.3% of 5 to 10 year olds, and 2.1% of 11 to 15 year olds had ever tried to harm, hurt or kill themselves. The number of children and adolescents who had tried to harm, hurt or kill themselves was far higher among those with a mental disorder. Rates were higher for both ages in England than they were in Scotland. The issue is not covered in guidance but a consultation document which outlines a national framework for the prevention of suicide and deliberate self harm in Scotland has been published by the Scottish Executive (2001b).

Children who run away or are forced to leave home

One in nine Scottish children run away or are forced to leave home before the age of 16 due to difficulties in their lives. Emotional and physical abuse and feelings of neglect and rejection are major reasons why young people run away. Young people in substitute care are over represented amongst runaways in Scotland. More than one in eight of the young people who run away overnight report being physically or sexually assaulted whilst away from home (Wade and Rees (undated)). There is evidence that children who run away may be at serious risk of being abused through prostitution (Palmer 2001). The issue of children who run away or are forced to leave home is not covered in the national guidance.

Medical neglect

Medical neglect occurs when there is a delay in seeking care that aggravates a child's condition. Parental beliefs about health care based on their religion or culture may result in children not receiving necessary medical attention, sometimes leading to serious harm or death. It is argued that the lack of medical care for any reason that results in significant harm should be considered medical neglect. Many lapses in health care e.g. where a parent fails to take a child to a medical appointment may not be considered neglect which is usually a concern if the lack of care results in actual harm or the risk of significant harm. It has, therefore, been suggested that consideration be given to a new category of medical neglect which is currently covered by the category of 'physical neglect' in national guidance (Dubowitz 2000).

Animal abuse

There is as yet a limited amount of research about the parallels between child abuse and animal abuse and much of the research which does exist has been conducted in the United

States. The Scottish Society for the Prevention of Cruelty to Animals (2000) found, however, that the link between children and animal cruelty is significant in three ways:

- if an animal has been harmed in a household there is an increased chance that some other form of family violence (child abuse, partner abuse, elder abuse) is occurring;
- if a child is cruel to animals then this behaviour may be an indicator that the child him/herself has been abused; and
- if a child is cruel to animals then there is an increased chance that s(he) will go on to be cruel to children and/or adults.

The results of the research suggest that early intervention can change a child's pattern of behaviour so that s/he is diverted away from abuse. Animal abuse is not covered in the national guidance.

System abuse

'System abuse may be said to occur whenever the operation of legislation, officially sanctioned procedures or operational practices within systems or institutions is avoidably damaging to children and their families.' (National Commission of inquiry into the prevention of child abuse 1996). System abuse is not perpetrated by any single person or programme but by a child care system which is incapable of guaranteeing safety to all children and which may be experienced as abusive. Children who are already likely to have experienced abuse can be further abused by the investigative process and may even refer to the process as being worse than the abuse itself. System abuse became an issue in social work practice following incidents such as Orkney and Cleveland where concern centred around the manner in which children were taken away from their families and homes (McGee and Westcott 1996; National Commission of inquiry into the prevention of child abuse 1996).

Evidence of system abuse has come from research which has been carried out with young people. Children often find the investigative interview difficult. The 29 children interviewed in the NCH action for children study (1994) found having to talk about the abuse to strangers, having the camera there, having to express things in the right words and having to repeat their account difficult. A fifth of them rated their experience as slightly unpleasant and 7 per cent as very unpleasant. The majority of children who were interviewed in the Westcott and Davies (1996) study experienced the investigative interview as stressful. Some described feeling apprehensive, uncomfortable and upset and some reported crying or shaking. They did not like having a parent present against their wishes, felt there was a lack of warning that the interviewers were coming, and said interviews were too long and contained too many questions or age inappropriate words and sentence structures. Children in the Taylor *et al* (1993) study were scared when interviewed by police and also found the medical examination unpleasant. They did not like being examined by the police and particularly disliked being examined by a male. Twenty-one children had experienced a medical examination in the NCH Action for Children study and the majority found it unpleasant (62%).

While the children in the Waterhouse *et al* study (1998) thought they had not been adversely affected by involvement in the children's hearings system, Hallett *et al* (1998) found that those attending for the first time felt nervous and scared and were worried about what decision would be made. Some said they did not want to speak in front of strangers or a large group of people. If they spoke at all their contributions were limited to very short answers to questions. Children in the Taylor *et al* (1993) study also found the hearings system difficult.

Participation in the criminal justice system can be particularly distressing for children. A number of improvements have now been made to prepare child witnesses for a court appearance and all child witnesses in Scotland are sent a colourful booklet that explains who they will meet in court and what is expected of them and when they will be called to give evidence (Doyle 1996; Flin *et al* 1996; Plotnikoff and Wilson 2001) but evidence suggests these measures do not go far enough. In evaluating child witness support in Scotland Plotnikoff and Woolfson (2001) observed a number of problem areas including:

- procurators fiscal failing to turn up at scheduled appointments for pre-trial court visits;
- children waiting in public areas;
- children being asked to give their address aloud at the start of their testimony; and
- the defence lawyer moving to stand by the accused while the child gave evidence, making the child look towards the accused while answering questions.

Davies *et al* (1999) found that the police and Crown prosecutors believed that the experience of testifying at trial was traumatic for children and they felt prosecution was not always in the public interest. Where a case did go to trial the average time from the initial complaint to the police to the start of a trial was 14 months. Children often tell ChildLine counsellors that they are scared and anxious about impending court cases and do not know what to expect (Keep 1996). Confronting the accused is one of the greatest sources of anxiety for child witnesses and having to point out the accused in court can be extremely stressful.

Children in the Taylor *et al* (1993) study found the court system particularly difficult. They were terrified of seeing their abuser, and scared of speaking to judges and of having to talk in front of so many people. The research team on the Lord Advocate's working group on child witness support (1999) found that children often experienced multiple interviewing. The children who participated in the NCH Action for Children (1994) study who had attended court all rated the experience as 'very unpleasant' due to the number of people in court, seeing the abuser, the adversarial style of cross examination by the defence and the ineffectiveness of screens. Most children wanted to be vindicated, they wanted justice and hoped and expected the criminal justice system would deliver this by bringing about a prosecution. The children who had given evidence in cases where the abuser was acquitted were left with feelings of not being believed, and having endured a traumatic experience only to have the abuser vindicated. Roberts and Taylor (1999) and Keep (1996) also found that

many children were angry with the law. They were unhappy with the criminal justice system's response to abusers and felt that the people who had abused them should have received heavier sentences. Some callers to ChildLine revealed that the legal system did not protect them since the abuse continued or started up again after a court case (Keep 1996). Goodman *et al* (1992) studied a sample of 218 children to test the effects of criminal court testimony on child sexual abuse victims. After seven months, testifiers experienced greater behavioural disturbance than non testifiers, especially if they took the stand multiple times, were deprived of maternal support or lacked corroboration of their claims. The study concluded that testifying in criminal court was associated with negative effects for many but not all child sexual assault victims and that having to testify could at least temporarily interfere with children's adjustment.

(iv) Defining child protection

Since the inquiry into the events at Cleveland the emphasis of central guidance has shifted from a focus on the concept of child abuse to a focus on the concept of child protection (Parton 1997). There are two main approaches to defining child protection. In the first approach the focus is on the identification of children who are being harmed or are likely to be harmed and the action which may be taken to prevent further harm to such children. For social workers and the police the focus of child protection is to protect children and young people from abuse, they have a legal responsibility to investigate alleged instances of such abuse and to follow legal and professional guidelines. *Protecting Children A Shared Responsibility* (Scottish Office 1998) and *Working Together to Safeguard Children* (Department of Health *et al* 1999) conform to this approach to defining child protection. The guidance is intended to guide professionals in making decisions about placing children's names on child protection registers. The definitions of child abuse used in the guidance are generally accepted as the 'official' definitions of child abuse. Corby (1993) concludes that *'the only safe definition of child abuse is that it is a conclusion reached by a group of professionals on the examination of the circumstances of a child, normally (in Britain) at a case conference. Such a definition is usually symbolised by placing the child's name on a child protection register'*.

The second approach to defining child protection is much broader and is concerned with protecting all children through general preventative services including health, education, recreation, family support and treatment services (Jackson 1994; National commission of inquiry into the prevention of child abuse 1996; Mellor *et al* 1998). The National commission of inquiry into the prevention of child abuse (1996) supported a broad definition of child abuse: *'Child abuse consists of anything which individuals, institutions, or processes do or fail to do which directly or indirectly harms children or damages their prospects of safe and healthy development into adulthood'* although it stressed that within this broad definition professionals needed technical definitions which could be consistently interpreted to assist their formal procedures. The National Commission stated that definitions of 'significant harm' and

'children in need' overlapped to some extent and both came within the broad definition of abuse which they adopted.

Research findings have also suggested that the distinction between children in need of protection and children in need is not a useful one in that families are seldom referred to other services which they may need to prevent longer-term problems once an initial enquiry has shown that a child is not at risk of significant harm. For example, only one in 10 families referred for neglect are offered a service and three-fifths of services offered to neglected children come direct from social services when their needs might be better met by other agencies such as health and education. The Department of Health (1995) suggest that there would be a better relationship between services if a continuum was established between family support and child protection rather than there being two separate services, with the primary focus on meeting needs. Family support could be offered to everyone with other specialist services including child protection being provided where and when necessary. Such frameworks already form the basis of child protection in some other countries such as France and it is felt that issues of neglect could be accommodated more successfully within such a framework (Fitzgerald 1996; Little 1996; Atherton 1996; Cleaver *et al* 1998a).

Education agencies normally adopt a broader definition of child protection. In 1995, Scotland's then Education Minister stated that: *'Child protection is seen as encompassing a wider range of issues which together contribute to a pupil growing up and acquiring skills, knowledge and understanding not only in matters relating to abuse but also to many other facets of growing up. Such an approach is not at odds with the major focus of social work and police but simply complements their work and recognises the wider role teachers are expected to play by parents and society at large. Those additional expectations embrace aspects such as home, road, rail and water safety, anti-bullying and important personal health matters, not least HIV/AIDS education, substance abuse education and equal opportunities, including anti-racist and multi-cultural education.'* (cited in Mellor *et al* 1998). *'Circular no 10 Protection of children from abuse: the role of education authorities, schools and teachers'* (Scottish Education Department 1990) states that *'Child abuse covers physical injury resulting from assault or neglect, emotional damage and distress resulting from persistent ill treatment or neglect, and sexual abuse', but Promoting personal safety and child protection in the curriculum* (Mellor *et al* 1998) gives a broader definition of child protection. It deals with the wider educational view of child protection as part of personal safety and how to incorporate education on this into the school curriculum. Child protection and personal safety in schools means not only reacting to abuse but taking a proactive approach, helping children and young people to develop skills and values to resist or avoid abuse and potentially dangerous situations.

An HMIC (Her Majesty's Inspector of Constabulary) Thematic Inspection Report on child protection (1999) stated that *'Child protection' has no precise definition within the police service. It usually denotes the work of dedicated Child Protection Units (CPU) within police forces. It is also understood to refer to the police service's responsibilities described in*

'Working together' under the Children Act 1989, the guide for inter-agency co-operation for the protection of children from abuse ... But the term Child Protection can also describe other statutory, procedural and investigative duties that the police undertake to safeguard the welfare and interests of child victims, witnesses and offenders'.

It goes on to stress that 'The report gives child protection a wide definition. The term includes the work of the dedicated child protection units that police forces have created as part of their commitment, under the Children Act 1989, to protect children from abuse. But it also covers other policing commitments such as protecting the interests of child witnesses, exercising powers to do with "care" issues, missing children, protective operations against child sex abusers and curbing child prostitution and child pornography.'

The National Commission of inquiry into the prevention of child abuse (1996) stressed the importance of considering the way in which the public define child protection since whatever broad or technical definitions of abuse have legal force, the general public principally see child abuse in terms of gross physical or sexual assault. Taking account of parents' and children's perspectives of what constitutes abuse is particularly crucial. Parents tend to worry about external influences on their children's wellbeing, for example, racial abuse or horror movies on television or video, and about environmental hazards such as the danger from busy main roads or unsuitable play spaces. Children worry about interpersonal relationships, particularly if they are unhappy at school, but such sources of potential harm are seldom part of professionals' reckoning. Evidence from calls to ChildLine suggests that children and young people are particularly worried about bullying but bullying is not normally defined as an example of child abuse (Macleod 1996). Research has also shown that people experiencing abuse often do not rate their treatment as abusive because they have learned to regard it as normal or deserved (Department of Health 1995; Cawson *et al* 2000). The people who sent letters to the National Committee of Inquiry into the prevention of child abuse (1996) offered definitions of child abuse which included:

- the more conventional descriptive terms (sexual, physical, mental and neglect);
- a broad range of actions which might harm a child;
- considerable emphasis on emotional as well as physical harms and injuries; and
- abuse linked into a context of inter-personal relations defined by how the adult and the child made sense of what might be happening to them.

The level and extent of child abuse and neglect

A recent estimate from the WHO (1999) shows that 40 million children aged 14 and under around the world suffer from abuse and neglect and require health and social care services. It is difficult to estimate the true extent of child abuse and neglect in the UK. There are two main sources of statistics which give some indication of the level and extent of child abuse. The first, drawn largely from government departments, measures the incidence of child abuse as reported, recorded or registered by official agencies. The second source of statistics, deriving from a much broader research base measures the incidence and prevalence of abuse in a given sample of people. Such research studies ask people, often adults, whether they experienced abuse or neglect in their childhood. These studies result in higher numbers of people reporting that they have experienced abuse or neglect than are shown in official statistics because they tell us more about the hidden problem of abuse that does not come to the attention of those officially authorised to deal with it because the child never told anyone about the abuse or the abuse was never identified (Corby 1993; Cawson *et al* 2000; Cawson 2002). This chapter looks at official statistics and prevalence studies and attempts to assess the level and extent of child abuse and neglect.

(i) Official statistics

Crime figures

Criminal conviction statistics generally represent cases of severe abuse where the evidence was considered strong enough to secure a conviction. Since the victim's age is not recorded by the police for some sexual crimes such as rape and for most offences involving physical violence, the total number of such cases where the victim is under 16 is unknown. In Scotland in 2000 231 persons were proceeded against for a sexual crime against children² (compared to 271 in 1995). The charge was proven in just over three-quarters (76%) of these cases (compared to 83% in 1995). 205 people were proceeded against for non-sexual crimes against children³ (compared to 237 in 1995). In more than three-quarters (78%) of these cases the charge was proven (compared to 76% in 1995).⁴

Since 1988/1999 there has been a steady decline in the number of successful prosecutions for sexual offences against children in spite of an increase in the numbers notified to the police. There are a number of reasons why this might be:

² This count only includes cases where the crime itself indicates that the victim was a child, e.g. defilement of a child under 15, figures for other crimes committed against children are not included.

³ This count only includes cases where the crime itself indicates that the victim was a child e.g. drunk in charge of a child, figures for other crimes against children are not included.

⁴ Figures supplied by the Scottish Executive Justice Department Justice Statistics Unit.

- it is possible that the age of child victims is being recorded less often so the true figure is being masked more often than previously;
- cases may be being dealt with in ways other than prosecution;
- the criteria which determines when to prosecute may have changed so that perpetrators are not prosecuted unless they commit more serious offences than previously; and
- there may have been a real decrease in sexual offending against children (National Commission of inquiry into the prevention of child abuse 1996; Grubin 1998).

Scottish Children's Reporters Administration Statistics

Scotland's children's hearings system was established under the Social Work (Scotland) Act 1968 and came into operation in 1971. The system which remains largely intact integrates decision making for children who offend and those lacking care or protection within the same forum. Referrals are made to the children's reporter (Waterhouse *et al* 1998). In 1999/2000 almost 3 per cent of Scotland's under 16 year olds were referred to the children's reporter on care and protection grounds⁵ - 16,106 girls and 16,322 boys. Forty-four per cent of all referrals on care and protection grounds were for lack of parental care and a further 29% involved a child being a victim of a schedule 1 offence (an offence against a child). The number of care and protection referrals increased by 238% between 1989 and 1999/2000. In 1999/2000 the total number of care and protection referrals was higher than offence disposals for the first time (Scottish Children's Reporters Administration 2001).

⁵ Care and protection grounds comprise grounds a) to g) of the alleged grounds for referral:

- a) beyond control
- b) moral danger
- c) lack of parental care
- d) victim of schedule 1 offence
- e) same household as victim of schedule 1 offence
- f) same household as schedule 1 offender
- g) same household as incest victim
- h) non-attendance at school
- i) offence/crime
- j) misuse of alcohol/drug
- k) volatile substance misuse
- l) local authority care
- m) Section 54
- n) Section 48.

Child mortality statistics

It is not known how many recorded deaths of children are the result of intra-familial child maltreatment. The number of Part 8 case reviews⁶ in England and Wales suggests that about one to two children a week or 100 children a year die as a result of abuse or neglect by parents or relatives (Department of Health 1995; Fitzgerald 1996; Dent 1998; Fitzgerald 1998; Reder *et al* 1993). Part 8 reviews do not exist in Scotland and it is, therefore, difficult to assess how many child deaths may involve abuse or neglect. In 2000 there were 457 deaths of children under 16 in Scotland⁷ and 10 of these were homicide victims. In 1999 there were three homicide victims.⁸ Figures show that most child homicide victims are killed by a parent.

Reder *et al* (1993) and Reder and Duncan (1999) looked at 35 cases of child death in England and Wales where abuse was confirmed as the cause of death. They found:

- the majority died as a result of violent assault, but most experienced neglect as well;
- a natural parent was implicated in 71% of cases and solely responsible in 54%; a step parent was involved in 31% of cases; and
- rates for fatal abuse fell with age with very young children more at risk of homicide than any other age group (17% of the children were under a year old and 46% were under 2; the mean age was 2 years and 7 months).

Official figures are likely to underestimate the true scale of fatal child abuse since deaths from child abuse are notoriously difficult to quantify. Failure to suspect child abuse and neglect, uncertainty about definitions, and fear of recriminations may result in vague descriptions on death certificates leading to miscoding of child abuse and neglect deaths as deaths due to natural causes, accidents or injuries of undetermined intentionality. For example, it has been suggested that up to a third or more of children who die or are injured in house fires have been left alone, but that such deaths are often reported as accidental (Squires and Busuttill 1995). It has also been suggested that the label of Sudden Infant Death Syndrome (SIDS)⁹ could, in some cases, be masking death as a result of neglect or abuse (this will be discussed in more detail in the section on identifying child abuse) (Department of Health 1995; Fitzgerald 1996; Hobbs and Hobbs 1999; Dent 1998; Fitzgerald 1998).

⁶ Part 8 Case reviews are normally carried out by Area Child Protection Committees when a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death and where a child has sustained a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect and the case gives rise to concerns about the way in which local professionals and services work together to protect children. Part 8 case reviews do not take place in Scotland.

⁷ Figure supplied by General Register Office for Scotland.

⁸ Figures on number of child homicide victims supplied by Scottish Executive Justice Department Justice Statistics Unit.

⁹ In 1989 the National Institute of Child Health and Human Development promulgated the following definition of SIDS: 'The sudden death of an infant under 1 year of age which remains unexplained after the performance of a complete postmortem investigation, including an autopsy, an examination of the scene of death and review of the case history'. Pathologists establish the diagnosis of SIDS by exclusion when they are unable to identify other specific causes for a child's death.

Child protection statistics

At the end of March 2000 one in every 370 children were on child protection registers in England, one in every 313 children in Wales and Northern Ireland and one in every 500 children in Scotland. In Scotland the number of children on child protection registers relates to children under 16 whereas statistics for England, Wales and Northern Ireland relate to children under 18. (Scottish Executive 2001a; Department of Health 2000; National Assembly for Wales 2000; Department of Health 1995). The reason for the variation between countries is unclear. There is also wide variation in registration patterns between different local authority areas. In Scotland the rates of children on the child protection register varied from 0.3 per 1,000 in South Ayrshire to 4.1 per 1,000 in the City of Edinburgh as at 31 March 2000 (Scottish Executive 2001a). Child protection figures have been available in England and Wales from the Department of Health since 1988. The number of children on child protection registers doubled in the 1980s and has nearly doubled again since then (Department of Health 2001a). The child protection statistics for Scotland only go back to 1992 and clear patterns can not yet be established although the number of children on child protection registers in 2000 was considerably less than in 1992.¹⁰

Official incidence figures for Scotland show us that in the year ending 31 March 2000:

- there were 7,201 child protection referrals (7.2 per 1,000 population aged 0 to 15);
- 2,593 of the referrals made in the year were subject to a case conference and 1,890 (73%) were registered; and
- there were 2,050 children on the child protection register, 13% less than a year earlier (Scottish Executive 2001a).

In England there were 5% less children on Child Protection Registers as at 31 March 2000 than there were a year earlier (Department of Health 2000). In Wales there were 12% less children than the previous year (National Assembly for Wales 2001). Fourteen per cent of children registered in England during 1999/00 had previously been registered (Department of Health 2000). The figures on reregistrations are not available for Scotland or Wales.

Official figures for Scotland show that in the year ending 31 March 2000:

- 38% of registrations on the child protection register were for physical abuse
- 15% were for sexual abuse
- 12% were for emotional abuse
- 34% were for physical neglect
- 1% were for other (Scottish Executive 2001a).

¹⁰ Information supplied by Scottish Executive Children's Statistics.

In England, Scotland and Wales physical abuse was the most common reason for registration in 1994/1995, followed by neglect and sexual abuse, with emotional abuse the smallest category in each country. In 1999/2000 physical abuse was still the most common reason for registration in Scotland but in England and Wales there were substantially more registrations for neglect than for physical abuse. While a third (34%) of registrations in Scotland were for neglect, 44% of registrations were for neglect in England and 48% in Wales (Scottish Executive 2001a; Department of Health 2000; National Assembly for Wales 2001; Department of Health 1995; National Commission of inquiry into the prevention of child abuse 1996).

There were 2000 children on child protection registers in Scotland at 31 March 2001, over 2% less than a year earlier which represents a rate of 2 children per 1,000 population aged 0-15 (Scottish Executive 2002). The figures for England show an 11% decrease in the number of children on the child protection register (Department of Health 2001b). 38.6% of registrations in Scotland during 2000/2001 related to children considered to be at risk of neglect, a small increase on 1999/2000 figures (Scottish Executive 2002). There was a further 2% increase in the number of children registered for neglect in England in 2001 (Department of Health 2001b).

Figures on child protection registers record the child protection process not the number of children who are abused and are, therefore, likely to underestimate the extent of abuse. The child protection register is not a register of children who have been abused but of children for whom there are currently unresolved child protection issues and for whom there is an inter-agency protection plan. The criteria for registration is based on perceived risk rather than necessary past abuse. Less than a quarter of cases judged to involve possible abuse or neglect reach an initial child protection case conference and only one in seven is subsequently registered (National Commission of Inquiry into the prevention of child abuse 1996). Numbers of children on child protection registers are not a correct estimate of the numbers of children who have been abused for the following reasons:

- registers mainly record cases of abuse within the family where urgent action is needed and generally exclude abuse by people outside the family when the family can protect the child;
- the fact that a child is not placed on the register does not mean no abuse has occurred, it means only that the child is no longer considered to be at risk;
- registers only include those children who come to the attention of social workers, they do not include those children who may have been abused or neglected but have not been referred to social workers;
- the placement of a child on the register is dependent on the definitions and interpretations of professionals and agencies and on thresholds determined by local circumstances, practices and resources which may account for different rates in different areas;

- there are many sources of bias, including a greater likelihood of children considered to be at risk in working-class families than in middle-class families and a tendency for families already known to agencies, because they have social problems, to attract more attention than others;
- annual statistical returns exclude cases which have been registered and deregistered in the year prior to the counting date;
- the children who are registered represent only a minority of those referred to the authorities and some referrals that never come to be registered will be cases of actual abuse or neglect where the necessary evidence has not been forthcoming;
- a group of children probably become registered inappropriately in that they may not have experienced or been at risk of experiencing significant harm; and
- there is evidence that the much greater concern for risk to very young children, reflected in registers and other official data sources seriously underestimates the levels of abuse of adolescents (National Commission of inquiry into the prevention of child abuse 1996; Brougham 1997; Platt 1996).

Government child protection figures do not provide information on disability. Cooke and Standen (2002) found that while half of Area Child Protection committees in the UK claimed to identify the disability of an abused child only 10% could give an actual figure. Research has demonstrated, however, that among all ages children with disabilities are at greater risk of all types of abuse and that the proportion of abused children with disabilities is at least twice the rate found for children in general (Russell 1996; National Commission of inquiry into the prevention of child abuse 1996; Cooke 1999). Sullivan *et al* (1987) (quoted in Westcott and Cross 1996) found that half of 322 students in a residential school for hearing impairment reported some form of sexual victimisation, 16% reported physical abuse and 7% reported both physical and sexual abuse. Kelly's (1993) review of the evidence found that prevalence estimates for the abuse of children with disabilities ranged from 25 to 83%.

Data regarding race and abuse have not been routinely collected by government departments and the amount of information on the ethnic background of abusers and those who have been abused is, therefore, negligible in the UK. It has been suggested that black children may be over represented in child abuse statistics, partly because their families are more open to surveillance as a result of figuring highly among indices of deprivation and partly because cultural misunderstanding and the operation of both institutional and direct racism may have increased the chances of suspicions of abuse in black families being confirmed (Corby 2000; Jackson 1996). It has also been suggested, however, that cultural ignorance and stereotyping may lead to less intervention rather than more as professionals are scared of being accused of being racist and therefore operating from a position of cultural relativism (Corby 2000; Jackson 1996; Channer and Parton 1990; Phillips 1995).

Child protection statistics were broken down by ethnic origin for 2001 in England. Of the 26,800 children on child protection registers as at 31 March 2001:

- 84% were of a white background
- 5% of a mixed background
- 4% black or black British
- 3% Asian or Asian British
- 3% were of other ethnic origins
- 1% were unborn (Department of Health 2001a).

Child protection statistics which are broken down by ethnic origin are not available in Scotland.

(ii) Incidence and prevalence studies

The level and extent of child abuse, which has been estimated by prevalence studies, varies according to the definition of abuse which has been used. The National Commission of inquiry into the prevention of child abuse (1996) stated that on the basis of their broad definition:

'Child abuse consists of anything which individuals, institutions, or processes do or fail to do which directly or indirectly harms children or damages their prospects of safe and healthy development into adulthood.'

On the basis of this definition they estimated that at least one million children and young people were harmed each year.

Physical abuse

Studies which have questioned parents and adults indicate that physical child abuse is far more prevalent in the UK than official rates would suggest i.e. not all physically maltreated children come to the attention of child protection agencies (Cleaver *et al* 1998; Corby 1993; Department of Health 1995; Sidebotham 2000).

Sidebotham (2000) followed a cohort of children born to mothers resident in Avon while pregnant. The mothers were asked whether or not they or their partner had been physically cruel to their children. The responses at all ages suggested a much higher rate of physical cruelty to children than is being recognised by the child protection systems although the nature of the cruelty reported by parents was not defined and may have included some behaviours that would not be considered abusive.

In 2000 the NSPCC (Cawson *et al* 2000) carried out a large scale-study of prevalence. They found that:

- almost three-quarters (72%) of their sample of 2,869 18 to 24 year olds had experienced physical discipline (for example, hitting or slapping) in some form;
- a fifth (21%) of respondents had experienced some degree of physical abuse by parents or carers and 7% of these had been seriously physically abused;
- more men than women had experienced serious physical abuse;
- respondents from skilled/unskilled social grades D and E were almost 50% more likely to have experienced physical abuse than those from professional AB grades; and
- 17% of respondents who had experienced any level of physical discipline or violence felt their treatment was too strict and harsh and 7% now considered their experience to be child abuse.

Sexual abuse

Recent research suggests that prevalence of sexual abuse is much higher than previously thought (Bolen *et al* 2000). Research has also shown that behaviour which might sometimes be thought of as sexual abuse occurs regularly in British families. For example, research has shown that substantial proportions of the child population at some point in their childhood will bathe with parents, masturbate, draw genitalia and touch their mother's breasts and suggests that such behaviours are not in themselves sufficient to suggest abuse. More important is the context in which the behaviour occurs, where it takes place, who else is present, what parents think about it and the age of the child (Corby 1993; Cleaver *et al* 1998; Department of Health 1995; Grocke *et al* 1995).

The number of people who report having experienced some kind of sexual abuse varies considerably between studies. A major reason for such variation is that studies have used quite different definitions of sexual abuse. Even the lower rates of sexual abuse found in studies indicate, however, that child sexual abuse is far from an uncommon experience for girls or boys (Parton 1997; Browne and Lynch 1995; Watkins and Bentovim 1992). Not all the variations in prevalence rates can be ascribed to definitions alone. A number of other aspects of research design such as the type of sample, the number and nature of questions asked to elicit details of sexual abuse, the gender of the interviewer and the training and preparation of interviewers have also been shown to influence the estimates of prevalence identified. When trying to establish a definition of child sexual abuse several points of controversy arise:

- disagreement as to whether non-contact offences such as exhibitionism should be considered as abusive;

- poor agreement on the essential elements involved in abuse such as the age limits for consent to sexual interaction, the acceptable and unacceptable age discrepancies between sexual interactants, the classification of the act in terms of seriousness, the degree of coerciveness and whether it was intra- or extra-familial abuse; and
- arguments about whether children can be perpetrators of child abuse. How young can a child be and still be regarded as a perpetrator? Mutual sexual exploratory play between children of similar ages is not considered abuse but where coercion is involved the situation is perceived differently. There is now an increased recognition that what was often viewed as inappropriate 'sex play' between siblings and peers was in fact abuse and exploitation. Sibling abuse is thought to be a particularly common form of incest (Parton 1997; Browne and Lynch 1995; Hobbs and Hobbs 1999; Gil and Cavanagh Johnson 1993; Watkins and Bentovim 1992; Finkelhor *et al* 1990).

Research shows consensus on some general points concerning sexual abuse:

- the majority of studies find that more girls than boys report having been a victim of sexual abuse with a ratio of between one-and-a-half to three times greater for girls; although sexual abuse is likely to be generally under reported it is likely that under reporting is particularly high for males due to their fears of disbelief and of being labelled homosexual;
- children are more likely to be sexually abused by a male;
- approximately one-quarter to one-third of sexual abusers are themselves juveniles; and
- prevalence studies show that sexual abuse is rarely reported to the authorities (Cawson *et al* 2000; Watkins and Bentovim 1992).

In the recent NSPCC study (Cawson *et al* 2000):

- 1% of the sample of 2869 had been sexually abused by parents/carers, and almost all of this abuse involved physical contact;
- 3% had been abused by other relatives, (2% contact and 1% non-contact);
- abuse by other known people was most common and experienced by 11% of the sample (8% involving physical contact and 3% non-contact);
- abuse by strangers or someone just met had affected 4% of the sample (2% contact and 2% non-contact);
- only a quarter of respondents with unwanted sexual experience or with sexual experience with a person five or more years older, had told anyone about the experience at the time and when they had, their confidant was usually a friend, less often a family member and very rarely the police or other professionals;

- the person responsible for the sexual abuse was almost always male, very few respondents of either gender said that the person involving them in sex acts was female; and
- 6% of the total sample assessed themselves as having been sexually abused.

Neglect

Very few studies have considered the prevalence of neglect. There have been one or two studies in the US but the NSPCC prevalence study (Cawson *et al* 2000) was the first to consider the extent of neglect in the UK. It found that:

- 18% of young adults sampled indicated that they had experienced some absence of care in their childhood of which 6% indicated this was a serious absence of care;
- a slightly higher proportion of young men (19%) than young women (16%) experienced absence of care;
- a socio-economic trend was found with 11% in the higher social grades AB, 15% CI, 18% C2s and 25% in semi-skilled/unskilled grades DE experiencing absence of care;
- 4% of the sample agreed they had not been well cared for and 2% considered their treatment amounted to neglect; and
- a fifth of the sample were assessed as experiencing less than adequate supervision, comprising 5% who experienced serious absence of supervision; a further 17% received a level of supervision which could be seen in some circumstances as problematic, such as being left alone at home in the evening when they were aged 10 or 11 years or being sometimes left in charge of younger siblings when parents were out when they were themselves aged under 12.

Emotional abuse

Emotional abuse is the least studied of all forms of child maltreatment and an area in which reliable prevalence data are almost non-existent. The Audit Commission in England and Wales found emotional abuse to be a major form of abuse (Audit Commission 1994). The NSPCC study (Cawson *et al* 2000) constructed a measure of emotional maltreatment and found that 6% of respondents had high scores indicating emotional abuse. When respondents were asked whether they thought the way they had been treated was child abuse, 3% said they had been abused and 2% were unsure. Parental responses in the Sidebotham study (2000) suggested that emotional cruelty of children was far more widespread than suggested by official figures from child protection agencies although the nature of emotional cruelty reported by parents was not defined and may have included some behaviours that would not normally be considered abusive.

Causes of child abuse and neglect

This chapter looks at the various theories which have been put forward to explain the incidence of child abuse and neglect and considers the characteristics of abusers and victims of child abuse. Corby (2000) has been used extensively throughout the chapter because it is a useful source in terms of providing an overview of the various theories.

(i) Psychological theories

Psychological theories focus on the instinctive and psychological qualities of those who abuse. It is abnormalities within the individual abuser that are responsible for abuse, for example, abusive parents may themselves have been abused in childhood (Corby 2000).

Attachment theory

Attachment theory derives from the work of Bowlby (1951) who carried out studies into the nature and effects of maternal deprivation on young children. He theorised that any significant separation of a child from the mother in the first five years of life could lead to a variety of psychological and social difficulties in later life since proper bonding and attachment to the mother was crucial if a child was to benefit from physical protection and psychological security. Until the mid 1980s attachment theory was not directly applied to the problem of child abuse but poor attachment experiences are now seen to be a cause and a consequence of child abuse (Crittenden and Ainsworth 1989). The theory has been criticised because the focus is almost exclusively on the mother-child relationship and insufficient account is taken of the total dynamics of the family. Neither does the theory adequately explain sexual abuse (Corby 1993; 2000).

Psychodynamic theory

Psychodynamic theory claims that abuse and neglect are associated with maternal deprivation. The primary carer, who has often suffered abuse herself, displays a lack of empathy, sensitive awareness and response to her child (Steele and Pollock, 1974; Steele 1987). There is significant overlap between psychodynamic theory and attachment theory. Although the primary caretaker is not always the mother, the main focus is again on the mother-child relationship, and the mother's psychological make up is key. Psychological treatment focusing on improving the parent's ability to relate to other people is seen to be the solution to the problem. The theory has been criticised because of its neglect of social and environmental factors and its inadequacy in explaining sexual abuse (Corby, 1993; 2000; Finkelhor, 1986).

Learning theory

Learning theory stipulates that behaviour is shaped or learned by the interaction of an individual with his or her environment. Child abuse is, therefore, the result of having learned

or experienced dysfunctional child care practices, or not having learned functional child care practices. For example, violent behaviour is learnt from observing aggressive role models, so that adults who have themselves experienced punitive treatment may rely on such methods to discipline their own children. Whilst the theory draws attention to the importance of childhood learning for adult development it has a number of flaws: it fails to take account of the gendered nature of most abuse, particularly sexual abuse and cannot explain why although both boys and girls are equally likely to have been abused, men are disproportionately represented among the abuser population; it can detract from the responsibility of the adult abuser; it does not explain why some people become perpetrators who have not themselves suffered abuse (Corby 1993; 2000; Brougham 1997; Browne, 1995; Deacon and Gocke 1999).

Cognitive approaches

Cognitive approaches merge to a large extent with modern learning theory approaches. The essential feature of cognitive theory is that the way people perceive, order, construct and think about the world is an important key to their behaviour. Lack of parenting skills, to cope with particular stages of their child's development, leads to patterns of child maltreatment. Cognitive theorists point to the value of finding out how parents who have abused children perceive that child's behaviour and intervention must be focused on helping them to perceive their children differently and using techniques to improve self control and self esteem (Corby 1993; 2000; Buchanan 1996).

(ii) Social psychological theories

Social psychological approaches fall between focus on the individual and focus on broader social factors, they focus on the dynamics of the interaction between abuser, child and immediate environment (Corby 2000).

Individual interactionist perspectives

Individual interactionist perspectives stress that behaviour is determined by interactions between people. Interactionists place greater attention on the dynamics of current relationships than on parental background or characteristics and take the child's contribution to situations of abuse much more into account and also that of the spouse or partner. They suggest that a climate of abuse can result from parents lacking skills to cope with difficult behaviour and from certain children continually exposing that inadequacy. A weakness of the theory as of many others is that individuals are seen in isolation from wider social influences and stresses (Corby 1993; 2000; Gardner 1993; Doyle 1996; Goddard 1996; Deacon and Gocke 1999).

Family dysfunction theory

Family dysfunction theory maintains that family dynamics contribute to abuse and that abuse occurs because 'normal' family boundaries, hierarchies and relationships have broken down. Family dysfunction theorists maintain that children are sometimes subject to violence by a parent as a means of 'getting at' the other parent or that a child may be a 'scapegoat', the bad one in the family and the reason for all the family's ills. With regard to physical child abuse family dysfunction theory has not had widespread influence as an explanatory theory but family therapy techniques as a mode of intervention have attracted more attention. Family therapy thinking has had more impact in explaining child sexual abuse. It suggests that child sexual abuse serves the function of keeping together families that would otherwise collapse, a classic scenario is the abuse of a teenage girl by her father who is considered to be seeking emotional and sexual gratification because communication and sexual relations with his wife have broken down (Kempe and Kempe 1978). A problem with family dysfunction theory as with many of the other theories is that it cannot account for abuse outside the family. It has also been criticised by feminist theorists for its lack of attention to power relations within the family (Hall and Lloyd 1992).

Social ecological approaches

Social ecological approaches hypothesise that where environmental conditions are unfavourable to families the incidence of abuse is likely to be higher. Stress as a result of living in environments that are not conducive to psychological health and development is seen to be a major contributory factor to child maltreatment which points to solutions other than focus on the individual, most notably community-based initiatives, to break down isolation and create a sense of belonging and shared problems (Garbarino and Gilliam, 1980). An ecological framework helps contribute to an understanding of why it is that families who are apparently similar in many key aspects can differ in their responses to stress and in their general ability to provide adequate parenting. There are difficulties with proving the validity of this theory, however, not least because of the fact that poorer communities are more likely to come under the close surveillance of public authorities and higher official rates of abuse could be a reflection of this (Corby 1993; 2000; Gardner 1993; Doyle 1996; Goddard 1996; Macdonald 2001; Deacon and Gocke 1999).

(iii) Sociological perspectives

Sociological perspectives emphasise social and political conditions as the most important reason for the existence of child abuse. It is forces in society which are responsible for child abuse, not individual factors. Sociological perspectives do not provide clear indicators for practice in that they look broadly at the conditions that create the climate for child abuse rather than at how this works out in individual cases. They have, therefore, not had a major influence on child protection thinking in Britain except in relation to sexual abuse and gender issues (Corby 2000).

The social cultural perspective

The social cultural perspective suggests there are certain factors within society which may contribute to the occurrence of abuse, for example, a society that endorses the attitude 'spare the rod and spoil the child' sets the scene for a variety of unwanted forms of violence of which physical child abuse is one. From this perspective child abuse is seen as similar to socially approved forms of violence rather than as a separate pathological phenomenon and the implications are that there is a need for change at a broad societal level to the way in which children are treated, in particular there is a need to encourage non-violent means of ensuring pro-social behaviour. The same sort of analysis can be applied to sexual abuse, i.e. because sexual exploitation of women is tolerated in advertising, prostitution, etc., and because children are sexualised in the media, a climate is set whereby sexual abuse results (Gil 1970). The major weakness of the perspective is that it does not explain why some people, living within a culture, abuse while most do not (Corby 1993; 2000).

The social structural perspective

The social structural perspective holds that child abuse is class related. It is the state not the abuser that is responsible for abuse because it sanctions inequality, and low standards of health, housing, education and leisure for the children of the poor (Parton 1985). The approach does justice to the fact that physical child abuse has a close association with deprivation but does not address child sexual abuse or emotional abuse which is generally considered not to be linked to class and poverty. Neither does it adequately explain why most poor people do not abuse their children (Corby 1993; 2000).

The feminist perspective

The feminist perspective has had a huge impact on practice. This perspective sees abuse as an extreme example of institutionalised male power over women and children, i.e. men sexually abuse children as a means of exerting power and control. Feminist commentators have provided a challenge to assumptions which equate abuse with maternal deficiencies, confuse the term 'parent' with mother and lead professionals to ignore male caregivers. With regard to physical abuse, women have been as implicated as men, but feminists argue that given the fact that women are mainly responsible for the care of children, they actually inflict less physical abuse in proportion to the amount of time children spend in their presence. Children spend far less time with their fathers and so they in fact pose a greater risk. Similarly mothers have been implicated in cases of neglect and emotional abuse to a greater extent than fathers because they are expected to be responsible for the care of their children. The role of men in neglect and emotional abuse has been ignored. The fact that a father may spend very little time with his children is not usually defined as neglect (Hall and Lloyd, 1992; Itzin, 2000; Farmer and Owen 2000; Corby 1993; 2000; Doyle 1996; Goddard 1996; Macdonald 2001; Deacon and Gocke 1999; MacLeod and Saraga, 1988; Daniel 1999; O'Hagan 1997; Tanner and Turney 2000).

The children's rights perspective

The children's rights perspective suggests that if children had the same rights in society as adults, rather than being the property of their parents, then they would be less likely to be the object of physical abuse and neglect. For example, we do not consider it proper to smack adults for misbehaving so neither should we smack children (Corby 1993; 2000; Doyle 1996; Goddard 1996). The United Nations Convention on the Rights of the Child recognises that the family has primary responsibility for the care and protection of children but states that there is also a need for legal protection (Buchanan 1996).

(iv) Integrated theories of child abuse

Virtually all researchers point to the dangers of adopting single cause explanations of child abuse. The term 'child abuse' covers a range of behaviours and problems so a search for a single or even a cluster of causes is likely to be in vain. Social work has been criticised for focusing too readily on problems and 'pathology' within individuals and families and not sufficiently taking into consideration the wider context within which individuals and families exist (Parton 1997; Goddard 1996; Corby 1993; Gardner 1993).

Finkelhor (1986) criticised single-factor theories for their inadequacies in explaining the diversity and complexity of child sexual abuse. He proposed an alternative integrated model which attempted to explain how it was that some adults became sexually interested in children and described the process whereby such offences were committed. The model suggests that four preconditions need to be met before abuse occurs:

- the potential offender needs to have some motivation to abuse the child sexually, e.g. there must be a degree of sexual arousal to a child;
- the potential offender has to overcome internal inhibitions against acting on that motivation, inhibitions which are built around notions of conscience, morality and fear of the law;
- the potential offender has to overcome external impediments such as protective adults so that unimpeded access to a child can be achieved, for example, through baby sitting or organising children's activities; and
- the potential offender has to undermine or overcome the child's possible resistance through sophisticated seduction techniques.

Finkelhor's model has been criticised, however, because it seems to say more about how sexual abuse occurs than why it actually happens (Goddard 1996; Macdonald 2001; Macdonald and Winkley 1999; Deacon and Gocke 1999).

Social interactional models emphasise the importance of viewing child maltreatment in the context of the family, community and wider society rather than emphasising only individual characteristics and stresses. There has been a move away from explaining child abuse as a symptom of an individual disorder or psychological disturbance towards seeing it as an

extreme disturbance of childrearing which itself is part of a wider context of other serious problems such as poverty and anti-social behaviour. Interactive models generally build on a probabilistic risk-assessment process assuming that child abuse occurs when multiple risk factors outweigh protective, compensatory factors some of which may be enduring and others transient. Risk does not arise from a single causal factor but a combination of multiple interacting elements located at the individual, family, community and societal levels. The complexity of such an approach cannot be reduced to a checklist of factors which can be used in any clear or categorical sense to identify and predict abuse. The chances of these situational stressors resulting in child abuse and other forms of family violence are mediated by and depend on the interactive relationships within the family and other compensatory factors such as social support. Multi-focus theories of child abuse and neglect suggest that intervention should be focused at every level - at the individual, family, community and society level (Parton 1997; Browne 1995; Macdonald 2001).

Macdonald (2001) states that:

- a range of factors can play a causal role in child physical abuse;
- some factors are 'proximal' i.e. operate in the 'here and now' or are of recent origin, whilst others are 'distal' and/or have a more cumulative effect, e.g. early childhood separation;
- some factors may exert a protective influence and act as 'buffers' against the deleterious effects or adverse events, e.g. a supportive adult partnership or social network; and
- the dynamic interplay of all factors means that the significance of one set of variables depends, to some extent, on the presence or absence of others.

The people who sent letters to the National Commission of Inquiry into the prevention of child abuse (1996) identified a range of causes of child abuse. The single largest cause identified by respondents involved social/cultural factors, particularly the taboo, stigma and ignorance surrounding child abuse. Other factors mentioned were negative changes in society such as poverty, people not caring, and social pressures and society's attitudes to children. Other respondents felt that abuse was caused by family factors with inadequate parenting, problems in marriage or other relationships and cycles of abuse suggested as causes. A smaller number of respondents felt that sick or evil adults were responsible for causing child abuse.

(v) The characteristics of abusers

It has been suggested that perpetrators of child abuse may have certain characteristics which predispose them to abuse:

History of abuse

One of the most consistent findings in the literature and research is that many parents who abuse their children were themselves maltreated as children. Gibbons *et al* (Department of Health 1995) found, for example, that one in seven parents under suspicion were known to have been abused as children. In Meadows (1990) study of likely cases of Munchausen's syndrome by proxy, at least 70% of the mothers had had unhappy childhoods and could be considered to have suffered emotional abuse and at least a quarter had suffered physical or sexual abuse as children.

Buchanan (1996) reviewed a range of studies and found that rates of inter-generational child abuse varied from 1% to 100% but most commentators now accept that between 30% and 40% of parents who abuse will go on to abuse their children. This is considerably higher than the 2% to 3% seen in the general population. Some studies have found that high proportions of young sexual abusers have been sexually abused themselves but the percentages of young sexual abusers reporting abuse in childhood varies from 30%-80% (Kelly *et al* 2000). Watkins and Bentovim (1992) state that current evidence supports the conclusion that the sexual abuse of boys in childhood is an important contributory but not a necessary factor in the development of a perpetrator since the development of a perpetrator may not include an experience of prior personal sexual abuse. There is less evidence for girls but it appears that abuse may be a necessary perpetrator developmental factor.

Boulton and Hindle (2000) found that past events were linked to present emotional abuse. The theme of re-enactment was key in the cases they studied with the parent either threatening the child in a similar way to how they had been treated or attributing in the child characteristics belonging to their own parents.

As an explanation for abuse, generational links are contentious because:

- most physical abuse studies focus almost entirely on the transmission of violence and abuse through mothers, there is very little research into the characteristics of male adults who physically abuse although men are responsible for at least half of all physical abuse cases;
- although women experience higher levels of sexual abuse than men, sexual abuse by women is rare; and
- the majority of abused children do not grow up to be abusing adults and knowledge of the circumstances in which abused parents do not abuse their own children is of as much importance to child protection workers as knowledge of the circumstances in which they do. Various protective factors in childhood such as the availability of other non-abusing carers and early secure attachment have been suggested as key (Gardner 1993; Corby 2000; Brougham 1997).

Social class/economic disadvantage

Some studies have demonstrated that there is a strong correlation between economic disadvantage and harm to children (Department of Health 1995; Baldwin and Caruthers 1998; Corby 2000; Gardner 1993). For example, Gibbons *et al* (1995) found that 57% of families involved in the child protection system lacked a wage earner and over half (54%) were dependent on Income Support. While there may be more cases of physical abuse or neglect amongst lower social classes, however, the same does not appear to be true of sexual and emotional abuse. Studies have been consistent in failing to find differences in rates of sexual abuse according to social class (Parton 1997). It has also been suggested that all forms of child abuse are a cross class phenomenon and that the higher proportions of lower social class families being suspected of physical abuse and neglect may only reflect the fact that such families are more susceptible to state surveillance. The link between economic disadvantage and child abuse is also contentious because not every parent who is disadvantaged abuses their children (Corby 2000).

Gender

Official child protection figures demonstrate that natural mothers play a negligible part in sexual abuse, are much more frequently implicated as abusers in neglect and emotional abuse cases and are slightly more frequently implicated as abusers than fathers in cases of physical abuse. The figures need further analysis, however: there is some support for the view that fathers, especially stepfathers, are more likely to abuse children seriously, for example, many child death inquiries are known to have been the result of father or male carer abuse (Corby 2000); figures for the perpetration of neglect and physical abuse may highlight the fact that mothers spend more time with their children than fathers and are not more likely to physically abuse or neglect them (this issue has already been discussed in the section on feminist perspectives on neglect) (Turney 2000; Tanner and Turney 2000).

Evidence about the gender of child sexual abuse perpetrators is more clearcut. Research has shown that the vast majority of sexual abusers of children are men (Eldridge 2000; Wyre 2000). Recorded crime rates suggest that sex offending by women is rare: between 50 and 100 women each year are convicted of sexual offences against children in England and Wales, in comparison with more than 5,000 men. Prevalence studies have produced a wide range of figures. Studies of female offenders suggest that:

- they are more likely to have a history of abuse themselves than male offenders;
- they are more likely to abuse boys than girls;
- they are sometimes coerced by men to offend and may co-offend with other women or men; and
- mental illness, or at least, psychological distress is commonly found in women abusers.

It is likely that levels of sexual abuse by females have been under reported because abuse by women, particularly mothers, has been a difficult issue for the community to contemplate. It is also possible that female-male abuse has sometimes been seen as a normative sexualisation experience or as of no consequence since males have retrospectively rated it as having no effect. Research has as yet failed to come up with a satisfactory explanation of why women are less likely to be the perpetrators of sexual abuse than men (Adshead *et al* 1994; Corby 2000; Watkins and Bentovim 1992).

Age

Physical abuse and neglect of children has been traditionally associated with young and immature parents but Corby (2000) concludes that the evidence is not strong enough to have much predictive value, even when it is considered in association with other factors indicative of risk. The age of the abuser is not generally considered to be an important issue in sexual abuse, although the abuse of younger children by adolescents has been the focus of much attention by researchers recently. It has been suggested that between a quarter and a third of all alleged sexual abuse involves young (mainly adolescent) perpetrators, and some studies have found that as many as half of all convicted child sexual abusers started to commit sexual offences in adolescence or earlier. Research has also shown that the risk of sexually abused boys abusing other children may be associated with factors in early childhood other than sexual abuse (Skuse *et al* 2000).

Family structure

Most official reports and surveys concur in their finding that children in lone parent families are more at risk of all forms of abuse and neglect than their counterparts in two parent families including sexual abuse which is perhaps surprising since children living in lone parent families might be expected to be safer from abuse by males (Department of Health 1995; Corby 2000). Finkelhor (1986) suggested that children in lone female headed households might be at greater risk of sexual abuse because they could be exposed to a greater number of male adult figures than those in two parent households. Hamilton and Browne (1999) found that children living in lone parent households were at greater risk of experiencing extra-familial abuse. It may be that there is less oversight or the lone parent is more reliant on extra-familial help and is, therefore, at risk of being targeted by potential abusers.

The statistics tell us nothing, however, about the reasons why levels of all forms of abuse are higher in lone parent families. Economic disadvantage is likely to be an important factor and issues surrounding the control and supervision of children and social isolation may also play a part. Moreover, more recent research has suggested that children in lone parent families are no more at risk of abuse than children in two parent families. Gibbons *et al* (1995) found, for example, that just over a third (36%) of the children in their sample dealt with under child protection procedures lived in a lone parent family and Egan-Sage and Carpenter (1999) found that less than a third of referred and registered children lived with a lone mother.

In Hamilton and Brown's (1999) study of referrals to police child protection units, children with step-parents were more at risk of experiencing an incident of maltreatment than children living with both biological parents. The child's stepfather or cohabitant of the mother was the perpetrator of the abuse in 11% of child protection referrals but if the rate of maltreatment by a stepfather was calculated as a percentage of stepfathers living in the child's home (18%), the rate of maltreatment by the stepfather, as a percentage of all cases, rose dramatically to 53%. While reconstituted families are over represented in abuse statistics there has been very little research into why this is the case or into the process of abuse in such families. There has been research into the issue of whether blood-tie parents are more likely to abuse their children sexually than non-blood-tie relatives, however, and findings seem to suggest that children are more at risk of being sexually abused by a step-parent or parent substitute than by a natural parent (Corby 2000).

Health

Research has documented high rates of psychiatric disorder in parents of maltreated children, for example, mental illness within the family featured prominently in 13% of child protection cases in the Gibbons *et al* (1995) study. Research has also demonstrated a significant association between fatal child abuse and mental health problems in caretakers. A study of Part 8 Reviews of child deaths and serious abuse in 1996 found that mental illness (maternal and paternal) was evident in 32 of the 100 cases. There has been no research linking mental illness with sexual abuse. Findings related to mental illness need to be treated with caution since mentally ill parents are over represented among poor, unemployed, socially and economically disadvantaged families and disadvantaged families are those most exposed to the surveillance of the child protection, mental health and other welfare agencies (National Children's Bureau Highlight (undated)).

There has only been a small amount of research into parents with learning difficulties who abuse their children but findings suggest there is evidence of a correlation between learning disability and officially reported child abuse. It is possible, however, that the difference is a result of people with learning difficulties having their child care practices exposed to greater scrutiny than those of other parents (Corby 2000; Cleaver *et al* 1998; Department of Health 1995; Lewis and Creighton 1999; Reder and Duncan 1999).

Alcohol and drug misuse

Alcohol has been linked with child abuse, particularly with child neglect, and there is growing concern about the association between drug misuse and child abuse. Studies in the US point to as many as half of all families being known to the public welfare system being affected by alcohol or drug misuse. Data available in Britain are patchy although information from Glasgow City's child protection register indicates that in 52% of cases on the register, alcohol and/or problem drug use was the underlying factor leading to registration (Scottish Executive 2001). There has been little empirical research into the connection between sexual

abuse and alcohol abuse. More detailed information on the subject is clearly needed with much greater attention being placed on how and in what circumstances children are placed at risk by parental misuse of drugs and alcohol, in order to avoid assuming an automatic linkage between substance misuse and abuse of children (Corby 2000; Reder and Duncan 1999).

Social support

A connection between social isolation and child abuse has been suggested by research, particularly in relation to neglect. There is an assumption that social isolation is a causal factor, but it may be that families isolate themselves to prevent the discovery of abuse or that they become isolated because they are neglecting their children. There is a need for more detailed research into the way in which these variables interact (Corby 2000; Reder *et al* 1993). Appropriate forms of formal and informal social support may also act as a protective factor against child abuse and neglect (Thompson 1995).

(vi) Characteristics of abused children

While all children are potentially vulnerable to abuse by those adults who care for them because they are dependent on them for physical and emotional protection and care, research has highlighted certain trends:

- under 1 year olds are more likely to be registered for physical abuse and neglect than those in older age groups, reflecting the concerns created by their particular vulnerability. The pattern is reversed for sexual abuse, with 10 to 15 year olds the age group most likely to be registered under this category;
- girls and boys are equally likely to be registered for child abuse. Boys are more likely to come to official attention as a result of physical abuse, neglect and emotional abuse than girls and girls are considerably more likely to be represented in official child sexual abuse registrations than boys; and
- although contentious, there is some evidence to suggest that particular children are singled out for abuse, for example, children who are not wanted, who are considered to be the wrong sex by their parents or who are perceived to be more difficult (Corby 2000; Gardner 1993; Goddard 1996).

All the evidence points to the fact that disabled children are more vulnerable to abuse than their non-disabled counterparts. Research has shown that children and young people with disabilities are at risk of abuse because:

- they are often more dependent on adults and may be less able to resist abuse, they may be cared for by a number of adults or in a variety of settings where there may also be the potential for abuse by peers;
- they may depend on adults for intimate care and may have little control in their lives;

- they may be unable to recognise abusive behaviour because of lack of education and information and because they have reduced exposure to 'normal' child/adult interactions;
- they may have little opportunity for involvement with adults or other children outside their home or care settings, and consequently may have reduced opportunities to disclose abuse;
- they may have communication difficulties and be unable to convey their experiences to others or adults may be unable to communicate with them;
- they may have low self esteem and may not be confident about the outcome of telling someone about the abuse;
- their parents may experience considerable stress in coming to terms with the disability and in coping with the ongoing care of the child;
- there is still considerable societal and professional reluctance to accept that disabled children are being abused; and
- the separation of services to children and families and to people (including children) with a disability may mean there is inadequate knowledge and experience of child protection issues within services for disabled children and inadequate knowledge of disability within child protection services (Westcott and Cross 1996; Doyle 1996; Hobbs and Hobbs 1999; McGowan and Peyton 1995; Marchant and Page 1992; ABCD Consortium 1993).

Evidence has also pointed to a correlation between birth problems and later abuse and neglect. It is suggested that where there are problems at birth, such as prematurity, which result in early separation of the mother and child, there is a potential for poor mother-child relationships, rejection and abuse. Doubts have been raised, however, about the importance attached to immediate post-birth bonding and it has been suggested that other factors could account for the correlation between neonatal difficulties and child abuse:

- looking after prematurely born and/or low birth-weight children who generally require more attention and care is likely to put carers under extreme stress;
- it is probable that the majority of the mothers in studies who were experiencing perinatal difficulties were from poor backgrounds and inadequate material resources for looking after young babies is probably a major factor in contributing to the quality of care that is provided. Much of the research which has been undertaken has been medical-based and has tended to underplay such social concerns; and
- the focus of studies has been on the mother, more attention needs to be paid to the involvement (or lack of involvement) of fathers in early child care particularly since some studies have suggested that the lack of early bonding between fathers and children could be a contributory factor in the causation of child sexual abuse (Corby 2000).

Conclusions

This section on definitions and information has covered some of the information from the research and wider literature about definitions of child abuse and child protection, the level and extent of child abuse and the causes of child abuse. It showed that there is no single agreed definition of child abuse and neglect or child protection. It is generally accepted that child abuse can be physical, sexual, emotional or involve physical neglect, but as our understanding of child abuse and neglect has increased there has been debate over whether a range of other situations should also be considered abusive. For example, official guidance now covers organised abuse and institutional abuse and issues such as the impact of domestic abuse on children or how children are affected by parental drug misuse have become more topical in recent years. We are also becoming more aware of the fact that children can actually suffer additional abuse as a result of having to go through the very systems which are intended to help them. It seems likely, as the WHO have pointed out, that one definition of child abuse cannot serve all purposes and professionals, researchers, the general public and children and young people themselves are likely to have opposing views about what constitutes child abuse and child protection.

If we are unable to define child abuse and neglect then it is probably no surprise that we are unable to measure the level and extent of the problem. This section of the literature review has shown that official statistics undoubtedly underestimate the extent of the problem, not least because many children do not tell anyone that they are being abused. Research studies which have asked people about their childhoods have revealed far higher levels of child abuse and neglect although levels have varied according to the definition of child abuse which has been used. While the findings of such studies are variable, however, they do show that a significant number of young people are being abused and neglected and their needs are not being met by the child protection system. Cawson *et al* (2000) make the important point that sources of bias in official figures affect the availability of help to children and families since service planning is built around information about existing service users. As a result unrecognised needs will not be met. Clients whose needs do not fit existing service patterns will be unable to locate the help they need, and in consequence will never become part of the official figures (Rees and Stein 1999).

The research findings are also inconclusive in relation to the causes of child abuse and neglect. It is likely that all the various theories which have been put forward as explanations of child abuse may play a part but no single theory can adequately account for the complexity of the problem. Research has attempted to identify the characteristics of abusers and of victims of abuse and has identified a range of factors which may be associated with an increased risk of abuse but are not in themselves sufficient to suggest that abuse will occur.

It is increasingly being recognised that multi-focus or integrated theories of child abuse may offer the best way forward. They suggest that risk does not arise from a single causal factor but from a combination of multiple interacting elements which are located at the individual, family, community and societal levels. Such theories are useful because they suggest that intervention to prevent or reduce child abuse needs to focus on the individual, family and community as well as on society as a whole.

"It's everyone's job to make sure I'm alright."



Identification and Assessment

Identifying child abuse and neglect

Reporting child abuse and neglect

Investigation and decision making

Conclusions

2

Identifying child abuse and neglect

The Department of Health (1995) research demonstrated that abuse comes to official attention in one of three ways:

- half (51%) of enquiries began when someone, usually the child or another member of the family, disclosed their concerns to a professional;
- in 39% of cases professionals already working with the family identified abuse; and
- in the remaining 10% of enquiries abuse was suggested during an unrelated event such as an arrest or home visit.

Diagnosing and confirming child abuse is not an easy task particularly since many of the signs and symptoms may indicate other problems or conditions (Goddard 1996).

This chapter considers some of the issues around diagnosing physical abuse, sexual abuse, neglect and failure to thrive and emotional abuse.

(i) Physical abuse

In order to identify physical abuse:

- professionals need a good knowledge of common accidental injuries. A useful indication is that sites where the skin is close to the bone are more commonly bruised in accidents. Injuries that are non accidental often present on tissue such as upper legs, buttocks, lower back and cheeks. Bruises may also be seen on the neck or genitals and mouth injuries are a cause for concern;
- a basic knowledge of child development is also very important in that it can assist in the interpretation of injuries and of explanations given for injuries, for example, certain injuries may be accidental in a toddler who is mobile but may be associated with abuse in a young child that cannot yet walk;
- the parent/child interaction can give valuable clues, for example, parents may have delayed bringing the child to medical attention or not taken the child to medical attention at all, they may demonstrate a lack of concern about the child's injuries or even hostility towards the child. Rough handling, how a parent undresses a child and how a child is spoken to or comforted may all give additional information; and
- the child's behaviour may be an indicator of abuse (Hobbs and Wynne 1996; Goddard 1996).

It is important that the basics of Munchausen's syndrome by proxy are understood by professionals. Children under the age of 8 or 9 are most at risk. The fabricated symptoms described, usually by the mother, often include the child having fits that are never seen by anyone else, blood found on the child's nappy or underclothes (often later found to be the mother's), and periods of breathlessness or cessation of breathing altogether. In order to produce symptoms the child may be given medications, often readily available to or prescribed to the mother, or the child may be partially smothered. Such behaviour has been recorded as continuing in hospital where samples and test results have also been tampered with. The abusive mother will often appear loving and concerned and prepared to go to any lengths to assist her child. A substantial number of mothers in such cases have been found to have some basic health or nurse training (Goddard 1996). In Meadows (1990) study of suffocation, most of the mothers did not seem unusual on superficial acquaintance to either their physicians or their neighbours. In most cases the suspicion of suffocation arose because no satisfactory cause for the apnea was found, recurrent apnea in a previously healthy child in the absence of viral infection or of cardiac, respiratory, metabolic or neurologic abnormality is rare. In some cases the unsatisfactorily explained death of a previous sibling led to suspicion. Meadows stated that it is always difficult to detect suffocation when it occurs for the first time within a family and particularly if it is the result of a single act rather than repetitive acts. Suffocation may cause obvious signs such as petechial haemorrhages but it can occur without incriminating findings on examination or at

autopsy so it will always be difficult to assess the number of deaths currently classified as SIDS that have been caused by parents. Covert video recording has provided proof that a parent has suffocated their child in some cases but this method is not likely to uncover many cases since it is reliant on the parent suffocating their child during the period of close observation in the hospital. Most child abuse, including suffocation, occurs at home.

Many risk factors associated with a higher incidence of SIDS such as low socio-economic status, maternal smoking during pregnancy, illicit drug use during pregnancy, inadequate prenatal care, prematurity, low birth weight, are also associated with an increased risk of child abuse. A small subset of infants whose unexpected death may be attributed to SIDS may have been smothered or poisoned. Although precise data are lacking, it has been estimated that less than 5% of apparent SIDS deaths are actually due to abuse in the US (Committee on child abuse and neglect 1994). Reece (1993) suggests that whenever an unexplained death occurs in infancy the question of fatal child abuse must be addressed and that death ascertainment should be accomplished in all children younger than the age of 18 years, not just in infants. He recommends that in order to establish whether child abuse or neglect is a contributory factor in unexpected infant deaths, death review teams should review all the data available, including previous medical records from all sources of medical care, and household members should be interviewed carefully, including being asked for an in-depth medical history. He also recommends that there should be more research into the etiology of both SIDS and child abuse.

There are further controversial issues associated with the identification of physical abuse, the most notable of which is whether osteogenesis imperfecta (brittle bone disease) might have been the cause of some symptoms diagnosed as being the outcome of child abuse, particularly in the case of infants (Corby 1993; Hobbs and Wynne 1996). Osteogenesis imperfecta (OI) is a group of disorders characterised by frequent fractures and other clinical manifestations as well as biochemical abnormalities of type 1 collagen and in the evaluation of suspected child abuse cases with suspicious fractures clinicians are taught to rule out the possibility of OI (Gahagan and Rimsza 1991). In most children the diagnosis of OI can be distinguished from child abuse radiographically but the condition may be difficult to identify in infants as radiographs may appear normal in the first year of life, even in infants who may later develop the obvious features of OI. Smith (1995) states that no type of fracture excludes OI and it is possible although uncommon for an infant with OI to sustain any type of fracture in a skeleton that is radiologically otherwise normal. He states that controversy exists in identifying non-accidental injury because metaphyseal fractures within a normal skeleton which strongly suggest non-accidental injury can actually be seen in OI. He also suggests that skull fractures can also occur in OI although this is contested by Carty (1995).

According to Smith (1995) one way of attempting to diagnose whether unexplained fractures in an infant are due to non-accidental injury or OI is to examine collagen synthesis from dermal fibroblast culture. Collagen abnormalities are found in 85% of patients with OI, but Smith states that apparently normal collagen synthesis by dermal fibroblasts does not

exclude OI. He states that the only other way to be clear that a child's injuries are caused by OI is to await events since an uncertain diagnosis of OI often becomes rapidly obvious after infancy. Children who have sustained non-accidental injury are unlikely to sustain further fractures if they are removed to alternative care. Where a diagnosis of non-accidental injury is made incorrectly in a child with OI fractures are likely to continue to occur after the child has been placed in alternative care. OI has an incidence that may be as high as 1 in 20,000 live births which would result in the birth of about 200 children with all forms of OI in the US in one year. The number of children from birth to 5 years of age who are physically abused each year in the US is estimated to be 100,000 to 150,000, about a third of whom have fractures (Steiner *et al* 1996). Although the number of children with OI out of the very large group who are abused is likely to be very small, therefore, there is as yet no way to indisputably diagnose OI in infants and to effectively rule out non-accidental injury. A further fact which needs to be borne in mind is that even if OI is diagnosed there is still a possibility that children with this condition may have been abused.

Clinicians also sometimes have to distinguish between inflicted and accidental cases of brain injury. It is believed that some children who sustain head injury may have been the victim of so called 'shaken baby syndrome' which refers to injuries caused through actions such as shaking an infant held by the arms or trunk or forcefully striking an infant's head against a surface. It is largely restricted to children under 3 with the majority of cases occurring during the first year of life. Although there is considerable controversy surrounding shaken baby syndrome, the available evidence suggests that it is the sudden deceleration associated with the forceful shaking of the head against a surface that is responsible for most, if not all severe inflicted brain injuries. The majority of abused infants have clinical, radiologic or autopsy evidence of blunt impact to the head and Duhaime *et al* (1998) suggest that the term 'shaking-impact syndrome' may be more accurate than shaken baby syndrome. Whether shaking alone can cause the constellation of syndromes associated with the syndrome is still debated but most investigators agree that trivial forces, such as those involving routine play, infant swings or falls from a low height are insufficient to cause the syndrome. Wilkins (1997) states that small infants rarely sustain serious injury from accidents in the home and that any brain injury with subdural or retinal haemorrhage should raise suspicions of abuse. Babies, however, can be dropped accidentally or fall from changing tables and sustain linear fractures and epidural haemorrhages.

(ii) Sexual abuse

The physical abuse of children is more readily and easily discovered than sexual abuse because technology can be used to confirm or deny it. The development of x-rays and use of photographs gave the diagnosis of physical abuse a scientific edge which is generally lacking in cases of sexual abuse where there are few clear cut medical signs of abuse and major problems in gathering evidence to prove suspicions (Goddard 1996; Corby 1993; Webury 1996).

Suspicion about sexual abuse can occur in three ways:

- the child may behave in ways that draw attention to the possibility;
- there may be signs and symptoms that lead to suspicion or confirmation of abuse, including abuse of another child; and
- the child may describe sexual abuse.

There may be other explanations for a child's behaviour but a large number of behaviours have been noted to be associated with child sexual abuse including reluctance to return home; running away from home; attempts at suicide or self mutilation; sexual behaviour or knowledge that is not age appropriate; reluctance to undress for school sports; indicators of stress such as sleep disturbance; regression to earlier behaviour; school problems and other acting out behaviour including violence towards other children. Sexually abused children may masturbate excessively and even publicly and may attempt sexual interaction with others. Sexual promiscuity may be caused by sexual abuse. Identification of sexual abuse is compounded by the fact that many victims will have had threats made to them in an attempt to enforce silence (Goddard 1996).

Physical indicators of sexual abuse include non-menstrual bleeding, dysuria, urinary frequency and symptoms of sexually-transmitted diseases but a significant number of children examined show no physical signs due to the non-violent nature of much sexual abuse and the frequent delay between the abuse and the disclosure. It may be difficult to ascertain whether injuries have been caused by sexual abuse, for example, white lines in the midline of the fossa *navicu laris* which have been mistaken for scars, are now recognised as being a normal congenital finding, and flattening of the labia majora which has been associated with the rubbing of the penis on the outside of the labia can be a normal finding (Rogers and Roberts 1995; Shapiro 2000). The Royal College of Physicians (1991) report advises that a pre-pubertal hymenal diameter of greater than 1.5 centimetres in association with other evidence of trauma would be supportive but not diagnostic of abuse. Sometimes a physician will be asked whether an adolescent is a 'virgin' but it is often impossible to tell. In most cases even where buggery is long standing, there will be no conclusive medical evidence. Only the presence of semen, sexual disease or pregnancy can confirm sexual activity. Detection of semen, hairs, lubricants, saliva, blood or other body fluids at a scene, on clothing or on a child when identified will corroborate a child's story and may also lead to the identification of alleged assailants by conventional or DNA grouping.

Bentovim (1998) found that children aged 2 and 3 made a relatively high number of false reports of sexual abuse, but that children aged 3 and 4 could provide accurate detailed accounts of personally meaningful events such as sexual abuse. Children aged 5 to 7 were not prone to give false reports of abuse. It was only by the age of 6 that children understood the context of what a lie was and it was not until 7 that a child could deceive by attempting to manipulate a listener's belief and could lie skilfully. This is, however, contentious. Saywitz and Goodman (1996) suggest that the amount of information a child can recall tends to

increase with age but that a young child's memory is not necessarily less reliable. Pre-school children in particular may be less resistant to leading questions.

There has been controversy over the use of anatomically correct dolls in diagnosing sexual abuse. There is, however, no support that dolls are too suggestive and over stimulating and there is little empirical evidence that exposure induces non-abused sexually naive children to have sexual fantasies and engage in sex play (Bentovim 1998). Samra and Yuille (1996) found that anatomically-neutral dolls did not adversely affect children's accounts. In fact they found that the use of dolls somewhat enhanced the accounts of eyewitnesses. The use of dolls appeared to be less successful in children aged 4 and under and they suggested the use of dolls for such young children should be avoided.

In the UK the emergence of false memory syndrome (FMS) as a public issue built on the networks established after Cleveland, Rochdale and Orkney. The term describes the phenomenon of adults in therapy recovering allegedly false memories of childhood sexual abuse. The premise is that therapists use a variety of methods to implant inaccurate memories of abuse into clients' minds. In the US, debate has polarised into two camps, one which claims all recovered memories are implanted, the other that they are all true. The main argument used to support the existence of FMS is that it is not possible to repress memories of repeated traumatic events and that since memories of repeated traumas cannot be repressed they must be false (Dobson 1995; Toon *et al* 1996). Lindsay and Read (1994) suggest that incautious use of memory recovery techniques may lead some adult clients who were not abused to come to believe that they were. Pezdek (1994) states, however, that the evidence for therapist-implanted illusory memories for incestuous sexual abuse is very weak.

The British Psychological Society (1995) working report stated that complete or partial memory loss was a frequently reported consequence of experiencing certain kinds of psychological traumas including child sexual abuse and that such memories could be partially or fully recovered after a gap of many years. The report attracted the attention of medical and health correspondents who suggested that the risks of false memory were not as great as previously suggested. While there was evidence for incorrect memories there was far less evidence supporting the creation of false memories. It was suggested that it may be possible to construct a memory of, for example, being lost in a mall as a child, but that it may not be possible to construct memories of events which more closely resemble sexual abuse. Of women who had been treated in hospital for sexual abuse when they were children, over a third (38%) evidenced no memory of the early emergency room visit or of the sexual assault when interviewed as adults. Overall evidence suggests that repressed memory can exist if abuse occurs when a child is under 7 years of age (Kitzinger 1996; Bentovim 1998). McGuire (1998) reviewed the various evidence relating to FMS and concluded that:

- many cases of remembering childhood sexual abuse are straightforward;

- amnesia for periods of childhood sexual abuse is possible;
- the recovery of memories of abuse for which the person has been previously amnesic is possible;
- false memory must be accepted as occurring in at least some cases; and
- the incidence of false memory is at present unknown but appears to be low.

(iii) Neglect and failure to thrive

Definitional problems are associated with the identification of neglect, for example, how ill-clad and dirty does a child have to be to be defined as neglected? At what age can a child be left unsupervised? It has been argued that definitions of neglect should take account of the emotional impact upon the child and the long-term impact of chronic neglect. Neglect is normally diagnosed by examining parental attitudes and behaviour or observing the effects of neglect upon the child. A prerequisite for recognising the neglected child is knowledge of the 'normal' child. Growth is a key indicator of a child's welfare and growth must be regularly charted if there is concern (Minty and Pattinson 1994; Stevenson 1998; Wilton 1996; Corby 1993; Goddard 1996).

Failure to thrive is technically easier to define and prove than general neglect since babies have an expected normal level of growth based upon their birth weight and size and those that fall well below this expectation with no apparent physical explanation are considered to be causes for concern. Non-organic failure to thrive can be described as a meeting point between neglect and emotional abuse. Maternal and child health nurses are ideally placed to pick up the first signs and suspicions of failure to thrive because of lack of parental care. Warning signs may be picked up even during pregnancy and include inadequate antenatal care; consideration of abortion and/or adoption; alcohol, drug or psychiatric problems; little emotional support; financial problems; a maternal history of abuse or neglect; and inadequate attachment to the baby after birth. There may be clues in the child's appearance, for example, it may appear pale and listless as well as unresponsive. Infants may develop developmental delays and repetitive behaviour such as rocking backwards and forwards (Goddard 1996; Skuse, 1985).

(iv) Emotional abuse

The very nature of emotional abuse being largely intangible and invisible makes it very difficult to detect and recognise and it is likely that the number of children acknowledged as being emotionally abused is, therefore, an underestimate. Emotional abuse covers a wide range of problems with family functioning and the parent's attitude towards the child and his/her understanding of the child's needs is key. Styles of parenting are brought into question by the issue of emotional abuse, for example, are authoritarian or permissive parenting styles abusive? Is constant criticism of a child abuse? Is it abusive to actively prejudice a child against people of different races and sexes (Corby 1993; Gardner 1993; Glaser *et al* 2001; Iwaniec 1995)?

Glaser *et al* (2001) define five forms of emotional ill-treatment within emotional abuse and neglect:

- emotional unavailability and neglect;
- negative attitudes to the child justifying harsh punishment and possible rejection;
- inappropriate or inconsistent developmental expectations;
- failure to recognise or respect the child's individuality and psychological boundary; and
- failure to ensure the child's functioning in the child's social context.

They point out, however, that most parents will exhibit many of these behaviours and attitudes at some time and the problem lies in deciding when the frequency or intensity reaches unacceptable or damaging levels.

O'Hagan (1993) draws a distinction between emotional abuse which is characterised by inappropriate emotional responses to the child's overtures and psychological abuse which is characterised by more active patterns of undermining and damaging behaviour towards the child.

Some commentators argue that parental behaviour in, and of itself, does not adequately predict the degree of emotional damage to a child and concentrate instead on specifying expected outcomes for children. This involves applying a developmental perspective in operationalising serious emotional damage to a child (i.e. depressions or withdrawal, severe anxiety, or untoward aggression towards self or others). Ignored and isolated infants may not learn to sit, crawl, walk and talk in the way other infants do. There may be a lack of social responsiveness evidenced by gaze avoidance, fleeting or muted smiles and general withdrawal. The psychologically-abused child may exhibit decreasing or static intellectual abilities, and/or a pervading sense of distress, fear or unhappiness. The main indicators of psychological maltreatment in pre-school children are usually behavioural. Children may have a poor attention span, be over active, aggressive and impulsive, there may be problems with peer relationships and language is particularly affected by psychological maltreatment. The main signs of psychological maltreatment in school-age children are poor social and emotional adjustment, behavioural problems and learning difficulties. Adolescents may become more severe and disturbed. They tend to act in one of two ways and exhibit avoidance or aggressiveness. A child who is depressed will present with a variety of symptoms depending on his or her age. It must be remembered, however, that children who have been emotionally abused may also have suffered other forms of abuse and it may be the results of that abuse which are being witnessed. A further problem is that all conceivable 'non-normal' conditions for children and adolescents can be described as possibly being the result of emotional abuse (Brougham 1997; Gardner 1993; Goddard 1996).

(v) Disability

Recognition of abuse in a disabled child may be even more complex. Spontaneous disclosures are less likely due to lack of knowledge or awareness by the child that the behaviour is abusive or because of communication difficulties and/or reduced opportunities for contact with other adults and children (McGowan and Peyton 1995; Turk and Brown 1993). Marchant and Page (1992) found that only four of the 15 disabled children in their study had disclosed abuse and, even where children were able to disclose, they sometimes had to do so very explicitly and sometimes repeatedly before they were heard or believed. One of the four children made an initial disclosure using an augmentative communication system and did not have the necessary vocabulary to clearly tell about the abuse because she did not have the words 'smack', 'shut' or 'hit' on her word board. Neither did the children who used communication boards have words to describe private body parts, even basic words like bottom.

Research findings suggest that professionals are less likely to notice abuse in a child with disabilities, in particular because they attribute all signs and indicators of abuse to disability (ABCD Consortium 1993). Cooke and Standen (2002) found that parents and teachers make a higher proportion of referrals about the abuse of disabled children than they do about the abuse of non-disabled children. In contrast social workers and health workers make a lower proportion of concerns about disabled children than they do about non-disabled children. They found that there was a tendency for social workers not to see the abuse of disabled children. For example, bruising could be seen as a result of clumsiness, sexual behaviour such as masturbation might be seen as being associated with a learning disability, with little consideration given to what might lie behind such behaviour. Cooke and Standen suggested there may also be possible greater empathy with parents and foster parents who are felt to be under particular stress. Turk and Brown (1993) found that professional/careworker's reporting of sexual abuse of adults with learning disabilities was low and family members rarely made the initial allegation. They concluded that their findings raised concerns about the likelihood of sexual abuse being detected and reported where the client has insufficient language to initiate the disclosure process.

There is some evidence that abuse may actually cause forms of physical and learning disability. For example, Groce (cited in Turk and Brown 1993) state that one in 10 children may have acquired their disability as a direct result of physical abuse or neglect. This issue needs further exploration, however, since research has concentrated on the psychological effects of abuse rather than on how it affects physical wellbeing (Kelly 1993). Scottish Women's Aid (1997) state that there needs to be further research into whether living in a household where violence occurs influences children's mental health to the extent that it results in what would be defined as a learning disability.

Reporting child abuse and neglect

This chapter discusses the ways in which abuse is reported to official agencies and discusses reasons why some professionals may be reluctant to report abuse.

The Council of Europe has urged all countries to have mandatory reporting of child abuse but the UK along with several other European countries does not have laws requiring mandatory reporting. Under UK law only local authority social workers, health and social service board social workers (Northern Ireland) and police have a duty to report suspicions that a child is in need of care and protection. Local child protection guidelines and professional codes of conduct may expect other professionals (teachers, health visitors and other medical staff) to report as part of their professional duty, but they do not have to do so as a matter of law (Madge and Attridge 1996; National Commission of inquiry into the prevention of child abuse 1996).

Gibbons *et al* (1995) found that:

- education services referred the most cases to the child protection process (23%);
- health visitors, GPs and hospital staff referred 17%;
- household members and other lay people 17%;
- social services professionals 13%;
- police or probation 12%;
- anonymous 6%; and
- other 12%.

Research in Europe, the US and Australia indicates that medical practitioners may be reluctant to report even when they have a legal mandate to do so. Indeed the referral rate by GPs is surprisingly low given the frequency of their contact with families with children. Despite mandatory reporting laws in the US research has shown that medical practitioners still do not report up to a third of what they consider to be possible child physical abuse cases. This is despite the fact that the practitioner only has to suspect abuse or neglect to make a report and is indemnified against prosecution for the making of such a report. There are various reasons for medical practitioners' reluctance to report including ideological and ethical concerns about confidentiality, family privacy, desire for autonomy in practice, and mistrust of state services. Research has also found that doctors may have difficulties delineating accidental and non-accidental injury and defining emotional abuse and neglect and that some express ignorance about reporting laws and procedures (Vulliamy and Sullivan 2000; Thorpe 1996; Haeringen 1998; Buckley 1998). Warner and Hansen (1994) found that cases of physical abuse were more likely to be reported by medical professionals than cases of physical neglect but cases of suspected sexual abuse were most likely to be reported. The type and severity of injury were related to identification. Reporting of physical

abuse and cases of physical abuse and/or neglect involving younger children and younger parents were more likely to be reported by hospitals than cases involving older children. African American and Hispanic families and lower income families had a higher probability of being reported.

US and Canadian studies have also demonstrated a poor reporting record amongst teachers. Despite an increase in reporting levels following the introduction of mandatory reporting, teachers' overall reporting rate has been estimated to be at about a quarter of the suspicious cases they encounter. Research has found that many teachers are unaware of standard child abuse reporting procedures and feel unprepared to report cases. The most common reasons cited for not reporting abuse are fear of making an inaccurate report, feeling as though child protective services do not help families and no apparent physical signs of abuse. Cases that do get reported generally involve disclosure, the observation and documentation of a series of bruises over time or one that was sufficiently serious and shocking to stimulate an immediate formal report. Special education teachers have been found to be more likely to report abuse, possibly because they may be more likely to see abused children (Tite 1993; Kenny 2001).

Where doctors, teachers and other professionals are reporting abuse, some commentators believe that mandatory reporting is still not effective in reducing child abuse and neglect. Ainsworth (2002) compared New South Wales which has mandatory reporting with Western Australia which does not. He found that mandatory reporting systems were overburdened with notifications, many of which proved to be unsubstantiated, but which were time consuming and costly. He concluded that mandatory reporting systems were inefficient and ineffective and that the money which was spent on them would be better spent on government and non-government family support and assistance programmes.

Investigation and decision making

When making decisions about whether a referral should be investigated or whether a case should be registered, professionals generally draw a threshold, which involves deciding the point beyond which a behaviour or parenting style can be considered maltreatment and the point beyond which it becomes necessary for the state to take action. Thresholds placed at different stages of the child protection process determine the way a case progresses from initial referral, for example, whether a case is investigated, whether a case conference is called and whether a child's name is added to the protection register (Gardner 1993; Department of Health 1995).

The Joint Steering Group for child protection in Scotland (Scottish Office Social Work Service Group 1992) document outlines the factors which need to be taken into account in making decisions about registration or continuing registration:

- the seriousness of the abuse, particularly in terms of the harm to the child;
- the level of risk to the future safety and welfare of the child; and
- the degree of professional confidence in the information either that abuse has occurred and is likely to be repeated or that the child is placed at risk, for instance because the household contains a known abuser.

The document states that de-registration should occur only when an objective assessment shows that the risk of abuse has been eliminated or reduced to an acceptable level. This chapter considers the way in which professionals investigate a child protection case and the factors which influence their decision making.

(i) Factors influencing progression of a case through the child protection system

Jones (1996) examined 701 case decisions in a local authority social services department in England and found that:

- 44% of new referrals were defined by a senior social worker as child protection cases and were investigated;
- only 45% of these initially defined child protection cases continued to be defined as child protection cases following investigation and proceeded to case conference;
- following case conference only 35% of children's names were added to the child protection register; and
- following a second case conference only 45% of children's names remained on the register.

Overall, the author stated that the research confirmed the appropriateness of decisions being taken. Farmer and Owen (1995) also found that only a quarter of referrals led to a meeting of professionals.

Research has attempted to illustrate which factors influence the progression of a case through the child protection system. The Department of Health (1995) research found that it was unlikely that anything other than a first enquiry would happen if:

- there was no man in the house;
- it was a suspected case of neglect or emotional abuse;
- it was not a particularly serious accusation;
- the suspected perpetrator did not live with the child;
- the source of the referral was anonymous;
- the case was new to social services; or
- there had been no previous legal orders.

If a family visit was undertaken it was unlikely that a conference would happen if:

- there were only girls in the family;
- it was a suspected case of neglect or emotional abuse;
- it was not a particularly serious accusation;
- the suspected perpetrator did not live in the household; or
- none of the parents had a criminal record or history of mental illness.

If a conference was called it was unlikely that the child's name would be placed on the child protection register and/or the child removed from home if:

- the suspected perpetrator was not the male parent or was an outsider;
- the suspicion did not concern sexual abuse;
- police and social services were not the investigative agencies taking the lead;
- family members had no previous record of child abuse or criminal behaviour;
- the family had a single problem rather than multiple problems; or
- the concerns were not pressed by the school.

A professional's judgement of a parent, particularly a mother is a major factor and unco-operative mothers have been found to trigger the instigation of a child protection conference even when concerns are relatively minor (Cleaver and Freeman 1996; Department of Health 1995). Fisher's (1995) findings in relation to physical abuse cases show that weight is placed upon

how far parents accept responsibility for what has happened, acknowledge problems and express a willingness to co-operate.

Research has consistently found that professional judgement on what to do can be unduly influenced by the status of the referrer i.e. reports from professionals such as doctors, teachers, and the police are substantiated more often than reports from the general public. Warner and Hansen's (1994) study revealed that physicians reported 8 per cent of the total number of cases reported to CPS in Virginia between 1979 and 1983 and 53 per cent of cases were validated, the highest rate from a reporting source in the state. Thorpe's (1996) Australian study found that referrals by the child, health professionals (including GPs) and siblings were more likely to be confirmed as abuse or neglect than not; schools, health centres and hospitals were in the middle range of reliability. A fifth of allegations by non-professionals arose within the context of conflicts between family members or neighbours. When reports from family, friends or neighbours are perceived as part of an ongoing feud the information may not be taken seriously, and in several cases when things have gone badly wrong there has been evidence that information from family, friends and neighbours was ignored (Wattam 1996; Cleaver *et al* 1998a; Hallett 1995). In the UK Cleaver and Freeman (1995) found that the chances of a child's name being added to the child protection register were stronger when social services, police, hospitals or probation rather than health visitors or GPs were involved in the initial referral. Schools were an important source of information but were a less coherent influence upon registration.

Cleaver and Freeman also found that likelihood of registration was greater if someone with a record of child abuse or violence was present in the family; if sexual abuse was alleged; or if the family was well known to social services and considered generally to be turbulent. Farmer and Owen (Department of Health 1995) found that the existence of secondary concerns was a factor associated with the placement of a child's name on the protection register.

Fisher *et al* (1995) found that type of abuse affected the progression of a case through the child protection system. There were double the number of conferences for sexual abuse and physical abuse than there were for neglect but all 'neglect' cases were registered as were four out of five cases involving only emotional abuse. In cases of physical or sexual abuse the outcome of the conference was significantly less predictable and cases of suspected or potential sexual abuse were significantly less likely to be registered than those involving suspected or potential physical abuse. In sexual abuse cases evidence of abuse appeared to be of central importance and cases were not registered where there was insufficient evidence that abuse had taken place. Considerations of dangerousness affected the progression of a case. Neglect and emotional abuse cases were not seen as immediately dangerous and were frequently brought to conference as a last resort after considerable unsuccessful professional input and by the time such cases came to conference,

registration was virtually inevitable. Glaser *et al* (2001) provided further evidence to support this. They carried out a study of 94 children whose names were on the child protection register under the category of emotional abuse. They found that 93 per cent of the children were known to social services prior to the current registration and the mean amount of time between the first report of concern to social services and the current registration for emotional abuse was 4.06 years. The majority of registration conferences (63 per cent) were convened as a result of an escalation of concerns or an altered perception of concerns rather than events. By the time of registration the implications of emotional abuse were found to be very serious, as indicated by the high rate of placements out of the home. In contrast physical and sexual abuse are viewed as more serious at the outset which explains the higher number of conferences for physical and sexual abuse (Fisher *et al* 1995).

Fisher *et al* (1995) pointed out that when answering questions about the reason for registration or the lack of it, social workers very rarely referred to the wishes or views of the children or parents or to evidence that the child was unhappy, frightened or worried. This was true for all types of abuse even emotional abuse where evidence of the child's state of mind or emotional distress might have been expected to be crucial.

(ii) Factors influencing prosecution

Hamilton and Browne (1999) found that

- 11% of referrals to police child protection units were already on the child protection register;
- a further 14% were registered following referral;
- a police response at index referral was applicable in 81% of cases; the remaining 19% were considered as accidental injuries or no cause for concern; and
- the perpetrator was cautioned or charged in 13% of cases, there was no further action on behalf of the police in 64% of cases, and investigations were still ongoing in 4% of cases.

Wattam (1997) found that the average submission rate to the Crown Prosecution Service was 24.5 per cent.

Davies *et al* (1999) found that most child protection cases referred to the police involved sexual allegations and Wattam (1997) found that the majority of children interviewed were the victims of alleged sexual abuse (64 per cent). Such findings suggest that alleged physical abuse is less likely to be prosecuted than alleged sexual abuse. Hallett (1995) found that the police distinguished between sexual abuse and physical abuse and in general they viewed sexual abuse more seriously. If the evidence was good enough in cases of sexual abuse then offenders were prosecuted and it was taken for granted that this would be in the public interest and in the interest of the child victim. The police appeared to

exercise far more discretion over decisions to instigate proceedings or recommend prosecution in cases of physical abuse and more emphasis was placed on the impact of prosecution on the family and on the child than in cases of sexual abuse.

The police and CPS in the Davies *et al* study (1999) stated that it was extremely difficult to secure a conviction where the sole evidence was that of an inarticulate child who had not given a clear account of the abuse. Where the account was clear, consistent and detailed or there was evidence supporting the child's allegations the case was more likely to proceed.

Cross *et al* (1994) found that acceptance for prosecution in the US was highly related to:

- age of the child;
- oral-genital abuse as the most severe type;
- use or threat of force;
- presence of physical or other eyewitness evidence;
- total maternal support and child internalising psychopathology; and
- children's relationship to the perpetrator.

Over two-thirds of cases involving children as victims of abuse aged 7 to 17 were prosecuted, compared with just over a third of cases involving pre schoolers. Those perpetrators who had a prior criminal record had a higher prosecution rate (71 per cent) than those who had no prior record (56 per cent).

(iii) Decision making by reporters

Children's reporters receive all referrals to the Children's Hearings system and must decide if there is sufficient *prima facie* evidence to establish a condition of referral and if so whether a child may be in need of compulsory measures of care. S/he can take no further action, refer a case to the local authority for advice, guidance and assistance, arrange a children's hearing, or refer a case to the police or juvenile liaison officer for a warning. At a hearing a lay panel of volunteers make decisions after discussion with parents and children. They can make a non-residential or a residential supervision requirement which will remain in force for a year. The vast majority of supervision requirements release children to the care of parents or guardians. Anyone can refer a child to the reporter but the majority of referrals come from the police followed by education and social work sources. Children can be referred to the reporter on a range of grounds including situations where a child had committed an offence and those where non-offence related issues predominate including truancy or where there are concerns for the care and/or protection of a child (Waterhouse *et al* 1998).

Hallett *et al* (1998) found that reporters' decision making had two key components: an appraisal of the evidence and consideration of the need for compulsory measures. In the 130 cases they sampled decisions were made on the basis of referral information and usually

supplementary written information, most often from social work departments and schools. Decision making by Children's Hearings was characterised by an individualised approach and the exercise of independent judgement. Structured schedules were not used in assessing the risk of future harm. In the majority of cases (84 per cent) the decision of the hearing accorded with the recommendation of the social work department. In 65 per cent of hearings there was no alternative discussed other than the decision which was finally reached. Waterhouse *et al* (1998) found that younger children, particularly girls, were more likely to be referred and placed under supervision for protection from neglect or victimisation.

(iv) Assessment

Professionals base their decision making on an assessment of risk which is the process of identifying and recording information about a given person or situation in order to predict the likelihood that the person will engage in particular behaviours in the future. The assessment must consider how best to safeguard and promote the welfare of the child, the child's developmental needs and wishes and the non-abusing carer's ability to safeguard and meet the needs of the child. The assessment should also include an evaluation of the future likelihood of abuse (Dent 1998; Fitzgerald 1998; Erooga and Print 2001).

Decision making about taking action to pursue a child protection enquiry is dependent not just on the presenting harm or injury but on making judgements about what is 'normal' behaviour in parents and children. Professionals need to assess parents' performance in the provision of affection, physical care, protection, stimulation, parental expectations of the child and control and discipline. Browne (1995a) suggests that there are five important aspects to the assessment of parent-child relationships:

- the evaluation of caretakers' knowledge and attitudes to parenting the child;
- parental perceptions of the child's behaviour;
- parental emotions and responses to stress;
- the observation of parent-child interaction and behaviour; and
- the quality of child to parent attachment.

Professionals must be aware of cultural diversity and norms of non-standard parenting, for example, they may be asked to assess the parenting skills of gay or lesbian parents. Parents with difficulties such as psychiatric problems, alcohol and drug problems or learning disability may require special consideration. The child's perspective needs to be an essential component of the parenting assessment and assessments need to be grounded in a valid theoretical framework (Erooga and Print, 2001; Cleaver *et al* 1998; Fitzgerald 1998; Pitcairn *et al* 1993). Cleaver *et al* (1998a) point out that parents' behaviour is often misinterpreted and that the way they react to an enquiry is not an indication of how they parent. The distress and fear of the enquiry may cause some parents to behave in ways which appear to an observer to indicate their guilt but their responses will be influenced by their past

experience of social services (two thirds of families referred because of suspected abuse have had some prior contact with social services and nearly half of these have been previously investigated for child abuse). Inquiry reports into child deaths or injuries illustrate the dangers of over reliance on parent co-operation. They show that parents who appeared co-operative sometimes did so as part of a strategy to deceive and disarm social workers and prevent them from insisting on seeing the child.

Assessment of parenting should be based on an assessment of both parents but social work practice and assessment has tended to focus on women. This has led to oppressive practice towards women who are blamed for their failure to conform to existing expectations of the ideal mother, particularly in cases of neglect. A mother blaming approach may contribute to a flawed understanding of the process and dynamics of child neglect and, in the long run, a failure to protect vulnerable children (Tanner and Turney 2000). Gough (1993) found that social work assessments and case conference deliberations tended to concentrate on the child's mother and the problem of abuse was perceived primarily in terms of her social context and personal relationships. Daniel (1999) describes the lack of attention paid to fathers in the literature on neglect and the fact that fathers are not considered to be perpetrators of neglect even when they spend no time with their children.

There has been very little research on this issue but the research which does exist suggests that mothers get very little support from the fathers of their children (Cooley 1995).

Holland (2000) found that three main areas were considered in the process of assessment:

- parent-related factors (including parenting skills and the relationship between parents);
- the ability of parents to change their behaviour and lifestyle within an acceptable time scale; and
- the verbal interactions between the assessing social worker and the parent being assessed.

Verbal interactions appeared to be given the highest status across different types and severity of abuse. The ability or otherwise of the parent to provide a plausible explanation of their behaviour or family situation appeared to play a central role in the process and outcome of the assessment and those who were articulate, plausible and co-operative possessed the attributes that led to a successful and positive assessment relationship. Holland points out that over emphasis on verbal skills might not be a fair way of assessing the parenting skills of those who are not so verbally proficient, particularly those with learning disabilities. It is also possible that those parents who succeed in assessments are those who are able to successfully adapt their behaviour to conform to the expectations of the assessor.

Waterhouse and Carnie (1992) studied 51 cases of familial child sexual abuse in Scotland. They found that social workers use a set of child protection criteria for the evaluation of risk in sexual abuse cases. There were two types of criteria: primary (child care) criteria which

concentrated on assessing circumstances prevailing within the family home and secondary (disclosure) criteria which served to either substantiate or refute disclosure. The primary child care criteria were:

- attitude of non-abusing parents to alleged perpetrator, this was seen as the most important criterion in terms of contributing to the children's likely safety;
- access between referred children and alleged perpetrators;
- type of alleged abuse (acts such as intercourse were seen as more serious than other acts);
- age of children or young people (younger children were thought to be more at risk);
- attitude of alleged perpetrator to allegations (admissions which incorporated responsibility for abusive actions caused social workers to worry less about children's safety); and
- parental attitude to social work investigation (where parental co-operation seemed forthcoming children were perceived to be less at risk).

Secondary disclosure criteria were:

- belief or disbelief in the child;
- psychological symptoms in children;
- physical signs of abuse;
- children's attitudes towards remaining at home; and
- criminal or psychiatric history including alcohol or drug abuse.

Child protection criteria were found to be used like a set of building blocks with tall towers representing higher risk and low towers less risk.

Farmer and Owen (1995) found that the professional assessment of risk was a puzzle to parents who were not clear how the assessment of risk was conducted or what methods of reasoning were used. They found that the most commonly used methods of assessing risks at a child protection conference were:

- accumulating concerns where conference members virtually piled concerns on top of each other to arrive at an assessment of risk;
- comparing present and previous contexts where conference members might concentrate on an incident which had caused great anxiety in the past and investigate whether the same series of events was likely to be repeated; and
- focusing on specific incidents of abuse or neglect where the conference might feel that the only really important point is that the child has suffered non-accidental injury.

They concluded that the best assessments:

- were based on good information;
- employed a variety of methodological approaches;
- made sure that information was seen in its cultural context; and
- provided a basis for planning.

Scott (1998) studied the process of assessment undertaken by Australian social workers in a hospital specialist service and in a statutory child protection service and found that both groups tended to adopt a proceduralised model of practice which narrowed the range of factors considered in assessment. Assessment of children who had allegedly been sexually abused was largely based on the following criteria:

- the child's capacity to disclose the sexual abuse;
- the degree to which the child was able to attribute responsibility for the abuse to the perpetrator;
- whether the child could say what constituted 'good' and 'bad' touching; and
- the child's stated intentions in the event of future situations of abuse occurring.

There was little consideration of the extended family with family tending to be equated with household. Scott concluded that her findings supported the argument about the proceduralisation of social work assessment and intervention in child welfare often had more to do with the resources available than with an assessment of the particular needs of the child.

Research has found that the range of information on which social workers base assessments is biased towards the more memorable data, towards evidence that is vivid and concrete and arouses emotion and towards either the first or last information received. Munro (1999; 1998) found that written information was less likely to be noticed than verbal and at case conferences written material was repeatedly overlooked in preference for the direct reports of those present. Social workers sometimes failed to look at their own files and so overlooked items of major significance such as previous abuse or in one case the fact that the child was on the child protection register. Research on child abuse was under used and more than half of reports criticised practitioners for failing to recognise the significance of known risk factors. Munro makes the distinction, however, between 'unavoidable' mistakes which are decisions made on the best available evidence that subsequently turn out to be wrong, and 'avoidable' mistakes which are decisions made without taking into account all the available evidence. Social Services Inspectorate (1997) found that most assessments were incomplete lacking systematic evaluation of information already available.

(v) Inter-agency working

Child protection investigations are supposed to be joint investigations involving all relevant agencies. Area Child Protection Committees (ACPCs) have a crucial role in ensuring co-operation and collaboration between all the agencies involved in child protection. Birchall and Hallett (1995) concluded that the child protection network operated on four layers:

- on the first layer were the core professionals such as social workers, paediatricians, and the police;
- on the second, the front line agencies such as schools, health visitors, and GPs;
- on the third, contact professions such as school nurses and educational welfare officers; and
- on the fourth, case specific professionals, for example, lawyers and psychiatrists.

The main findings of Hallett's (1995) study were that:

- the inter-agency referral process for child protection cases was generally experienced as working reasonably well;
- one third of cases were investigated by the social services department without police involvement in joint investigation;
- with the notable exception of GPs attendance rates at child protection conferences were considered to be satisfactory indicating a degree of commitment to inter-agency working; and
- the role of agencies other than the social services department were mentioned in only just over half (58%) of child protection plans.

There was a peak of inter-agency involvement at the initial child protection conference but it diminished thereafter, leaving the social services department with prime responsibility for case co-ordination and service provision. Hallett found that conference minutes demonstrated that there was a high degree of inter-agency consensus in relation to conference decisions concerning registration and the child protection plan. Professionals reported that inter-agency relationships had improved in recent years, particularly those between police and social workers and health visitors and social workers, but doctors were often perceived as difficult to collaborate with. Agencies frequently exchanged information, there was a degree of joint planning, and there was some shared decision making, but with the exception of some joint police/social work investigation Hallett found little evidence of more radical forms of co-ordination.

The majority of respondents thought inter-agency co-ordination worked reasonably well in the Birchall and Hallett (1995) study but only a fifth felt it worked well in the assessment phase and over a quarter considered ongoing co-ordination was poor. Good communications, good relationships between practitioners and good policy co-ordination were seen as conducive to case co-ordination. Obstacles to co-operation ranged from conflicting priorities in different agencies and other professional tensions to shortage of time. Buckley (2000) found that inter-agency co-operation could not always be taken for granted in the Irish child protection system even though social work is part of the health board. She found that professional responsibilities were rigidly differentiated and the unpalatable aspects of child protection work were only devolved to the health board and police (An Garda Síochána).

In their study of policing child sexual abuse, Hughes *et al* (1996) found that overall inter-agency work had improved considerably and most officers reported good local relationships between agencies and between individual practitioners. Almost all 10 police forces reported problems with joint video interviewing, however, claiming that there appeared to be a reluctance on the part of social workers to do video work. The lack of co-terminosity between social services and police areas together with the lack of consistency between the guidelines and procedures of different ACPCs created major organisational problems for most of the police forces. Some police forces proposed that local ACPC guidelines should be replaced by national guidelines in order to address cross boundary problems. Many police officers discussed the poor working relationship between paediatricians and police surgeons and/or the lack of specialist paediatric training amongst police surgeons.

Much research has highlighted that GPs are more reluctant participants in the child protection process than other professionals. Buckley (1998) found that GPs were the least frequent attenders at case conferences, coming to only a fifth of meetings to which they were invited. Simpson *et al*'s (1994) Scottish study confirmed low levels of participation by GPs in contrast to high levels of attendance and report submission by health visitors. Evidence suggests that GPs appear to be concerned about the legal implications of becoming involved in the child protection process and that primary care doctors are particularly sensitive to this issue because of their unique relationships with families and their concerns about maintenance of confidentiality (Bannon *et al* 1999; Cooper 1996). Hallett (1995) concluded that the mandate to work together was not widely accepted by GPs who often had the status and independence to ignore it. She suggested that further research was required to provide more information about GPs potential role and to document how their participation in inter-agency work could be facilitated and maximised. Rogers and Roberts (1995) demonstrated that the interface between medicine and law could be particularly complex. They found that although child sexual abuse is a crime doctors are often confused about disclosure of information to investigating authorities due to issues of patient confidentiality.

Taylor and Daniel (1999) found that inter-agency practice could be problematic in relation to failure to thrive (FTT) because the medical profession are concerned with the aetiology and medical management of FTT and regard social treatment as being the responsibility of social services but social workers are not in a position to diagnose FTT and tend to see it as a medical problem.

Barter (1998) found only limited evidence of multi-disciplinary working in institutional abuse investigations. Only two out of 36 investigations studied constituted formal joint working where both agencies had acknowledged procedures on joint working, including their respective roles in this. In these two investigations the police were present from the initial strategy meeting through to completion of the investigation. Other investigations had a police presence but it was usually limited to the introductory stages of an investigation.

Conclusions

Section 1 looked at issues relating to defining and measuring child abuse and assessing the causes of child abuse and neglect. This section considered the way in which the child protection system operates by focusing on identification and assessment. It looked at identifying child abuse, reporting child abuse and investigation and decision making of child protection cases. It showed that identifying child abuse can be extremely problematic. While physical abuse may be considered easier to identify because it is more likely to be accompanied by medical evidence, the chapter on identification showed that such evidence can be open to alternative diagnosis, for example, in the case of SIDS or Munchausen by proxy. Identifying sexual abuse, neglect and emotional abuse are even more problematic because there is usually less physical evidence that the child has been abused. Once child abuse or neglect has been identified it needs to be reported to child protection agencies in order for a child protection investigation to begin. Research evidence suggests, however, that professionals do not always report their concerns to child protection agencies, even in countries where mandatory reporting systems operate.

Considering the problems involved in identifying child abuse and the fact that abuse may not be reported even where it has been identified or at least suspected, it is likely that a significant number of cases of child abuse never come to the attention of child protection agencies. Once a case is notified to the child protection system, professionals have to make decisions about whether it warrants investigation and if so about what further protection the child needs. Research has attempted to study the process of decision making and assessment and to examine why some cases become registered, result in criminal proceedings or lead to a Children's Hearing while others do not. The findings of these studies have been presented in this section. Child protection investigations in the UK are supposed to be multi-agency and this section, therefore, ended by considering the research evidence in relation to inter-agency working.

'It's everyone's job to make sure I'm alright.'



Addressing the problem and 'what works' in child protection

Messages from elsewhere

Prevention

Messages from reviews and inquiries

What works in child protection: practice issues

Conclusions

Messages from elsewhere

This chapter briefly considers the ways in which some other countries address child protection concerns.

(i) Standardised risk assessment and differentiated response systems

Precise risk assessment tools have been used in North America and Australia with the aim of ensuring judgements about eligibility for services or the need for investigation and intervention are standardised and comprehensive. In many ways the Australian child protection system is similar to that found in the UK. Some states have, however, introduced much more standardised risk assessment and case response differentiation mechanisms than found here (Hill 2002). Most services have adopted some form of structured risk assessment tool or checklist. Attempts have also been made to more efficiently tailor the response to reports of child maltreatment through the introduction of some form of differentiated response system or the streaming of reports based on an initial assessment of the extent to which reported concerns require/do not require a child protection assessment. Central intake teams have been introduced. Some agencies have pioneered new ways of helping families, for example, the Strengthening Families Model in Victoria provides support to families 'at risk' to prevent them becoming child protection clients. Staff work primarily to build on families' strengths rather than modify their deficiencies and seek to engage families in developing their own solutions. The benefits of these new practices in Australia are that families are not unduly traumatised by inappropriate protective investigations and are more likely to accept assistance. Family problems can be comprehensively assessed and appropriate services put in place to address them. The new risk assessment schedules, however, have been found to take up a lot of staff time and lead to a more rigid response to families and their effective use is dependent on appropriate training. Most importantly, there needs to be adequate investment in the resources available to support families, otherwise an approach based on central intake and a differentiated response system merely improves investigatory processes with limited impact on clients (Tomison and Poole 2000; Tomison 2002).

Four types of risk assessment system are used in the US:

- The Matrix approach which contains 16 to 35 factors which describe a level of child, parent or family functioning each of which is rated on a 3- to 5-point scale in terms of its contribution to low, moderate or high levels of risk to a child.
- The empirical predictors method which focuses on a small number of risk factors more predictive of child abuse or neglect. The child, parent or family characteristics associated with child abuse or neglect are considered but not included in the final set of risk factors unless they actually predict the re-occurrence of one or more types of child abuse or neglect.
- Family assessment scales where assessment of child and family functioning is the primary focus of the instrument rather than identification of risk factors. The family is rated at multiple points during casework with a view to identifying risk factors as well as family strengths and resources.

- Child at risk fields which use an ecological approach and are organised around five forcefields - child, parent, family, maltreatment and intervention. A series of open-ended questions and rating scales are used to help workers identify risk influences that may be operating in the family situation. This is one of the most comprehensive forms of risk-assessment systems available in that it considers a variety of risk influences, helps workers make decisions about initial safety and promotes the use of risk assessment throughout the entire casework process.

At least 42 states have now adopted risk-assessment schedules. There is evidence that they can be helpful but also that they vary considerably in their definitions, purposes and the quality of evaluation (Dent 1998 Haggell 1998). DePanfilis and Scannapieco (1994) recommend that controlled studies which compare safety outcomes between groups of maltreated children whose caseworkers use models for assessing risk and safety and those who do not use any particular model or criteria should be carried out.

Risk assessment tools have been used far less in the UK although there is currently interest in developing them. There has also been very little research into the effectiveness of different ways of assessing risk in the UK in comparison with the US where risk-assessment models have been assessed for their effectiveness in terms of validity and reliability (Sargent 1999). The Department of Health have recently introduced a framework for the Assessment of Children in Need and their families (Department of Health *et al* 2000). Research is currently being carried out into the effectiveness of the framework. There are to date no similar national guidelines in place in Scotland although work has been taking place in relation to assessment frameworks. For example, the Assessment Development Project, a joint initiative between Dundee University and local authority social work departments. The project began following an evaluative study of assessment in cases of neglect which indicated the need for a flexible framework for assessment with guidance on how to move from the gathering of information to the development of a purposeful plan of intervention (Daniel 1999a). The Glasgow Assessment framework (Glasgow Assessment Framework Guidance Notes (undated)) is being devised so that all assessment activity which involves services to children can be considered within a single framework. It is based on the Department of Health framework but has been adapted to local circumstances.

(ii) Family support

The child protection systems of Sweden, France, Germany and Belgium have a much stronger emphasis on family support and mediation than those of the UK, North America and Australia. In Sweden and Belgium child protection is rooted in traditional social policies that seek to provide social assistance and public services on a comprehensive basis (Hill 2002). In Sweden the system works in partnership with parents, as part of the general system of social welfare offered as a right, voluntarily and with resources to support families. Social workers usually have good relations with service users. An example of the extent to which professionals work with families to keep them together while ensuring appropriate care is the possibility of housing whole families together for four months for assessment (Khoo *et al* 2002).

In Germany the concept of family rights is very strong. Judges are often reluctant to order the removal of a child from the family home against the wishes of parents even where the reasons for doing so are compelling. Indirectly this forces local authorities to allocate more resources to preventative work. Germany's Children and Youth Services Act has been successful in persuading local authorities to allocate a greater share of resources to family support work. The emphasis in family support is on helping the family to help themselves by identifying problems and building on strengths. The emphasis on family rights has been successful in reducing the number of children in public care but there is concern that this is at the expense of the rights of the child to protection (Buchanan 1996).

Formal intervention in the French system is framed in terms of a package of support and education rather than child protection. The Children's Judge acts as a kind of case manager combining a judicial, therapeutic, social and moral function. S/he rarely uses his or her authority to impose measures, but instead to develop trust and negotiate outcomes with professionals and families. Social workers together with the Inspecteur or the Children's Judge are freer to take risks to keep the family together. There is an investigation of risk as in the UK but this appears to result in more preventive action rather than investigation and surveillance and parents seem less fearful of the system (Buchanan 1996, Cooper 2002).

(iii) The confidential doctor service

The confidential doctor service which is predominant in the Netherlands, Belgium and parts of Germany offers an alternative and therapeutic approach to dealing with child protection. It was first developed in the Netherlands and is essentially based on the notion that parents with difficulties, or those who have abused or neglected their children, should be able to come of their own free will, to an agency which they can be confident will give them help without the risk of being judged or prosecuted (Borthwick and Hutchinson 1996; Madge and Attridge, 1996; Marneffe 1992).

The confidential doctor centres in Belgium are located in hospital settings and directed by a consultant psychiatrist leading a multi-disciplinary team of professionals including social workers, psychologists, nurses, speech therapists and health visitors. Services offered include crisis intervention; telephone counselling; child, individual, couple and family therapy; and residential accommodation in the hospital. The centres also offer support and counselling to professionals involved in child protection work, together with training, information and research. The aim is to help parents acknowledge their action and take responsibility for not harming their children in the future. Emphasis is put on supporting the non-abusing parents' capacity to protect the child. Families are followed up over a considerable period of time. There are a high number of self referrals to the confidential doctor service. Self-referrals or referrals from the parents themselves make up more than 30 per cent of cases. Incidence of reabuse has been found to be low (Borthwick and Hutchinson 1996; Madge and Attridge 1996; Marneffe 1992). A number of concerns have, however, been expressed about the confidential doctor system:

- the child's interests might be subordinated to the parents' rights and wishes;
- children might undergo continuing abuse while agencies seek to work with their families; and
- family therapy may not address issues of power within families, particularly power imbalances related to gender (Hill 2002).

(iv) Family Group Conferencing

Family Group Conferences were originally used as an alternative way of dealing with juvenile justice. They have since been used in the area of child protection where they operate on the basis that extended family networks are the prime repositories for creative solutions to the problems of child abuse and neglect. The Family Group Conference (FGC) was developed in New Zealand. It is a legal process based on traditional Maori decision-making practices which brings the family and the state together in a shared decision-making process. Established under the Children, Young Persons and their families Act 1989 Family Group Conferences were an attempt to address the cultural gaps in service delivery and to place the family, particularly the extended family, at the heart of the child protection process. The Act moved decision making about children in need of care and protection and young offenders from the court room and professional office to the Family Group Conference, reduced the power of social workers and increased the role and authority of the child's extended family (Connolly and McKenzie 1999; Swain 1995).

An FGC is convened by a Care and Protection co-ordinator and has three phases:

- information sharing;
- private deliberation; and
- reaching agreement.

During private deliberation the professionals withdraw and the family consider whether the child is in need of care or protection and make decisions on the basis of this discussion. Only a very small percentage of FGCs fail to reach agreement and when they do not, dispute is usually between family members, not between family and professionals. Families from other cultural groups as well as Maori have welcomed the opportunity to be involved in decision making about their children. There has been a world-wide interest in the FGC approach as it seems to offer a vehicle for creating a genuine partnership between families and services and a strong likelihood of children maintaining links with their families. The FGC model is increasingly being used in Canada, Australia and the US and there have been a range of local pilot FGCs in the UK, for example, the Hampshire Social Services Department pilot (Connolly and McKenzie 1999; Swain 1995; Marsh 1996).

The benefits of using FGCs include the healing of family rifts, indications of a lower reabuse rate and the potential for services to have an improved public image. Gilling *et al* (1995) found that the FGC process was a positive experience for some family members and

assisted them in addressing care and protection difficulties. Family Group Conferences are not necessarily beneficial for every child, however, and a number of problems have been associated with their use:

- family members are not always given sufficient information about the circumstances of the care and protection situation or about the FGC process;
- the assumption that family placement is inherently better than non-family placement is not universally valid and the automatic inclusion of family is not always a straightforward matter: extended family networks might not exist or someone may be alienated from family members; the FGC may arouse previously dormant family problems or disputes and protection for vulnerable family members may need to be provided; the power of more dominant family members may need to be challenged otherwise less assertive but important family members may not be heard;
- the family decision-making process enables children's views to be heard but within some traditional indigenous practices, for example, some Pacific Island cultures children's opinions are not privileged and disagreement with adults is not necessarily sanctioned;
- there have been concerns about inadequate resourcing of FGCs. The process can be expensive in terms of getting family members to meetings and in the need for a range of supportive services and programmes to enable families to succeed with their new responsibilities. It is difficult to say whether FGCs save money but the fact that fewer families are referred to court would suggest savings are likely. There may also be savings in terms of placements with families instead of outside placements; and
- there are a lack of effective systems for monitoring the implementation of conference decisions and for taking action where the decisions are not implemented as agreed.

It has also been suggested that children and young people's interests will be compromised or that families involved will be dysfunctional and unable to make decisions but the experience of FGCs has found that most of these criticisms are of limited significance (Connolly and McKenzie 1999; Swain 1995).

Initial findings from research in the UK suggest that Family Group Conferences may be useful in that they are based on a 'strengths' model, seeing families as having positives to offer rather than a 'deficit' model which assumes that families are not fit to plan for their child's welfare (Morris, 1996). Families seem to make safe plans and experience ownership in the plan. People who have experienced child protection conferences and FGCs point to stark differences between the two. They find conferences intimidating and do not like being with strangers who talk about their lives. FGCs make them feel more at ease because it is just family rather than strangers. The Hampshire research found that:

- 73% of people felt positive about being asked to participate;
- neutral ground away from social services buildings and family homes was felt to be important by nearly everyone;
- the large majority appreciated being left to deliberate in private without professionals involved;
- 80% of people felt they were listened to;
- 37% would have liked more information about the FGC process as they were not clear how the family meeting would work;
- 80% of people were satisfied with their plan and 12% partially satisfied; only 8% were dissatisfied;
- 86% said the FGC process was good, 10% were undecided, only 4% felt it was bad;
- the great majority (86%) of social workers endorsed the model wanting FGCs to remain available; and
- social workers reported that setting up the meetings could be very time consuming (Nixon *et al* 1996; Crow 1996).

Prevention

The respondents who wrote to the National Commission of Inquiry into the prevention of child abuse (1996) suggested various ways in which they felt child abuse could be prevented. They suggested:

- more education so that children would know where to get help;
- families should talk more about child abuse, the subject should not be taboo;
- the media could play a greater role in promoting greater awareness to communities and families;
- communities and families should be better able to see the signs of child abuse;
- the community should take a collective responsibility. They should be encouraged to report child abuse, should encourage children to tell of child abuse and should listen to children; and
- schools had a vital role to play in helping to prevent child abuse: they should provide education on child abuse and sex, parenting skills and education on children's rights.

The Commission pointed out that people who have experienced abuse have valuable insights into how it can be prevented and they recommended that more participative research and empowering research should be undertaken.

The Commission concluded that most of the abuse children suffer is preventable. Prevention of child abuse has, however, been a somewhat neglected area in the UK. The report of the review of CPCs in Scotland (Scottish Executive 2000a) found that some local authorities were undertaking preventative work and the development of local preventative strategies appeared to be an emerging area of CPC work but on the whole, prevention work was not widespread.

Hardiker *et al's* (1997) model of prevention in child care consists of four levels of prevention:

- in the first level the aim is to prevent problems from arising and to stop people becoming 'clients';
- the second level targets early risks and involves early identification of the problem and intervention;
- at the third level intervention is aimed at serious risks, to prevent clients being drawn into increasingly intrusive and damaging interventions; and
- the fourth level is based on rehabilitation and addresses families for whom severe past problems have been identified and those children who have entered the care system. It also addresses the institutional abuse of children.

This section looks at different prevention schemes which attempt to prevent child abuse and neglect or the recurrence of child abuse and neglect.

(i) Primary prevention

Primary prevention entails supporting children and families to prevent abuse from ever happening. Intervention involves programmes targeted at the whole population such as community education programmes. Primary prevention strategies aim to:

- alleviate social and economic pressure where possible;
- enhance informal and formal networks, thus reducing social isolation; and
- provide opportunities for parents to improve particular skills such as parenting, child management, social skills (so enhancing economic opportunities); literacy, etc.

Projects typically target both formal and informal support networks. Interventions aimed at primary intervention include such things as: teaching parenting skills; preventing teenage pregnancy; teaching conflict negotiation skills to young people; promoting values which eschew violence, sexism and racism (National commission of inquiry into the prevention of child abuse 1996; Macdonald 2001).

Examples of primary prevention aimed at the general population are midwifery, health visiting, and GP child health surveillance services. Schools can exercise significant preventative action on future parents although in Britain school-based prevention has often been limited to the prevention of child sexual abuse using the 'Say no!' campaigns which have led to an increase in disclosures (Dent 1996; Blumenthal 1994; Dickon Reppucci 1997; Macdonald 2001; Corby 1993). Official advice to schools on their role in child protection has concentrated on the detection and reporting of child abuse but Mellor *et al* (1995) believe that there are three main aims associated with protecting children in school:

- detection and response - identifying children who are, or may be, in danger and taking appropriate action to ensure the safety of the children involved;
- curriculum - helping young people to develop skills and values which will assist them to assert their rights, accept their responsibilities, build better relationships and to resist or avoid hazards such as abuse or harassment; and
- ethos - creating an ethos within a school which promotes values such as self esteem, openness, tolerance and caring so that children are less likely to become adults who misuse their power.

A US study by Gibson and Leitenberg (2000) was the first study to find that school-based child sexual abuse prevention programmes are associated with a reduced incidence of child sexual abuse by demonstrating that rates of victimisation differed between children who had, and had not, received a sexual abuse prevention programme. The results indicated that young women who had not participated in a school prevention programme in childhood were about twice as likely to have experienced child sexual abuse. The authors suggested that a potential sex offender may be less likely to approach a child who has participated in a prevention programme because they may perceive them as less vulnerable. They may be

less likely to approach them out of fear that they will disclose the abuse or reject their inappropriate sexual overtures. There was also a trend for those who participated in a programme to disclose sexual abuse sooner than those in the no prevention group. The authors stated, however, that their findings were based on a white, female, primarily upper-middle-class sample and that their study should be replicated with a more diverse sample. They suggested that the most appropriate future study would involve random assignment of children to prevention versus no prevention programme groups during childhood with long-term follow-up into young adulthood.

Parent education has traditionally been directed towards small and select groups such as parents at high risk of maltreating their children, instead of towards a broad spectrum of new and potential parents. Parent education classes geared towards young people are important since educating children and adolescents about child-rearing roles and responsibilities before they are parents may decrease the risk that they will abuse their children as adults. Primary prevention programmes in relation to sexual abuse have been criticised for placing the responsibility of prevention on the shoulders of potential victims but there is undoubtedly merit in equipping children in general self-protection skills by means of abuse awareness campaigns (Dent 1996; Blumenthal 1994; Dickon Reppucci 1997; Macdonald 2001; Corby 1993).

Primary prevention programmes highlight the important role of agencies other than social welfare agencies in preventing child abuse and neglect. Such programmes are broader and generally have a more positive focus so they are likely to avoid the stigmatising features of interventions that address the problems of individuals already labelled as abusive or neglectful. Their biggest disadvantage, however, is their cost (Macdonald 2001). It can be difficult to demonstrate the cost effectiveness of programmes which are designed to be offered to whole communities or populations (e.g. all new parents). The WHO (1999) state that preventive costs are many times less than the combination of treatment and long-term costs to the individual; the family and society in terms of medical care, mental health and substance abuse care; criminal justice systems expenditure; legal costs; costs to the educational system caused by poor school performance; and years of life lost due to death, disability and other long-term costs. The National Commission of Inquiry into the prevention of child abuse (1996) estimated that the cost of child abuse to statutory and voluntary agencies was £1 billion a year, much of which was spent dealing with the aftermath of abuse rather than its prevention. The main agencies involved in preventing and investigating child abuse did not know what they spent on it at local and national levels nor what return they got for their investment and effort. The Commission concluded that insufficient priority was given to preventing abuse and that investing in prevention should save money in the long term. It stressed that evaluation of good practice and effective means of preventing child abuse was urgently needed.

(ii) Secondary prevention

Secondary prevention involves early identification and intervention targeted at certain communities. Subsets of the population known to be at risk of child abuse are targeted, typically poorer members of society, and those with least family support such as lone parents. An example of secondary prevention is local authority nurseries for children in need. Effective secondary prevention hinges on our ability to reliably identify factors which place individuals or groups at increased risk of abuse. In some areas, such as prenatal screening, there is evidence that this can be done to a fair degree of accuracy and there is mounting evidence that agencies can subsequently intervene effectively. One of the most developed areas of secondary prevention has been that of identifying women thought to be at risk of problems with parenting, including abuse and neglect, and providing a variety of forms of assistance during and/or after pregnancy. The majority of such programmes comprise home visiting. The emphasis has been on identifying mothers with problems of parenting. Such programmes rarely consider working with fathers to improve their parenting skills (Macdonald 2001; Blumenthal 1994; Macdonald and Winkley 1999). Health visitors have commonly used checklists of risk factors to give special attention to those in greatest need of help in parenting before child maltreatment begins. The checklists used have not been systematically evaluated and some non-abusing families can be incorrectly identified as high risk for potential child abuse if they have a number of risk factors. Such cases are known as 'false positives' (Browne 1995b).

Leventhal (1997) lists what he believes to be nine ingredients of successful home-based services:

- they should begin early either pre-natally or shortly after a child's birth;
- visits should occur frequently and over an extended period of time so that relationships can develop between the home visitor and the parents;
- the primary goal of the home visitor is to develop a therapeutic relationship with the family;
- the home visitor needs to be a watchful eye in the home;
- the home visitor needs to focus on parenting;
- the child's needs should be the primary focus of the intervention;
- the home visitor should be able to provide concrete services, such as helping to find appropriate housing, and providing transportation to the child's health-care provider;
- fathers need to be included in the preventative efforts; and
- the frequency and intensity of services need to be tailored to the family's needs.

Olds *et al* (1986) carried out a randomised trial of nurse home visitation for high-risk, first-time, young new mothers in New York which had a significant impact on the knowledge base of the field and thoughts about best practice and helped prompt a host of thoughtfully designed projects around the world aimed at helping new parents get off to a good start. Families were assigned at random to one of the four treatment conditions. Some parents were allocated nurses who visited regularly during pregnancy and until the child was 2 who educated the parent on foetal and infant development, enhanced the informal support available to women during early child rearing, and connected families with community health and human service agencies. By providing frequent support, identifying family strengths, adopting a structured yet flexible curriculum and summoning both formal and informal community support, the nurses were successful in preventing a number of care giving dysfunctions including child abuse and neglect. This finding was supported by a variety of sources: department of social service records, maternal reports of child behaviour and maternal caregiving, observations of maternal caregiving, the children's developmental tests and emergency room records. The nurses were not only able to improve the quality of caregiving but were also able to affect pregnancy outcomes and maternal life course development (such as rates of employment, education and fertility) as well. Because of its service intensity the program was expensive but cost-benefit analysis suggested that a major portion of the cost of home visitation could be offset by avoided foster care placements, hospitalisations, emergency room visits, and child protective service worker time incurred during the same time the program was provided and the long-term financial savings to the community were likely to be substantially greater.

Parenting programmes aim to:

- provide information about child development, health, hygiene, safety, etc.;
- help parents reconsider and reframe 'age inappropriate' expectations and misattributions;
- enhance the quality of child-parent relationships by, for example, teaching play skills, structuring the day so that time is set aside for themselves and their children;
- develop parents' ability to monitor and track their children's behaviour and to respond appropriately, including the management of challenging behaviour; and
- increase support networks (Macdonald 2001; Dickon Reppucci 1997).

Smith (1997) studied the range and spread of group-based parenting programmes in the UK and found that there was little systematic attempt to match the development of parenting programmes with the particular characteristics and needs of different parents. Few fathers were involved and black families did not always find the approach of the programme appropriate to their cultural attitudes to parenting. There is little evidence based on rigorous evaluation methods about the effectiveness of parenting programmes in the UK but Smith maintains that anecdotal evidence, parents' self reporting and the views of a range of professionals all suggest positive outcomes for parents and children in terms of a number of indicators.

(iii) Tertiary prevention

Tertiary prevention aims to reduce the severity and effects of child abuse after it has occurred by some means of rehabilitation and treatment. Intervention targets certain groups of families in which children are considered to be at risk. Prevention is intended to prevent recurrence or minimise psychological damage. Measures include therapy, identifying and reporting child abuse, following abuse procedures and reporting to the courts if necessary. Certain intervention efforts aimed at identified abusers and children are useful and relatively successful if implemented properly, but the utility of such intervention must be weighed against the very high costs (in human suffering as well as financial) of efforts that focus on reversing long-standing problems that have worsened to the point of abuse or neglect. Such intervention needs to be combined with primary and secondary prevention programmes (Blumenthal 1994; Dickon Reppucci *et al* 1997; Macdonald and Winkley 1999).

Some countries, such as the US are more advanced than the UK in terms of treatment approaches. Gray *et al* (1997) found that statutory agencies in the North East of England concentrated on investigation and assessment of 'cases' rather than on longer-term therapeutic assistance and facilities for abusers who were children were particularly limited. Therapeutic provision for survivors of sexual abuse was a relatively low priority for statutory services and where it existed it was generally provided by large 'voluntary' agencies. Half the survivors who were interviewed said they wanted open access to therapists and almost all indicated that therapeutic help should be available as long as an individual felt s/he needed it. There was a general need for much more therapeutic work, a need for assistance to partners of people who had been abused, and flexibility of provision and services to people of minority ethnic origin. Sharland *et al* (1995) found that families affected by extra-familial abuse received least help from child protection agencies.

Treatment methods can be targeted at perpetrators and survivors of abuse. Treatment for survivors of child abuse includes:

- individual treatment approaches (anxiety reduction strategies, social learning strategies, eclectic therapeutic treatment);
- paired treatment approaches (pairing, sibling group pairing);
- group treatment approaches (short-term behavioural group, long-term psycho-dynamic therapy, structured coping skills group, eclectic group treatment); and
- combined treatment approaches (individual, groupwork and family therapy programme parallel groupwork with survivors and carers).

Evaluation suggests that individual treatment packages should be tied to a quality assessment process reflecting the child's individual needs. Long-term involvement is indicated for all but minor abuse. The decision on appropriate treatment should be a multi-disciplinary one made at a child protection conference or child care review and all relevant agencies should be involved in continued liaison and review of treatment. There is accumulating research evidence

that the involvement of non-abusive mothers in the treatment of their sexually abused children leads to improved parenting practices and to decreased behavioural difficulties and less depression in the children. Cognitive behavioural approaches to the treatment of survivors of sexual abuse have been shown to be effective, particularly when the non abusing parent receives support as well (Simpson 1994; National Research council 1993; Murray 1999; Deblinger and Hope Heflin 1996).

Grosz *et al's* (2000) US study found that a family centred approach to intervention was essential and that a significant factor in recovery for child victims of extra-familial sexual abuse was the parents' capacity to resolve their own distress and support the child victim. A decrease in behavioural symptoms based on clinical observation and parent reports was the major indicator that children had improved sufficiently to graduate from treatment. Progress observed in children after participation in group treatment included significant decreases in sleep disturbances, angry outbursts, moodiness, clinging behaviours, separation anxiety, fearfulness, emotional frailty, and belligerence. Parents reported improvement in children's self esteem, self confidence, school performance and relationships with parents, siblings and peers. Significant indicators of recovery for parents were decreases in anxiety, anger, sadness and guilt felt about the sexual abuse.

For male adult perpetrators treatment methods include:

- individual treatment approaches (surgical treatment and drug therapy; psychoanalytic therapy; behavioural therapy; cognitive behavioural therapy; telephone helplines);
- group treatment approaches (cognitive behavioural group treatment; staged multi-agency group treatment);
- family treatment approaches (psychodynamic family therapy); and
- combined treatment approaches (combined family therapy; self help and volunteer programmes).

All evaluations conclude that to be effective interventions must be long term and there appears to be a strong argument for statutory treatment because if treatment is delivered on a voluntary basis denial may enable the abuser to counsel himself out of treatment (National Research Council 1993). Simpson (1994) argues that treatment needs to be delivered within the context of the child protection system since child protection issues may be generated within the abuser's treatment programme and there needs to be constant review of progress and feeding of this information to all the relevant agencies in the child protection system.

Treatment of female abusers is at an early stage with few programmes in existence in the UK. Some people argue against using male treatment interventions with female abusers because differences exist in the type of abuse women commit, their motivation to abuse and in their response to treatment but some methods used for male offenders may also be useful for females. It is generally felt that treatment should be long term but it may be possible to deliver it in a voluntary context as women tend not to deny the abuse and are more willing to take responsibility for it. As with male abusers there needs to be reviews of

progress and feeding of the information to all relevant agencies (Simpson 1994; National Research council 1993).

For child and adolescent abusers treatment is a recent development in the UK. It is suggested that a case conference should be called for all children and young people who abuse so that treatment can be integrated within the child protection context. Clear definitions about when a child's sexual behaviour should be regarded as abusive are important since professionals may interpret abusive behaviour as 'experimentation' or 'exploration'. Alternatively they may be over zealous and behaviours that are 'normal' sexual experimentation may become caught in the net resulting in unnecessary labelling and treatment of the child (Simpson 1994; National Research council 1993).

Gough (1993a) reviewed the research literature on child abuse interventions. He found that studies which used volunteers and parent aides to carry out preventive work with individuals who may commit abuse, in circumstances where parenting difficulties had been identified, all reported improvements and the interventions were positively perceived by both users and workers. He concluded that while further research was needed, the low cost and acceptability of lay services by clients suggested that they offered considerable potential for development. He also found that behavioural interventions were effective in cases of physical abuse and that improvements in parenting can occur in a relatively short period, usually in well under six months. Studies of non-organic failure to thrive described interventions ranging from support and advice to individual therapy to rigorous behavioural programmes. The studies demonstrated marked improvements in weight gain.

(iv) Community intervention

Prevention and intervention can be:

- at the individual level, for example psychotherapeutic help for abusive parents; treatment for abused children; alcohol and drug rehabilitation programmes; job search assistance; stress-relief measures;
- at the level of the family, for example marriage counselling; help with managing home budgets; parenting skills training; home safety training; antenatal parent craft training; health visiting;
- at community level, for example provision of good housing, health and social services; professionals trained to recognise abuse; provision of a child protection service; screening of child care personnel/foster and adoptive parents; establishment of crisis telephone lines; facilitation of community support groups; provision of foster/respite care for families in need; provision of family planning and immunisation clinics; and
- at a cultural level, for example enacting child protection legislation; prohibiting corporal punishment; promoting alternative forms of discipline; campaigning to increase public awareness; auditing prevalence and undertaking research into prevalence (Blumenthal 1994).

The National Commission of inquiry into the prevention of child abuse (1996) concluded that to prevent child abuse the whole community needed to be encouraged to take responsibility for the care and protection of children. Jackson (1994) believes that everyone in a community should be given a feeling of responsibility for protecting children rather than a few designated professionals. She maintains that the media has enormous potential for informing the public, helping to shape parenting practices and creating a general sense of responsibility for the protection of children. Gray *et al* (1997) also believes that a truly effective challenge to child sexual abuse can best be founded upon a community-orientated approach. She feels that services should be user-led and user provided within a community-orientated model but would need to be adequately supported by central and local government in terms of money, and staff time. The role of welfare professionals would be to act as enablers via advice and consultancy and to provide the mechanism for legal mandates and criminal sanctions where required. She discusses the work of Smith whose central idea is to devise a protective ring of adults within the community which can 'insulate' a child from potential perpetrators. She argues that instilling knowledge and skills into the community about the reality of sexual abuse and informing them about how to reduce the risks must be an essential part of an overall child protection strategy.

Nelson (1998) argues that social work cannot solve the problem of child sexual abuse alone, it can only contribute positively to a massive task in which every section of society needs to play a part. She proposes a new strategy for social work where community prevention approaches which create safer living environments for children are the priority and reactive intervention in individual cases is secondary. Social work resources would be used to create safer communities for children such as low cost babysitting schemes for single mothers on housing estates; safe supervised outdoor play areas; high quality creches and after school care; outreach information; and advice services for groups such as homeless or drug using teenagers who are targeted by abusers, including convicted sex offenders released into the community. Self-protection programmes for children and programmes aimed at changing attitudes which rationalise sexual abuse (such as the Zero-tolerance campaign) would be central to the work of social work. They might share a multi-disciplinary input to schools programmes and projects with boys and young men in the community which challenge their attitudes to sexual violence.

The Henley Safe Children Project (Baldwin and Carruthers 1998) operated in an area of Coventry which had the highest rates of child protection referrals, registrations and admissions to public care and recorded crimes. The project was based on an ecological approach which viewed the child and family within wider social and economic contexts. Local people were asked to identify major sources of stress and risk in bringing up children, to give their views of what support systems were needed in Coventry and to suggest ways in which parents could support each other. Key action points were identified as: day, evening and respite childcare; safe play areas; better transport; flexible user-friendly clinics; counselling for parents and children available when they said they needed it; behaviour management courses and preparation for parenthood classes; street safety. Attitudes

identified as most in need of campaigns and projects included 'macho', racist and sexist street cultures; intimidation of children with disabilities; aggressive assertion of power by white people; male attitudes to power and sexuality (Baldwin and Carruthers 1998).

Baldwin and Carruthers (1998) concluded that the findings of the project supported wider research findings and evaluations which suggested the need for multi-agency, long-term neighbourhood strategies. They suggested that such strategies should be developed in partnerships between local people and voluntary and statutory organisations and have the following elements:

- comprehensiveness, offering a broad spectrum of services, flexible and informal as well as intensive;
- family and community oriented;
- staff with time and skills to develop relationships of respect, trust and collaboration;
- continuity of small committed teams;
- support from organisations for workers to cross boundaries, and change roles; and
- recognition that needs are untidy and cross professional and bureaucratic boundaries.

Key action points were identified as:

- family support both practical (childcare during the day, out of hours and respite as well as emergency sitting services; user-friendly clinics, surgeries, shops, etc.; safe play areas; accessible transport) as well as social and emotional (local social networking; counselling for parents and children, accessible when they say they need it; behaviour management and preparation for parenthood classes);
- social environment (safe constructive play and activities for all ages; action against crime, drug abuse, violence, bullying, racism, sexism, prejudice); and
- partnership and participation opportunities (needs-led flexible services; recognition of the expertise of local people; links to training and job opportunities; anti-poverty initiatives, anti-oppressive policies and practices).

Communities that Care (CTC) (Joseph Rowntree Foundation 2001) is another example of a community-based prevention programme designed to ensure that children and young people grow up in safer and more caring communities. The programme was developed in the US but 23 projects now operate across England, Scotland and Wales. The CTC process provides a blueprint by which communities can identify the particular local risks that face their young people and work with others to implement evidence based projects targeting those risks.

Messages from reviews and inquiries

At least one to two children in the UK die every week from abuse and neglect. In spite of many inquiries and changes to child protection practice over the last 30 years, child deaths from abuse and neglect have not decreased (NSPCC 2001). Of the 70 reports identified by Corby *et al* (1998) 13 were statutory, 34 were carried out by authorities using an independent inquiry panel and 19 were carried out largely on an internal basis. 51 of the 70 inquiries were concerned with physical abuse of individual children living in their own homes or in foster families, three were concerned with gross neglect and one with sexual abuse. Three of the inquiries - Cleveland, Orkney and Newcastle Upon Tyne dealt with the response of public agencies to multiple cases of alleged sexual abuse in the family home and in day care and the remaining 13 were concerned with the physical and sexual abuse of children in residential care. The aim of public inquiries into child abuse is to find out about causes, to establish responsibility where possible and to arrive at recommendations to avoid the recurrence of similar events in the future. The findings of child abuse inquiries continually stress the fact that many fatal child abuse deaths are preventable. Inquiries and reviews tend to repeat the conclusions of previous inquiries and reviews which would seem to suggest that lessons are not being learned (Reder *et al* 1993; Longlade 1999; Brandon *et al* 1999). Inquiries into child deaths have repeatedly identified problems in the management of the cases involved (Department of Health 1991; Munro 1998; 1999; Fitzgerald, 1998; 1996; Corby *et al* 1998; Ibbetson 1996; Greenland 1986). This chapter considers the findings of reviews and inquiries into child protection practice.

(i) Professional standards

Many inquiries have highlighted unacceptably low professional standards. The reports make constant reference to the clouding of professional judgement and lack of professional experience and expertise. Inquiries often have difficulty ascertaining what judgements and decisions social workers have made and the reasoning behind them (Munro 1998; Department of Health 1991). The Hammond report concludes that no single person was responsible for Kennedy's death and that the staff did their best in difficult circumstances. The report states, however, that there were numerous opportunities when the extent of the risks to Kennedy could have been identified and effective intervention implemented. The report points to the fact that health colleagues could have challenged the decision to discharge Kennedy during or after the meeting and to the fact that the team manager should have felt that there was enough concern/evidence of harm to justify a case conference (Hammond, 2001). Some inquiries have pointed to breaches of departmental policy (Department of Health 1991). For example, the Kennedy McFarlane report concluded that Dumfries and Galloway had in place practice and procedures in keeping with current guidelines which if fully invoked would have led to her protection, but the procedures which should have led to full multi-agency investigation, risk assessment and a child protection plan were never fully instituted (Hammond, 2001). Brandon *et al* (1999) also found many instances of non-procedural adherence in their analysis for the Welsh office of serious child abuse cases in Wales.

The process of assessment is consistently criticised in inquiries, particularly in relation to professionals' understanding of risk factors (Department of Health 1991; Brandon *et al* 1999). In assessing risk and family functioning there is sometimes a tendency to overlook the mother's male partner, the father's past is not always examined or his role in the current circumstances assessed. Domestic violence is sometimes ignored, particularly its significance in assessing risk to children, for example, the reports in relation to Sukina and Rikki Neave highlighted the impact of domestic violence and showed that there was a lack of any systematic assessment of the male carer's capacity to parent and of their dangerousness to the children in their care (Munro 1998; Fitzgerald 1998; O'Hara 1993; Cleaver *et al* 1998; Brandon *et al* 1999; Hill 1990). The McFarlane report highlighted the lack of methodical investigation and analysis throughout the case, particularly at team manager level. Lack of effective documentation and presentation of the medical evidence resulted in a failure to give an implicit account of the inherent risks to Kennedy's safety. Subsequent investigation produced a lot of information about the problems of the family, the mother's health, etc. which would have been very relevant to the risk assessment and planning for Kennedy. This was available to be gathered at the time had a full investigation in line with child protection procedures been triggered (Hammond, 2001).

Inquiries also highlight inadequate social work training and an inadequate grasp of the theoretical knowledge needed to make sense of the information which is gathered. Reports continually recommend more training. They suggest that social workers need a working knowledge of research on factors which are predictive of child abuse eg domestic violence, and some reports comment on the need for greater knowledge of the relevant procedures and legislation (Munro 1998; Greenland 1986; Department of Health 1991; Brandon *et al* 1999). There was uncertainty over the legal procedures in the McFarlane case. The professionals interviewed shared a lack of clarity about procedures and decision making. At the early stages they were unsure whether the case was a child care or child protection referral. Health and social workers were unclear whether the planning meeting was an informal preliminary case conference, a pre-referral sharing of professional concerns or a meeting of professionals to plan ongoing child protection investigations. As a result they were confused about its status and whether or not parents could be excluded (Hammond, 2001).

Lack of supervision and incidence of poor line management has been a further theme of inquiry reports (Greenland 1986; Department of Health 1991; Brandon *et al* 1999). The McFarlane report highlights the need for regular and meaningful supervision. The report states that there was inappropriate reliance on the opinions and advice of others and over confidence in the decision making by/of team managers and a failure to recognise the need to introduce checks and balances by testing out theories and plans with experienced colleagues. The team manager never mentioned the case to her line manager in monthly supervision sessions although a number of these were cancelled due to pressure of work. The tendency for professionals who perceived themselves to be at a lower level in the hierarchy to defer to those at a higher level was another feature of the case (Hammond, 2001).

Poor recording has also been highlighted by a number of inquiries and there are numerous examples of information not being recorded or being recorded incorrectly. Many reports have concluded that the low standard of record keeping adversely affected the way a case was handled. It has been recommended that the quality of record keeping should be monitored and referral information properly recorded (Munro 1998; Department of Health 1991; Brandon *et al* 1999). The failure of social work staff to complete the forms required in child care and child protection was a repeated finding of the McFarlane inquiry (Hammond, 2001).

(ii) Communication

A second finding from inquiries is the failure of professionals and agencies to communicate appropriately or share information. Almost every review or inquiry report has catalogued the failure of communication and stated that professionals need to bring accurate information together at an earlier stage, accurately analyse the context of the information and think qualitatively as well as quantitatively about the information. There is a particular problem of inter-disciplinary communication and co-operation with relevant information not being passed between agencies, for example, a failure to communicate admission to, or discharge from, hospital to social services departments (Greenland 1986; Department of Health 1991; Ibbetson 1996; Munro 1999; Brandon *et al* 1999; Hill 1990). Professionals sometimes base assessments of risk on a narrow range of evidence which is biased towards the information readily available to them and they overlook significant data known to other professionals. For example, in the inquiry into the death of 'Paul' it was found that a number of agencies had contact with Paul's family but one of the problems identified was of information being buried in large numbers of files across different agencies (Fitzgerald 1996; 1998).

The Kennedy McFarlane inquiry report highlights a failure to work in partnership with other agencies. Lack of effective communication and joint decision making was a recurrent issue through the inquiry. The team manager took the decision not to request joint investigation although local guidance makes it clear that information from the relevant agencies including police, health and education services should be sought even in referrals not deemed to require an immediate response. Police involvement was not sought until the death despite the fact that accepted good practice in inter-agency practices should have led at least to a discussion with senior police colleagues experienced in child abuse work at each point of referral. The difficulties experienced by professionals in effectively sharing their concerns at case conferences particularly when they conflicted with others' views or where parents were present was a common theme of the case. The inquiry along with many others (Department of Health 1991) highlighted the need for effective sharing of information and stressed the need for team building and training between agencies (Hammond, 2001).

(iii) Interpretation of information

Incorrect interpretation of information is a further finding of inquiries into child deaths. Failure to distinguish fact and opinion can lead to relevant information not being appreciated,

for example, if the source of the information is not trusted. Inquiries have often found, for example, that warnings of abuse from extended families or neighbours are unheeded because they are regarded as malicious. Reports are not responded to although the information they contain may be extensive. The inquiries also demonstrate that information may not be appreciated due to a false sense of security, it can be overlooked if it does not fit the current mode of understanding. On many occasions reports have highlighted that social workers tend to be too optimistic, they often see progress when it is not really there or is so small as to be ineffective. A recurring theme is the extent to which parents will lie and seek to deceive professionals and reports stress that workers must be on their guard against the risk of seeing what they want to believe. Professionals are slow to revise their judgements. Pre-conceived ideas about abusive families can affect professional judgement and information about family features which do not fit these preconceptions can be ignored or misinterpreted which can lead to dangerously low standards of childcare being accepted. For example, there is evidence that the professionals involved in the case of 'Paul' failed to take on new information. Inquiry reports repeatedly comment on workers' reluctance to alter their views and it has been suggested that the involvement of an independent colleague might bring a fresh perspective (Department of Health 1991; Munro 1998; 1999; Fitzgerald 1996; Ibbetson 1996; Cleaver *et al* 1998a; Hill 1990).

There are examples of difficulties in classifying information or distinguishing it from a flood of relevant data, for example, there is a lack of clarity about how to assess medical opinion where injuries or the clinical state of the child are concerning but not clearly non accidental in origin. Medical assessments must be put into context and seen in the light of previous information about the child (Department of Health 1991). The McFarlane inquiry asked the question why the medical information was not gathered, collated and interpreted effectively so that it could be used to trigger an appropriate inter-agency response. Clusters of signs can be more important than any one on their own, for example, in the Beckford case non attendance at nursery, disharmony between parents, the fact that Jasmine had not been seen for some time and absence of information about her health and development were important. Inquiry reports criticise social workers' failure to see the overall picture of the family or the risk emerging over time. They are engrossed in present day issues and fail to stand back and place these issues in a historical context (Department of Health 1991; Brandon *et al* 1999; Hill 1990). By the time of Kennedy McFarlane's discharge from hospital, despite repeated concerns, referrals and admissions a formal child protection investigation had not been triggered. No one had put all the pieces of the puzzle together creating a total picture of escalating harm (Hammond, 2001). Inquiry findings suggest that workers need to be responsive to new information and prepared to reassess and reappraise. They need to recognise that their former views were wrong even though reasonable at the time they were made, that mistakes are an inevitable part of practice and that recognising them is an essential element of good practice and that errors can be alleviated if people are aware of them but strive consciously to avoid them (Munro 1996; 1999; Cleaver *et al* 1998a; Fitzgerald 1996).

(iv) Contact

It is a characteristic of many of the cases in which a child dies at the hands of a parent that it emerges that no one from any of the agencies saw the child during the last few weeks of its life. Families refusing contact or avoiding contact with agencies has been a recurrent theme of inquiry reports. In some instances families have disappeared and their whereabouts have become unknown as they move between areas. Many children fail to attend nursery or school and there are many examples of failure to gain access by health visitors or social workers (Department of Health 1991; Hill 1990). Visits are often recorded without giving details of who was seen so the failure to see a child for a long time may not be apparent in the record. Out of 13 cases looked at by Munro (1998) where a child was withdrawn from public view the absence was only noted and seen as worrying in three. Hostility and violence may accompany the refusal to allow contact with agencies and professionals can be frightened of a parent and avoid contact. Professional fear has an inevitable impact on judgement and discretion (Brandon *et al* 1999). Even where children have been seen there has often been a failure to listen to them. In many cases where children were killed or seriously injured social workers failed to adequately observe the child's demeanour. It is essential that children are seen, not just the subject child but all children in the family, and it is essential that they are spoken to. The detection of changes in children's behaviour over time is important and listening to children is a lesson to be drawn from all inquiries (Department of Health 1991; Fitzgerald 1998).

(v) Staffing

Many inquiry reports highlight problems in delivering an effective service due to staff shortages, over high work loads, failure to provide adequate cover during periods of staff sickness or leave, absence of psychiatric involvement and threats of violence to staff (Department of Health 1991). Fear of violent men is a frequent theme of many inquiry reports into the circumstances of a child's serious injury or death, for example, that of Sukina Hammond in 1991. When a child's father is physically intimidating or where family members are known to be hostile or have a known record of violence professionals are often intimidated from pursuing enquiries, they may refuse to make home visits at all, yet children live in these homes and need to be seen and agencies therefore need to offer adequate support to professionals in contact with violent families (Munro 1998; O'Hara 1993; Cleaver *et al* 1998a; Fitzgerald 1998).

Problems connected to staffing were a feature of the McFarlane inquiry. Heavy workloads and problems with the availability of professional/specialist support was a feature of the case and the risks to children when key professionals are absent on leave and the dangers of expecting workers with no statutory responsibility, for example, health visitors, to monitor a high-risk situation were frequently highlighted in the inquiry. The inquiry also recommended that staff needed rapid access to debriefing and counselling and mental health services when a child for whom they were caring died (Hammond, 2001).

'What works' in child protection: practice issues

This final section pulls together some of the messages from the research literature about 'what works' in child protection.

(i) The need to listen to, and support, children and young people

The Bridge Childcare Development Service (Fitzgerald 1998) concluded that a key issue contributing more than others to the development of a dangerous situation in child protection practice is a failure to hear the views of the child. Children have told researchers what aspects of practice they find difficult and have suggested ways in which involvement in an investigation could be made easier for them and this information needs to be used constructively to bring about change. Their most powerful concerns are for the abuse to stop and a fear of the family being broken up but they are often failed on both these counts. Research has demonstrated that professionals do not always listen to children.

The criminal justice system particularly fails vulnerable children (Fitzgerald 1996; Platt 1996). Research findings suggest that:

- the number of repeated interviews during the investigation and pre-trial period should be minimised;
- children should be kept informed about their case;
- child witnesses should meet the judge and prosecuting and defence barristers before trial and receive thorough pre-court preparation;
- all the child's evidence should be taken on one day where possible, regular breaks be offered, a support person be present and the public gallery cleared if appropriate;
- a 'Memorandum of Good Practice' should be prepared for lawyers;
- the prosecuting lawyer should meet the child after the trial to thank him/her and explain the outcome;
- proper therapeutic services should be offered to the child and his or her family irrespective of the outcome;
- judges and barristers should be trained in child development; and
- the cross examination of children should be regulated - the number of closed and leading questions put to children should be minimised; language should be age-appropriate; concrete examples should be used to assist the child in understanding some concepts, for example, dates, times and locations; interviewers must avoid intimidating the witness (Westcott 1995; Davies *et al* 1999).

Research has also shown that social workers do not always listen to children. Findings suggest that:

- children want to be believed;
- children's wishes and views should be recorded;
- children should be well prepared for case conferences;
- children should feel comfortable at, and able to participate at case conferences;
- child protection proceedings should be explained to children and they should be kept fully informed;
- children appreciate being offered the choice of a female to interview them; and
- children appreciate social workers who are supportive and show they care (Munro 1999; Social Services Inspectorate 1997; Thoburn *et al* 1995; NCH Action for children 1994; Cleaver *et al* 1998a; McGee and Westcott 1996; Westcott and Davies 1996; Barford 1993).

Some children find the medical examination distressing. The medical examination should not be more intrusive than the alleged offence. Good planning should ensure that only one examination is required and children should be given the opportunity to express a preferred gender for the examining physician. It is good practice to explain to children the need for the examination, the nature of the examination, the benefits/disadvantages and possible outcomes of the examination and their right to refuse part or all of the examination (Webury 1996; Rogers and Roberts 1995). The use of the colposcope is good practice in child sexual abuse cases. The colposcope is a binocular system of lenses of varying strength coupled to an integral light source and mounted on a rigid structure, usually a stand or cantilevered arm and cameras can be attached. It can be used in the examination of the anus in boys and girls and both prepubertal and pubertal genitalia in the female. A study in Leeds found that the ability to recognise with greater confidence both normal and abnormal findings has increased with the use of the colposcope. The use of colposcopes is far less invasive for the child since they are not inserted into the child. They also have advantages in that standard photographs incorporating a scale can be taken and used as evidence for second opinions and for peer review without the need to re-examine the child and when combined with a one way screen that overlooks the consulting or examination area physicians in training are able to observe the examination findings within the context of the clinical consultation with minimal intrusion for the child (Hobbs and Wynne 1996). The major disadvantage of the technique is that their cost can be prohibitive (Muram and Jones 1993). Colposcopes are not yet routinely used for genital inspection in Britain although they are popular in America and Australia. In 1998 Edinburgh and Glasgow were the only two units in Scotland which offered facilities for video colposcopy in the examination of children who alleged sexual abuse (Mok *et al* 1998). Plotnikoff and Woolfson (2001) found that many examinations were carried out by police surgeons who had not been trained in the use of colposcopes.

Research has revealed that children who are abused need more therapeutic support from child protection agencies. They need to be able to talk about the abuse or to write down what happened if they find saying the words too difficult. They say that not being able to discuss the abuse is one of the most difficult things about the whole experience of being abused (Taylor *et al* 1993). Where they have received counselling they value this highly. Children who receive no counselling or any other direct help adjust markedly less well (Farmer and Owen 1995; NCH Action for Children 1994). Young people who allege organised abuse are not always provided with adequate support by the local authority and the needs of the other children living in the facilities are not always adequately recognised (Barter 1998; 1999; 1999a).

Research has shown that many children do not tell anyone about abuse at the time and some never tell anyone. Those who do speak out talk to friends and relatives, only a small minority speak to professionals. Most never use the professional systems which they consistently claim to be hostile, confusing and traumatic (Cawson *et al* 2000; Cawson 2002). The NSPCC's Full Stop campaign is developing a range of new services in conjunction with young people. There4me.com a new interactive website for 12 to 16 year olds will offer information advice and online counselling. The NSPCC is also developing a network of young people's centres to provide a 'safe' environment for children in their community which are designed to reach children who do not tell anyone about their abuse. The first of these centres opened in Warrington in 2000. It was designed in consultation with and is staffed by young people. It includes a cafe, IT suite and studios, private rooms for chat and a range of activities including peer support groups and therapeutic workshops. Twenty-five thousand young people visited the centre in 2001 and additional centres have now opened in other areas. The NSPCC has also expanded the service offered by its national child protection helpline.

(ii) The need for inter-agency working

The way in which the various health, welfare and police agencies work together has been viewed as the crucial factor in child protection work in the UK. The Bridge Child Care Development Service (Fitzgerald, 1998) stress that a key issue contributing to the development of a dangerous situation in child protection is the failure of professionals and agencies to communicate appropriately or share information and inquiry reports and reviews into child deaths have continually stressed the importance of inter-agency working (Corby, 1995).

Research shows that inter-agency working is required to improve outcomes for children. Evidence concerning case outcome shows that the specialist resources that might make a difference to the protection of children are largely controlled by the education and health authorities. For example, for children with failure to thrive a multi-disciplinary team where professionals work together enhances the chances of bringing about change for the child. Health visitors, clinical psychologists, community paediatricians, community dieticians, nursery nurses and social workers need to be involved in the failure to thrive team (Gibbons *et al* 1995a; Hobbs and Hobbs 1999).

Research has highlighted best practice in relation to inter-agency work, for example:

- An innovative inter-agency training programme which was piloted in the North Tipperary region in 1999 and involved primary and post primary teachers, the police, youth workers and health board professionals which had some degree of success in improving inter-disciplinary relationships (Buckley 2000).
- The joint paediatric-forensic examination which operates in Edinburgh and the Lothians. Named paediatricians within each NHS Trust in Lothian are responsible for taking the lead role in the conduct of the examinations and they have worked closely with police surgeons. Mok *et al* (1998) believe that the bringing together of the two separate specialties has resulted in a high level of skill and expertise which ensures the best clinical response to the child and has also achieved the best practice and service to the prosecutors, resulting in a higher standard of evidence to the courts.
- Barnardos Street and Lanes project (SALS) a partnership initiative between Barnardos and the statutory agencies in Bradford. Social services, education, youth and community services and health agencies are involved in the project and it is supported by the police and probation service. The project has shown that a confidential service centre can be effective in meeting the needs of girls whose lifestyles often cause them to avoid contact with statutory agencies (Barnardos 1998).

(iii) The need to measure outcomes

A key test of the child protection system is whether children are protected from abuse and whether they function and develop satisfactorily (Macdonald 2001; Fitzgerald 1996). The Department of Health (1995) state that three sets of outcomes for abused children are important:

- the effects of abuse on children;
- the extent to which children are protected; and
- the effects of abuse enquiries on families.

The research findings demonstrate a need for more evaluation and outcome studies in child protection work. By far the largest number of outcome studies conducted in the area of child protection have been in the US with very few undertaken in the UK particularly with routine rather than specialist services. There is relatively little use of specialist social work or referral to other disciplines such as child psychology or psychiatry in this country. Specialist services have, however, attracted most research interest and there have been few studies which have evaluated routine case work or described its effect on case outcomes. There is a great need for more research in this area. The effects of intervention by child protection agencies need to be measured longitudinally. The Triseliotis *et al* study (1995) is one of the few longitudinal studies in the UK. It attempted to measure outcomes in order to assess the effectiveness of social work intervention for teenagers in England and Scotland. The authors concluded that they found it difficult to indicate whether services contributed to successful

outcomes. They found that each service was helpful to some teenagers but not others. For example, foster care had afforded some young people very satisfactory outcomes but also had a number of breakdowns. What seemed to be important was the particular match of services to individual needs accompanied by skilled and reliable support.

Gough (1993a) stated that data currently available suggested that child protection had little impact on re-referral rates or on long-term outcomes for children. Gough's (1993) small longitudinal two-year study of children who had been on the child protection register in Glasgow found that 45 per cent of children were received into care at some point, some on a voluntary basis. Evidence suggested that the outcome for the children in terms of their functioning and development was one of little change. The only improvements noted in children were when they were taken into foster care. In their study of children and young people referred to the Children's Hearings System, Waterhouse *et al* (1998) found that the likelihood of young children, especially girls, referred on care and protection grounds ending up under supervision was substantial. Patterns over time show with some clarity that for some children grounds of referral change over time, usually from care and protection to offending. Waterhouse *et al* state that these findings point to the need for early intervention in the lives of some children, especially attempts to offset the development of offending. They state, however, that the nature of this intervention requires consideration because as yet little is known about the links between intervention and outcome. The findings suggest that further research is needed in this area.

Some studies have attempted to assess levels of re-abuse. Between a quarter and a third of children are known to be reabused after they come to the notice of the child protection agencies although it is possible that the figures may be influenced by the fact that children who have already been brought to the attention of the child protection agencies are more likely to be closely monitored so that re-abuse is more likely to be recognised (Department of Health 1995; Hobbs and Hobbs 1999). Gibbons *et al* (1995) found that at a minimum estimate a fifth of the abused children in their sample experienced further physical abuse and 5 per cent some sexual abuse after their names had been placed on the child protection register, although the incidence of severe maltreatment was low. Evidence suggests that a combination of different kinds of abuse or of abuse and neglect together tend to make the longer-term projections worse, as probably does persistent abuse (Department of Health 1995; Hobbs and Hobbs 1999).

In Hamilton and Browne's (1999) study of referrals to police child protection units:

- a quarter of children (24%) were subject to at least one rereferral in a 27-month follow-up period;
- two-thirds of children who were rereferred had one rereferral, a fifth had two, 7% had three, and the remainder had between four and eight rereferrals;
- the average time between the index referral and the first rereferral was 40.5 weeks; the greatest risk of rereferral was found to be within the first 30 days;

- once a child had been referred on at least two occasions, his or her risk of rereferral within 27 months more than doubled;
- more than half (57%) of rereferrals suffered repeat victimisation by the same perpetrator, a quarter suffered revictimisation by a different perpetrator, and 18% suffered both;
- the most predictive warning signs of rereferral were family psychiatric problems, drug or alcohol abuse, child learning difficulties, behavioural problems or previous referrals; and
- children registered for neglect or for failure to thrive were the most likely to be re-referred, with sexual abuse cases the least likely.

Research has demonstrated that long-term harm is not an automatic consequence of abuse and damage is not irreparable. There has been increasing interest in the fact that some children raised in adversity progress to a good level of functioning and maturity in adulthood. Existing research indicates that factors of individual temperament, attachment relationships and community resources can all be associated with enhanced resilience in children who have experienced adversity (Werner, 1990; Department of Health 1995; Gibbons *et al* 1995a; Hobbs and Hobbs 1999; Fitzgerald 1998; Macdonald 2001; Grosz *et al* 2000). Romans *et al*'s (1995) New Zealand study compared sexually abused women with a good outcome, defined as having no psychiatric disorder and high self esteem, with sexually abused women with poor outcomes in order to determine which variables were related to good or poor psychological outcomes on these two measures. Adolescent experiences with parents were found to be of critical importance. They also found that secondary school played a decisive role in the outcome of sexually abused girls and that school might be able to neutralise some of the negative consequences of an abusive, non-supportive family environment. It would be useful to have a better understanding of the factors which influence or shape resilience in the UK as this information is important in developing strategies for intervention and prevention. There is a need, however, to ensure that the term resilience is not misused to blame those children who fail to be sufficiently 'resilient'.

(iv) The need for good training

Triseliotis and Marsh's (1996) study which evaluated outcomes in social work education and the first year in work found that before starting work around half the newly qualified had many anxieties about their levels of preparedness especially in the area of child protection. Once in work Scots were more likely, than their English counterparts, to carry heavier caseloads and more complex cases, including child protection cases, which they were not supposed to have at this stage. Over a third said they were struggling to cope or struggling some of the time. Research findings have found that professionals do not always feel they are adequately trained in child protection and demonstrate a need for more training for all agencies, including:

- more evaluation of the impact of training on practice;
- more effective staff supervision;
- more training in relation to neglect and emotional abuse;
- a need for specialist advice when dealing with many situations such as disability, mental illness or substance abuse;
- a formal accreditation process for doctors who wish to specialise in the field of child abuse and for police officers employed in the investigation and prosecution of child abuse cases;
- joint training programmes for physicians and social workers and teachers and social workers;
- more training for medical students and education students in all aspects of child abuse;
- continuing education in child protection for all physicians and teachers;
- guidance for GPs on what was expected of them at child protection conferences and in particular with respect to the sharing of potentially sensitive information especially when parents are present; and
- training in child protection for all police officers not just those working in child protection units (Social Services Inspectorate, 1997; Cleaver *et al* 1998; Mok *et al* 1998; Vulliamy and Sullivan 2000; Bannon *et al* 1999; Baginsky 2000; The National commission of inquiry into the prevention of child abuse 1996; Davies *et al* 1998; Hughes *et al* 1996).

(v) The need to work in partnership with parents

The Cleveland report emphasised the traumatic effects that an abuse investigation can have on families and research studies have confirmed the sense of shock, fear and anger felt at the point of confrontation (Department of Health 1995; Cleaver and Freeman 1996; Platt 1996; Jones and Ramchandani 1999; Farmer and Owen 1995; Central Region Child Protection Committee 1993; McGee and Westcott 1996; Corby *et al* (1996). Many research studies have found evidence of a link between better outcomes for children and greater involvement of parents (Thoburn *et al* 1995; Jones and Ramchandani 1999; Farmer and Owen 1995). The Department of Health (1995) research concludes that failure to achieve a high level of co-operation with parents helps explain why some children remain safe when others do not. A recurrence of abuse was less common in those families where some agreement was reached between professionals and family members about the legitimacy of the enquiry and the solutions adopted. Briggs (1996) found that when parents were involved in the reinforcement of the child protection programme in schools, their 10- to 12-year-old children were perceived to be the most confident, the most safety conscious and the most open in their family relationships.

Research findings suggest that parents want:

- to be listened to;
- to be able to participate and be involved in decision making;
- to be provided with written information;
- to be provided with information on how to appeal or complain; and
- more information about the children's hearing system (Sharland *et al* 1995; Thorburn *et al* 1995; Social Services Inspectorate 1997; Waterhouse *et al* 1998; Hallett *et al* 1998; Shemmings and Shemmings 1996; Cleaver and Freeman 1996; Cleaver *et al* 1998a; Department of Health 1995; Stainton Rogers 1996; Central Region Child Protection Committee 1993; Platt 1996a).

Platt and Burns (1996) suggest that there may be a potential for expanding the use of recorded agreements in child protection work. A recorded agreement is a document which is agreed between the child, parents and agencies involved and covers the main details of how the enquiry will be conducted. Agreements have been used by social workers in a number of areas of child care practice but their application to child protection enquiries has not yet been adequately explored. The use of recorded agreements might give an opportunity for more positive relationships to be formed with parents in child protection work.

(vi) The need to take account of issues about race and culture

While research findings have found that the needs of children and their parents are not always being met by the child protection system, the evidence suggests that the needs of minority ethnic children and parents are even less likely to be met (Social Services Inspectorate 1997; O'Neale 2000; Jackson 1994; Dutt and Phillips 1996). 'Under-intervention' and 'over-intervention' or the 'punitive' and the 'liberal' approach have been identified as two opposing child protection responses to minority ethnic children and families. Research has shown how racial stereotyping underpinned by racist assumptions results in under-intervention which can lead to dangerous, even tragic outcomes, for example, there can be a conflict between seeing physical chastisement as a 'cultural norm' in some communities and the need for children to be kept safe (Phillips and Butt 1996; O'Neale 2000). Over-intervention refers to practice which is punitive as a result of negative judgements and stereotypes of black families and results in the inappropriate removal of black children from their families (Sanders 1999; Cemlyn 2000; Wattam 1996; Dutt and Phillips 1996).

The research findings demonstrate that:

- professionals should have a good understanding of race and culture;

- ACPCs should collect and collate information about current practice and analyse this information and carry out a service audit to establish whether current services meet the needs of black service users; religion and language need to be monitored as well as ethnicity;
- there is a need for more appropriate therapeutic work for black children who have been abused and their families; and
- there needs to be a clearer analysis of the reality for black children in the child protection system through looking at the outcomes of current practice (Barter 1999b; Dutt and Phillips 1996; Gray *et al* 1997).

Successful matching across the dimensions of ethnicity and race has also been found to contribute to parent satisfaction (Farmer and Owen 1995; Barter 1999b; Jackson 1996). Satwant (1996) offers a word of warning, however. She says that for services for children in need families find it easier to walk into a social work office or pick up the phone to ask for help if a social worker speaks their language and has the same cultural background. For child protection services, however, parents may view the black practitioner with suspicion perceiving them to be in direct contact with the community and gossiping about their family's business and may prefer a white worker. They may also feel that a black social worker will be on their side and help them hold their own against white people interfering in their life, e.g. they may expect a black social worker to agree that they should be able to physically assault their children if they are being unruly.

(vii) The need to take account of disability

Research suggests that disabled children are less likely to be put on the child protection register than non-disabled children and child protection workers feel they have insufficient training in relation to disability and feel that children with disabilities do not receive the same protection from abuse as children without disabilities. Local authorities do not all have specific guidelines in relation to the protection of children with disabilities and do not always have reliable information about the number of children with disabilities who are being abused (Cooke and Standen 2002; Cooke 1999). Children who are disabled are in most senses just like other children but may have particular needs in relation to the investigation of abuse. Children who are disabled cannot be offered the same child protection services as those which are offered to non-disabled children because they often have different needs in relation to communication, mobility, dexterity, physical strength and cognitive abilities (Kennedy 1995; Shortreed 2000). The research findings suggest that:

- existing definitions of child abuse may need expanding to cover the abuse of children with disabilities, for example, 'abuse' of disabled children may include force feeding, medical photography, physical restraint, misuse of medication, etc.;
- there needs to be greater inter-change between disability and child protection services with common training and greater awareness of their respective contributions to protecting children with disabilities;

- communication systems used by people with disabilities need to have symbols for anatomical body parts and genitals so that if required children can discuss their worries and concerns;
- staff need specialist training in the investigation and treatment of abuse of children with disabilities;
- there should be clear child protection procedures and guidelines in relation to working with children with disabilities and in providing intimate care;
- there should be appropriate sex education and keep safe programmes within special school and units;
- national statistics on the abuse of children with disabilities should be collected; and
- the issue of how disabled children can be helped to give evidence in court needs further consideration (McGowan and Peyton 1995; Russell 1996; Cooke 1999; Kennedy 1995; Cooke and Standen 2002; Westcott and Cross 1996; Davies *et al* 1998).

(viii) The need to take account of gender and domestic abuse

Research studies have illustrated the significant gender bias at all stages of the child protection process (Ryan and Little 2000; Farmer and Owen 1998). It has, therefore, been suggested that social workers and researchers should make greater efforts to include men in their practice and studies and to stop seeing the term 'parent' as synonymous with 'mother' (Jones and Ramchandani 1999).

Research has demonstrated the links between domestic abuse and child abuse (Hester *et al* 1998; Farmer and Owen 1995; 1998; Scottish Women's Aid 1997). Research has found, however that four of the eight police forces in Scotland have no formal policy on the way in which social work departments or reporters to children's panels should be notified of incidents of adult domestic abuse occurring in households with children. Routine cross referral of information contained in separate databases on adult domestic abuse and on child abuse occurred in only three forces (Scottish Office Home Department: HM Inspectorate of Constabulary 1997). If they are working with abused or neglected children it has been suggested that child protection workers should assess the presence or absence of other types of violence in the home (Scottish Women's Aid 1997). Similarly, it has been suggested that professionals should consider the potential risk to children when dealing with domestic abuse. This suggestion is, however, controversial since some victims of adult domestic abuse would be reluctant to report incidents if they felt this might ultimately lead to their children being taken into care and it has been suggested that some violent men deliberately manipulate this fear in order to further control women. (Scottish office Home Department: HM Inspectorate of Constabulary 1997; McGee 2000). Scottish Women's Aid (1997), therefore, suggest that help is not best offered by routinely placing children on the child

protection register. Instead they suggest that there needs to be constructive working with children and their non-abusing mothers to make sense of what has happened and to assist them in drawing on their coping strategies for the future. They believe that a key principle to work from is that woman protection is frequently the most effective form of child protection. In developing local and national strategies against domestic abuse they suggest that children and young people should be consulted and that there should be a stronger knowledge base on children's own experiences, understandings, responses and feelings about domestic abuse.

Research has shown that contact arrangements can put women and children at further risk of abuse because violent fathers may use contact arrangements to harass or harm women and children. Children's views on contact are regularly ignored if indeed they are ever obtained in the first place (O'Hara 1993; Ashworth 1995; Mullender 1996; Hester and Radford 1996). Such findings suggest that the issue of contact arrangements following parental separation also needs to be considered.

(ix) The need for cultural change

Authors such as Wattam (1996) have argued that research findings suggest a need for clear standards of child care to be made explicit and publicly available, particularly in relation to 'leaving alone' and parental neglect. Clear indications must also be given about what is and is not acceptable in relation to the physical punishment of children since the current defence of 'reasonable chastisement' is not always clear to parents (Goddard 1996). The National commission of inquiry into the prevention of child abuse (1996) concluded that children would continue to be abused until the law as it affects the physical punishment of children was amended and children were given the same protection against assault as adults. They believe that the defence of 'reasonable chastisement' should be removed. Research on the effect of the ban on corporal punishment in Sweden suggests that support for physical punishment has decreased dramatically over the past 30 years and the corporal punishment ban and ongoing public education campaigns appear to have been extremely effective in altering the social climate with regard to physical discipline (Durrant 1999; 1999a).

New proposals have been put forward by the Scottish parliament in an attempt to clarify the law on the physical punishment of children. The proposals were included in the Criminal Justice White Paper and included a ban on the smacking of children under 3, making it illegal to hit children on the head, shake them or strike them with an implement and a ban on the use of corporal punishment in childcare centres, by childminders and in non-publicly funded pre-school centres. The ban would not cover babysitters or nannies working in the family home. The proposals were made following a Scottish Executive consultation exercise which included a consultation with children and young people (Children in Scotland 2000).

Conclusions

The last section considered the research evidence in relation to identification and assessment, this section looked at issues relating to addressing the problem of child abuse and ‘what works’ in child protection practice. It looked, albeit briefly, at how some other countries address the problem of child abuse and neglect and assessed some of the research evidence relating to the success of such methods. Family Group Conferencing is becoming increasingly popular in the UK and initial research findings have been positive with regard to their use in the field of child protection.

The section also considered the issue of prevention of child abuse. Research evidence has been lacking in this country in relation to primary prevention but information from elsewhere suggests that over the long-term interventions which target the wider society may have huge benefits. A number of studies have also suggested that secondary prevention programmes may have a positive impact on levels of child abuse but again more research is needed in this country. Further research is also required in the UK in relation to therapeutic support for children and adults who have been abused and for abusers themselves. The research evidence currently suggests that while counselling projects are generally seen as beneficial by service users, they are not available to enough people in this country. Community intervention programmes, which encourage everyone in the community to play a part in preventing child abuse, are becoming more widespread in the UK and initial findings, for example, from the Henley Safe Project, have been positive.

A number of research studies have analysed the various reviews and inquiries into child protection practice which have been undertaken. Although child protection practice has frequently been criticised for being error-led, reviews and inquiries are undoubtedly useful in terms of highlighting where problems in practice lie and providing pointers for the future. Research has also highlighted good practice in relation to child protection and suggestions have been made on the basis of research findings about basic principles which are likely to contribute to better outcomes in child protection practice. For example, research has suggested that outcomes are likely to be better if children are listened to and properly consulted and supported and if agencies work effectively with parents and other family members. Practice issues in relation to what research evidence suggests may work in child protection have been considered in this concluding section.

'It's everyone's job to make sure I'm alright.'



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