This item was submitted to Loughborough's Institutional Repository by the author and is made available under the following Creative Commons Licence conditions.

For the full text of this licence, please go to:
http://creativecommons.org/licenses/by-nc-nd/2.5/

SAFEGUARDING CHILDREN:

A SCOPING STUDY OF

RESEARCH IN THREE AREAS

Harriet Ward, Lisa Holmes, Sue Moyers,

Emily Munro and Dina Poursanidou

Version Two: July 2004

© centre for child and family research

CONTENTS

Acknowledgements

The authors would like to acknowledge the advice and assistance provided by experts in the field who generously gave time to exploring key messages with the research team and to commenting on early drafts of this report. The names of those who contributed are listed in Appendix Three. We would particularly like to thank Carolyn Davies and Jenny Gray for their guidance and encouragement from the outset of the study.

We would particularly like to thank the Department for Education and Skills for their support throughout the review.

Finally, we would like to say a big thank you to Sophie Winfield, without whose administrative support the project would never have been completed.

1.0   Introduction

This scoping review was commissioned by the Department of Health to provide a summary of the current knowledge base in three areas of research on safeguarding children.

1) The recognition of abuse
2) Emotional abuse and neglect
3) Inter-agency working

For each of the areas identified above the research team were asked to identify what is already known and then to suggest issues that would benefit from further research.

It should be noted that this is a scoping study and not an exhaustive review of all the literature on safeguarding children. It had to be undertaken within a fairly short timescale, and therefore within specific parameters. We have produced a broad overview of the literature since 1995, rather than a systematic analysis of all studies completed. A number of issues such as, for instance, the use of pornographic images of children on the Internet[1], bullying in schools and other institutions, and cases of fabricated/induced illness have been deliberately excluded as being outside the remit of this study.

The research team used a variety of search strategies and sources of information. Initially literature searches of key terms and authors were carried out using the relevant databases detailed below:

- ASSIA (Applied Social Science Index and Abstracts)
- Social Services Abstracts
- Sociological Abstracts
- Medline
- Psychinfo
- IBSS (International Bibliography of the Social Sciences)

---

[1] The EU DAPHNE research programme includes research on this topic

These searches were limited to literature post 1995, when the last major British programme of studies on child protection was concluded (Department of Health 1995). Appendix One details the database searches, which included references from both the UK and overseas. However, empirical studies were prioritised rather than commentaries. Key references identified from the searches were then followed up.

Further information was obtained from key websites, including those of organisations that had carried out relevant research, for example the NSPCC, and others that provided definitional information, for example, the World Health Organization. Websites from countries outside the UK, such as the National Child Protection Clearinghouse (Australia) and the National Clearinghouse on Child Abuse and Neglect Information (USA) were also accessed to provide an international perspective on safeguarding children. Details of all the websites accessed are given in Appendix Two.

Finally, the preliminary findings were discussed with a number of acknowledged experts in the field, and their suggestions followed up and incorporated into this report. Advice was given either jointly at a meeting between the research team and experts in research, policy and practice, or through individual interviews held with those who were unable to attend. All expert advisers were asked to comment on the first draft of this report; five people produced written comments, which have now been incorporated into the current draft. A list of expert advisers is given in Appendix Three.

2.0   Literature Review

Introduction

The following sections of this report cover the review of the literature in the three areas specified in our brief. At an early stage it became apparent that issues specific to children with disabilities cut across each of these areas, and formed an extensive literature in themselves. We have explored this literature separately, and in the following review we have discussed the results of the search in a separate section. However, although the situation of children with disabilities raises additional issues, in our view these should be integrated into the overall research initiative. In the final sections of this report the points specific to children with disabilities have therefore been integrated into the rest of the discussion.

The reader should note that while Sections 2.2 and 2.3 focus specifically on emotional abuse and neglect, other sections of this report have a broader remit, and cover issues that relate to all types of abuse.

2.1   Recognition

Introduction

Differences in thresholds, changes in terminology and differences in the language used by specific professional groups all lead to difficulties in conceptualising, and therefore recognising abuse. The parameters change over time and place, and are influenced by the interplay of strengths and weaknesses within the child, the family and the environment. Abuse now has to be understood within the broader context of safeguarding and promoting the well being of children. Much of the literature explored in the following paragraphs considers these issues.

The Children Act 1989 introduced 'the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children'. (Department of Health, 1991a). Under the Children Act 1989, where it has

'reasonable cause to suspect that a child …is suffering, or likely to suffer, significant harm' a local authority has a duty to 'make enquiries or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare' (Children Act 1989, s.47.1). The legal definition of 'harm' is 'ill-treatment or the impairment of health or development' (Children Act 1989, s.31.9). Recent amendments clarify that the definition includes 'impairment suffered from seeing or hearing the ill-treatment of another' (Adoption and Children Act 2002, s.120). Ill-treatment is either assumed to have occurred when the physical signs are *attributable* to ill-treatment, or ill-treatment is *observed*, as in emotional abuse. The focus of our brief is maltreatment or abuse which results in significant harm, how it can be better recognised, and particularly why the physical and emotional abuse and neglect suffered by Victoria Climbié, was so difficult to identify by the wide variety of professionals who saw her.

Stress factors

Numerous factors have been identified as indicators of an increased likelihood that children will suffer significant harm without the provision of services; whilst these factors do not necessarily cause abuse, they can be attributed to stress and are considered to be cumulative (Spencer, 2002). These factors are broad ranging, encompassing wider societal issues as well as stressors within the family or the immediate environment (Hobbs *et al*, 1999; Department of Health, Department of Education and Employment and Home Office, 2000).

Certain child characteristics have been associated with an increased risk of significant harm. Hobbs and colleagues (1999) assert that boys are more likely to be physically abused than girls and research by Sibert and colleagues, (2002) indicates that infants under the age of one are at a greater risk of severe physical abuse than older children. Furthermore, babies under the age of six months are most at risk of death or suffering damage as a result of physical abuse. Premature babies have also been identified as a group who are at greater risk of physical abuse due to disruptions to the attachment process. Research evidence indicates that between 20 and 25% of premature babies will be physically abused at some stage of their lives (Reece 1994).

Research demonstrates the co-occurrence of domestic violence and physical abuse; an issue that Spencer (2002) suggests has been overlooked. A review of studies revealed 30-60% co-occurrence of domestic violence and physical abuse (Edelson, 1999). Links have also been made between child neglect, emotional abuse and domestic violence. In another review of the literature, Cleaver, Unell and Aldgate (1999) identify several ways in which parental mental illness, problem alcohol and drug use and domestic violence can impact on a parent's ability to respond to a child's needs. Specific studies have explored different aspects of the inter-relationship between the child's developmental needs and their parents' or carers' ability to respond to these needs within the context of the wider family and environments (Velleman, 1993; Ghate and Hazel, 2002; Horwath, 2001).

Rees and Stein (1999) identified the need for greater recognition of adolescent abuse in England and Wales. Research on young runaways has found a high incidence of abuse. Stein and colleagues (1994) found that 47% of these young people had been physically abused and 7% had experienced sexual abuse (cited in Rees and Stein, 1999).

Physical signs

Research demonstrates that bruises are the most common presenting sign of physical abuse and are present in 90% of cases (Hobbs *et al*, 1999). However, specific features need to be considered, as bruising is normal during childhood play. Thus, Hobbs and colleagues suggest that multiple bruises at various stages of healing may be a sign of abuse and patterned bruises such as bite marks and finger marks are a sign of inflicted injury. Spencer (2002) also suggests that suspicions should be aroused by bruising to certain parts of the body, such as the ears, which are normally well protected. Bruising at this body site may therefore be the result of the child being pulled by the ear.

Spencer (2002) draws together a number of research studies, and outlines hallmark features of abusive fractures; spiral fractures of long bones, metaphyseal injuries, rib fractures in shaken babies and skull fractures. Age at injury should also be

considered; 'any fracture in a child less than two years old should raise suspicion' (p.145) (see also, Hobbs *et al*, 1999; Reece, 1994; Cadzow and Armstrong, 2000).

Shaken baby syndrome, normally in response to a child's inconsolable crying, leads to long-term neurological damage or death in 50% of cases (Kairys *et al*, 2001). Premature babies, children with disability and children with colic may be particularly at risk (Coody *et al*, 1994; Brooks and Weathers, 2001). David (1999) suggests that the majority of children with subdural haematoma, retinal damage and diffuse axonal injury have suffered serious non-accidental injury.

Whilst a range of stressors and physical signs may lead to the recognition of abuse, it should be acknowledged that only looking for known risk factors may result in cases being overlooked.

Impact of getting it wrong

High profile cases such as that of Victoria Climbié provide illustrative examples of the tragic consequences of a failure to recognise abuse and the subsequent significant harm to an individual child. Despite the involvement of professionals from various agencies, there were a series of omissions that resulted in Victoria's death (Laming, 2003).

Whilst the consequences of failing to recognise that abuse is or has occurred can be fatal, there are also negative implications for families in cases where abuse is wrongly insinuated. These 'false positive' cases can lead to the separation of the child from their parent(s), parental imprisonment and can cause substantial distress (Jones, 2001; Cleaver and Freeman, 1995). This issue has recently been the focus of considerable media attention following the challenge to Roy Meadows' expert evidence concerning the likelihood of children suffering sudden infant death syndrome.

When considering the issue of wrongly identifying child abuse, it is necessary to explore the question of false allegations, in particular those that occur as a result of an investigation that entails leading or suggestive questioning (see Hershkowitz, 2001).

Whilst the occurrence of false allegations needs to be acknowledged, nevertheless, children play a fundamental role in disclosing abuse, a point that reiterates the importance of listening to them.

Listening to children

> *An allegation of abuse made by the child is now recognised as the single most important diagnostic sign and evidence of abuse* (Poblete, 2002 p.5).

It should be acknowledged that 'not all abused children can (because of their age) or do (because of their fear) explain what has happened to them' (Leventhal, 2000, p. 139). Disabled children may also have difficulties in communicating abuse (Kennedy, 1995; Morris, 1999). Nevertheless, there is evidence that professionals may lose sight of the child and focus more upon the parents (Ayre, 1998a). Moreover, in the course of the Laming Inquiry it became evident that some professionals did not speak to Victoria Climbié about her injuries for a variety of reasons, including the need for an interpreter, and because they were concerned that their questions would be leading, and hence compromise a future investigation (see for example, Laming, 2003, p.227). The Inquiry recommended that:

> *when deliberate abuse is suspected …consideration should be made of whether it is in the child's best interests to obtain a history directly from the child, even before consent is obtained from the carer* (Laming, 2003: p.244).

The role of social services in recognising abuse

> *Social work decisions are often problematic balancing acts, based on incomplete information, within time constraints, under pressure from different sources, with uncertainty as to the likely outcome of different options* (O'Sullivan, 1999: 3).

Brandon and colleagues (1996) identify how the concept of 'significant harm' and understanding of 'what is acceptable behaviour towards children by parents and others, is socially defined, historically located, and changeable' (p.2).

13

Jowitt (2003) suggests that 'in many cases the identification of child abuse or neglect falls into a 'grey area', in that there may be some serious concerns about parenting but a lack of clear evidence that maltreatment has occurred, or is likely to occur' (p.5). Research on decision-making in child protection (Munro, 1999; Ayre, 1998b, Macdonald, 2001) reveals that 'human reasoning' can influence the process of needs assessment.

Ayre (1998b) found that in acute cases (physical abuse and sexual abuse) practitioners had few problems in determining that the 'likelihood of significant harm' threshold had been crossed; a serious incident would trigger a child protection intervention. However, the identification of *chronic* neglect and emotional abuse was more problematic. Cumulative concerns may not be recognised as information may be held in different files, or by different agencies. In order to identify chronic emotional abuse and neglect it is necessary to collate serial information from a file or files and to have a system of doing this that reveals the extent of any harm in individual cases. Proportionality of response to the incident is also an issue. Instigating safeguarding children procedures can be perceived as disproportionately severe in response to a single relatively minor incident. Professionals may fail to consider this incident alongside past incidents and fail to identify patterns of worrying behaviour. Professionals may also become acclimatised to low standards of care within a family (Ayre, 1998a). Ayre (1998a) suggests 'the rule of three', that is that 'agencies will initiate a review when they have accumulated three referrals or expressions of concern' (p.35). Such an approach is intended to ensure that worrying patterns of abuse are not overlooked. Glaser (personal communication) also points out that while signs of both emotional abuse and neglect should be apparent to an observer, they are often under-recognised.

The introduction of the *Framework for the Assessment of Children in Need and their Families* (Department of Health *et al*, 2000) addresses some of these issues, and the subsequent implementation of the *Integrated Children's System* (Department of Health, 2000a) should cover others. However, although we know that the process of undertaking assessments within the Framework increases parental involvement and inter-agency collaboration (Cleaver, Walker and Meadows 2004a), implementation has not yet been sufficiently long-term to explore how far such a comprehensive

system succeeds in improving the recognition of slowly accumulating patterns of abuse over a lengthy period; similarly, although there is increasing evidence that the introduction of the Assessment Framework is having a major influence on initial and core assessments (Scott, Walker and Cleaver, 2004), we do not yet know how far this is translated into early recognition of abuse.

Research conducted by Munro (1999) on all child abuse inquiry reports published in Britain between 1973 and 1994 identified a number of common errors of reasoning in child protection work. Risk assessments were rarely revised unless a child suffered a further serious injury. 'Sixteen reports (36%) criticize the failure to use past history in assessing current functioning. Ten reports (22%) highlight professionals' failure to take a longer term perspective and notice an emerging pattern of risk' (p.751).

It has been suggested (Fitzgerald 1996, cited in Jones and Gupta, 1998) that the recognition of neglect has been inhibited by the belief that children do not die as a result, although there have been well known cases where this is clearly not the case (for example, Liam Johnson, Ricky Neave). This perceptual problem has also been acknowledged as affecting the recognition of emotional abuse and the provision of appropriate services. The connection between poverty and neglect (Parton and Otway, 1995) may also influence service responses. Aldgate and Tunstill (1995) found that children referred to social services as a result of concerns regarding neglect were referred as being 'unlikely to achieve or maintain a reasonable standard of health or development without the provision of services' (Children Act 1989, s.17.10 (a)), rather than at risk of significant harm (Children Act 1989, s.17.10 (b)). Resource issues meant service provision was largely limited to the latter.

Social services often fail to see running away as a child protection concern, although the research demonstrates that a high proportion of young runaways have experienced physical abuse (Barter, 1996 in Rees and Stein; 1999 p.21). Barter (1996) also found that the police were more concerned about crime prevention rather than safeguarding children when considering adolescent runways. This may be seen as part of a wider issue concerning social attitudes towards youth and an emphasis upon their responsibilities, and not their corresponding rights.

The role of professionals in the health care field

Health professionals have a critical role in safeguarding children. However, Ayre (1998b) suggests little guidance is available to support health professionals in judging what constitutes 'significant harm' and found that the 'effectiveness of work in the identification and assessment of abuse may be marred by significant flaws in the general approach adopted' (p.36). Education and further training are required to address such issues.

Health visitors

> *The primary focus of health visitors' work with families is health promotion. Like few other professional groups, health visitors provide a universal service which, coupled with their knowledge of children and families and their expertise in assessing and monitoring child health and development, means they have an important role to play in all stages of family support and child protection.*
> (Department of Health *et al*, 1999a, section 3.35)

The universality of the health visiting service, together with the mandatory requirement to visit new babies at home, means that health visitors are ideally placed to identify any needs or familial stresses, without the negative connotations associated with receiving services from professionals such as social workers. Historically the role of the health visitor has been to promote the health and well being of the child. This role is based on a relationship of working in partnership with parents. However, as Lupton and colleagues (2001) acknowledge, there are ethical conflicts between the role of a health visitor as an advisor and means of support for the parents, and their responsibility to report concerns about safeguarding children.

In 1991 the Personal Child Health Record (PCHR) was introduced as part of a movement towards greater involvement of parents and professionals and an ethos of working in partnership. In an attempt to address the balance of working in partnership with parents, coupled with the anxieties of discussing child welfare concerns with families, Glew and Herron (1998) carried out a study that introduced a child protection page to the PCHR. They reported that many of the parents felt that using

16

the page was a positive step towards sharing concerns, whereas health visitors expressed difficulties in raising the subject of abuse.

Glew and Herron's universal approach raised awareness about child welfare concerns with all families; however a selective approach has been introduced elsewhere. In Barnet, the Joint Professional Record (JPR) was introduced in 1995, again as a record to be used alongside the PCHR. The JPR was only implemented for selected children, primarily for those where there were concerns. It was designed as a central, multidisciplinary record for all professionals involved in a case. In accordance with working in partnership with parents, the health visitor was required to notify all parents of the existence of the JPR and the need to open a record if there were child welfare concerns. An audit of the JPR indicated that case recordings improved and that duplication was minimised. The authors concluded that the JPR was a useful tool (Knowles *et al*, 1999). Similar results were found in implementing the North Lincolnshire Parenting Assessment Programme, which identified thresholds and indicators of concern that were agreed by all professionals working in a given area (see Ward and Peel, 2002; Pithouse *et al*, 2004).

As well as promoting the well being of the child by working in partnership with parents, the role of the health visitor in safeguarding children has been widely acknowledged. Again, because of the universality and nature of the service, health visitors are able to provide support and advice to parents when there are early indications of difficulties (Hendry, 2002).

Home visiting programmes that aim to promote and safeguard children's welfare, whilst working in partnership with parents, are widespread in the USA. Barlow and colleagues (2003) are currently evaluating a home visiting programme for vulnerable families in two counties in the UK. The programme emphasises the need for proactive strategies and early interventions and is being facilitated by health visitors. Although the evaluation of the new home visiting service is not yet complete, assessments of other such intensive programmes have reported a reduction in the instances of abuse and neglect, along with a reduction in accident rates and emergency hospital visits (Olds *et al*, 1986). Elkan and colleagues' (2000) review of the effectiveness of health visiting identified a number of benefits associated with home visiting, including improvements in parenting skills and the quality of the home environment.

17

Referrals to Home Start initiatives have been found to be made predominantly by health visitors (McAuley, 1999). An evaluation of Home Start in Scotland (Kirkaldy and Crispin, 1999) found that the number of families reporting behavioural problems in their child(ren) halved following referral. Referrers also felt that in the majority of cases families' management of their children improved (see also, McAuley, 1999 and McAuley *et al*, forthcoming).

The research evidence above emphasises the role of the health visitor in safeguarding children and highlights the importance of working in partnership with parents. Work by Ling and Luker (2000) takes a different approach by exploring the meanings that health visitors attach to certain events when identifying child abuse and the use of intuition in recognising it. The study found that 'intuitive awareness' as a form of knowledge was utilised by health visitors when safeguarding children.

General practitioners

Whilst *Working Together to Safeguard Children* (Department of Health, 1999a) emphasises the role of the GP in identifying child abuse, the issue of medical confidentiality is frequently cited as posing difficulties. It is well documented and openly acknowledged that GPs are often less involved in child abuse cases than other health professionals; both workload pressures and insufficient training have been cited as explanations. The joint Chief Inspectors' Report, *Safeguarding Children* (Department of Health, 2002) raised concerns that GPs rarely attended either child protection conferences or multi-agency training. Similar issues have been raised by Greenfields and Statham (forthcoming, 2004), who found that custodians of child protection registers considered GPs to be disengaged from child protection procedures and that they were unlikely to make enquiries to the register, or refer children to social services. The issue of medical confidentiality is also regarded as a major obstacle for GPs when they have concerns that the welfare of children is not being adequately safeguarded. The involvement of the GP with both the child and their family is usually sustained over a long period of time; many question the impact that reporting such concerns will have on the family unit and the GP's future relationship with its

members (Simpson *et al*, 1994; Hallett, 1995; Lupton *et al*, 2000). Moreover, these concerns are exacerbated with the possibility of a referral being a 'false positive'.

The issues discussed above highlight the apparent obstacles faced by GPs in reporting child welfare concerns. However, prior to this there is obviously an earlier process of recognising that the child's well being is not being adequately safeguarded. As has been noted, there are difficulties in recognising non-physical signs of all types of abuse. In a retrospective study of the role of GPs in detecting sexual abuse, Maddocks and colleagues, (1999) reported that sexually abused boys did not appear to present with behavioural or somatic symptoms that distinguished them from boys who had not been abused. Furthermore, none of the sample of sexually abused boys disclosed abuse to their GPs. The lack of non-physical evidence and the absence of disclosures highlight the difficulties of recognition.

Whilst GPs are acknowledged to play a vital role in the recognition of abuse, work by Robinson and colleagues (1999) has broadened the focus to examine the role of other staff within general practice. Although this study focuses on the communication of child welfare concerns between primary health care personnel, the researchers report that there is some debate regarding the role of the practice receptionist in processes for safeguarding children and recommend that this is incorporated into their training.

Hospitals

Accident and emergency departments

The exact number of children presenting at hospital emergency departments as a result of abuse is unknown, but often as a first point of contact staff working in these departments play a key role in identifying non-accidental injuries. Whilst there are national guidelines for emergency department staff on dealing with child welfare concerns (Department of Health *et al*, 1999a; Royal College of Paediatrics and Child Health, 1999; Department of Health, 2003a), a national audit indicated that although the recommendations from this guidance are being met, there is still a need for improvements in training and communication (King and Reid, 2003). Furthermore,

findings from this audit showed that there was substantial variation in practice between departments.

The need for improved training in safeguarding children for emergency department staff has been highlighted in other research studies (for example, Benger and McCabe, 2001). This study also indicated that the recognition of burns and scalds as a type of abuse was improved by the introduction of a checklist as a reminder mechanism when coupled with an improved programme of education for staff. A similar tool formed the basis of a wider study that included children presenting to emergency departments with a broader range of injuries (Benger and Pearce, 2002). In this study a flowchart was used as a means of improving the recognition of non-accidental injuries and was found to improve the referral rates for further assessment.

Both the checklist and the flowchart used in the above studies focus on the same key indicators, namely, a delay between the occurrence of the injury and seeking medical advice, an inconsistent history provided by the parent/carer and the identification of any unexplained injuries. Whilst both the above studies indicate that the use of these tools resulted in an increased awareness and documentation of non-accidental injuries, the Laming inquiry demonstrates that there is still evidence of insufficient recognition and recording of abuse in emergency departments.

> *When a child has been examined by a doctor, and concerns about deliberate abuse have been raised, no subsequent appraisal of these concerns should be considered complete until each concern has been fully addressed, accounted for and recorded* (Laming, 2003: p.247).

However, the CHI audit of implementation of the Laming recommendations in NHS organisations found that 24-hour access to the child protection register is still limited, especially for ambulance trusts, mental health trusts and NHS direct sites (Commission for Health Improvement (CHI), 2003).

Nurses

In discussing lessons to be learnt from the Climbié enquiry, Mulholland (2003a) suggests that while nurses identified possible signs of abuse 'they were often poor at relaying that information because of inadequate record keeping' (p.11). Laming also identified the problem of 'status inequality' that left nurses feeling their views were less important than those of other professionals.

Paediatricians

A survey involving 4776 paediatricians revealed that complaints against those involved in safeguarding children may deter them from this type of work. The number of complaints against paediatricians had risen dramatically since 1995, although only 3% of cases dealt with locally were upheld (Royal College of Paediatrics and Child Health, 2004, p.1).

An American study involving 241 physicians, most of whom were paediatricians, identified factors that facilitate or obstruct child protection evaluations (Socolar and Reives, 2002). The researchers found that the most common problem was time constraints, cited by 71% of respondents. Only 13% claimed that they were restricted by not knowing what they were required to do. Open-ended comments revealed that interaction with the legal and judicial systems was commonly seen as problematic. Concerns were also expressed about the quality of work undertaken by social services. Informative articles and regional training were found to be the most helpful facilitators in child protection work (cited respectively by 87% and 75% of respondents).

Vulliamy and Sullivan (2000) found that physicians' decisions concerning reporting child abuse depended upon how comfortable they were with the process. However, paediatricians felt that they received little information or feedback from child protection services, once the case had been referred. The research suggests that feedback from child protection services would promote better inter-agency working and also enhance knowledge and understanding between physicians and the child protection agency. Similar responses were found in studies on inter-agency referrals

to social services undertaken by Ward and Peel (2002) and subsequently replicated by Pithouse and colleagues (2004).

Radiology

Carty (1997) suggests that radiological evidence of abuse may on occasion be stronger than clinical and social features. This may also be pivotal in proving that a child 'on the balance of probabilities' has suffered significant harm as the result of physical abuse (Carty and Pierce, 2002). Radiology is therefore important in the investigation and diagnosis of non-accidental injury. James and colleagues' (2003) survey of 97 hospitals in England, Scotland and Wales found that there was considerable variation in practice between hospitals. Furthermore, there are currently no national standards or an accepted protocol to support non accidental injury imaging. Accurate identification and assessment of non accidental injury is required in order to prevent children suffering further significant harm. The authors therefore suggest there is a need for 'standardization of the performance and reporting of imaging in cases of suspected abuse' (p.699).

Role of teachers/schools

Both the Children Act (1989) and *Working Together to Safeguard Children* (Department of Health *et al*, 1999) outline the role of local education authorities in safeguarding children. In addition the Department for Education and Employment (now Department for Education and Skills) (1995) has issued guidance on safeguarding procedures for local education authorities (LEAs) and schools. Whilst the majority of education institutions and LEAs have implemented the required procedures, it is not clear how far the guidance has facilitated the recognition of abuse by teachers or their awareness that pupils may be suffering significant harm. Research evidence has indicated that, although the vast majority of LEAs had processes for safeguarding children in place, there were concerns that not all teachers were confident in their ability to recognise signs of abuse (Baginsky, 2000). Likewise, Kirkland, Field and Hazel (1996) reported that, although procedures were in place, not

all teaching staff were aware of appropriate child welfare concerns, thereby preventing them from taking necessary action.

The study by Baginsky (2000) also indicated that many schools were unsure when to report child welfare concerns to social services, and were concerned about the channels of communication between agencies. These findings support those of Birchall and Hallett's earlier study (1995), which pointed out that many schools were confused by the decisions made by social services following a referral. This study also showed that schools were unclear as to the thresholds being used by social services when deciding if further action was required. A further study by Baginsky (2003) also replicated findings from other studies that showed that teachers were not always informed of the outcome of a case following a referral to social services, and also highlighted the communication difficulties between agencies.

Evidence from the above studies suggests that although the national guidance has resulted in established procedures both by LEAs and within schools, many teachers are either unaware of the processes for safeguarding children or are unsure when to report concerns to social services. In light of Baginsky's finding (2003) that over half (52%) of teachers had been involved in at least one child protection case, these issues need to be addressed. Although there were some indications that the appointment of designated teachers had improved the situation (Jones, personal communication) we could find no hard evidence of this. The National Clearinghouse (2003a) suggests that health visitors and teachers are particularly well placed to recognise emotional abuse *if* they know the signs to look for.

Cultural issues

The Children Act 1989 (s.22(5)) states that local authorities 'have a duty to give due consideration 'to the child's religious persuasion, racial origin and cultural and linguistic background' in decision-making. However, as Boushel (2000) points out, there are only a small number of studies that incorporate 'race' and 'ethnicity' in social welfare research. Nevertheless, the evidence suggests that such issues influence the decision-making process in the recognition of, and responses to, abuse.

The research demonstrates that children from minority ethnic groups are disproportionately represented both in child protection registrations and in the looked after population (Barn *et al*, 1997, Department for Education and Skills, 2003a). Disparities have been found to be particularly pronounced in local authorities that have a small proportion of ethnic minority families (Social Services Inspectorate, 2000).

Hunt and colleagues (1999) found that court proceedings were instigated faster when children came from minority ethnic groups, although the families displayed less pathological profiles. Moreover, more children from minority ethnic groups were permanently placed away from their birth parents than their white peers, although they were more likely to be placed with relatives. Such placements *may* reflect stereotypical views concerning the family support available to minority ethnic groups. However research evidence (Ghate and Hazel, 2002; Quereshi *et al*, 2000; Jones *et al*, 2002; Chamba *et al*, 1999) indicates that the perception that minority ethic groups receive additional support from their extended family is an oversimplification, and that there is considerable diversity across minority communities. Many parents from minority ethnic groups have restricted informal social networks, less practical and emotional support from family or friends and are less likely to use community-based services. Basing decisions upon erroneous assumptions about different cultures can have grave consequences. Professionals' perceptions of respect and obedience in Afro-Caribbean families were cited as a reason why they failed to note or act upon signs of ill treatment in the case of Victoria Climbié (Laming, 2003, p.16). As the report states 'cultural norms and models of behaviour can vary considerably between communities and even families' (p.345).

In practice, social work staff do not necessarily have sufficient understanding of cultural diversity (Farmer and Owen 1998). This may lead to a failure to conduct 'culturally competent assessment and intervention' (Brissett-Chapman, 1997, cited in Welbourne, 2002, p.346). It may also undermine the emphasis placed upon the child's needs (Harran, 2002a), and cause delays in the decision-making process (Ward *et al*, 2003).

The Social Services Inspectorate report on services for minority ethnic children and families, *Excellence, Not Excuses* (Social Services Inspectorate, 2000), expressed

concerns about assessment and care planning and identified cases where children's safety was compromised because physical and sexual abuse had not been identified or properly dealt with. The authors found that, although it was generally acknowledged that meeting the holistic needs of the child was important, in practice this was problematic, particularly when children were of mixed ethnicity.

Assessing Children in Need and their Families: Practice Guidance (Department of Health, 2000c) identifies the importance of taking a child development approach in the assessment of each individual child and includes a chapter dedicated to assessing black children in need and their families (Dutt and Phillips, 2000). The authors suggest that practitioners should ask two questions:

> *What are the developmental needs of black children and their families, and in what ways are these similar, and in what ways do they differ from the developmental needs of white children and families?*

> *How can these developmental needs be responded to in work with black children and families?* (Dutt and Phillips, 2000, p.38)

They go on to point out that 'both black and white children require their parents or carers to respond to their same fundamental care needs' and state that 'the base lines for assessing parenting capacity and the child's developmental needs should be the same irrespective of whether a black child or a white child is being assessed' (p.38).

Although, in the United States, statutes specify exemptions regarding abuse thresholds, most commonly in relation to religious belief (for example, concerning withholding medical treatment on religious grounds), or in regards to cultural practice (National Clearinghouse, 2003b), such considerations do not operate in the UK. As Chand points out:

> *Cultural differences in the way families rear their children should be respected, but where child abuse does occur it should be understood that this particular family has gone beyond what is acceptable not only in the British culture, but in their own* (Chand, 2000, cited in Harran, 2002a, p. 411).

Harran (2002a) emphasises the importance of recognising 'that professionals and clients are not culturally neutral but a product of their own cultural conditioning and life experiences (p. 413). Lynch (personal communication) points out that extensive recruitment from overseas into the health and welfare services may increase the diversity of cultural norms and expectations. Social workers and other professionals need to be aware that their beliefs may impact upon the decisions they make (O'Sullivan, 1999). Furthermore, Welbourne (2002) emphasises the importance of taking into account the fact that 'tensions exist between different cultural norms and values within the UK, not only between ethnically and culturally distinct groups of people' (p. 353).

Case examples outlined by Webb, Maddocks and Bongilli (2002) raise additional issues that may influence the recognition of abuse in children from minority ethnic groups. Dark skin complexions may mask evidence of bruising; language barriers may prevent children from expressing their wishes and views or disclosing abuse; and professionals may be reluctant to express concerns for fear of being viewed as racist.

Gray (2003) found that a close cultural match between worker and service user was beneficial as it provided shared goals and broke through language barriers. Workers from a similar culture were more aware of local issues, and better able to understand the problems faced by families and offer culturally sensitive responses.

The Social Services Inspectorate (2000) found that 'most councils did not have strategies in place to deliver appropriate services to ethnic minorities and families were often offered services that were not appropriate or sensitive to their needs' (p.1). This social services inspection also found there was variable practice in relation to the recruitment of black staff. Quereshi and colleagues (2000) also found that social services only employed a small number of Asian staff. Few local authorities had considered staffing of reception areas and language and translation issues in this context. Families did not necessarily understand the role of social services nor was it easy for those requiring support to access it. However, families were generally positive about the services they eventually received, a point also made in Butt and Box's (1998) study of the use of family centres by black families.

Duty to report

In the United States and some parts of Australia there is a mandatory duty to report cases of suspected abuse. In practice, Foreman and Bernet (2000) suggest that there are disagreements as to whether mandatory reporters must report allegations made by third parties, even if they do not share their suspicions. The authors identify a range of reasons for this confusion. There is a lack of knowledge of state law; the laws themselves are ambiguous and lack clarity, and finally, practitioners sometimes decide to disregard the law and do 'what they think is best' (p. 190). They recommend that mandatory reporters do take seriously statements made by third parties, but that they use their professional experience and expertise to judge the claims and evaluate the possibility of abuse. Only in those cases where the reporter suspects abuse should the case be referred to protective services. Mandatory reporting in the UK might increase the perception that safeguarding children is a responsibility of the whole community rather than a few select professionals, and thereby strengthen accountability and increase the likelihood that abuse will be recognised. However, similar difficulties may be encountered to those experienced elsewhere.

Potential impact of the Assessment Framework and the Integrated Children's System

The introduction of the Assessment Framework and the *Integrated Children's System* is expected to address many of the issues identified above. The emphasis on exploring the interrelationship between factors within the child's development, parenting capacity and the wider environment when undertaking assessments of need, the introduction of structured and detailed core assessments and standardised questionnaires and scales to evidence decision-making all facilitate the identification of needs within a family and assist in the recognition of abuse resulting in significant harm. The Assessment Framework has been introduced into the practices of a range of child welfare agencies and now forms a core part of numerous policy initiatives. This should increase the likelihood that abuse will be recognised by a range of professionals who come into contact with children and families. However, the research undertaken so far on the implementation of the Assessment Framework has identified extensive training needs amongst different staff groups (Cleaver *et al*,

2004a). We also do not, at this stage, know how well some of the assessment procedures will be implemented as a routine part of practice, or how far their implementation will impact on service delivery. The *Integrated Children's System* (Department of Health, 2002) incorporates the Assessment Framework and accompanying materials and the Looking After Children programme to provide a more streamlined system for assessment, planning, intervention and review, but again, we do not know how successful implementation will be, or how far implementation will impact on practice. These are among the areas where we have suggested that further research would be valuable (see Section 4 below).

2.2   Emotional Abuse and Neglect

Common features

The second area of research reviewed covered issues concerning emotional abuse and neglect. There is a paucity of literature in both these areas. Behl and colleagues' (2003) study of trends in maltreatment literature found that 'the percentage of articles examining child neglect or emotional abuse remain consistently low' (p.215) and concluded that further theoretical and empirical work was required.

Emotional abuse and neglect are particularly difficult to identify; there is overlap between the two phenomena, which adds to difficulties in reaching an agreed definition. Birchall and Hallett (1995) found that there was the least consensus amongst practitioners over how these two types of maltreatment should be identified. Coohey (2003) suggests that 'the lack of a reliable classification and definitional system for child neglect…has made it difficult to compare findings from studies' (p. 145).

Both emotional abuse and neglect are longstanding, multi-factorial phenomena, which rarely become evident through a particular crisis. However processes for safeguarding children tend to be incident orientated, with the result that there are often delays in identifying these cases (Birchall and Hallett. 1995). Other common features include difficulties in determining thresholds and identifying the 'point of no return' when compulsory intervention is required (Coohey, 2003; Stone, 1998; Black and Dubowitz, 1999; Birchall and Hallett, 1995). The Assessment Framework, with its developmental/ecological approach, offers the opportunity for greater clarity and consistency in identifying emotional abuse or neglect, although this still has to be evaluated in practice.

Emotional abuse

Definitional issues

Evans (2002a) identifies how different terminology is used to describe 'emotional abuse' across different countries. For example, in the United States, categories of maltreatment in statute refer to emotional/mental injury (National Clearinghouse on Child Abuse and Neglect Information, 2003a). O'Hagan (1995) points out that psychological and emotional abuse are terms that have tended to be used interchangeably; however he argues that the phenomena are not the same, although it is 'highly probable that the perpetrator who is abusing the child emotionally will to some extent also be abusing the child psychologically, and vice versa' (p.458). Whilst the authors recognise differences in terminology, for the purposes of this report 'emotional abuse' is used throughout, given that this is the term predominantly used in UK literature.

The Department of Health employs the following definition of emotional abuse:

> *Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to the child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone* (Department of Health *et al*, 1999, p.15).

The complex and multifaceted nature of emotional abuse means that a broad range of operational definitions have been utilised for research purposes and there is limited consensus concerning how it should be assessed (Iwaniec, 1995). Nevertheless, common elements in the conceptualisation of emotional abuse are that it is a) longstanding, repetitive and sustained and b) relates to a relationship between a caretaker and child, rather than a single event.

Sexual abuse, physical abuse, and neglect, can be repetitive and sustained, but they can also appear in single, isolated incidents. Articles on emotional abuse tend to acknowledge that most parents do occasionally respond to their children in a manner that is emotionally inappropriate. However with emotional abuse, such isolated incidents do not require intervention to safeguard the child's well being (O'Hagan, 1995; Tomison and Tucci, 1997). O'Hagan (1995) therefore emphasises the 'repetitive' and 'sustained' nature of inappropriate emotional responses to a child in his definition of emotional abuse. Glaser and Prior (1997) suggest that,

> the significant harm threshold is reached when the balance between good
> enough and unacceptable interaction is skewed so as to render the abusive
> aspects *typical* of the relationship (p.323).

Glaser and Prior also point out that processes for safeguarding children tend to be triggered by specific incidents and events; the absence of such events means that there can be a 'genuine delay in recognizing or defining emotional abuse and working towards protection for the child' (p.325).

Parents or primary caregivers tend almost always to be the perpetrators of both emotional abuse and neglect; although anyone in a caretaking position may be responsible. There have, for instance, been reports of teachers emotionally abusing collections of students (Jones, personal communication).

 An American study based on a nationally representative sample of over 5,600 professionals found parents to be the perpetrators in 91% of neglect and 81% of emotional abuse cases. On the other hand, nearly half of sexually abused children have been found to have been abused by someone other than a birth parent (Sedlak and Broadhurst, 1996, 11).

Glaser and Prior also make the point that parent-child relationships 'may take different forms and therefore constitute an heterogeneous collection of psychologically undesirable interactions' (1997, p.315). In addition, others have suggested that perceptions of emotional abuse are relative and culturally specific

(Iwaniec, 1997; Tomison and Tucci, 1997; Briggs and Hawkins, 1996). Given the emphasis upon child-parent interactions, the concept of 'good enough parenting' is of fundamental importance in this area. Winnicot (1958) states that this should be judged in terms of adequacy for a child at a particular time. However, the concept is elusive.

As Tomison and Tucci (1997) acknowledge, the work of Garbarino and colleagues (1986) has provided the basis for more recent attempts to define emotional abuse. Five categories of harmful behaviour were classified as psychological maltreatment, that is: 'a concerted attack by an adult on a child's development of self and social competence, a pattern of psychically destructive behaviour (Garbarino *et al*, 1986, cited in Tomison and Tucci, 1997, p. 4).

1) Rejecting: behaviours which communicate or constitute abandonment of the child
2) Isolating: preventing the child from participating in normal social interaction
3) Terrorising: threatening the child with severe punishment, or deliberately cultivating a climate of fear or threat;
4) Ignoring: where the caregiver is psychologically unavailable to the child or fails to respond to the child's behaviour;
5) Corrupting: caregiver behaviour which encourages the child to develop false social values that reinforce antisocial or deviant behavioural patterns (cited in, Evans, 2002b, p.2)

Garbarino and colleagues (1986) also emphasised that such psychologically damaging behaviours may have a different impact depending upon the child's age and stage of development. Such a definition allows a broader view of emotional abuse that could include caregivers and significant others such as teachers, nursery staff and youth leaders as well as parents. This categorisation of emotional abuse has been developed further (see for example, Hart *et al*, 1987).

Brassard and Hardy (1997) also build on this classification and point out that emotional abuse (or psychological maltreatment) can be both indirect as well as direct. Indirect abuse would include being *terrorised* by witnessing domestic violence, or *corrupted* through observing parental involvement in pornography. The authors

have also developed psychological maltreatment rating scales (Brassard *et al*, 1993). These instruments offer a useful tool in the assessment of psychological abuse and pro-social parenting, and are of particular value given the difficulties of identification and definition.

However, more recently in the UK, Glaser (2002) proposes the following:

1) Emotional unavailability, unresponsiveness, and neglect. In these instances the primary carer is preoccupied with their own needs and difficulties; these may include mental ill-health, substance misuse, alcoholism.

2) Negative attributions and misattributions to the child. These include hostility, denigration and rejection of the child who is perceived as deserving of this treatment.

3) Developmentally inappropriate or inconsistent interactions with the child. These include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning.

4) Failure to recognize or acknowledge the child's individuality; failure to respect psychological boundaries.

5) Failure to promote the child's social adaptation. This includes promoting mis-socialization (including corruption) and psychological neglect.

    This final category includes acts of both omission and commission.
    (Glaser, 2002, p.703)

Whilst there is general agreement about key aspects of emotional abuse, some researchers (McGee and Wolfe, 1991) have focused upon parental behaviour that is viewed as harmful, whilst others have focused upon the impact of parental behaviour on the child's development and outcomes (Kavanagh, 1982). There has also been some debate as to whether definitions should focus upon abusive behaviour or the consequences for the child. Glaser (2002) identifies a problem with using a definition

that requires the presence of ill effects, in so far as this does not promote the effective prevention of abuse (p. 701).

Jones (private communication) suggests that different definitions may have arisen because of the way in which the concept is applied in different settings, such as research, prevention, and the family justice system. In his view the whole concept needs to be thoroughly reviewed with the aim of redefining emotional abuse in a manner that could be of utility to practitioners, researchers, the family justice system and policymakers.

Legislation and decision-making

Tomison and Tucci (1997) have suggested that clarity of definition is of particular importance in policy and legislation aimed at safeguarding children. In their view there is a clear definition of emotional abuse in England and Wales and the provisions of the Children Act 1989 provide a practice framework that makes it possible to 'single out emotional abuse as a discreet entity' (p.8). The 'significant harm threshold' requires 'the abuse or likelihood of abuse to be *attributable* … to the care given to the child, or likely to be given to the child…not being what it would be reasonable to expect a parent to give him' (s. 31(2)). Glaser (2002), therefore, acknowledges that within this legal framework 'there is no requirement to prove parental or the abuser's intent to abuse the child' (p. 702).

However, although the legislation may enable professionals to act, this is not to say that timely intervention and service provision necessarily occur. Trowell, Hodges and Leighton-Lang (1997) suggest that 'where there are no medical/physical indicators, the emotional abuse in a situation may be missed' (p.358). The 'burden of proof' is more difficult to establish in the absence of such evidence. However, the systematic collection of consistent observations of parent-child relationships should provide this.

Ayre (1998a) found that responses to chronic neglect and emotional abuse were inadequate in the child protection system operating in the 1990s. There was evidence that professionals tended to focus upon parental behaviour and 'intangible factors such as…'improved'' attitude rather than their capacity to meet the child's needs. As

such they could become blind to the persistence of 'unacceptable squalor or danger' (p. 336) (see also, Stevenson, 1998; Jones and Gupta, 1998). Hall (2003) emphasises the importance of observation of child-parent interactions over time. In practice, Ayre found that failure to record information, share information across agencies and review case histories meant that longstanding problems did not necessarily trigger intervention, on the basis that the single incident (albeit one of many) seemed relatively minor. Similarly, Munro (1999) found that 'professionals become absorbed in present-day issues and fail to stand back and place current issues in the long-term history of the family' (p.751). These factors are particularly relevant in that cases of emotional abuse and neglect tend to centre around parent-child interactions and longstanding problems.

> *Professionals in the field continue to find difficulty in recognizing and operationally defining [emotional abuse], and experience uncertainty proving it legally…These difficulties have led to delays in recognition and protective intervention* (Glaser, 2002, p. 697).

Prevalence

A number of reasons for the under-recognition of emotional abuse have been posited. Firstly, Glaser (2002) suggests that, particularly in cases of emotional abuse that are not intentional, the pejorative nature of the terms *abuse* and *maltreatment* leads to 'a reluctance to label or blame caregivers who hold primary responsibility in the child's life' (p.700). However, she suggests that without the use of these terms, professionals fail to recognise the imperative to intervene actively to protect children from harm. Secondly, Tomison and Tucci (1997) suggest that the prevalence of emotional abuse is underestimated, both because of the absence of physical injuries and because its ongoing nature means there is no crisis to promote recognition by health or social work professionals (see also, Oates, 1996). Iwaniec (1997) also suggests that the differences in operational definitions, together with the difficulties in disentangling emotional from other forms of abuse, mean that the latter are used as the primary category labels by child and health professionals. Lynch (private communication) questions whether professionals routinely look for emotional abuse when children have been physically or sexually maltreated. Finally, it can be difficult to prove that

significant harm is a result of emotional abuse (Glaser and Prior, 1997). Such issues are equally applicable in cases of neglect.

Evans (2002a) acknowledges that child protection registrations do not provide a true picture of the incidence of emotional abuse: the figures are likely to under-estimate its extent, although they do offer some insight into the scale of the problem. Emotional abuse was the least common reason for placing a child on the child protection register between 1998-2000, although the number and percentage of registrations rose slightly over this period, from 5,200 in 1998 to 5,500 in 2000 (see Table 1, below). In 2001, registrations fell to 4, 800, although for the first time a larger number of children were registered under this category than as a result of sexual abuse (4, 500).

Table 1

Children and young people on child protection registers in England at 31 March 1998-2002, under the category of emotional abuse (Department of Health, 2003a)

Year	Number	Percentage
1998	5200	16
1999	5400	17
2000	5500	18
2001	4800	18
2002	4500	18

Glaser and Prior's (1997) study of 94 children in 56 families registered on the CPR under a sole or joint category of emotional abuse explored the prevalence of six different types identified: developmentally inappropriate interaction, denigration or rejection, emotional unavailability or neglect, repeated separations or moves, using the child for emotional needs of adult/s, and mis-socialization and terrorizing. The study revealed that the most common form of maltreatment was in developmentally inappropriate interactions with the child, affecting 42% of the sample. The least common manifestation was in mis-socialization and terrorizing, affecting only 2%. However, nearly half (41%) of the children experienced more than one of these forms of emotional abuse from those identified (p.319). Thoburn and colleagues (2000) found that multiple and longstanding problems were more prevalent in families

referred for family support because of concerns regarding emotional abuse than those referred for other reasons, suggesting that this may be an indicator of deep-seated family dysfunction.

Doyle found that 29% of undergraduate and mature students in a population survey of 429, had been emotionally abused by their carers, in comparison with 14% who had been physically and 9% who had been sexually abused (p.335). Doyle (1997a) indicates the similarity between these findings and those of other British studies (Creighton and Russell, 1995; Smith; 1998). However, a larger scale study of 2,869 18-24 year olds, conducted by the NSPCC, revealed that 6% of the sample had experienced emotional maltreatment, defined as adverse treatment in at least four of the following seven dimensions: psychological control and domination; psycho/physical control and domination; humiliation/degradation, withdrawal; antipathy; terrorising; proxy attacks by abusing someone or something the child loves or values (Cawson *et al*, 2000, p.13). Disparities in findings could be due to different definitions of emotional abuse.

What type of child or sort of family experiences emotional abuse?

A study by Doyle found that 'there appears to be no type of child who is more vulnerable to emotional abuse in terms of age, gender, ordinal position in the family and health or disability' (Doyle, 1997a, p.335). However, it should be noted that she also found that disability could compound emotional abuse as a result of additional burdens, such as isolation and discrimination. Tomison (1996a) suggests that physical or intellectually disabled children may be more vulnerable to abuse because of their additional needs and greater chances of disruption in the attachment and bonding process.

Depression and substance misuse have also been found to increase the potential for emotionally abusive responses (Tomison 1996b). Glaser and Prior (1997) found that 63% of parents with children registered on the CPR under the category of emotional abuse displayed one or more of the following attributes considered to contribute to the risk of significant harm: mental ill-health; domestic violence; alcohol and drug abuse. Another study of 2084 child abuse referrals to the NSPCC revealed that in 10% of

cases a parent or carer was reported as having a mental health problem. In these cases there was an increased concern regarding emotional abuse and greater levels of violence between parents (Lewis and Creighton, 1999).

In Rushton and Dance's study of scapegoating (in press) 53 child and adolescent mental health practitioners were asked to identify a number of hypotheses to explain why some children were singled out for negative attention. The following reasons were given:

- Scapegoating: singling out and blaming one child is seen as serving a function for the family system. For instance, marital tensions may be displaced onto a single child.

- Projection: unacceptable and uncomfortable feelings within the parent may be attributed to an individual child. Depression in the parent may lead to this kind of distortion.

- Symbolisation: negative feelings from another relationship may be mis-attributed to one child.

- Lack of bonding: this may be the result of an unwanted or difficult pregnancy, post natal depression or disability which may inhibit the mother's bonding with one particular child.

- Trans-generational abuse: parents, themselves rejected as children, feel compelled to repeat this behaviour.

- The goodness/badness of fit: the temperamental style of the child and parent may be very different and the parent may have difficulty relating to the child.

- The family secret: one child may be singled out for holding a family secret.

Children who are singled out for negative attention may be referred as single cases.

Rushton and Dance (in press) also found that when compared with joint referrals of sibling groups, 'single referral cases were significantly less likely to be accorded high priority and much less likely to receive thorough and structured assessment' (p. 17).

Social status and emotional abuse

Lewis and Creighton (1999) suggest that 'disadvantaged families are those most exposed to the surveillance of the child protection…and other welfare agencies' (p.153) and all forms of abuse may be less recognised in middle class families. A study undertaken by Covitz (1986) revealed many examples of emotional abuse in wealthy families. Doyle (1997b) also found that 'emotional abuse can occur in families who are free of obvious stress and interpersonal problems'. Iwaniec (1995) suggests that social status can prevent the recognition of abuse in affluent families. This is particularly the case when the child is physically healthy and school attendance is not problematic. Glaser, Prior and Lynch (2001) suggest that emotional abuse does not 'respect' class boundaries.

Divorce affects children and families across all classes; however the impact of highly conflicted divorce or separation situations, including those in which domestic violence is involved, has received limited research attention (Logan *et al*, 2003). The recent Green Paper *Parental Separation: Children's Needs and Parents' Responsibilities* (Department for Constitutional Affairs, Department for Education and Skills and Department for Trade and Industry, 2004) emphasises the importance of resolving disputes during parental separation, so that children's needs are met. If handled badly, it is acknowledged that conflict can have very damaging and longstanding effects on the child. The Children Act Sub-Committee have also developed guidelines for the courts on dealing with domestic violence and contact Arrangements.

Consequences

Emotional abuse and neglect have been found to undermine children's development, although the consequences may differ depending upon their age, stage of development

and capacity for resilience. In infancy, stability and continuity of carer are required to support the development of secure attachment (Bowlby, 1969; Ainsworth *et al*, 1978). Rejection and emotional unresponsiveness in early infancy are likely to lead to insecure or avoidant attachment and delayed psycho-motor development (Iwaniec, 1995). More recent studies have also identified disorganised/disoriented attachments in which the parent-child interaction is characterised by the infant's fear of the caregiver (Bukato and Daehler, 1998) and 'alternating or simultaneous approach and avoidance, 'freezing', incomplete or stereotyped actions' (Martins and Gaffan, 2000, p.738). Martins and Gaffan (2000) cite two studies that indicate that disorganised attachment is a stronger predictor of 'cognitive delay in later childhood' (Lyons-Ruth, 1996) and psychopathology and dissociative symptoms in adolescence' (Carlson, 1998) than avoidant attachment (p.744).

In later developmental stages a range of problem behaviours have been identified as being associated with emotional abuse. These include: 'eating disorders, substance abuse, aggression, withdrawal and criminal activity' (Doyle, 1997a, p.337). It should be acknowledged that, given the difficulties in recognition, identification of emotional abuse in later childhood often indicates its prolonged duration, rather than late onset (Glaser, 2002).

In Rushton and Dance's forthcoming study, health visitors found that most singled out children presented as anxious and/or withdrawn, while a few were attention-seeking, and over-active, with behavioural problems and developmental difficulties. Health visitors also found that there were difficulties in responding to emotional abuse on a multi-agency basis as social services departments tended not to appreciate the potentially serious consequences of this form of maltreatment.

Glaser, Prior and Lynch (2001) identified a wide range of impairments to children's development in a sample of 94 children placed on the CPR under the category of emotional abuse: 63% showed impairment of emotional state (unhappy/low self esteem, frightened, distressed, anxious); 49% displayed behavioural difficulties (oppositional, age inappropriate responsibility, attention seeking, antisocial/ delinquent); 47% were underachieving, or not attending school; 35% displayed difficulties related to peer relationships (withdrawn or isolated, aggressive); and 35% were physically neglected, of small stature or unkempt (cited in Glaser, 2002, p.710).

The National Clearinghouse (2003a) suggests that the *possibility* of emotional abuse should be considered when a child:

- Shows extreme behaviour patterns, such as overly compliant or demanding behaviour, extreme passivity, or aggression.
- Is either inappropriately adult (parenting other children for example) or inappropriately infantile (frequent rocking or head-banging, for example).
- Is delayed in his/her physical or emotional development.
- Has attempted suicide.
- Reports a lack of attachment to the parent.

And when the parent or caregiver:

- Constantly blames, belittles, or berates the child.
- Is unconcerned about the child and refuses to consider offers of help for his/her problems.
- Overtly rejects the child

Glaser (2002) states that currently there are no reliable data on specific impairments resulting from different categories of emotional abuse; nor do we know whether certain types of emotional maltreatment have particularly damaging consequences in the longer term.

Doyle challenges the perception that emotional abuse tends not to have fatal consequences: 'suicide and self abuse were in evidence in all the sample groups' (Doyle, 1997a, 337). A study conducted by Claussen and Crittenden (1991) also found that in most cases of physical abuse there was also evidence of psychological maltreatment. This was a predictor of detrimental outcome, whereas severity of physical injury was not (cited in Iwaniec, 1997, p.370; see also, Cantwell, 1997). Glaser (2002), citing Hart and colleagues (1998) concludes that 'it may indeed be the attendant emotional abuse which is the mediator of the abuse caused by other forms of child abuse and neglect' (p. 699). Bentovim (personal communication) regards emotional abuse as the pervasive factor that runs through all types of child abuse.

Failure to thrive

Failure to thrive (FTT) is the term used to 'describe infants and young children whose weight, height and general development are significantly below expected norms' (Iwaniec: 1995, p.18). Tomison and Tucci (1997) describe non-organic failure to thrive as 'one of the few forms of emotional abuse that generates observable physical symptomology' (p. 11). FTT may be caused by organic illness or result from psychosocial causes and lack of nurturing (non-organic FTT), or a combination of these. It 'places children at risk of negative developmental, social, physical and emotional consequences' (Taylor and Daniel, 1999, p.325).

Wright and Talbot (1996) found that 'only around 5% of children in [their] screened population had *major* organic conditions as the *main* cause of their failure to thrive' (p.225, emphasis added). However, only a small number of cases resulted in child protection registration. The authors suggest that effective communication with parents concerning the seriousness of the child's poor weight gain does usually result in parents responding to the need for modification of the child's food intake. They argue therefore, that only after parents have been informed of the seriousness of the problem and the remedy and then failed to respond, does the question of neglect or abuse arise. Wright and Talbot (1996) found a time lapse of 1-3 months post intervention before any demonstrable effect on the child's growth was detected (p.227). More recently, Jones (personal communication) challenges the idea that failure to thrive is a form of emotional abuse on the grounds that it has now been established that insufficient calories are a major component.

Interventions

Interventions to address emotional abuse have received limited attention in the literature. Evaluative studies have tended to explore a wide range of family-centred initiatives, but have not focused solely on cases of emotional abuse. Cohn and Daro (1987) evaluated nineteen projects aimed at safeguarding children in the United States; these included intensive casework, family support, vocational training, and mental health services. They found that emotional abuse (psychological maltreatment)

was the most resistant to treatment and demonstrated a recidivism rate of 75%. Emotional abuse is almost always an element in other forms of abuse (Lynch, personal communication). Brassard and Hardy (1997) suggest that treatments that focus upon 'psychological maltreatment and the related relationship disorders that exist in most maltreating families will prove more effective than treatments that do not' (p.401).

Macdonald (2002) has drawn together the available studies on primary, secondary and tertiary prevention in all forms of abuse and neglect. She found that many interventions currently in use may, or may not, be effective, but have no evidence base. However one of the conclusions was that 'the prevention of psychological maltreatment appears more effective when parents are involved in group work as well as individual parent training' (p.222).

Jones (2001) identifies the necessary components for planning any intervention to safeguard children; these include weighing the relative significance and interrelationship of all factors to determine the current levels of risk of recurrence; assessment of the current status of the child's welfare; identification of future circumstances that might increase or decrease the risk to the child; estimating the likelihood for change; criteria for evaluating the effectiveness of the intervention and timescales in relationship to child's developmental needs. However, with regard to emotional abuse, he reiterates Macdonald's point (2002) that very little is known about the effectiveness of specific approaches, which means that we do not really know when it is worth intervening, and what the likelihood of success will be (Jones, personal communication).

There is some evidence that agencies may be slow to respond to concerns about emotional abuse. Glaser and Prior (1997) found that 93% of children placed on the child protection register under this category had been known to social services prior to registration, and that the delay between concerns being raised and registration ranged from 8 months to 14 yrs 8 months. Agencies may also register children because of general, non-specific concerns about families or because a child is living with a substance abusing or mentally ill parent, without any clear articulation of either the impact of the experience on the child, or the manner in which parenting capacity may be affected (Jones, personal communication). Glaser (1997) suggests that in order to

determine the appropriate intervention, it is first necessary to establish whether the cause is 'primarily based on negative attributions (erroneously assigned to the child) or on parental preoccupation with their own issues' (p.374).

Iwaniec (1995) suggests that intervention strategies need to be tailored to the individual child and family and involve professionals from a range of disciplines; further support may also be available from friends, volunteers or community resources. In supporting children, day care may be provided, and strategies such as play therapy adopted to improve the child's self-esteem. Individual or group work may be undertaken with parents to improve parenting skills, interaction and relationships, and to develop assertiveness and social skills; counselling may also be offered to help parents reflect on their problems.

Thoburn and colleagues (2000) found that in cases of emotional abuse and neglect, families did not necessarily utilise neighbourhood resources, although they were aware of their availability. There were considerable variations in the availability of relatives and friends who would reliably offer support to these families during stressful times. Families were, however, least likely to have someone to turn to if they required material or financial support. Wright and Talbot (1996) suggest that community interventions to address failure to thrive may be more appropriate than those offered by social services, although this may depend on the severity of the abuse.

Doyle (1997a) found that survivors of emotional abuse cited the importance of one supportive person in their lives. These tended not to be professionals, but included aunts, siblings, neighbours and so on (see also, Briggs and Hawkins, 1996). Doyle also found a wide range of interventions used by social services in registered cases of emotional abuse. These included material support, individual, family and group therapy, and specialized services such as drug rehabilitation (p.338). Past research, however, demonstrates that timeframes for rehabilitation may not be compatible with very young children's need for stability and security (Ward *et al,* 2003), and that adult services may not be sufficiently responsive to the needs of patients' children (Aldridge and Becker, 2003).

44

2.3   Neglect

Definitional Issues

The Department of Health employs the following definition of neglect:

> *Neglect is the persistent failure to meet a child's basic and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical abuse or danger, or failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs* (Department of Health *et al*, 1999, p.15).

The last sentence of this definition demonstrates the overlap between the two concepts of neglect and emotional abuse noted above.

The National Clearinghouse (2001) suggests that despite different methods of assessment, there is universal consensus that the following behaviours should be classified as neglectful:

- Inadequate nutrition, clothing, or hygiene
- Inadequate medical, dental or mental health care
- Unsafe environments
- Inadequate supervision, including the use of inadequate caretakers
- Abandonment or expulsion from the home

(Barnett, Manly and Cicchetti, 1993; Sedlak and Broadhurst, 1996, in National Clearinghouse, 2001, p.2). Such classifications have informed the identification of the dimensions of parenting/caregiver capacity to respond to children's needs outlined in the *Framework for the Assessment of Children in Need and their Families* (Department of Health *et al*, 2000).

There is a general consensus that neglect is characterised by the omission of care (Evans, 2002b, Cawson *et al*, 2000, Stevenson, 1998; Zuravin, 1999). As such, cultural perspectives on 'good enough parenting' and identification of children's needs at different ages and stages of development are relevant. Cawson and colleagues (2000) found that significant parental omissions differed according to the child's age (see also, Cleaver *et al*, 1999).

Stevenson (1998) has argued against the tendency to focus upon omissions in the *mother's* provision of care (see also, Turney, 2000). However, the NIS-3 data showed that in 87% of neglect cases the perpetrators were females (Sedlak and Broadhurst, 1996). The researchers argue that this finding is congruent with the fact that 'mothers…tend to be the primary caretakers and are the primary persons held accountable for any omissions/failings in caretaking' (Sedlak and Broadhurst, 1996, p. 12).

Stone describes neglect as a 'loosely defined category of concerns about child care' and suggests 'no simple litmus test will reveal the presence or absence of neglect' (1998, p.91). In this study practitioners identified 35 different key features in defining neglect, relating to: the child, parents/caregivers, family dynamics, supervision, compliance and social factors. The mean number of features viewed as relevant in individual cases was 18.5 (p.91).

A range of subcategories has been developed to reflect the multidimensional nature of neglect. These include physical neglect, emotional neglect, supervisory neglect, fatal neglect, prenatal neglect, medical neglect and domestic violence. Again, there is considerable overlap between some categorisations of emotional abuse and neglect. For example, exposure to domestic violence is also identified in Glaser's (2002) 'developmentally inappropriate or inconsistent interactions with the child' category of emotional abuse and in Brassard and Hardy (1997) as an example of terrorising behaviour. Stone (1998) has suggested that the link between physical neglect and emotional abuse is particularly strong.

Coohey (2003) defines supervisory neglect as occurring 'when a parent or caretaker fails to provide the child with adequate protection from abuseful people or situations'. This author divides neglect into five different parenting behaviours: 'did not watch

closely enough; provided inadequate substitute childcare; failed to protect from a third party; allowed to engage in an abuseful activity; and drove recklessly or while intoxicated' (p.824).

Prevalence

Neglect is the most common reason for inclusion on the child protection register, accounting for 48% of all registrations in 2001 and 39% in 2002[2]. The lower percentage in 2002 is likely to be the result of a change in categorisation, rather than a reduction in neglect registrations (see Table 2, below).

Table 2

Child and young people on child protection registers in England at 31 March 1998-2002, under the category of neglect:

Year	Number	Percentage
1998	13000	41
1999	13900	44
2000	14000	46
2001	12900	48
2002	10100	39

(Department of Health, 2003a)

Despite its recognised predominance in CPR registrations, neglect may be accorded a low priority by practitioners (Stone, 1998). Gibbons and colleagues (1995) found 'thresholds' for intervention tended to filter out neglect cases and that these families were accorded few services until specific incidents of physical abuse were discovered. As with cases of emotional abuse, the longstanding, and cumulative consequences of

---

[2] Mixed categories were incorporated into the main categories in order to show the total numbers of children for whom each category of abuse was cited on the register between 1998-2001. The 2002 figure excludes mixed categorisations.

most instances of neglect are less likely to be picked up by a system that is geared to crisis interventions.

A British population study found that 17% of a sample of 2869 respondents had experienced an absence of physical care or supervision during childhood and that for 6% this had been serious (Cawson *et al*, 2000, p.52, cited in Evans, 2002b).

Data on the national incidence of child abuse and neglect in the United States (NIS-3) were explored by Sedlak and Broadhurst (1996). Two types of definition were employed in this study. Firstly, children were considered to have been maltreated if they had suffered significant harm from abuse and neglect (the Abuse Standard). Secondly, children were also included if they had experienced abuse or neglect that put them *at risk* of significant harm (the Endangerment Standard) (Sedlak and Broadhurst, 1996, p.2). Under the Abuse Standard (the more stringent definition) an estimated 338, 900 children were found to have been physically neglected in 1993. This represents a 102% rise in incidence compared with 1986 (NIS-2) (Sedlak and Broadhurst, 1996). In 2000 more than half of child maltreatment cases in the United States of America were categorised as due to neglect (Connell-Carrick, 2003; USDHHS, 2002).

What type of child or family?

Connell-Carrick (2003) undertook a systematic review of the empirical literature on the correlates of child neglect between 1990 and 2002 in the United States. This study, which examined 24 articles (Appendix 4), found that the following were correlates of child neglect:

1) Child's age – younger children were more likely to be victims
2) Poverty
3) Lone parenthood
4) Unemployment status
5) Young maternal age
6) Overcrowded housing conditions
7) Limited social networks or emotional support

These factors are almost identical to those found to increase the likelihood of admission to public care (Bebbington and Miles, 1989).

The following variables were also identified as potentially significant: ethnicity, gender of the child, parenting skills, parent's history of victimization and/or substance abuse. However the relationships were found to be inconclusive, either because research evidence was contradictory, or because only a small number of studies included the variable (Connell-Carrick, 2003, p. 417).

Overall, Connell-Carrick concludes that:

> *The typical neglecting family includes a young, single parent with a large number of individuals living in the home, who have little social support and perceive their social support as inadequate. The family is also poor, living in poverty and/or receiving various forms of public assistance* (Connell-Carrick, 2003, p.417).

Research on cases of fatal neglect (Morgolin, 1990) found that the majority of victims were aged three or under, male (71%) and from families with large numbers of children. Neglect fatalities are more likely to be associated with a single life-threatening incident in which the caregiver is absent at a critical moment than with chronic abuse, although this is not always the case (see Bridge Consultancy Service, 1995).

Egan-Sage and Carpenter (1999) explored a total of 2069 child abuse and neglect *referrals* to social services, derived from cases prior to and post implementation of the Children Act 1989. They found that children aged under eight were significantly more likely to be registered on the CPR under this category. Only 29% of these referred children lived with a lone parent. Gibbons and colleagues (1995) also found that a relatively low percentage (32%) of referrals involved lone parents (cited in Egan-Sage and Carpenter, 1999, p.310). However this is in contrast to findings from other studies (see for example, Caplan *et al*, 1985; Zuravin, 1999), which showed a higher incidence of lone parents. Egan-Sage and Carpenter (1999) also found that 45% of mothers whose children were placed on the CPR in this category were aged 21

or less at *the time the child was born*. Children were more likely to be registered if they came from large sibling groups, and if their siblings were also very young (p.311).

Research in England conducted by Stone (1998) revealed that common features in neglect cases were 'parents' preoccupation with their own needs' and disorganization/ mismanagement', both of which occurred in 18 out of twenty cases. Poor parenting skills were also cited in 14/20 cases. In over half of the cases (12/20) caregivers had experience of the care system or prison. Substance misuse, mental ill-health or learning disability were also common (Stone, 1998, p.92). Cleaver and colleagues (1999) spell out the relationship between parental problems such as mental illness, alcohol and drug misuse and domestic violence, parental pre-occupation and disorganisation, and showed how they impact on children at different ages and stages of development. The *Children Act Report 2002* also identifies the prevalence of parents' significant learning disability in chronic neglect cases, and also cites domestic violence as a further feature (Department for Education and Skills, 2003b, p.27).

Stone (1998) also identified poverty as a common factor in chronic cases of neglect. In seventeen of the twenty cases in this study parents were dependent on benefits; fifteen were living in poverty, and eighteen were in financial difficulties. Thoburn and colleagues (2000) also found that 98% of families whose children were at risk of suffering emotional maltreatment or neglect were characterised by the extreme poverty of their material situation.

Rosenberg and Cantwell (1993) suggest that a distinction should be made between neglect resulting from material poverty and neglect attributable to emotional unresponsiveness. However, it should not be forgotten that children whose parents have adequate incomes may also suffer neglect (Cantwell, 1997). Dubowitz and colleagues (1993) suggest that meeting the needs of a child is not only the responsibility of the parent, but also the wider community. They argue that society's failure to address material deprivation and poverty constitutes child neglect in a country with immense resources. The ecological approach they adopt suggests that failure to meet a child's needs should be defined as neglectful, regardless of the cause (see also Jack, 2001). The *Framework for the Assessment of Children in Need and*

their Families (Department of Health *et al*, 2000) also adopts an ecological approach and requires assessment of the child's developmental needs and their parent's capacity to respond to these needs within the context of their wider family and environment (Horwath, 2002).

Consequences

A number of studies demonstrate the adverse impact of neglect not only on children's physical development, but also on their emotional development and self esteem. Physical and/or emotional neglect in early infancy has an adverse effect on children's ability to form attachments; it may also lead to poor language development, poor growth rates, developmental delay, conduct disorder, poor educational performance, recurrent and persistent minor infections. Neglected children may also experience low self-esteem, feelings of being unloved and isolation (Bridge Child Care Consultancy Service, 1995; see also, Dent, 1996; Bifulco and Moran, 1998, Gaudin, 1993). However, the impact is likely to vary depending upon how long the child has been neglected, their age and the multiplicity of neglectful behaviours they have experienced. Resilience factors within the child may mediate the detrimental effects of neglect (Prilleltensky and Pierson, 1999, cited in National Clearinghouse on Child Abuse and Neglect, 2001).

Children may experience significant harm through neglect *in utero* as a result of maternal substance abuse (Cantwell, 1997). Those born with foetal alcohol syndrome have complex, long-term health needs, and arguably require better than 'good enough parenting' (Ward *et al*, 2003). Those born with withdrawal symptoms may be difficult to care for. Children with health and sleeping problems have been found to be at increased risk of abuse as such difficulties may interfere with parent-child bonding (Spencer, 2002).

The National Clearinghouse (2003a) suggests
that the possibility of neglect should be explored when a child is:

- Frequently absent from school
- Begs or steals money or food

- Lacks needed medical or dental care, immunizations, or glasses
- Lacks sufficient clothing for the weather
- Abuses alcohol or drugs
- States that there is no one at home to provide care

And when the parent or caregiver:

- Appears to be indifferent to the child
- Seems apathetic or depressed
- Behaves irrationally or in a bizarre manner
- Is abusing alcohol or other drugs

Intervention

> *To have the best chance of preventing the more serious family and child care problems, what we might call child neglect, the best chance of success is to improve and develop universal, non-stigmatising services which are integrated into the mainstream of social provision for children* (Parton, 1994, p.75-76)

Thus part of the response to neglect fits within the wider social policy context and the government commitment to tackling poverty and social exclusion. Evidence from Nelson and Macleod's (2000) meta-analysis of 56 programmes designed to prevent child maltreatment suggests that proactive or preventive approaches, delivered through improved universal services or targeted at specific at risk groups before difficulties become apparent, more frequently produce sustainable gains than reactive interventions introduced in response to emerging concerns (quoted in Statham, 2004a). Jones (personal communication) and Macdonald (2002) both argue that there have been scandalously few studies of the effectiveness of interventions designed to help protect children from abuse and neglect. In circumstances where neglect has already occurred, there is some evidence that cognitive-behavioural approaches are the most effective known interventions in preventing a recurrence of neglect and, indeed other forms of abuse and that parent training appears to be particularly effective for parents with learning difficulties (Macdonald, 2002).

Aldgate and Tunstill (1995) identified problems regarding resource allocation in chronic neglect cases and found that categorising neglected children as 'in need' rather than as 'children in need of protection' meant they received limited services. Similarly, Gibbons and colleagues (1995) found that referrals concerning emotional maltreatment and neglect were 'filtered' out of the child protection system without measures being taken to safeguard and promote their welfare. The low priority given to neglect in processes for safeguarding children may relate to the fact that this is frequently a long-term developmental issue that is seldom revealed by a specific incident or crisis (Stone, 1998). There are also misperceptions about the severity of neglect, as compared with other forms of abuse. Birchall and Hallett (1995) found that social workers had poor understanding of the consequences of neglect, which they perceived as less severe than the significant harm inflicted by physical, sexual and emotional abuse. Research also demonstrates that social workers find it particularly difficult to know when to intervene in cases where parents are hovering on the border of 'good enough' parenting (Allsop and Stevenson, 1995).

The multifaceted nature of neglect makes intervention in such cases particularly challenging. Stevenson (1998) suggests appropriate interventions may include therapeutic work with the child and/or parent, parenting training, nursery provision and practical support. She also acknowledges that substitute care may be required to safeguard children and promote their welfare. Professionals' perceptions of neglecting families as non-compliant and having limited willingness or ability to change represent a further challenge (Stone, 1998). Browne and Lynch (1997) suggest that long-term intervention is required in cases of neglect. Inter-agency work is also identified as important; health visitors, for example, are well placed to support and monitor the development of children for whom there are concerns (Jones and Gupta, 2003).

The *Framework for the Assessment of Children in Need and Their Families* and accompanying practice guidance (Department of Health *et al*, 2000; Department of Health, 2000c), assessment schedules (Department of Health and Cleaver, 2000), and questionnaires and scales (Cox and Bentovim, 2000) provide a framework that supports and enables professionals to identify the impact of neglect and assess how the child's needs may be met (Horwath, 2002). Jones and Gupta (2002) suggest that:

An assessment that explores the complex and dynamic interplay of individual, familial and societal factors which frame the lives of many neglectful families is likely to lead to a multifaceted plan of intervention by a number of professionals (p.79).

However, Horwath and Morrison (2000) argue that the effective use of the Framework is dependent upon local implementation. Horwath's (2000) study of early implementation found that 'practitioners do not pay equal attention to all three domains of the triangle' and that 'parenting capacity and social context are marginalized…Consequently, interventions resulting from this type of assessment ignore parenting issues and the parenting environment' (p.199-200).

Currently, little is known about the effectiveness of interventions and how best to safeguard neglected children and promote their well being. The task is particularly complex given the number of sub-categories of neglect and differences in parental circumstances, stressors and wider environmental factors that may impact upon parent's ability to adapt their behaviour in the short or longer term.

2.4 Inter-agency Issues

> *The diversity of agency functions between social workers, the police, health personnel, mental health professionals, lawyers and teachers makes child protection an issue of greater or less familiarity and priority to each of them* (Holt, Grundon and Paxton, 1998, p.268).

Successive government guidance has stressed how the task of safeguarding and promoting children's wellbeing is a joint responsibility, to be shared by a range of child welfare agencies, all with different areas of expertise (see Department of Health 1999a; Department of Health *et al*, 2000). The third area we were asked to explore covered the inter-agency issues that sometimes act as obstacles to successful practice.

Definitional issues

The literature on inter-agency working in safeguarding children is characterised by definitional ambiguity and a lack of conceptual clarity with respect to the terminology used (Lupton and Khan, 1998; Hudson *et al*, 1999). 'Inter-agency', 'inter-disciplinary' and 'inter-professional' are terms that are often used interchangeably and the intended meaning is not always clear. Similarly, there is considerable overlap between terms such as 'collaboration', co-ordination' and 'co-operation'. Furthermore, as well as issues concerning working practices *between* different agencies, there are also questions to be resolved about working practices *within* agencies, characterised by a further selection of apparently interchangeable terms - 'intra-agency', 'intra-disciplinary' and 'intra-professional. Appendix Five provides a glossary of the many terms used.

Theoretical frameworks: factors conducive to effective inter-agency working

There is a wealth of sociological, psychological and management theory and research about organisational and inter-organisational working that could usefully inform joint

working in social care, including work on group dynamics, power relationships, conflict and consensus and gender relations. Much of this was undertaken between and immediately after the two world wars. Despite the length of time since the formative studies were carried out, the theoretical and empirical work undertaken then continues to inform developments in these disciplines (see for example, the structural-functionalist theories of Talcott Parsons (1937 – 1969)). Subsequent work has explored how groups operate and has focused on practical problems such as leadership, productivity, conflict, consensus, gender relationships, power, status, group cohesiveness and group decision-making (see for example Bales, 1950; Janis, 1972; Shaw, 1981; Tajfel and Turner, 1986; Zander, 1979; Zimbardo, 1975). The findings from these studies are pertinent to current discussions of how to ensure more effective inter-agency and inter-disciplinary working to safeguard children.

More recently, Hudson and colleagues' (1999) article on inter-agency collaboration in the public sector pulls together strands of theoretical, conceptual and empirical research literature from diverse disciplines (sociology, social policy, public administration and management, and philosophy) to explore inter-agency collaboration as a concept and as a process. The authors propose a theoretical framework that identifies a number of components of the collaborative process. The key issues and concepts include: recognition of the limits of organisational individualism; how recognition of the need to collaborate should be combined with an awareness of the problematic nature of collaboration as a concept and as a policy tool; the need for collaborating organisations to perceive mutual benefits; the critical importance of clear and attainable collaborative goals; the need for commitment at both strategic/senior management and front-line staff levels; trust as a *sine qua non* and mistrust as a primary barrier to successful collaboration.

Cooper and colleagues (2003) view trust between professionals as essential for good inter-agency communication. They acknowledge that one of the major weaknesses in the processes for safeguarding children in England and Wales is an erosion of trust between different professionals and agencies that has led to a lack of communication. They maintain that inter-professional trust is not enhanced by protocols, guidance, rules or procedures, but through positive experiences of one another, leading to positive expectations for the future, as well as through good communication. On that basis, the authors identify the following three processes that would help promote

trust: forums to promote open communication between professionals; the need for professionals to develop a common understanding about child abuse and safeguarding children (involving a shared professional language and theoretical stance); working together in multi-agency and multi-disciplinary teams. Alongside trust, they suggest that negotiation must underpin communication between professionals. Cooper and colleagues (2003) acknowledge that tensions exist between the need for open communication between professionals and issues of confidentiality, but that these are reduced by improved trust.

Morrison (2000) argues that 'effective inter-agency processes are highly dependent on the quality of collaboration *within* agencies and disciplines' (p. 368). Furthermore, he calls attention not only to the inter-relationship of partnerships between and within agencies and disciplines but also to the inter-relationship of these partnerships and those between professionals and service users.

Building upon Howe's (1992) framework for the worker-client relationship, Morrison (2000) explores intra- and inter-agency relationships across four types: i) paternalistic ii) adversarial iii) play fair iv) therapeutic/developmental. Morrison uses this framework to define intra-agency cultures and at the same time to examine relationships between such cultures, attitudes to inter-agency work and attitudes to service users. An intra-agency culture is defined as paternalistic when, within the agency, emphasis is placed on hierarchy and negotiation is absent. Within such a culture, inter-agency collaboration is viewed as an activity which is engaged in on the agency's own terms. 'The agency views itself as having unique expertise and finds it hard to respect or involve others with different skills' (p. 370). In addition, the agency's relationship with service users is also characterised by paternalism. An adversarial intra-agency culture raises a different set of difficulties; in such a culture, intra- and inter-agency communication is frequently conflictual and bureaucratic, characterised by power struggles. Furthermore, service users may be seen as enemies.

Barriers to inter-agency working to safeguard children

Hardy and his colleagues (1992), as cited by Hudson and colleagues, (1999), have identified a range of barriers to inter-agency collaboration. Structural barriers include

fragmentation of service responsibilities within and across agency boundaries. Procedural barriers relate to differences between organisations in planning, budgetary cycles and processes. Financial barriers reflect differences in funding mechanisms and resources. Professional barriers include differences between professional groups in ideologies and values; professional self-interest; threats to job security; and conflicting views about user interests and roles. Barriers relating to status, autonomy and professional domain involve both organisational self-interest and also concerns on the part of individual organisations over potential threats to their status, autonomy and area of professional expertise posed by collaboration.

Jones and colleagues' review of the literature on collaborative practice in child welfare (2002) identified the following barriers to success: variations in the socialisation process within different professional groups; lack of understanding of other professionals' roles; perceived status differences and role competition between professionals; inability to deal directly with conflict (organisational, inter-organisational, inter-professional or inter-personal); differences in orientations, vocabularies and working styles among professionals; differences in intervention strategies and funding mandates between agencies; competition between agencies for scarce funding; and concerns on professionals' part about loss of autonomy and professional domain. These researchers also make reference to 'system barriers' to collaboration (at both intra-organisational and inter-organisational levels), including agency leaders not being supportive of collaboration and agencies having unrealistic expectations of other agencies.

Easen and colleagues' (2000) UK study of 14 'front-line managers' from education, health, social work and community projects in two areas of high social need, found 'culture differences' across professional groups (p. 357). There were differences in their conceptualisation of roles, purposes and practices, a key source of difficulty for inter-professional collaboration. Conditions of professional work, the extent of shared values and purposes and the historical, geographical and political contexts within which attempts at inter-professional collaboration take place were also relevant. Lupton and Khan (1998) identified similar issues in relation to collaboration between health and other professionals in the context of safeguarding children. They also note that 'discussion of inter-agency working [in the literature] tends to focus on the process and structures of co-operative arrangements in isolation from their wider

financial and political contexts' (p. 210) and maintain that 'there is a need for a more detailed investigation of the impact of developments at the 'political economy' level on the ability of different groups of health [and other] professionals to work collaboratively in child protection' (p. 209). These authors also appear to endorse the argument that the competitive culture of the health market within the NHS, characterised by fragmentation of services and a multiplicity of purchasers and providers, may militate against the collaborative ethos, creating obstacles to co-ordination of services and collaboration between health and other professionals.

Area Child Protection Committees (ACPCs)

> *The ACPC is a multi-agency forum for agreeing and promulgating how the different services and professional groups should co-operate to safeguard children in that area, and for making sure that arrangements work effectively to bring about good outcomes for children* (Department of Health, 1999a, p.46).

Until the development of Children's Trusts, ACPCs were the chief strategic and policy for local inter-agency working in safeguarding children. Government guidance clearly sets out their roles and responsibilities (Department of Health, 1999a, p.33). It is evident from both research (Horwath and Glennie, 1999, Narducci, 2003) and the inspections that there is huge variation in their levels of representation, structure and practice. The joint Chief Inspectors' report, *Safeguarding Children* (Department of Health, 2002) highlighted that only a few ACPCs were equipped and able to carry out their responsibilities. These committees came under further scrutiny and were criticised by the Laming Inquiry (2003) following the death of Victoria Climbié.

Some studies have identified size as one of the problems facing ACPCs (Hallett, 1995; James, 1987 in Calder and Barrett, 1997), although Rose (personal communication) would question the strength of this evidence. Some ACPCs are unwieldy and have dealt successfully with the problem of size by forming an executive group that meets regularly to deal with the core business, whilst having a broader membership of specialists that meets two or three times a year to discuss particular issues, such as domestic violence (Horwath, 2004, personal

communication). Other areas have introduced a county ACPC with local ACPC panels. This latter model appears less successful, being characterised by communication breakdown, a lack of clarity about the roles and responsibilities of the members of the different parts of the organisation, and frustration of members. The optimum size of a group may be dictated in part by local conditions. Some ACPCs are able to manage groups of up to twenty members because individuals have established relationships and often work together in other groups for different purposes (Horwath, personal communication).

At an inter-personal level, ACPCs may also encounter the type of difficulties identified by research in psychological processes as characteristic of groups. If they become too large it is very difficult for them to function effectively; if they are too small, they may become cliquey and exclude others with expertise and knowledge to offer. They may also become complacent so that group members do not evaluate their performance and become defensive if challenged (see Hogg and Abrams, 1988). Such processes are known to affect social work decision-making (Jowitt, 2003; Munro, 1999; Kelly and Milner, 1996).

However difficulties are, perhaps, more likely to be attributable to issues concerning authority and leadership. Various writers have stressed that a skilled Chair is essential to the effective functioning of an ACPC (Hallett, 1995). Such a person needs to have the necessary technical knowledge of issues concerning safeguarding children, be skilled in managing meetings made up of a disparate group of people with a range of different skills, experience, knowledge and perspectives, and at the same time, have the ability to focus on and complete the tasks for which the group is assembled. Horwath argues that different leadership styles are necessary for different types of multi-disciplinary teams. She maintains that committed and enthusiastic Chairs who are prepared to *'go the extra mile'* are necessary for managing an ACPC or other group which functions as a network (Horwath, 2004, in press).

However even the most skilled and enthusiastic Chairs may prove ineffective because at present they lack authority. ACPCs are not statutory bodies; the joint Chief Inspectors' Report indicated that this was a major obstacle to their being able to carry

out their responsibilities, for local agencies did not generally accept that they were accountable to their local ACPC (Department of Health, 2000). The new Children's Safeguarding Boards that are due to replace existing ACPCs will, however, have statutory powers (Children Bill, 2004). It remains to be seen whether this will improve their functioning.

Exploring whether statutory powers improve the effectiveness of ACPCs is an obvious area for further research. There are also a number of other issues that relate to the daily processes of inter-agency working where more evidence appears to be required. There appears to have been little recent research on how child protection conferences work; nor could we find information about the content, processes and effectiveness of strategy discussions or about the strengths and weaknesses of inter-agency work in implementing the safeguarding plan.

The role and involvement of different professional groups in the inter-agency process in child protection: related difficulties

Disparities in the levels of involvement in safeguarding children by different professional groups have been identified as a difficulty in multi-agency work. Furthermore, confusion about the roles and responsibilities of the main professional groups with responsibilities in this area has been identified by a number of authors (Calder and Barratt, 1997; Hallett, 1995; Taylor and Daniel, 1999). Such confusion can sometimes be compounded by inter-personal difficulties between and within the various professional groups involved, which themselves may be exacerbated by professional jealousies and arguments over resources (Easen *et al*, 2000). All are thought to hamper the working of some ACPCs, as well as to contribute to the lack of involvement by some groups of professionals.

General practitioners

Hallett (1995) found that, although general practitioners were regarded by 90% of her study participants as key players in ACPCs and as either 'essential' or 'important'

(Birchall and Hallett, 1995; Hallett, 1995), in practice, they 'proved to be the largest single professional group of non-attenders at initial child protection conferences' (Hallett, 1995, p. 333). Furthermore, general practitioners rarely referred children as a result of concern about possible child maltreatment, and their role with families following registration on the child protection register was also minimal. Hallett (1995) concluded that 'the mandate to work together is not widely accepted by general practitioners who may have the status and independence to ignore it' (p.333). Hendry (2002) argues that in the past, general practitioners have been concerned that a referral to social services might trigger an investigation but offer little help to families in need. She also states that there may be a conflict of interest if the general practitioner is responsible for the care of the parents and other family members as well as children (p.162). Bannon and colleagues (1999a) found that general practitioners lacked confidence in child protection work, felt inadequately trained and, because they were also unsure of their role, tended to delegate the responsibility for safeguarding children to the health visitors within their practice.

Paediatricians

Paediatricians traditionally play a central role in safeguarding children, but a potential obstacle to their future involvement in this work has recently been highlighted. The first results from a national survey show that 14% of paediatricians have been the subject of a formal complaint about their child protection work. None of these complaints were upheld by the General Medical Council despite rigorous investigations, but nearly a third of those who had received them, said that they were now less willing to become involved in this area of work. Nationally, about a third of posts for designated doctors for safeguarding children are currently unfilled (Royal College of Paediatrics and Child Health, 2004).

Staff in adult services

Issues affecting collaboration between staff in adult and children's services largely parallel those that impede or enhance inter-agency working in safeguarding children, already discussed above. Studies reveal that social workers often lack training and expertise in working with parents with mental health, drug or alcohol problems, that an integrated approach to services for children and parents is often lacking and that appropriate links between adults' and children's services can be hampered by the absence of a shared professional language (see for example, Kearney *et al*, 2000; Harwin and Forester, 2002). The two studies presented below address collaboration between safeguarding children on the one hand, and services for women suffering domestic violence as well as adult mental health on the other.

Beeman and colleagues (1999) explored collaboration between safeguarding children and services for women suffering domestic violence in the United States. The study involved 15 child protection workers and eight advocates for women suffering domestic violence. It was found that there were differences in (and tensions between) professional perspectives, philosophies, approaches to practice and priorities endorsed by the two groups of practitioners. Child protection workers had a child-centred philosophy and approach to practice, whereas advocates for women suffering domestic violence adopted a woman-centred philosophy and approach to practice, focusing on and prioritising help for the mothers. Child protection professionals also tended to hold mothers accountable and responsible for change, whereas advocates held the abusive males accountable. The authors recommended cross-training of the two professional groups as an important mechanism for overcoming barriers to effective collaboration between them.

Tye and Precey (1999) identified a range of difficulties in bringing together adult mental health and child protection practitioners at the assessment interface. These related to differences in: thresholds for intervention, definitions of significant harm, knowledge bases, ethical frameworks and vocabulary. A case study showed that 'the key problem…was the difficulty faced by mental health professionals in translating psychiatric diagnosis and manifestation into an analysis of child protection risk' (p.168). This was further compounded by child protection workers' lack of familiarity with psychiatric language. The authors recommend a number of strategies

for building bridges between adult mental health and safeguarding children, such as representation of adult mental health services on the ACPCs, and the inclusion of data about the mental health status of parents/carers, as well as information about substance misuse, on the child protection register. They also suggest that practitioners who have experience of both the worlds of adult mental health and safeguarding children should be identified and their expertise used to help those less familiar with the issues (see also, Reder and Duncan, 1999).

Police

Hallett (1995) found that by the mid 1990s there had been a marked change in emphasis from the earlier socio-medical discourse to a socio-legal model and that police officers had become central to child protection work. Relationships between the police and other agencies were not particularly problematic, but there were some fundamental differences in focus and approach. Police were found to be frustrated with the difficulties of securing sufficient evidence to proceed with a prosecution and, despite their extensive involvement, their contribution to safeguarding children was limited.

A mixed methodology study of police child protection units in Scotland (Lloyd and Burman, 1996), which examined police practice both at inter- and intra-agency levels, identified obstacles to information-sharing between social workers and the police at referral stage: not all allegations of child abuse were passed between social work and police staff; many social workers identified situations where they were unsure of the necessity of a joint social work-police approach; and less serious cases of suspected physical abuse and neglect were not referred to the police until initial enquiries had been made by social workers. Differences in professional perspectives, priorities, values and concerns between police staff and social workers were also identified as a source of difficulty for joint working. In addition, there were different professional views about the quality and type of information to be sought and valued. Police officers required factual evidence and appeared to undervalue social workers' tendencies to look deeper into the possible reasons for alleged abuse. Furthermore,

the police appeared to be preoccupied with facts, whereas social workers' concerns appeared to focus on the well being of children and families. Different working hours, different geographical areas of jurisdiction and lack of resources were also cited as problems.

On a more positive note, both professional groups identified a range of advantages in joint working, including: improved communication between the police and social services; more equal sharing of information; more comprehensive planning; increased knowledge of respective professional roles; and mutual support and teamwork in relation to difficult cases. The authors also found that both professional groups benefited from increased skills and understanding as, for example, police staff learned more about communication with children and social workers learned more about the criminal justice system.

Education staff/Teachers

Hallett (1995) argues that 'teachers share with general practitioners contact with a universal or near universal child population' (p. 333); their knowledge and contact with children in school was valued by other child protection professionals in her study. Nevertheless, Birchall (1996) found that teachers, like general practitioners, were unclear about their role in safeguarding children and about the appropriate procedures. On the other hand, Calder and Barratt (1997) found that teachers were clear about what their role in safeguarding children *should* be, but that there were many contributing reasons for their lack of participation in formal procedures:

> *national curriculum demands on teachers; relegating child protection to a low priority in many schools; the decentralisation and fragmentation of the education system leaves individual schools in charge of their own agendas and priorities; ... the lack of finances available to provide supply cover to release teachers for child protection meetings and the lack of take up on multidisciplinary child protection training courses* (p. 218).

A report published by the NSPCC (Baginsky, 2001) summarises research findings on schools' and LEAs' involvement in safeguarding children procedures in England and Wales. Questionnaires were sent to 385 schools and to all LEAs to follow up their attitudes to child protection issues. There was an 85% response rate. The schools survey found that all but one school had a designated teacher responsible for safeguarding children and the majority had a formal policy and established procedures in place.

While the respondents, on the whole, were reasonably confident that they would be able to recognise signs of abuse in children in their care and act on them, most schools had some concerns that this would not be the case for all teachers. Many schools reported uncertainty about when to contact social services in relation to concerns.

Additional concerns were expressed by a number of schools. These included: poor inter-agency communication in the area of safeguarding children; teachers' own vulnerability when they report abuse; how best to support children after disclosures have been made; how best to support teachers faced with the task of dealing with children who may be experiencing abuse; how to handle accusations made by pupils against teachers; and how to maintain relationships with parents during the schools' involvement in child protection cases. Many schools reported that they would like to work closely with social services or LEAs to address some of these concerns, a point which highlights the critical importance of, and need for, improved inter-professional liaison.

The survey of LEAs revealed that there were considerable variations between them with respect to: who provided training in safeguarding children, who received it, and the proportion of schools in their areas that had been involved in such training during the past three years. Ten per cent of LEAs had had fewer than 25% of their schools represented on training in practice and procedures for safeguarding children in the previous three years. Furthermore, issues of funding and continuity of current training provision were frequently raised.

Baginsky (2001) concludes that:

> *although the role of the school in relation to child protection has been set out in guidance issued by the Government, the reality of day to day practice depends on a number of factors. These include: the training which teachers have received and the confidence they feel about operating in this area; the relationships which are established with social services and the perceptions which each agency has of the other; the priority which schools and LEAs give to this aspect of their work; and the shared understanding between schools and social services about what constitutes an appropriate referral* (p. 7).

More recently, further work by Baginsky (2003) has focussed on the inclusion and impact of training in safeguarding children for newly qualified teachers. This study found that the amount of time allocated to this issue was minimal and that there was variation between training institutions concerning its content. Whilst many newly qualified teachers had received some training, others reported a conflict between what had been taught and what happened in reality.

Insufficient resources

The different agencies involved in ACPCs are expected to contribute to the financial costs of running them. However, Hallett (1995) found that some members had no funds available within their budgets to contribute to these costs. It is important to note here that the fieldwork for this study was carried out before 1995, however, Howarth argues that there are still issues associated with financial arrangements (Horwath, 2004, in press).

Narducci (2003) argues that funding for ACPCs continues to be inadequate, despite the fact that *Working Together to Safeguard Children* requires all agencies to adequately support the ACPC work. He also states that joint working requires additional specialist time and financial resources at a time when professionals in all disciplines have increasing workloads and fiscal pressures. Others, (Lupton *et al*, 2001) have also identified the disincentives for agencies to co-operate with each other.

With tighter funding controls in their own organisations, and with increased competition in the delivery of health services, leading agencies may be more interested in survival than in co-operation (p. 90). The new Children Bill (House of Lords, 2004) aims to address some of these resource issues.

Representation on ACPCs

Each agency makes different decisions about who are the most appropriate representatives to serve on the ACPC. Some choose to send senior managers, who have decision-making authority, particularly around resource allocation, but who may not have knowledge or interest in issues concerning safeguarding children. Other organisations choose to send professionals with more appropriate knowledge and interests, who may not have decision-making status. This mismatch in status and professional focus can be difficult to manage and creates frustrations and tension within a group. Horwath (personal communication) argues that the professionals who feel the most intimidated are those without an understanding of child protection, and that the lower status members acquire status by knowledge. Some organisations have dealt with the problem by sending two representatives -one with decision-making ability and one with the necessary expertise and knowledge- but this remedy increases the costs for individual organisations as well as the size of the ACPCs. Horwath argues that if this problem is not effectively dealt with, it will create real difficulties in managing ACPCs or future Safeguarding Boards.

Information sharing

Information-sharing failures between agencies have been implicated in many of the inquiries into child deaths over recent years (see for example Laming, 2003). Research by Munro (1996) found that all the relevant information was available on each of the cases they explored; however, small pieces of information were held by different agencies and, as with a jigsaw puzzle, one isolated indicator did not create much concern until all the pieces were put together and the whole picture became apparent. Similarly, Sanders and colleagues (1996a) found that decisions were rarely based on a complete set of information; Macdonald (2001) has also argued that

decisions based on incomplete information are likely to miss warning signs that might challenge professionals' perception of a situation.

In a similar vein, Tomison's (1999) study, conducted just prior to the introduction of mandatory reporting of child abuse in the State of Victoria, identified inter-professional communication problems in safeguarding children in Australia. A sample of 295 individual cases of suspected child abuse was drawn together from the work of 37 professionals. Difficulties in information sharing were identified, particularly regarding inter-agency referral protocols and formal inter-agency/inter-professional methods of communication. Some professionals openly refused to refer some of their cases to the child protection service or the police for further investigation and intervention, possibly due to previous inter-agency conflicts. It was also evident that the child protection service and the police were reluctant to refer cases formally on to one another, so that many cases of suspected physical and sexual abuse were only known to one agency. Tomison (1999) states:

> *it would appear…that the main means of information dissemination in this study was by informal methods. It appeared that the informal contacts developed between professionals in the region supplemented and/or supplanted the more formalised communication pathways* (p. 10).

Whilst acknowledging the importance of informal professional relationships in safeguarding children, Tomison (1999) warns against relying entirely on informal communication methods, stating that 'running a child protection system on an *ad hoc* basis may result in poor information sharing' (p.11).

The need to preserve confidentiality between professionals and their clients or patients is cited in the literature as a reason for reluctance to share information. There appears to be confusion about how information can legally be shared across disciplines and between professionals. Recent changes in the legislative framework and the implementation of the Data Protection Act (1998) and The Human Rights Act (1998) have further complicated these issues. More recently, attempts have been made to clarify the positions of various professional groups in relation to confidentiality, information sharing and the law (Department of Health, Home Office, Department for

Education and Skills, Office of the Deputy Prime Minister, Lord Chancellor and DCMS, 2003, pp. 39 - 49).

Assessment

Assessing children's needs within the context of safeguarding their well being raises a number of further issues. One of the main questions to resolve is how to avoid numerous, overlapping assessments by different agencies, whilst ensuring that specialist issues are adequately addressed within a common framework. The implementation of the *Integrated Children's System*, which builds on the *Framework for the Assessment of Children in Need and their Families* (Department of Health, *et al,* 2000) should begin to address this issue. There may also be conflicts, particularly for social workers, in assessing the needs of children who may be at risk of abuse, while also attempting to work in partnership with parents or carers (Bell, 1999). Reder and Duncan's (1999) exploration of Part Eight reviews found that there was an 'assessment paralysis' when a parent had mental health difficulties and that decisions were dependent on whether the psychiatrist considered problems to have been present at the time the abuse took place. They argue that parents' behaviour should be assessed in parallel with their mental health because:

> *professionals should have recognised that the child was at risk from their parent's **behaviour**, not from their **diagnosis**. If this had occurred, child protection interventions could have been indicated irrespective of the parent's diagnosis* (p. 48).

Attempts to address difficulties in inter-agency working in safeguarding children

Joint training

Surprisingly little attention appears to have been given to training in safeguarding children in any professional group, either before or after qualification. Birchall and Hallett (1995) found that social workers and health visitors were the most likely to

70

have received training but over 40% of their sample had had no in-service training at all. Only 20% of teachers and general practitioners had received any child protection training, and those who received it post-qualification, received less than two weeks in aggregate. Baginsky's more recent study (2003) still identified considerable weaknesses in the training of newly qualified teachers. This lack of training and subsequent awareness of child protection issues is likely to have serious consequences for safeguarding children in the settings in which professionals are likely to have first contact with children in need and their families; it is also likely to reduce the effectiveness of joint working.

Inter-agency/joint training initiatives

Kolbo and Strong's (1997) national survey of multi-disciplinary team approaches to the investigation and resolution of child abuse and neglect in the United States, found that the most frequently cited strategy for addressing the challenges of inter-disciplinary working was the provision of initial and ongoing training to new multi-disciplinary teams. Their study showed that 'training is recognised as a key to overcoming turfism, language barriers, role confusion, misconceptions about the function and value of other disciplines, and other obstacles to successful implementation of multi-disciplinary teams' (p.70).

In a similar vein, *Working Together* guidelines (Department of Health, 1991b and 1999a) in the UK acknowledge the difficulties in forming the close relationships necessary for effective joint working, and recommend regular joint in-service training for professionals involved in safeguarding and promoting the well being of children in need.

Various initiatives have been undertaken to provide training for general practitioners in attempts to improve their engagement in safeguarding children procedures (Weir *et al,* 1997; Starling and Boos, 2003; Hendry, 1997). Initiatives designed to provide training in a format attractive to general practitioners, that take account of their working constraints, such as by offering lunch-time sessions, have been successful.

A national survey by NISW found that collaborative working between agencies tends to focus on safeguarding issues and procedures, rather than developing a joint understanding of how the needs of children and their families can be identified and met. As a result, joint training often means little more than inviting other professionals to join safeguarding children teams in sessions that aim to familiarise them with agency procedures (Kearney *et al*, 2000). However, Stanley and colleagues (1998) argue that joint training in safeguarding children should also be part of the basic curriculum, so that all relevant professionals acquire this essential core skill before they qualify. They identify two key professional groups, social workers and health visitors, who might benefit from joint pre-qualification training. Health visitors play an important advocacy function in promoting child health and in facilitating networks for child protection, whilst social workers also have a key co-ordination function in safeguarding children's well being; to work effectively, both health visitors and social workers need to understand not only child protection issues but also the roles and perspectives of other professionals. Following their joint training initiative, the authors conclude that inter-professional training in safeguarding children necessarily concentrates on differences between professional groups and needs to be closely tied to case material. This can be anxiety provoking and personally challenging for students. They argue that:

> *Such learning needs to be approached in a spirit which recognises and values difference and conflict … it is important that those entering work in child protection learn together to manage complexity and uncertainty* (p. 40).

Evaluation of inter-agency training in safeguarding children has been limited. Jones and colleagues' (2002) report on an evaluation of the outcomes and the impact of one university-based programme, which offered a five-day training series on inter-agency collaboration for public child welfare/protection workers and other community professionals in the fields of substance misuse, mental health and domestic violence in the United States. A quasi-experimental design and a self-report instrument (a Collaboration Scale) were used to assess the impact of training and trainees' perceptions of their acquisition of knowledge and skills; 119 trainees completed a pre- and post-test assessment, the latter being given to all participants at the conclusion of training; 52 trainees were interviewed six months later to test for retention and transfer of learning. The study found that trainees acquired knowledge and skills in

72

the areas of child maltreatment, substance misuse, domestic violence and mental health and that collaboration increased, and was self-sustaining at follow-up. Professionals were also more positive about working together following training and had greater understanding of their role in a collaborative structure. Overall, the findings of the study support the value of inter-agency training.

On the other hand, following training, participants reported greater awareness that: other agencies had unrealistic expectations of their own organisations and that senior managers were not supportive of collaboration. The authors note that during training, participants became aware of many 'system barriers' to collaboration at both intra- and inter-organisational levels (p. 36). They suggest that such improved awareness of difficulties may help explain why trainees' attitudes to collaboration do not appear to be entirely positive following a course, a finding which points to both potential benefits and potential costs of inter-agency training.

Finally, Horwath and Glennie (1999) identify important issues relating to models of delivering and co-ordinating inter-agency training in safeguarding children; they also raise key questions about the funding and resources available. This study provides 'an impressionistic picture' of the structural dimensions of inter-agency training (IAT) in safeguarding children in the UK, drawing on questionnaire data from 31 ACPC inter-agency training co-ordinators. Key findings suggest that respondents favoured the appointment of specialist inter-agency training co-ordinators as this gives status and legitimacy to such initiatives. Furthermore, specialist appointees would be more likely to be professionally neutral. Respondents also emphasised the importance of sufficient resources and funding and argued that ACPC training sub-committees should be involved in the development, implementation and evaluation of training strategies. However, the authors suggest that the small scale of the study means that findings may not be representative.

Features of successful interagency collaboration: what works and why?

A number of authors have drawn attention to the disruption caused both to service delivery and professional morale when organisations are restructured (Packman and Hall, 1998; Hall, 2000; Ward *et al*, 2004). One of the many adverse effects can be the

destruction of both formal and informal inter-professional networks when staff are re-located. The joint Chief Inspectors' report on *Safeguarding Children* (2002) identifies the need to maintain stability and avoid excessive and disruptive change in public service organisations in order to promote the development of successful inter-professional relationships. The establishment of stability in professional relationships might be regarded as a *sine qua non* for successful collaboration.

Horwath (personal communication) argues that good practice in safeguarding children takes place within the context of a good ACPC. The ACPCs that work well are those that have a charismatic and committed senior manager who champions the cause of safeguarding children's well being and motivates members to perform their tasks well. These ACPCs are also characterised by an understanding that a long-term commitment of about five years is necessary to ensure that systems are well set up to make things work and have identified clear roles and responsibilities at all levels. When all these features are in place and have become established, the team continues to work well even when individuals leave and are replaced by others. Some of the good ACPCs use a 'buddy' system to introduce new people into the team (Horwath, personal communication).

Narducci (2003) has found that ACPCs with a strategic focus are more effective and, like Horwath, identifies strong leadership as one of the essential components of the successful working of these bodies. ACPCs with a strategic focus concentrate on the bigger picture, produce a business plan, set objectives, create an action plan to achieve them and put the processes in place to monitor and evaluate progress. They are characterised by being open to exploring the best options for achieving their goals. They develop clear job descriptions for the roles of group members, which enable organisations to choose the most appropriate representatives and to clarify their roles and responsibilities. These ACPCs discuss the optimal structure of the group and some organise sub- or *ad hoc* groups to deal with specific issues, all of which have committee representation for feeding back to the main body. In this way, the main committee can use specialist expertise without becoming unwieldy or its officers becoming overburdened. Successful groups also understand the need to resolve administration issues; failure to produce minutes of meetings will hinder progress, and result in frustrated members and, ultimately, poor decision-making.

Under new arrangements in England, announced in March 2004 (House of Lords, 2004) new Directors of Children's Services will be appointed and made accountable to the Children's Commissioner. They will be responsible for developing Children's Trusts, incorporating social care, health and education, together with Connexions and youth offending teams. Directors of Children's Services will also be responsible for the activities of the new local Children's Safeguarding Boards (CSBs), which replace ACPCs and, unlike ACPCs, will have statutory powers. The role of the CSBs will be to co-ordinate services and ensure the effectiveness of local arrangements; analyse current arrangements; identify necessary improvements and reach agreement about how these will be achieved. They will have a duty to commission services through Children's Trusts and identify training needs (Department for Education and Skills, 2004b).

Horwath (personal communication) argues that well-functioning ACPCs will probably make the transition to CSBs more readily because their core business will not change and they will have the robust structure necessary to allow change to take place without disrupting activities. The less successful ACPCs are likely to find the task more challenging.

Outcomes of joint working

Joint working in safeguarding children has been found to produce positive outcomes for the professionals involved. Jones and colleagues' (2002) review of the literature on collaborative practice in child welfare identified the following benefits: more accurate and effective assessments of complex cases; more creative and effective interventions; less fragmentation and duplication of services; more efficient use of resources; fewer cases being overlooked; enhanced inter-professional communication; less role confusion; greater advocacy and emotional support for clients; enhanced ability to overcome professional stereotypes; increased professional development and improved working environments; and a greater sense of accomplishment among the professionals involved (p. 25).

Similarly, Townsley and colleagues (2003) identified greater satisfaction amongst professionals involved in a joint working project. However, they questioned whether improvements in working practices positively affected children and their families. There was only minimal evidence of change in this area; the authors argued that the focus needed to shift from professionals' views of changes in practice to an evaluation of outcomes for service users.

Glisson and Hemmelgarn (1998) tracked 250 children over a three-year period and collected qualitative and quantitative data from 32 public children's service offices in 24 counties (12 pilot sites and 12 matched control sites) in Tennessee. They tested a model previously developed by one of the authors (Glisson and James, 1992) that linked county demographics, organisational characteristics and the quality and outcomes of services. Service outcomes were measured by improvements in each child's psychosocial functioning over the twelve-month period from data obtained from a number of standardised instruments. Service quality, service co-ordination, organisational climate, inter-organisational relationships and county demographics were all measured and assessed.

The authors found that *inter*-organisational co-ordination had a negative effect on service quality and had no identifiable effect on outcomes for children. In their view, increased service co-ordination deflected caseworkers from those activities associated with improving outcomes for the children on their caseloads. Although joint working between different agencies appears to be a logical and obvious way of improving services for those individuals with the most extensive needs, the authors argue that 'evaluations of services co-ordination efforts have been unsuccessful in documenting any major benefits' (p. 403). However, they found that the working culture *within* teams (including low conflict, co-operation, role clarity and personalisation) was the main predictor of positive outcomes for children (in improved psychosocial functioning) and was a significant predictor of service quality. They claim that *intra*-organisational factors are largely ignored in the theoretical and research literature, which focuses on *inter*-organisational issues; their research shows this to be a 'critical deficit'. In their view:

Efforts to improve public children's service systems should focus on creating positive organizational climates rather than on increasing inter-organizational services coordination [and that] many large-scale efforts to improve children's service systems have focused on inter-organizational coordination with little success and none to date have focused on organizational climate (Glisson and Hemmelgarn, 1998, p. 417).

2.5 Disability

It was evident from the literature search in the three areas that we were asked to cover (recognition, emotional abuse and neglect and interagency issues) that although children with disabilities and their families face the same issues as other children, there are also a number of reasons why they are additionally vulnerable. This following section draws together the research that gives particular attention to these issues across the three areas studied. As noted above, this section explores the relationship between disability and all areas of abuse, and is not restricted to neglect and emotional ill-treatment.

It is clear from much of the literature that fundamental questions about how disabilities are classified and defined have not yet been resolved (Paul and Cawson, 2002; Gordon, 2000; Department of Health, 1999b; Kennedy, 1995). In the absence of universally agreed definitions, each researcher or writer uses their own criteria and these may either include or exclude children with emotional and behavioural difficulties. To complicate matters further, disabilities in the same category may result in different degrees of impairment for different children with the same condition. A child with cerebral palsy, for example, may have a profound physical disability and be wheelchair-bound or s/he may have a slight weakness on one side of his or her body. Similarly, children with asthma may be severely impaired by the condition, and their survival threatened by it, or may experience only minimal restrictions on their daily functioning. Similar difficulties, discussed above, concerning how significant harm, emotional abuse and neglect are all defined and identified, compound the difficulties in comparing and interpreting research findings in this area.

What we know about the living situations of children with disabilities

Disabled children represent 3% of the child population in the UK (Department of Health, 2000b). However, information about their living arrangements is patchy; the

most comprehensive (but old) data are from the OPCS study, undertaken in the 1980s (Bone and Meltzer, 1989). This study collected data on children with disabilities aged between five and sixteen and found that 90% lived at home with parents or other relatives, whilst others either boarded weekly, or lived in foster homes or residential establishments. A re-examination of the OPCS data showed that children with disabilities who were looked after away from home were more likely than others to be placed in residential units (either residential homes, residential health units or residential schools) (Gordon, 2000).

More recently, the NSPCC National Working Group on Child Protection and Disability highlighted the particular 'vulnerability of disabled children in residential settings, with a focus on residential schools as this is the most common residential experience for disabled children' (National Working Group on Child Protection and Disability, 2003, p.10). They concluded that:

> *local education and social services authorities do not pay sufficient attention to the welfare of disabled children placed at residential special schools"* and that " *there are inadequacies in the application of current child protection procedures and practices to disabled children in these settings. While the work of the National Care Standards Commission/Commission for Social Care Inspection should mean that children and their families become more aware of their entitlement to safe and protective care, concerns remain about how effective the new inspection regime and complaints procedures will be, particularly in terms of adults' abilities (including that of inspectors) to communicate with children* (National Working Group on Child Protection and Disability, 2003, p.10).

Recent research by Barter and colleagues (2004) also suggests that children in residential units are vulnerable to abuse by peers. Their sample did not include units specifically for children with disabilities and the numbers of disabled children they studied were too small for findings to be definitive, but this is an area that would merit further exploration.

Although *Every Child Matters: Next Steps* (Department for Education and Skills, 2004b) implicitly aims to address the needs of children with disabilities, they are only once mentioned specifically in relation to aims for 'an inclusive system for children

with Special Educational Needs (SEN)' and in aims for 'earlier identification of disabilities and better family support services which are responsive to their particular needs' (p.28). Townsley and her colleagues argue that, although the recent Green Paper *Every Child Matters*' (Department for Education and Skills, 2003a) is broadly welcomed, 'it fails to specifically recognise the issues relating to the safeguarding of deaf and disabled children' (Townsley *et al*, 2003, p.9).

What we know about significant harm and children with disabilities

Significant numbers of local authorities in the UK do not collect data on disabled children whose welfare gives significant cause for concern. Cooke (2000) found that only 51% recorded whether children who suffered significant harm were disabled, whilst only 14% could give actual figures.

Edwards and Richardson (2003) argue that children with disabilities are less likely to be referred as needing to be safeguarded from abuse. They identify a number of barriers that prevent concerns being recognised and appropriate referrals being made (p.32). These include difficulty in believing that a disabled child is at risk of significant harm; assumptions that a disabled child could not be a credible witness and a reluctance to challenge carers. The authors also argue that the police are less likely to investigate abuse of a disabled child because a criminal prosecution is less likely (p.40).

Morris (1999) argues that children with disabilities are less likely to be placed on the child protection register and when they are, the category used is more likely to be neglect or emotional abuse. She also found that there is little understanding of disability issues in child protection teams and that current safeguarding systems are not meeting the needs of children with disabilities. 'Evidence from this research indicates that there is commonly a failure to fulfil the statutory obligations which the Children Act created, particularly in relation to short-term placements' (Morris, 1999, p.107). Furthermore, she states that some policies that advocate working in partnership with parents hinder attempts to safeguard and promote the welfare of children with disabilities.

Williams and Morris (2003) argue that disabled children are often denied the safeguards of being 'looked after'; they quote a survey by Abbott and colleagues (2001) which found that 'about one in four of social services departments do not treat the children they fund at residential schools as being 'looked after''(Williams and Morris, 2003, p.47), despite their statutory obligations to do so (Platt, 2002; Department of Health, 2003). Other researchers have also found that disabled children living in residential schools or residential health establishments are not necessarily classified as looked after by local authorities and may not appear in government statistics (Paul and Cawson, 2002; Abbott *et al*, 2000; Morris, 1999). This is an issue of particular concern in view of a general acknowledgement that children in residential settings are especially vulnerable to maltreatment (Paul and Cawson, 2002).

There is little UK research about children with disabilities and significant harm, although there is a growing awareness that these children are particularly vulnerable; the need to address this issue has been recognised in numerous government documents, including: *Safeguards Review* (Utting *et al*, 1997), *Quality Protects* (Department of Health, 1998), *Working Together* (Department of Health, 1999a), *Framework for the Assessment of Children in Need and their Families* (Department of Health *et al*, 2000), *Assessing Children in Need and their Families: Practice Guidance* (Department of Health, 2000c), *Lost in Care* (Waterhouse and Department of Health, 2000), *Learning the Lessons* (Department of Health, 2000d) and *Every Child Matters* (Department for Education and Skills, 2003a). The Strategic Agreement, to be published in the Spring 2004, 'will emphasise the importance of taking a multi-agency approach to the planning and commissioning of placements and services for looked after children and children with special educational needs or disabilities in residential special schools' (Department for Education and Skills, 2004b, p.2).

International research strongly suggests that children with disabilities are at greater risk of significant harm than their peers. Sullivan and Knutson (2000) carried out a large epidemiological study of 40,000 children in the USA for which data on maltreatment was collected from educational, medical, social services and legal records. It is worth considering their findings in some detail since there is no comparable study of this size or quality in the UK. They found that:

- Children with disabilities were 3.4 times more likely than others to suffer abuse or neglect. Overall, 31% of the disabled children in the study had been maltreated compared with 9% of children with no disabilities. They were 3.8 times more likely to be neglected; 3.8 times more likely to be physically abused; 3.1 times more likely to be sexually abused and 3.9 times more likely to be emotionally abused.

- Children with health or orthopaedic disabilities were more likely to be maltreated between the ages of 0 and 5 years, a finding which suggests that these conditions place children at particular risk of significant harm. In contrast, children without disabilities were more likely to be maltreated between the ages of 5 and 9 years.

- Immediate family members were overwhelmingly the perpetrators of maltreatment of all children in the sample, whether or not they had disabilities. Female family members were responsible for 67.4% of the maltreatment in the immediate family. Males were responsible for 59.8% of maltreatment by extended family members and 88.5% of extra-familial maltreatment (mainly sexual abuse).

- Children (with and without disabilities) who were neglected, or suffered neglect as well as other forms of maltreatment, were significantly more likely to be living in families with high numbers of family stressors. High stressors were most prevalent in the pre-school (0-5 years) and elementary years (5-9 years). Children with disabilities were significantly more likely than others to suffer neglect or neglect with other forms of maltreatment; they were also significantly more likely to live in families with high numbers of family stressors. Marchant (2001) argues that the risk of family breakdown is higher for children with disabilities and that their families may find it harder to access informal supports.

- Maltreatment may leave a child with physical and/or mental disabilities and/or emotional and behavioural difficulties.

- School attendance rates were significantly associated with both maltreatment and disability. There was a clear pattern of increasing numbers of missed school days by children experiencing multiple forms of maltreatment. Children with disabilities who suffered multiple forms of maltreatment had the highest number of missed school days; at the other end of the spectrum, children without disabilities, who had no history of maltreatment, had the lowest number of missed school days. Neglect or neglect with other forms of maltreatment had a greater impact on school attendance than other types of abuse.

- Educational achievement was similarly associated with disability and maltreatment. After children below school age and those with severe intellectual disabilities were removed from the analysis, significantly higher achievement in reading and maths was evident for children without disabilities who were not abused, while the lowest achievement was apparent for maltreated children with disabilities.

Goldson's (1998) study of data from one children's hospital in the USA showed that, out of 949 children referred for suspected maltreatment, 420 (56%) were behaviourally disturbed; 171 (21%) were developmentally disabled before the abuse; 51 (5%) became permanently disabled as a result of the abuse and 15 (9.5%) of those who had been physically abused died as a result (Goldson, 1998). Disabilities may therefore either place children at greater risk of significant harm or be an outcome of the abuse. Again in the USA, Crosse and colleagues (1993) estimated that 147 per 1,000 of children who suffered significant harm were developmentally impaired as a result.

Why are children with disabilities more at risk than other children?

The number of children with disabilities has steadily increased in western societies as medical techniques and technology have enabled more infants to survive and to live much longer than they did in the past. This means that there is increasing pressure on medical, educational and social services to meet the needs of these children and their

families. Families looking after children with disabilities are also more likely than others to be managing with limited financial resources and in difficult social situations (Goldson, 1998).

Goldson (1998) considers why children with disabilities may be particular targets for abuse. He argues that at a societal level:

- Society does not celebrate difference between people – rather it tends to denigrate those who are different from the majority and imbue them with stereotypical attributions;
- children with disabilities are regarded as being less than human and therefore they are less worthy of care;
- there is a perception that children with disabilities do not have the same feelings as others;
- children are regarded as being the property of parents;
- parental stress and frustration in caring for a child with disabilities, combined with difficulties in accessing services can lead them to lash out at their children as the perceived, and real, source of their frustrations;
- violence is condoned by society as a means of resolving conflicts and/or tension.

Different types of disability have been shown to evoke varying responses from professionals. Resnick (1984) found that professionals in the USA rated mental impairments as being the 'least acceptable', whilst conditions such as blindness, deafness, epilepsy and learning difficulties were rated as being of 'medium acceptability'. The most 'acceptable' conditions, from a professional perspective, were physical difficulties or chronic illness that meant that children were incapacitated physically but remained intellectually competent (for example, cancer, amputation or conditions that resulted in children being wheelchair-bound) (Resnick, 1984). However, Sullivan and Knutson's later study (2000) found that it was this latter group of children who, at a very young age, were most at risk from maltreatment by parents.

In what ways are children with disabilities more at risk of significant harm than others?

Much of the literature identifies factors that place children with disabilities at particular risk of significant harm. A number of studies have shown that communication difficulties and a lack of knowledge about acceptable behaviour by adults and other children may render them ill-equipped to make allegations of abuse. They and their parents may also be reluctant to complain for fear of losing services (Kennedy, 1995; Morris, 1999). Morris (1999) found that only 27% of the children with disabilities in one area in her study had speech and a further 25% had limited speech. Furthermore, workers often do not have the appropriate skills to communicate easily with disabled children; nor is their acquisition of these skills always encouraged or facilitated (Kennedy, 1995). Morris cites one social worker who funded her own attendance on a Makaton course although her department subsequently refused to pay for more advanced training (Morris, 1999).

Oosterhoorn and Kendrick argue that it is possible to overcome communication difficulties with many disabled children if properly trained staff use the appropriate tools (Oosterhoorn and Kendrick 2001). The Department of Health is currently funding the Children's Society to undertake the *I'll Go First* project, which offers initial training to professionals in communicating with disabled children (Department of Health, 2003b).

Children with disabilities are often isolated from others, particularly when placed in residential establishments where they may not have access to, or be able to use a telephone, their letters may be censored and their visits observed and supervised (Paul and Cawson, 2002; Kennedy, 1995). They can therefore be isolated from parents, siblings, extended family members, teachers and neighbours who might otherwise recognise indicators of abuse.

A health condition often encourages passivity and compliance in children with disabilities, a tendency that leaves them vulnerable and even less able to protect themselves (Kennedy, 1995; Goldson, 1998). Westcott and Jones (1999) suggest 'that

a child's impairment may make some acts abusive when they would not necessarily be considered so with a non disabled child' (p.499) and that it could be argued that the duty of care is even higher when a child's impairment means they are more dependent. Children with some physical disability, and particularly those who require intimate care, are also vulnerable because they cannot physically get away from an abuser. Furthermore, signs and symptoms of possible abuse shown by children with disabilities may be misinterpreted. Bed-wetting, fear of the dark and withdrawn behaviour, for example, may wrongly be interpreted as resulting from the child's disability (Kennedy, 1995).

Professional attitudes to abuse of children with disabilities may also sometimes act as barriers to the recognition of significant harm. Even though there has been compelling evidence about the abuse of disabled children over recent years, some still find it unthinkable that adults with the responsibility for caring for disabled children could abuse them (NSPCC, 2003).

In addition, there is often a mismatch of skills between different groups of workers. Workers with disabled children are rarely trained in safeguarding children and child protection workers are infrequently trained in disability issues (Kennedy, 1995; Morris, 1999).

Finally, Kennedy (1995) argues that children with disabilities often encounter other types of abuse in addition to those generally recognised as relating to all children. These include force-feeding, over-medication, medical photography, deprivation of visitors, lack of privacy (including the opening of their letters), being dressed in communal clothing and their personal toys being relegated to a communal toy pool. They may also be segregated in special schools; their right to privacy may be ignored on open days when visitors are shown their personal living space; and they may be subjected to intrusive behaviour modification programmes and physical therapies.

Conclusion

The research studies explored in this section raise innumerable questions in the three areas of recognition of abuse, emotional abuse and neglect and inter-agency issues. Issues specific to children with disabilities run through each area, as well as raising additional questions in themselves. Section Four brings together these strands of research and identifies a number of issues that a new initiative would need to cover. However, we have already seen that safeguarding children is a fast moving area of work. Differences in terminology mark a broadening of understanding of what constitutes significant harm and the nature of the task is therefore constantly evolving. Policy and practice in this area has been closely informed by messages from research, however, new developments need to be explored to determine whether and how far changes improve the safeguarding of children. Section Three explores these developments in an attempt to identify where old issues still need to be addressed and where new policies might benefit from evaluation.

3.0　Policy Issues

3.1　Introduction

Section Two of this report explored the results of a review of key research findings in the three topic areas of recognition, emotional abuse and neglect and interagency issues. Studies published between 1995 and 2004 were covered; the bibliography and the key messages identified by the research team were also discussed with a number of recognised experts in the field, whose views have also been included (see also Appendix Three). Specific issues concerning children with disabilities were also explored and added as a separate section to this report (2.4).

However the research papers covered in this study were not published in a vacuum. Over the last ten years a number of policy initiatives have been introduced that address some of the earlier findings; if these are effective, children's experiences may be different from those identified even by relatively recent research programmes. Moreover this scoping study was commissioned in response to some of the questions raised by the inquiry into the death of Victoria Climbié (Laming, 2003). The findings of Laming's report echo a number of the issues raised by the research literature and give them a sharper focus. New policies and legislation, currently being introduced in response to Victoria Climbié's death, are intended to address further some of these issues. Section Four of this report will suggest that a new research initiative will need to incorporate evaluation of some of the new policy initiatives. This section specifies what these are, and what they are intended to achieve.

The most recent government policy and proposed legislation (*Every Child Matters: Next Steps* 2004b and the Children Bill 2004) build on and incorporate issues previously raised and embodied in earlier government initiatives (*Looking After Children* 1995; *Quality Protects* 1998; *Framework for Assessment of Children in Need and their Families* 2000; *Working Together to Safeguard Children* 1999a; *Safeguarding Children* 2002; *Keeping Children Safe* 2003d and *Every Child Matters* 2003a). The new legislation aims to change the way in which services are provided to children and families in order to safeguard and promote their well being, identify and

88

protect those at risk of significant harm, as well as improve support for families and outcomes for children generally in the United Kingdom.

The new policy and legislation seeks to remedy the four pitfalls of 'organisational individualism' identified by Huxham and Macdonald (1992) (see also, Hudson *et al*, 1999, p.49):

a) repetition of tasks between agencies;

b) omission of tasks across agencies;

c) a lack of common goals;

d) counter-production where the actions of one agency adversely affect the working of another.

This will be achieved by promoting effective joint working within supportive structures. It is thought that a key means of ensuring that this happens is to structure services in such a way that joint working is facilitated rather than obstructed. A great deal of effort and hard work have gone into setting up and maintaining multi-disciplinary and multi-agency working over recent years. Nevertheless, although there are many examples of good working practice, experience has shown that it is extremely challenging to achieve and sustain, and that structural and policy issues have often acted as barriers to practice.

The Green Paper *Every Child Matters* (Department for Education and Skills, 2003a) recognised that four main areas needed particular attention:

- support for parents and carers to enable them to protect and nurture the children in their care;

- early intervention and effective protection of children at risk from negative forces;

- accountability and integration of services at all levels – locally, regionally and nationally and;

- reform of the workforce, to enable these changes to take place.

3.2 Improved outcomes for children

There is a change of emphasis in the Children Bill away from processes and agreed procedures towards a stronger focus on improved outcomes for children. The outcomes which children's services should aim to achieve were defined in consultation with children and young people and are specified as 'being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well being' (Department for Education and Skills, 2003a, pp.6-7). Children's services are free to deliver these desired outcomes by whatever means are thought to be necessary, but this freedom will be balanced by tighter accountability. An integrated inspection framework will underpin this change. Margaret Hodge (Minister for Children, Young People and Families) states that new powers to pool budgets, share information and streamline management will enable local practitioners to develop ways of working together to achieve the desired outcomes (House of Lords, 2004, p. 4).

3.3 Early intervention

Effective early intervention will be achieved through the use of a common assessment framework and multi-disciplinary teams based around existing universal services. Multi-disciplinary teams should provide suitable support services for children and their families; they will aim to identify disabilities early in childhood; they should create services that are inclusive of children with special educational needs and accessible for children with disabilities.

Effective early intervention and appropriate support should address some of the issues that put children at increased risk of harm: these would include increased stressors when parenting in poor environments, or when caring for very young children with complex needs, or for more than one disabled child.

3.4 Integrated information sharing systems

Information sharing has been identified as problematic in all areas covered in this review: in the recognition of abuse, in protecting children with disabilities and particularly in joint working practice. Particular areas of difficulty lie in the concerns of different professionals about the legality of sharing information with others; the potential impact on the confidentiality of relationships between themselves and their clients or patients and in the legal implications of recording and storing relevant information. In particular, some professionals express concern about sharing confidential information in meetings when parents are present - an increasing practice as a result of policy changes which advocate closer partnership working. These issues have become more complex and more prominent since the implementation of the Data Protection Act 1998 and the Human Rights Act 1998 and were identified as the main barriers to effective information sharing by respondents during consultation on the Green Paper *Every Child Matters* (Department for Education and Skills, 2004b, p. 20).

Lord Laming (2003) suggested that improvements in the exchange of information were needed at governmental as well as at local level to protect children and that a national database was necessary to enable this to happen. The Children Bill requires children's services to establish and operate databases containing basic information about children in their area.

Currently the Department for Education and Skills is testing Information, Referral and Tracking (IRT) systems in ten 'Trailblazer' local authority areas to develop new ways of information sharing and multi-agency working and to resolve issues and barriers to change (see Cleaver, Barnes, Bliss and Cleaver 2004b). In the interim, the inter-relationships between confidentiality and information sharing and other relevant legislation such as the common law duty of confidence, the Human Rights Act 1998 and the Data Protection Act 1998, have been clarified for professionals in the booklet *What to do if You're Worried that a Child is Being Abused* (Department of Health *et al,* 2003).

The inter-agency pilot of the *Integrated Children's System* is also intended to explore some of these issues (Cleaver *et al,* forthcoming). These developments in social care are happening alongside the construction of Connexions Customer Information Systems and others being developed by the police and health services.

Not only do integrated databases need to be developed, it is equally important that relevant information is added, maintained and collated and is prominent enough to alert enquirers to potential concerns. The Bichard Inquiry into the circumstances that allowed Ian Huntley to be employed as a school caretaker has shown that the management and use of database information by the police, education and social services can be inadequate.

It is also apparent that existing databases such as child protection registers are not always consulted and used effectively; 24-hour access to the child protection register is still limited in some NHS organisations and there is evidence that professionals do not always make checks when they do have access to it (CHI, 2003). Greenfields and Statham (forthcoming, 2004) found that three quarters of child protection register custodians reported concerns around interagency working and information sharing and felt that simply placing a child's name on the register may provide a false sense of security.

Consulting the child protection register has been shown to improve when staff members are trained and their awareness about child protection issues raised and when reminders and checklists are prominently placed in departments (see Section 2.1). However there appears to be little evidence that the existence of a child protection register makes any difference to safeguarding children's well being; nor are there indications as to whether such registers could be made more useful.

Setting up an integrated national database is therefore only the first step in improving the collection and sharing of information to safeguard children. Particular concerns have been noted about disabled children who are placed outside local authorities in residential special schools and other organisational settings (see Section 2.4). An integrated national database of children may address some of these concerns by ensuring that these children are at least included in systems designed to safeguard their well being. However, their welfare requires particular focus and awareness

because the evidence shows that these children are the most vulnerable to harm and neglect.

3.5 Assessments

The information systems designed to safeguard children will additionally be supported by the use of integrated and concurrent assessments such as the Core Assessments and Assessment and Progress Records in the *Integrated Children's System, Connexions Assessment, Planning, Implementation and Review Framework*, *ASSET*, used by youth offending teams and other procedures in use in health and social care. These assessments are intended to be complementary and to dovetail: to deal with issues relevant to specific agencies and disciplines, whilst, at the same time, preventing the need for each professional to repeat assessments of children and their families.

Integrated assessments should eliminate unnecessary repetition of tasks. They may also prevent the omission of tasks across agencies by making it clearer who is doing what and preventing agencies from making assumptions about the actions of others. If designed and used well, they also have the potential to prevent the actions of one agency adversely affecting the working of another. Previous experience, however, has shown that the implementation and subsequent use of such materials needs to be carefully managed to ensure that these potential benefits are realised (Scott, 1999; Pithouse *et al*, 2004; Cleaver *et al*, 2004a). The extent to which assessments are truly integrated will therefore need to be evaluated.

3.6 Accountability

The Laming Report argued that a clear line of accountability was necessary at national, regional and local levels to improve services to children (Laming 2003). The consultation feedback received after the publication of *Every Child Matters* also stressed that strategic direction at national level was necessary to enable the new structure to be integrated successfully (Department for Education and Skills, 2003a).

Integration at national level is being achieved through the appointment of a Minister for Children, Young People and Families to work across government departments to ensure that children's services are well co-ordinated, a new cabinet sub-committee, chaired by the Secretary of State for Education and Skills, and designed to oversee the delivery of children's services, and the establishment of a Children's Commissioner whose remit is 'to promote awareness of the views and interests of children in the United Kingdom' (House of Lords, 2004). Integration and accountability will also be strengthened at national level through the publication of a joint framework for the inspection of children's services and new arrangements for intervening where deficiencies are identified.

3.7 Developments at local level

New positions will be created at local level for a Director of Children's Services and a local councillor who will have responsibilities for children. The new Director of Children's Services will have overall responsibility for both education and social services and will take a lead role in developing Children's Trusts. These will be multi-disciplinary and will include social care, health and education and may also include Connexions, youth offending teams and the police service. Their primary purpose will be to secure integrated commissioning of services through pooled budgets and to deliver integrated services to result in better outcomes for children and their families.

The Director of Children's Services will be responsible for the activities of the new local Children's Safeguarding Boards that replace existing ACPCs. These bodies, unlike ACPCs, will have statutory powers. This will give them the necessary status and power to ensure that their objectives are met and that the various agencies perform the duties that are required of them.

The primary role of the Boards will be to co-ordinate services and ensure the effectiveness of local arrangements. The initial tasks will be to analyse current arrangements, identify improvements that are needed and reach agreement about how

these will be achieved. Boards will have a duty to commission services through Children's Trusts and identify the training needs of professionals working in child protection (Department for Education and Skills, 2004b).

It is as yet unclear exactly how Boards will operate and how existing ACPCs will make the transition to the new structure. The proposal to make them statutory bodies was widely welcomed in the consultation exercise. This should mean that their increased accountability, responsibilities and status will enhance their ability to ensure that key agencies pay due regard to safeguarding and promoting the welfare of children in the discharge of their normal duties. However much will depend on the powers, duties and sanctions that they are eventually given (Rose, personal communication).

One of the issues consistently raised by research into the functioning of ACPCs is the varying commitment and participation of members from different organisations (see Section 2.3); the conferment of statutory powers will begin to remedy some of these difficulties. Continuing poor commitment and participation of Board members will be addressed by joint inspections and, ultimately, the intervention of the relevant Secretary of State.

The establishment of the new Children's Safeguarding Boards will not deal directly with differences between the status, autonomy and power of different professional groups, also raised by the research (see Section 2.3). Similarly, inter-personal and inter-group factors, such as the attribution of negative stereotypical judgements to other professional groups and the rivalries and jealousies between groups that have been identified in the literature will need attention (see Section 2.1). Some of these issues may be addressed by better integrated training (see below).

Research into ACPCs has found that a key issue was insufficient funding to enable them to fulfil their remit (see Section 2.3). The proposed pooled funding from all members of Children's Safeguarding Boards should ensure that they now have sufficient resources to undertake their tasks. Financial commitment may also result in safeguarding children becoming more prominent in the daily working practice of the different professional groups who work with children and families in various settings.

3.8 Workforce reforms

The consultation exercise undertaken after the publication of *Every Child Matters* (Department for Education and Skills, 2003a) identified that workforce reforms would be necessary to accomplish the proposed changes in children's services. The first goal in reforming the workforce is to make working with children an attractive and high status career and to develop a highly skilled and flexible workforce. Secondly, the new services will aim to break down professional barriers that inhibit joint working, encourage recruitment and prevent wastage through retention difficulties.

One of the most pervasive findings from previous research has been that inadequate services to children have, in part, resulted from inadequate staffing (Social and Health Care Workforce Group, 2000). This has had the effect of increasing pressure on existing staff, resulting in them having inadequate time to undertake direct work with children and families or to perform their duties satisfactorily. Staff members have often been working without adequate supervision and support and have been unable to use opportunities to increase their skills and competence by attending post-qualification training. These factors have too often resulted in staff burnout, high numbers of staff on long-term sick leave and poor retention rates of key workers. Good working conditions result in workers having sufficient time, competence and confidence to work directly with children and their families, the factor that has been shown to be the most important in improving outcomes for children (Glisson and Hemmelgarn, 1998).

In order to determine the skills that are necessary to provide a suitable workforce and ensure that workers have adequate time to do direct work with children and families, a workload survey will initially be undertaken. More flexible and attractive entry routes into social work will be devised, including work-based training routes for graduates. Common occupational standards across practice with children will be linked to modular qualifications to allow workers to move between different jobs more easily. In addition a common core of training for staff from different agencies will be developed (Department for Education and Skills, 2003a). These changes will begin to address some of the issues identified in the early sections of this scoping study (see Sections 2.1-2.4). Common thresholds of concern, common understanding of the

issues and a shared language between professionals may also result from the proposed workforce reforms and, in particular, in training that involves different professional groups that have a common interest in safeguarding and promoting children's well being (see Section 2.1 and 2.3).

Some re-structuring of services has already taken place. A Children's Workforce Unit has been established in the Department for Education and Skills that will develop a pay and workforce strategy to

> *enhance the skills, effectiveness and coherence of the children's workforce; to foster high quality leadership; and to make working with children and young people a more rewarding and attractive career* (Department for Education and Skills, 2004a, 3.25)

The Sector Skills Development Agency (SSDA) will work with Government and a wide range of employers to set up a Sector Skills Council (SSC) for Social Care, Children and Young People. The SSC will bring together occupational groups that work with children and young people and their families across disciplines and agencies. There are also plans to enhance and reform the role of schools in safeguarding children, and to review and strengthen the role of nurses, midwives and health visitors in this area. New guidance has been published on the role of general practitioners in safeguarding children (Carter and Bannon, 2003).

One of the areas that does not appear to be addressed by new arrangements is how children's and adult's services, such as adult psychiatry, can effectively be brought together where appropriate. Raising awareness by ensuring that all professionals receive core training in safeguarding children might be appropriate even when their client group is restricted to adults. There is considerable evidence to suggest that providers of adult services can unwittingly overlook the potential effects on children of parental mental health or physical conditions (Falcov, 2002; Ward *et al*, 2003; Statham, 2004b).

The consultation following the publication of *Every Child Matters* also revealed a continuing need to recruit and retain more foster carers for children who are looked after by the state. The work of Choice Protects will continue to expand and

97

strengthen this service by improving the status, support and training of foster carers; extra funding of £1.5 million has been allocated to this initiative.

Exploring how far initiatives to reform the workforce have been successful both in improving recruitment and retention of staff and in addressing some of those inter-agency issues identified in the research literature, would be a fruitful area for further research. Another area that might merit exploration would be how far the perceived increased emphasis on education services in the new structures affects the delivery of children's services overall. The British Association of Social Workers has queried the value of an enhanced role for education, although the president of the Association of Directors of Social Services has reportedly stated that he: 'Does not have a problem with the proposal changes but that [they] would have to be rigorously tested' (Children Now, 17 March, 2004).

In order to contribute to the debate and help local organisations to manage forthcoming change, a large inter-agency group, comprising a wide range of key stakeholders, has looked at how the vision inherent in the new children's services can be transformed into reality (Inter-Agency Group, 2004). Their aims are to support local partners to:

- improve outcomes for children on a sustainable basis;
- create a whole system approach;
- ensure local delivery of improved services for all children with an emphasis on strengthening preventative and universal services and on safeguarding children.

(Inter-Agency Group 2004 p. 2)

They recognise that 'genuine reform requires profound change by people and organisations' and provide suggestions about how to:

- design a change process;
- achieve cultural and organisational change;
- plan services that make sense, and use resources effectively;

- improve outcomes for all children and for those who are vulnerable or need extra support, active protection, or alternative care.

(Inter-Agency Group 2004 p. 2)

They rightly identify the successful management of organisational change as being central to the implementation of new structures and initiatives. £20 million has been set aside for a change management programme, although it is unclear whether this budget includes an allocation for learning and evaluation. If not, this is an area where research would be valuable.

3.9 Private fostering

One final issue that has not yet been touched on in this report but was raised both by the Laming Inquiry and also by Philpot (2001) is the potential vulnerability of children who are placed with foster carers by private arrangement.

The Children Bill initially makes provision for strengthening the existing private fostering notification scheme. Many carers are currently unaware that they need to register with the local authority when they undertake to foster a child by private arrangement. Strengthening the existing system should improve awareness, but registration will continue to rely on individuals voluntarily notifying the local authority of their fostering activities. If these measures prove to be unsuccessful, further powers are included in the Bill; accountability to ensure inter-agency co-operation in this area will lie with Children's Safeguarding Boards. Again this is an area that would benefit from continuing research and evaluation.

3.10 Conclusion

Safeguarding children is an area of continuing policy development that has evolved against a background of constant changes in children's services in health, education and social care. Research studies that collect baseline data about the current position

are necessary to facilitate subsequent monitoring and evaluation of the effects of future changes and, in particular, to assess any anticipated improvements in outcomes for children and their families. Moreover, the Children Bill and the accompanying policy initiative is complex and has far-reaching consequences for children's services. Many of these will not become apparent until its provisions are enacted and implementation begins in earnest. Research is clearly needed to identify how far the new Act addresses the many issues raised by the research literature as well as by inspections and inquiries such as that into the death of Victoria Climbié.

4.0   Areas for further research

4.1   Overarching issues

A new research initiative on safeguarding children will need to take account of a number of over-arching issues that emerged from all three areas that this scoping study was asked to consider.

Firstly, an ecological approach needs to be adopted in reaching better understanding of how children's well being can be adequately safeguarded. This means that studies which explore the inter-relationship between factors within the child, the parent and the environment are more likely to produce useful findings than those which focus on a single issue.

Similarly, safeguarding children is not only a multi-faceted, but also a multi-agency issue. Multidisciplinary research is needed because 'child abuse and neglect are societal problems that cut across medical, educational, social service and legal disciplines and data must be obtained from all of these domains' (Sullivan and Knutson, 2000, p.1270).

These points are reinforced by the evidence gathered from the literature review, and substantiated by the interviews with experts, that much of the empirical research in the UK has been confined to specific disciplines, often using a clinical sample of children or adults who have already been identified and/ or taking the form of a relatively small-scale case study or audit. Research on inter-agency issues has tended to use cross-sectional or retrospective designs. We not only need well-constructed longitudinal studies, which draw their samples from a wider population of children and parents; they also need to draw on multi-disciplinary expertise.

Moreover, many of the inter-agency questions concern the nature and consequences of organisational change – research in this area needs to draw on theoretical

understanding about the management of organisations, more frequently developed in business schools than in departments of social sciences or schools of medicine. This is particularly pertinent in view of the substantial sums currently allocated to fund organisational changes designed to promote better integration and delivery of children's services.

The most useful research in this area is therefore likely to be undertaken by multi-disciplinary teams, whose members have expertise in at least two, and preferably more, disciplines relevant to children's and adult's services.

Secondly, findings from some of the studies covered in the literature review cannot be adequately compared because of differences in the way in which abuse is defined. This is, of course, more complex as abuse is increasingly understood as an interrelationship between factors rather than as a simple entity. We recommend that all studies in the initiative are advised to use the definitions agreed by the WHO, in order to facilitate not only national, but also international, comparison of findings.

Finally, one of our broad conclusions from the literature review is that in all three areas, there is a need for both empirical and impact studies. The former are needed to improve the available data on the identification and long-term consequences of whatever is defined as abuse, and the latter to evaluate the impact of the following: specific interventions that focus on the relationship between child development factors, parenting factors, and environmental factors; organisational change; training; and overarching changes in legislation and policy. As Section Three has indicated, this is an area of continuing policy development. We particularly need studies that collect some baseline data concerning the current position in order to make it easier to monitor future changes.

The following are the key points from the literature review in each of the study areas that indicate a programme for further research.

4.2   Recognition of abuse

A number of studies show that abuse is most likely to be recognised both by talking to children and by observing their appearance and behaviour (Poblete, 2002; Ayre, 1998b, Jones, 2001). However there is also evidence that professionals often find it difficult to communicate with children, and that confusion about jeopardising future court proceedings has sometimes prevented them from asking questions (Morris, 1999; Laming, 2003). Professionals may find it particularly difficult to communicate with disabled children who require specific aids to do so (Kennedy, 1995; Morris, 1999).

Very young children are at greatest risk of life-threatening physical abuse. A number of children are adversely and permanently affected by pre-natal neglect, through conditions such as foetal alcohol syndrome. Disabled children aged 0-5 are particularly vulnerable if parents have insufficient support to cope with increasing stressors (Sullivan and Knutson 2000). Those who are most likely to be in a position to identify these potentially damaging family and environmental circumstances will be professionals who deliver services to very young children and their families: general practitioners, midwives, health visitors and the staff of nursery schools and day nurseries (Hendry, 2003). Yet little is known about, for instance, the role of the health visitor or the nursery nurse in recognising abuse.

Children with disabilities are particularly vulnerable to abuse both by parents and also by other carers. Yet comprehensive and current information about the numbers of children with disabilities living at home with parents, with relatives, in health establishments, in residential schools and in the care of councils is either out-dated or unavailable. There is also little information about children who are disabled or whose existing impairments are worsened as a result of maltreatment (Goldson 1998; Morris 1999; Sullivan and Knutson 2000).

Lack of clarity concerning appropriate 'partnership' between professionals and service users can obstruct the recognition of abuse. Similarly, recognition can be

hampered by difficulties in relationships between and within agencies. The issue of how recognition is passed on and dealt with is also problematic. Once practitioners suspect or have identified abuse they need to know what to do next. The referral process can be hampered if the views of some practitioners are ignored because of their perceived low status. Studies which explore these issues further would be valuable.

Recognition may also sometimes be hampered by cultural issues. For instance, there is evidence that practitioners sometimes make false assumptions about the amount of support available from extended families in the Asian and African communities or about the more formal parent child relationships in some ethnic minority groups (Quereshi *et al*, 2000). Increasing recruitment of staff from diverse cultures in the NHS, social services and education means that practitioners may hold varying expectations about thresholds for good enough parenting; there is also evidence that they may fail to notify abuse for fear of being considered racist. Staff may also be hampered by language difficulties; they may have difficulties in recognising bruising in dark skinned children (Webb, Maddocks and Bongilli, 2002). While studies which focus specifically on these issues would be welcomed, all studies would need to take account of cultural diversity and its implications for understanding how children's well being can be safeguarded.

Recognition may also be hampered by poor information-sharing and communication between professionals. Particular difficulties have been identified in the sharing of information between Accident and Emergency departments, but this is an issue that cuts across all agencies (CHI, 2003). There are particular problems in clarifying what confidential information can be shared and under what circumstances. Policy initiatives concerning the integration of information sharing systems and the development of shared databases have been designed to address these issues.

4.3 Emotional abuse and neglect

Emotional abuse may be regarded as a core thread that runs through all forms of maltreatment. The points covered in Section 4.2 above, concerning the recognition of

abuse, are all pertinent to this area of safeguarding children. In addition, there are a number of issues that are particularly relevant to recognition and successful intervention in this area.

Both emotional abuse and neglect are particularly difficult to identify. They may be masked by other forms of abuse; moreover, where children are emotionally abused or neglected, the distorted relationship builds up slowly over a lengthy period and, in the absence of critical incidents, is harder to identify (Coohey, 2003; Stone, 1998). Common agreement concerning those behaviour patterns and circumstances that lead to or constitute emotionally abusive relationships would facilitate identification and promote early intervention.

The *Framework for the Assessment of Children in Need and their Families*, and now the *Integrated Children's System*, have been designed to introduce a more holistic approach into the identification of the inter-relationship between those factors within the child, the parent and the environment which are more, or less, likely to lead to the promotion of children's well being. We do not yet know, however, whether their introduction promotes better recognition of and more timely responses to emotional abuse and neglect and this would be an important area for exploration.

Although there is some evidence that perceived unfairness, or being singled out, is particularly damaging (Rushton and Dance, forthcoming), we do not know enough about the long-term relationship between forms of maltreatment and the nature of harm to the child. Different children have different strengths and coping strategies; we need to know more about how these can be promoted.

Similarly, parents may fail to safeguard the well being of their children for a number of reasons. Children may experience emotionally abusive relationships that are due to parents' mental health problems very differently from those which have their roots in domestic violence (Glaser, 2002). We need to know more about which interventions are most likely to be effective in different family situations.

Finally interventions need to be evaluated within the context of children's ongoing development. Changes in parenting capacity need to occur within a child's timeframe (Ward *et al*, 2003). We need to know more not only about those factors that influence

parents' capacity to change but also about the timeframes within which such change might take place.

4.4   Inter-agency issues

Many of the issues identified above imply better collaboration between agencies. Recent policy initiatives and forthcoming legislation are directed towards more integrated service delivery (see Section Three). Some of these, such as the introduction of Children's Trusts, the implementation of information, referral and tracking systems and the piloting and implementation of the *Integrated Children's System* are already being researched. However other initiatives engendered by changes in policy would merit further research.

Greater understanding is needed of both the theoretical and empirical issues that promote or prevent successful multidisciplinary working in this area. Work that has been undertaken across a range of disciplines needs to be brought together to determine those factors that may promote or inhibit successful multi-disciplinary working at an operational level.

Introducing a mandatory citizen's duty to report abuse might strengthen accountability both amongst the general population and between agencies. However, we do not know whether the difficulties experienced in other countries where this had been introduced would simply be replicated in the UK (see Foreman and Bernet, 2000).

The replacement of Area Child Protection Committees with statutory Children's Safeguarding Boards is also designed to improve accountability. We need to know how far this new structure will improve their effectiveness in carrying out their responsibilities as outlined in the Guidance (Department of Health, 1999a, p.33), and how they begin to achieve the safeguarding of children in local communities.

One of the duties of the Children's Safeguarding Boards will be to ensure inter-agency co-operation in safeguarding children who are privately fostered. These children are particularly vulnerable: we do not know how many there are or where they are placed. Nor do we have adequate information about their current circumstances. It is important to know more about these children, and particularly whether new structures and procedures are more likely to promote their well being. Some work in this area is, however, being undertaken by Thomas Coram Research Unit (Owen, Barreau and Peart, forthcoming), and it would be important to ensure that any new studies complemented this work.

One of the key components of successful inter-agency working is a clear understanding of the expectations and roles of different disciplines. A number of studies have shown that the police tend to adopt a different perspective from other professionals (eg Lloyd and Burman, 1996; Hallett, 1995): we particularly need more information about how they can be better integrated into multidisciplinary teams – and the value of doing so. There may be lessons to be learnt here from the work of youth offending teams.

Children's attendance at school, achievement levels and behaviour patterns are also powerful, and often early, indicators of abuse. These are significant indicators for all children, but particularly so for those who are disabled (Sullivan and Knutson, 2000). We need to know more about the appropriate role of educational professionals – including teachers and educational psychologists – in safeguarding children.

We need to know more about effective methods of bringing together different perspectives, for instance between professionals working in adult psychiatry and child care, or between the police and social services. Conflicts of interest need to be explored and their implications addressed, for instance as when a GP has both a child and an alleged perpetrator as patients.

Many of the obstacles to successful inter-agency working might be addressed by improved communication. Shared information about the aetiology and long-term consequences of abuse, the development of common understanding and a shared language, as well as the identification and agreement of common thresholds of concern would improve inter-agency working. Such initiatives would introduce

greater transparency about the roles and responsibilities of different agencies and might overcome some of the difficulties in the sharing of confidential information.

Pooling of budgets, as introduced through the implementation of Children's Trusts, should reduce incentives to delay interventions or to pass on responsibility to other agencies. We need to know whether this is indeed the case. Better understanding of the cost as well as the psychosocial implications of delayed recognition and intervention would also be valuable.

Many of the studies we have explored recommend the introduction of joint training initiatives, a theme taken up in the proposed workforce reforms (Department for Education and Skills, 2003a, 2004c). It is clear that all professionals working in this field need a basic understanding of child development as well as of those family and environmental factors that distort developmental processes. They may also need to improve their understanding of specific issues relating to children with disabilities. Joint training is also likely to break down some of the misunderstandings and prejudices that impede satisfactory inter-agency working. However joint training can range from invited attendance at an inter-disciplinary seminar to shared modules on undergraduate courses, and much of the evaluation is currently focussed on the satisfaction of participants. We need to know more about the long-term consequences of joint training for service delivery, rather than the possibly short-term benefits for staff.

Finally, however, we need to know whether and to what extent improvements in inter-agency working affect the well being of children. Some of the studies from the United States have produced disappointing findings in this area (see Glisson and Hemmelgarn, 1998). A replication of the Glisson and Hemmelgarn study (1998) in this country would be a valuable way of exploring whether and to what extent improved inter-agency working promoted the well being of children in the UK context.

4.4 Conclusions: Implications for a research programme

A future research programme will need to include studies designed to answer the following questions: How can recognition and early identification of abuse be improved? How can agencies work better together to meet the needs of children at risk of significant harm? What have been the effects of recent policy changes in reducing the risk of significant harm? Which interventions are effective in preventing and addressing emotional abuse and neglect? What training programmes and methods are effective in improving professional practice?   This report concludes by suggesting the type of studies that might be most likely to answer such questions. However this is intended as an outline of the areas that could be explored and the approaches that might prove most valuable. Further discussion needs to be held to ascertain the priorities of policy makers before a full specification can be drawn up.

Literature searches

This scoping study is based on the findings from a relatively limited literature search, focussing on three specific areas. There is a wealth of literature that has not been addressed, either because it has been outside the brief of this study, or because it has been too extensive to meet our timetable. Much more could be learnt by undertaking comprehensive and systematic literature searches: these could cover, for instance, the management of organisational change and the elements of effective inter-agency working as they relate to children's services. Such searches would need to cover both theoretical and empirical research in these areas; they would need to be undertaken systematically, and to categorise studies by methodology in order to facilitate the evaluation of findings.

A comprehensive review of the whole concept of emotional abuse is also needed, in order to clarify differences in understanding between professionals with a view to establishing a common language and agreed thresholds that can be utilised by practitioners, the family justice system, policymakers and researchers. A study in this area might make extensive use of literature searches, as well as undertaking empirical work with different professionals.

Empirical/population studies

In some areas there appears to be insufficient information about the numbers of children in particular circumstances or with specific characteristics that increase the likelihood of abuse, or the effectiveness of arrangements to safeguard their well being. Two such groups are children placed privately in foster care, and children with disabilities. We need studies that focus specifically on these groups of children; that can provide up to date information about their numbers, their whereabouts and the extent of their vulnerability. Such studies would need to look at how their needs are assessed – and what assessments are required, in addition to those that form part of the *Integrated Children's System*, - and examine procedures in place to safeguard their well being in whatever households or institutions they are living.

The findings from this scoping study would also suggest that we need more prospective, longitudinal studies that follow the aetiology and consequences of abuse over a number of years, conducted by multidisciplinary teams of researchers. Such studies would need to take account of the inter-relationships between factors within the child, the family and the environment that promote or inhibit children's well being; they could focus specifically on the aetiology and consequences of emotional abuse and neglect. Longitudinal studies have the potential to explore both the consequences of abuse for children living in different situations (eg living with mentally ill or drug abusing parents, singled out or rejected children, those exposed to domestic violence or highly conflicted divorce situations) and the impact of specific interventions for children and their parents facing different types of difficulty. The findings can provide valuable evidence of the long-term consequences of abuse in terms of both personal distress and future dependence on services, as well as the impact of certain interventions. Longitudinal studies are likely to be more comprehensive and useful in answering the research questions than cross sectional surveys in this area. However they can be expensive; the scale and duration of such studies would need to be balanced against the likely value of the findings.

Impact studies

Smaller studies might be undertaken to evaluate the effectiveness of specific interventions. At present we have little information on which interventions are most effective in addressing emotional abuse and neglect, which are most likely to be acceptable to parents and children, or which can help to support parents' capacity to change within a child's timescale. Emotional abuse in particular is often covert or denied, and studies would need to aim at improving understanding of how to engage perpetrators in treatment programmes, as well as evaluating the effectiveness of interventions themselves. Where mothers are misusing drugs or alcohol the risk of neglect can often be identified pre birth. We need more information about which interventions could be delivered within an appropriate timescale to reduce the risk of conditions such as foetal alcohol syndrome, as well as neglect of very young children. Studies in this area might be undertaken by staff in a range of agencies providing services for very young children and might be suitably approached by random controlled or quasi- experimental designs.

While the impact of interventions with service users is an obvious area to be covered by the programme, the impact of changes in service delivery, such as different methods and structures for inter-agency working should also be evaluated. Both the impact on professional relationships and the consequences for service users should form part of the evaluation.

Numerous research projects conclude with a section on the relevance of findings for training. This research initiative will need to take a more dynamic approach and include studies which explore the effectiveness of training programmes both in terms of improving understanding between professionals, through, for instance, joint training approaches and a shared curriculum, and also improving their understanding of how the well being of children can be safeguarded. One area that might produce valuable findings would be the subsequent practice of social workers who have gained the post qualifying award in child care.

Training may be the most effective method of improving recognition of abuse, of improving decision-making when children are at risk of significant harm, of developing a common language and agreed thresholds, and of improving inter-agency

working, though we need to know much more about effective methods of delivery. Specific training issues that need to be addressed and evaluated are the effective use of checklists and flowcharts; the effective use of aids to communicate with children with disabilities; and how direct work with children can be improved. Studies of the effectiveness of different training models could be undertaken as action research programmes, and follow an experimental or quasi-experimental design.

Finally, the research programme would need to look at the impact of changes in policy. These would include, for instance, the effectiveness and potential overlap of different assessment procedures such as the *Integrated Children's System* and ASSET; the effectiveness of policies introduced to improve appropriate information–sharing between professionals; and the effectiveness of changes such as the introduction of Children's Safeguarding Boards, designed to improve accountability. A study to re-examine some of the accepted, longstanding processes for safeguarding children, such as, for example, child protection conferences and strategy discussions, and explore their effectiveness in different areas would also be useful.

The above outline indicates those areas where research would seem most necessary to fill some of the gaps in our knowledge. A new research initiative will not be able to include the full range of studies indicated, and decisions will need to be made as to which are most likely to produce findings of value to the development of policy and practice. Priorities will need to be set, and a more definitive programme developed after further consultation and discussion.

5.0   Appendices

Appendix One: Database searches

Date	Database	Key word(s)	Author	No of Hits	No of relevant hits	Notes
18/12/2003	ASSIA	Child abuse	n/a	921	90	Dates 1995 -
18/12/2003	Social Services Abstracts	Child abuse	n/a	1191	32*	Dates 1995 -
18/12/2003	Sociological Abstracts	Child abuse	n/a	712	9*	Dates 1995 -
05/01/2004	ASSIA	Emotional abuse	n/a	101	13*	Dates 1995 -
05/01/2004	Social Services Abstracts	Emotional abuse	n/a	85	0*	Dates 1995 -
05/01/2004	Sociological Abstracts	Emotional abuse	n/a	80	1*	Dates 1995 -
06/01/2004	ASSIA	Child neglect	n/a	73	13*	Dates 1995 -
06/01/2004	Social Services Abstracts	Child neglect	n/a	411	6*	Dates 1995 -
06/01/2004	Sociological Abstracts	Child neglect	n/a	189	1*	Dates 1995 -
06/01/2004	ASSIA	Child protection and inter-agency working	n/a	3	3	Dates 1995 -
06/01/2004	Social Services Abstracts	Child protection and inter-agency working	n/a	2	0*	Dates 1995 -
06/01/2004	Sociological Abstracts	Child protection and inter-agency working	n/a	0	0	Dates 1995 -
06/01/2004	ASSIA	Non-accidental injuries	n/a	0	0	Dates 1995 -
06/01/2004	Social Services Abstracts	Non-accidental injuries	n/a	0	0	Dates 1995 -
06/01/2004	Sociological Abstracts	Non-accidental injuries	n/a	0	0	Dates 1995 -
06/01/2004	ASSIA	Body map	n/a	0	0	Dates 1995 -
06/01/2004	Social Services Abstracts	Body map	n/a	0	0	Dates 1995 -
06/01/2004	Sociological Abstracts	Body map	n/a	0	0	Dates 1995 -
07/01/2004	Medline	Identification of child abuse	n/a	224	5*	Dates 1995 -
08/01/2004	Medline	Non-accidental injuries	n/a	64	22*	Dates 1995 -
08/01/2004	Medline	child abuse and body map	n/a	1	1	Dates 1995 -
08/01/2004	Medline	child abuse and inter-agency working	n/a	1	0	Dates 1995 -
08/01/2004	Medline	Child protection and inter-agency working	n/a	1	0	Dates 1995 -
08/01/2004	Medline	child emotional abuse and neglect	n/a	207	1*	Dates 1995 -

09/01/2004	ASSIA	Child protection	n/a	729	119*	Dates 1995 -
12/01/2004	Social Services Abstracts	Child protection	n/a	462	9*	Dates 1995 -
12/01/2004	Sociological Abstracts	Child protection	n/a	115	1*	Dates 1995 -
13/01/2004	Psychinfo	Identification of child abuse	n/a	7	0	Dates 1996 -
13/01/2004	Psychinfo	non-accidental injuries	n/a	0	0	Dates 1996 -
13/01/2004	Psychinfo	child abuse and body map	n/a	0	0	Dates 1996 -
13/01/2004	Psychinfo	child abuse and inter-agency working	n/a	3	2	Dates 1996 -
13/01/2004	Psychinfo	child protection and inter-agency working	n/a	1	0	Dates 1996 -
13/01/2004	Psychinfo	child emotional abuse and neglect	n/a	47	3	Dates 1996 -
14/01/2004	ASSIA	Failure to thrive and child protection	n/a	6	0	Dates 1995 -
14/01/2004	Social Services Abstracts	Failure to thrive and child protection	n/a	1	0	Dates 1995 -
14/01/2004	Sociological Abstracts	Failure to thrive and child protection	n/a	0	0	Dates 1995 -

* The number of relevant hits does not include duplicates

Appendix Two: Websites accessed

Commission for Health Improvement – www.chi.nhs.uk/

Department for Education and Skills – www.dfes.gov.uk/

Department of Health – www.dh.gov.uk/Home/fs/en

DH Disabled Children website -
www.children.doh.gov.uk/qualityprotects/work_pro/project_6.htm

HM Inspectorate of Constabulary – www.homeoffice.gov.uk/hmic/hmic/htm

National Child Protection Clearinghouse – www.aifs.org.au/nch/nch_menu.html

National Clearinghouse on Child Abuse and Neglect Information –
www.nccanch.acf.hhs.gov/index.cfm

National Clearinghouse on Family Violence –
www.hc-sc.gc.ca/hppb/familyviolence/index.html

National Data Archive on Child Abuse and Neglect – www.ndacan.cornell.edu

NCB Council for Disabled Children – www.ncb.org.uk/cdc

NSPCC – www.nspcc.org.uk/html/home/home.htm

Royal College of General Practitioners – www.rcgo.org.uk

Royal College of Paediatrics and Child Health – www.rcpch.ac.uk/

World Health Organization – www.who.int/en/

Appendix Three: Consultation with experts

The following people were consulted in the construction of the report:

Arnon Bentovim – London Child and Family Consultation Service

Pat Cawson - NSPCC

Hedy Cleaver – Royal Holloway, University of London

Carolyn Davies – Department of Health

Bernard Gallagher – University of Huddersfield

Danya Glaser – Great Ormond Street

Jenny Gray - Department for Education and Skills

Jan Horwath – University of Sheffield

Cathy James – Department of Health

David Jones – University of Oxford

Margaret Lynch – Guys Hospital

Wendy Rose – The Open University

Alan Rushton – Institute of Psychiatry, Kings College

Marjorie Smith – TCRU

Beth Tarlton - Norah Fry Unit, University of Bristol

June Statham – TCRU

Tara Weeramanthri – Institute of Psychiatry, Kings College

Debby Watson – Norah Fry Unit, University of Bristol

Appendix Four: Research on neglect

Studies included in Connell-Carrick's review of empirical literature on the correlates of neglect 1990-2000.

Brayden, R., Atemeier, W., Tucker, D., Dieterich, M. and Vietze, P. (1992) Antecedents of Child Negelct in the first 2 years of life. *Journal of Paediatrics*. 120, 426-429

Brown, J., Cohen, P., Johnson, J. and Salzinger, S. (1998) A longitudinal analysis of risk factors for child maltreatment: Findings of a 17 year prospective study of officially recorded and self reported child abuse and neglect. *Child Abuse and Neglect*. 22 (11), 1065-1078

Chaffin, M., Kelleher, K. and Hollenberg, J. (1996) Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risks from prospective community data. *Child Abuse and Neglect*. 20 (3), 191-203

Christensen, M., Brayden, R., Dietrich, M., McLaughlin, F. and Sherrod, K. (1994) The prospective assessment of self concept in neglectful and physically abusive low income mothers. *Child Abuse and Neglect*. 18 (3), 225-232

Coohey, C. (1995) Neglectful mothers, their mothers and partners: The significance of mutual aid. *Child Abuse and Neglect*. 19 (8), 885-895

Coohey, C. (1996) Child maltreatment: testing the social isolation hypothesis. *Child Abuse and Neglect*. 29 (3), 241-254

Coohey, C. (1998) Home alone and other inadequately supervised children. *Child Welfare*. 77 (3), 291-201

Drake, B. and Pandy, S. (1996) Understanding the relationship betwwn neighbourhood poverty and specific types of maltreatment. *Child Abuse and Neglect*. 20 (11), 1003-1018.

Dubowitz, H., Black, M., Kerr, M., Starr, R. and Harrington, D. (2000) Fathers and child neglect. *Archives of Pediatric and Adolescent Medicine*. 154, 135-141.

Gaudin, J., Polansky, N., Kilpatrick, A. and Shilton, P. (1996)

Gaudin, J., Polansky, N., Kilpatrick, A. and Shilton, P. (1993) Loneliness, depression, stress and social supports in neglectful families. *American Journal of Orthopsychiatry*. 63 (4), 597-605

Gillham, B., Tanner, G., Cheyne, B., Freeman, I., Rooney and Lambie, A. (1998).

Jones, E. and McCurdy, K. (1992) The links between types of maltreatment and demographic characteristics of children. *Child Abuse and Neglect*. 16, 201-215.

Lee, B. and Goerge, R. (1999) Poverty, early child bearing and maltreatment: A multi-nominal analysis. *Child and Youth Services Review*. 21, 755-780

Margolin, L. (1990) Fatal child neglect. *Child Welfare LXIX.* 4, 309-319

Raiha, N. and Soma, D. (1997) Victims of child abuse and neglect in the US army. *Child Abuse and Neglect*. 21 (8), 759-768

Sedlak, A.J., and Broadhurst, M.L.A. (1996) 'Executive summary of the third national incidence study of child abuse and neglect', *Administration for Children and Families,* Vol.9

Sobsey, D., Randall, W. and Parrila, R. (1997) Gender differences in abused children with and without disabilities. *Child Abuse and Neglect.* 21 (8), 707-720

Sullivan, P. and Knutson, J. (1998) The association between child maltreatment and disabilities in hospital based epidemiological study. *Child Abuse and Neglect*. 22 (4), 271-228

Sun, A., Shillington, A., Hohman, M., Jones, L. (2001) Caregiver AOD use, case substantiation and AOD treatment: Studies based on two southwestern counties. *Child Welfare*, 80 (2), 121-128

Taylor, C., Norman, D., Murphy, M., Jellinek, M., Quinn, D. Poitrast, F. and Goshko, M. (1991) Diagnosed intellectual and emotional impairment among parents who seriously mistreat their children: Prevalence, type and outcome in a court sample. *Child Abuse and Neglect*. 15, 389-401

Weston, J., Colloton, M., Halsey, S., Covington, S., Gilbert, J. Sorrentino-Kelly, L. Renoud, S (1993)

Zuravin, S. and DiBlasion, F. The correlates of child physical abuse and neglect by adolescent mothers. *Journal of Family Violence*. 11 (2), 149-166

Appendix Five: Terminology, definitions and conceptual issues

Inter-disciplinary   Across disciplines e.g. health, education, law and social services.

Inter-agency   Between specific agencies – for example, Social Services office, School, Nursery, Child and Adolescent Mental Health Service (CAMHS) and Hospital.

Inter-professional   Across different professional groups within the main disciplines of Social Services, Health, Law and Education:

Social Services

- Social Workers (Social workers, Disability Social Workers, Child Protection Social Workers and Social Work Managers).

Health Services

- Doctors (General Practitioners, Community Paediatricians, Hospital Paediatricians (including consultants, registrars and house doctors, Accident & Emergency consultants, registrars and house doctors, Psychiatrists);

- Nurses (Accident and Emergency Nurses, Health Visitors, School Nurses, Midwives, Paediatric Nurses and GP Practice Nurses);

- Mental health workers (Clinical Psychologists, Educational Psychologists, Drug and Alcohol workers and Community Psychiatric Nurses);

- Health-related occupations (Occupational Therapists and Physiotherapists).

  Law

- Law and Policy making (Government agencies: Home Office, Department of Health, Department for Education and Skills, Crown Prosecution Service);

- Law enforcement: (Solicitors, Lawyers, Barristers, Magistrates, Judges, Court Welfare Officers, Child Protection Police Officers and School Liaison Police Officers).

Education

- Local Education Authorities (Educational Welfare Officers, School inspectors);

- Teachers (including those in the private and grant-maintained sector and special schools) (Head Teachers, Class Teachers, Special Educational Needs teachers, Portage teachers, Nursery teachers).

Cross-disciplinary professions

- Guardians ad litem, Educational Social Workers, Hospital Social Workers, Youth offending teams, Court Welfare Officers, School liaison Police Officers.

Intra-disciplinary   Working relationships within disciplines. Within the health discipline for example, working relationships between GPs, Practice Nurses, Health Visitors, Paediatricians, and Occupational Therapists.

Intra-agency   Working relationships within specific agencies. These may also be intra-disciplinary as above within a GP practice and would additionally include receptionists or they may be inter-professional within, for example a CAMHS team that might include a Psychiatrist, Consultant Psychologist, Social Workers and Therapists.

Intra-professional   Working relationships between individuals within the same professional group, for instance, between doctors in different settings and in different specialities: GP's, A&E Consultants, Paediatricians and Community Paediatricians.

Bibliography

Abbott, D., Morris, J. and Ward, L. (2001) *The Best Place to Be: Policy, Practice and the Experience of Residential School Placement for Disabled Children.* York: Joseph Rowntree Foundation.

Abbott, D., Morris, J. and Ward, L. (2000) *Disabled Children and Residential Schools: A Study of Local Authority Policy and Practice.* Bristol: Norah Fry Research Centre.

Ainsworth, M. D. S., Blehar, M. C., Waters, E. and wall, S. (1978) *Patterns of Attachment: A Psychological Study of the Strange Situation.* Hillsdale: Erlbaum.

Aldgate, J. and Tunstill, J. (1995) *Making Sense of Section 17.* London: HMSO.

Aldridge, J. and Becker, S. (2003) *Children Caring for Parents with Mental Illness: Perspectives of Young Carers, Parents and Professionals.* Bristol: The Policy Press.

Allsopp, M. and Stevenson, O. (1995) *Social Workers Perceptions of Risk in Child Protection (a discussion paper).* University of Nottingham: School of Social Sciences.

Ayre, P. (1998a) 'Assessment of significant harm: improving professional practice', *British Journal of Nursing,* 7, (1), 31-36.

Ayre, P. (1998b) 'Significant harm: making professional judgements', *Child Abuse Review,* 7, (5), 330-342.

Baginsky, M. (2003) 'Newly qualified teachers and child protection', *Child Abuse Review,* 12, 119-127.

Baginsky, M. (2001) *Child Protection and Education.* London: NSPCC.

Baginsky, M. (2000) *Child Protection and Education.* London: NSPCC.

Bales, R. F. (1950) *Interaction Process Analysis: A Method for the Study of Small Groups.* Reading: Addison-Wesley.

Bannon, M. J. and Carter, Y. H. (2002) *Protecting Children from Abuse and Neglect in Primary Care.* Oxford: Oxford University Press.

Bannon, M. J., Carter, Y. H., Barwell, F. and Hicks, C. (1999a) 'Perceptions held by general practitioners in England regarding their training needs in child abuse and neglect', *Child Abuse Review,* 8, (4), 276-283.

Bannon, M. J., Carter, Y. H. and Ross, L. (1999b) 'Perceived barriers to full participation by general practitioners in the child protection process: preliminary conclusions for focus group discussions in West Midlands, UK', *Journal of Interprofessional Care,* 13, (3), 239-248.

Barlow, J., Brocklehurst, N., Burns, C., Callaghan, H., Davis, H., Stewart-Brown, S. and Tucker, J. (2003) 'Working in partnership: the development of a home visiting service for vulnerable families', *Child Abuse Review,* 12, (3), 172-189.

Barn, R., Sinclair, R. and Ferdinand, D. (1997) *Acting on Principle: An examination of Race and Ethnicity in Social Services Provision for Children and Families.* London: BAAF/Council for Racial Equality.

Barnett, D., Manly, J. T. and Chicchetti, D. (1993) 'Defining child maltreatment: the interface between policy and research.' in D. Cicchetti and S. L. Toth (eds). C*hild Abuse, Child Development, and Social Policy.* Norwood: Ablex, pp. 7-73.

Barter, C., Renold, E., Berridge, D. and Cawson, P. (2004) *Peer Violence in Children's Residential Care*. London: Palgrave Macmillan

Barter, C. (1996) *Nowhere to Hide: Giving Young Runaways A Voice.* London: Centrepoint.

Bebbington, A. and Miles, J. (1989) 'The background of children who enter local authority care'. *British Journal of Social Work,* 19, 349-368.

Beeman, S. K., Hagelmeister, A. K. and Edleson, J. L. (1999) 'Child Protection and Battered Women's Services: From Conflict to Collaboration', *Child Maltreatment,* 4, (2), 116-126.

Behl, L. E., Conyngham, H. A. and May, P. F. (2003) 'Trends in child maltreatment literature', *Child Abuse and Neglect,* 27, (2), 215-229.

Bell, M. (1999) 'Working in partnership in child protection: the conflicts', *British Journal of Social Work,* 29, (3), 437-455.

Benger, J. R. and McCabe, S. E. (2001) 'Burns and scalds in pre-school children attending accident and emergency: accident or abuse', *Emergency Medicine Journal,* 18, (3), 172-174.

Benger, J. R. and Pearce, A. V. (2002) 'Simple intervention to improve detection of child abuse in emergency departments', *British Medical Journal,* 324, (7340), 780-782.

Bifulco, A. and Moran, P. (1998) *Wednesday's Child: Research into Women's Experience of Neglect and Abuse in Childhood and Adult Depression.* London: Routledge.

Birchall, E. and Hallett, C. (1995) 'Working together in child protection', *Health Visitor,* 68, (10), 406-409.

Birchall, E. and Hallett, C. (1996) 'Working together: inter-professional relations in child protection', *Health Visitor,* 69, (2), 59-62.

Black, M. and Dubowitz, H. (1999) *Child neglect: research recommendations and future directions*. in H. Dubowitz (ed). *Neglected Children: Research, Practice and Policy.* California: Sage, pp. 261-277.

Bone, M. and Meltzer, H. (1989) *OPCS Survey of Disability in Great Britain Report 3: The Prevalence of Disability Among Children.* London: HMSO.

Boushel, M. (2000) 'What kind are people are we? 'race', anti-racism and social welfare.' *British Journal of Social Work,* 30, 71-89.

Bowlby, J. (1969) *Attachment and loss.* New York: Basic books.

Brandon, M., Lewis, A. and Thoburn, J. (1996) 'The children act definition of `significant harm'-interpretations in practice', *Health and Social Care in the Community,* 4, (1), 11-20.

Brassard, M.R., Hart, S.N. and Hardy, D. (1993) 'The psychological maltreatment rating scales', *Child Abuse and Neglect*, 17, 715-29.

Brassard, M.R. and Hardy, D.B. (1997) 'Psychological Maltreatment', in Helfer, M.E., Kempe, R.S. and Krugman.M.D. (eds). *The Battered Child*. Chicago: University of Chicago Press.

Bridge Child Care Consultancy Service. (1995) *Paul: Death by Neglect.* Islington ACPC.

Briggs, F. and Hawkins, R.M.F. (1996) *Child Protection: A Guide for Teachers and Child Care Professionals.* NSW: Allen and Unwin.

Brissett-Chapman, S. (1997) 'Child protection, risk assessment and African American children: cultural ramifications for families and communities.' *Child Welfare LXXVI, 45-63.*

Brooks, W. and Weathers, L. (2001) 'Overview of shaken baby syndrome', *Journal of Aggression, Maltreatment & Trauma,* 5, (1), 1-7.

Browne, K. D. and Lynch, M. A. (1997) 'The cost of child abuse and neglect', *Child Abuse Review,* 6, (4), 237-240.

Bukato, D. and Daehler, M. W. (1998) *Child Development: A Thematic Approach.* Boston: Houghton Mifflin Company.

Butt, J. and Box, L. (1998) *Family Centred. A Study of the use of Family Centres by Black Families.* London: REU.

Calder, M. C. and Barratt, M. (1997) 'Inter-agency perspectives on core group practice', *Children and Society,* 11, (4), 209-221.

Cantwell, H.B. (1997) 'The Neglect of Child Neglect', in Helfer, M.E., Kempe, R.S. and Krugman.M.D. (eds). *The Battered Child*. Chicago: University of Chicago Press.

Caplan, P. J. and Hall-McQuodale, I. (1985) 'Mother blaming in major clinical journals', *American Journal of Orthopsychiatry,* 55, 345-353.

Carlson, E. A. (1998) 'A prospective longitudinal study of attachment disorganization/disorientation.', *Child Development,* 69, 1107-1128.

Carpenter, R. F. (1999) 'The prevalence and distribution of bruising in babies', *Archives of Disease in Childhood,* 80, (4), 363-366.

Carter, Y. and Bannon, M. (2003) *The Role of Primary Care in the Protection of Children from Abuse and Neglect.* Royal College of General Practitioners. www.rcgp.org.uk/corporate/position/childprotection.pdf.

Carty, H. (1997) 'Non-accidental injury: a review of the radiology', *European Radiology,* 7, (9), 1365-1376.

Carty, H. and Pierce, A. (2002) 'Non-accidental injury: a retrospective analysis of a large cohort', *European Radiology,* 12, (12), 2919-2925.

Cawson, P., Wattam, C. and Brooker, S. and Kelly, G. (2000) *Child Maltreatment in the United Kingdom: A Study of the Prevalence of Abuse and Neglect.* London: NSPCC. (http://www.nspcc.org.uk/inform).

Chamba, R., Ahmed, W., Hirst, M., Lawton, D. and Beresford, B. (1999) *On the Edge: Minority Ethnic Families Caring for a Severely Disabled Child.* London: The Policy Press.

Chand, A. (2000) 'The over-representation of black children in the child protection system: possible causes, consequences and solutions', *Child & Family Social Work,* 5, (1), 67-77.

ChildrenNow Magazine. (2004) 17 March. www.childrennow.co.uk London.

Claussen, A.H. and Crittenden, P.M. (1991) 'Physical and psychological maltreatment: relations among types of maltreatment', *Child Abuse and Neglect,* 15, 5-18.

Cleaver, H. and Freeman, P. (1995) *Parental Perspectives in Cases of Suspected Child Abuse.* London: HMSO.

Cleaver, H., Unell, I. and Aldgate, J. (1999) *Children's Needs - Parental Capacity: The Impact of Parental Mental Illness, Problem Alcohol and Drug Use, and Domestic Violence on Children's Development.* London: The Stationery Office.

Cleaver, H., Walker, S. and with Meadows, P. (2004a) *Assessing Children's Needs and Circumstances: The Impact of the Assessment Framework.* London: Jessica Kingsley Publishers Ltd.

Cleaver, H., Barnes, J., Bliss, D. and Cleaver, D. (2004b) *Developing Identification, Referral and Tracking Systems: An Evaluation of the Processes Undertaken by Trailblazer Authorities – Early Findings.* London: Department for education and Skills.

Cleaver, H., Pithouse, A., Rose, W., Scott, J., Walker, S. and Ward, H. (forthcoming) *A Pilot Study to Assess the Development of a Multi-agency and Integrated Approach to the Delivery of Services to Children and their Families.* London: Royal Holloway.

Cohn, A. and Daro, D. (1987) 'Is treatment too late: what ten years of evaluation research tell us', *Child Abuse and Neglect*, 11, 433-442.

Commission for Health Improvement (CHI). (2003) *Protecting Children and Young People: Results of an audit of NHS organisations in England.* London: CHI.

Connell-Carrick, K. (2003) 'A critical review of the empirical literature: identifying correlates of child neglect', *Child and Adolescent Social Work Journal,* 20, (5).

Coodey, D., Brown, M., Montgomery, D., Flynn, A. and Yetman, R. (1994) Shaken baby syndrome: identification and prevention for nurse practitioners. *Journal of Paediatric Health Care,* 24, 536-540.

Coohey, C. (2003) 'Defining and classifying supervisory neglect', *Child Maltreatment,* 8, (2), 145-156.

Coohey, C. (2003) 'Making judgments about risk in substantiated cases of supervisory neglect', *Child Abuse and Neglect,* 27, (7), pp.821-840.

Cooke, P. (2000) *Final Report on Disabled Children and Abuse.* Nottingham: Ann Craft Trust.

Cooper, A., Hetherington, R. and Katz, I. (2003) *The Risk Factor: Making the Child Protection System Work for Children.* London: Demos.

Covitz, J. (1986) *Emotional Child abuse: The Family Curse.* Boston: Sigo.

Cox, A. B. and Bentovim, A. (2000) *The Family Pack of Questionnaires and Scales.* London: Department of Health.

Creighton, S. J. and Russell, N. (1995) *Voices from Childhood.* London: NSPCC.

Crosse, S. B., Kaye, E. and Ratnofsky, A. C. (1993) *A Report on The Maltreatment of Children With Disabilities.* Washington DC: National Center on Child Abuse and Neglect.

Data Protection Act. (1998) *Data Protection Act,* London: Information Commissioner.

David, T. J. (1999) 'Shaken baby (shaken impact) syndrome: non-accidental head injury in infancy', *Journal of the Royal Society of Medicine,* 92, (11), 556-561.

Dent, R. J. (1996) 'Neglect: its effects on children and young people.' In M. Pritchard (ed.) *Neglect: A Fifty Year Search for Answers.* The Bridge Child Care Development Service and Islington Child Protection Committee.

Department for Education and Skills. (2004a) *The Strategic Agreement.* London: Department for Education and Skills.

Department for Education and Skills. (2004b) *Every Child Matters: The Next Steps.* Nottingham: Department for Education and Skills Publications.

Department for Education and Skills. (2004c) *Choice Protects Update Bulletin*, (5) London: Department for Education and Skills.

Department for Education and Skills. (2003a) *Every Child Matters: Green Paper on Children's Services Cm5860,* London: The Stationery Office.

Department for Education and Skills. (2003b) *Children Act Report 2002,* London: Department for Education and Skills.

Department for Education and Skills, Department of Health and Home Office. (2003) *Keeping Children Safe: The Government's Response to the Victoria Climbié Inquiry Report and Joint Chief Inspectors' Report Safeguarding Children.* London: HMSO.

Department of Health. (2003a) *Referrals, Assessments and Children and Young People on Child Protection Registers,* London: Department of Health.

Department of Health. (2003b) *Disabled Children's Website.* Department of Health. www.doh.gov.uk/eor/children.htm.

Department of Health. (2002) *Safeguarding Children. A joint Chief Inspectors' report on Arrangements to Safeguard Children,* London: Department of Health.

Department of Health. (2000a) *Integrated Children's System: Briefing paper No. 1,* London: Department of Health.

Department of Health. (2000b) *Quality Protects: Disabled Children Numbers and Categories and Families.* London: Department of Health.

Department of Health. (2000c) *Assessing Children in Need and Their Families: Practice Guidance.* London: The Stationery Office.

Department of Health. (1999a) *Working Together to Safeguard Children,* London: Department of Health.

Department of Health. (1999b) *Quality Protects: First Analysis of Management Action Plans with Reference to Disabled Children and Families.* London: Council for Disabled Children, National Children's Bureau.

Department of Health. (1998) *Quality Protects: Framework for Action.* London: Department of Health, Social Care Group.

Department of Health. (1995) *Child Protection: Messages from Research.* London: HMSO.

Department of Health. (1991a) *The Children Act 1989: Guidance and regulations.* London: Department of Health.

Department of Health. (1991b) *Working Together to Safeguard Children.* London: Department of Health.

Department of Health and Cleaver, H. (2000) *Assessment Recording Forms.* London: Stationery Office.

Department of Health, Department for Education and Employment and Home Office. (2000) *Framework for the Assessment of Children in Need and their Families.* London: Stationery Office.

Department of Health, Home Office, Department for Education and Employment, and The National Assembly for Wales. (1999) *Working Together to Safeguard Children:*

A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children (Consultation Draft), London: Department of Health.

Department of Health, Home Office, Department for Education and Skills, DCMS, Office of the Deputy Prime Minister and Lord Chancellor's Office (2003) *What to Do if You're Worried a Child is Being Abused.* London: HMSO

Doyle, C. (1997a) 'Emotional abuse of children: issues for intervention', *Child Abuse Review,* 6, (5), 330-342.

Doyle, C. (1997b) 'Protection studies: challenging oppression and discrimination', *Social Work Education,* 16, (2), 8-19.

Dubowitz, H., Black, M., Starr, R. and Zuravin, S. (1993) 'A conceptual definition of child neglect', *Criminal Justice Behaviour,* 20, 8-26.

Dutt, R. and Phillips, M. (1996) *Report of the National Commission of Inquiry into the Prevention of Child Abuse. Volume 2, Background Papers.* London: The Stationery Office.

Easen, P., Atkins, M. and Dyson, A. (2000) 'Inter-professional collaboration and conceptualisations of practice', *Children and Society,* 14, (5), 355-367.

Edelson, J. L. (1999) 'The overlap between child maltreatment and woman battering', *Violence Against Women,* 5(2), 134-154.

Edwards, H. and Richardson, K. (2003) *Child Protection and Disability, Report of the National Working Group on Child Protection and Disability.* In NSPCC (ed) *It Doesn't Happen to Disabled Children.* London: NSPCC,

Egan-Sage, E. and Carpenter, J. (1999) 'Family characteristics in cases of alleged abuse and neglect', *Child Abuse Review,* 8, 301-313.

Elkan, R., Kendrick, D., Hewitt, M., Robinson, J.J.A., Tolley, K., Blair, M., Dewy, M., Williams, D. and Brummell, K. (2000) 'The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature', *Health Technology Assessment*, 4, (13), (executive summary).

Evans, H. (2002a) *Emotional Abuse,* London: NSPCC.

Evans, H. (2002b) *Child Neglect,* London: NSPCC.

Falkov, A. (2002) 'Addressing Family Needs When a Parent is Mentally Ill.' In H. Ward and W. Rose. '*Approaches to Needs Assessment in Children's Services.*' London: Jessica Kingsley Publishers.

Farmer, E. and Owen, M. (1998) 'Gender and the child protection process', *British Journal of Social Work,* 28, (4), 545-564.

Fitzgerald, J. (1996) Fifty years of neglect: an overview. In M. Pritchard (ed.) *'Neglect: A Fifty Year Search for Answers'.* The Bridge Child Care Development Service and Islington Child Protection Committee.

Foreman, T. and Bernet, W. (2000) 'A misunderstanding regarding the duty to report suspected abuse', *Child Maltreatment,* 5, (2), 190-196.

Garbarino, J. and Guttmann, E. and Wilson Seely, J. (1986) *The Psychologically Battered Child.* San Francisco: Jossey Bass.

Gaudin, J. (1993) *Child Neglect: A Guide for Intervention.* National Centre on Child Abuse and Neglect: US Department of Health and Human Services.

Ghate, D. and Hazel, N. (2002) *Parenting in poor Environments: stress, support and coping.* London: Policy Research Bureau.

Gibbons, J., Conroy, S. and Bell, C. (1995) *Operating the Child Protection System.* London: HMSO.

Glaser, D., Prior, V. and Lynch, M. A. (2001) *Emotional Abuse and Emotional Neglect; Antecedents, Operational Definitions and Consequences.* York: British association for the Study and Prevention of Child abuse and Neglect.

Glaser, D. (2002) 'Emotional abuse and neglect (psychological maltreatment): a conceptual framework', *Child Abuse and Neglect,* 26, (6/7), 697-714.

Glaser, D. and Prior, V. (1997) 'Is the term child protection applicable to emotional abuse?', *Child Abuse Review,* 6, (5), 315-329.

Glew, A. and Herron, H. (1998) 'Child protection: developing the personal child health record', *Community Practitioner,* 71, (10), 328-329.

Glisson, C. and Hemmelgarn, A. (1998) 'The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems'. *Child Abuse and Neglect,* 22, (5), 401-421.

Glison, C. and James, L. (1992) 'The interorganizational coordination of services to children in state custody'. *Administration in Social Work,* 16, 65-80.

Goldson, E. (1998) 'Children with disabilities and child maltreatment', *Child Abuse and Neglect,* 22, 663-667.

Gordon, D. (2000) *Disabled Children in Britain: A Re-analysis of the OPCS Disability Surveys.* London: The Stationery Office.

Gray, B. (2003) 'Social exclusion, poverty, health and social care in Tower Hamlets: the perspectives of families on the impact of the family support service', *British Journal of Social Work,* 33, (3), 361-380.

Greenfields, M. and Statham, J. (forthcoming, 2004) *The Use of Child Protection Registers.* London: Thomas Corum Research Unit.

Hall, C. (2000) *Organisation and Outcomes in Children's Services.* Totnes: Dartington Social Research Unit.

Hall, D. (2003) 'Child protection - lessons from Victoria Climbié', *British Medical Journal,* 326, (7383), 293-294.

Hallett, C. (1995) *Interagency Coordination in Child Protection.* London: HMSO.

Hardy, B., Turrell, A. and Wistow, G. (1992) *Innovations in Community Care Management.* Aldershot: Avebury.

Harran, E. (2002a) 'Barriers to effective child protection in a multicultural society', *Child Abuse Review,* 11, (6), 411-414.

Hart, S. and Binggeli, N. and Brassard, M. (1998) 'Evidence of the effects of psychological maltreatment.', *Journal of Emotional Abuse,* 1, 27-58.

Hart, S. N. and Germain, R. B. and Brassard, M. R. (1987) 'The challenge to better understand and combat psychological maltreatment of children and youth.' in M.R. Brassard, R. Germain and S. N. Hart (eds). *Psychological Maltreatment of Children and Youth.* New York: Pergamon Press.

Harwin, J. and Forrester, D. (2002) *Parental Substance Misuse and Child Welfare: A Study of Social Work with Families in which Parents Misuse Drugs or Alcohol.* Report to the Department of Health. London: Department of Health.

Hendry, E. (2002) *'Roles and Responsibilities'* in Bannon, M. J. and Carter, Y. H. *'Protecting Children from Abuse and Neglect in Primary Care'.* Oxford: Oxford University Press.

Hendry, E. (1997) 'Engaging general practitioners in child protection training', *Child Abuse Review,* 6, (1), 60-64.

Hershkowitz, I. (2001) 'A case study of child sexual false allegation.', *Child Abuse and Neglect,* 25, 1397-1411.

Hobbs, G. F., Hobbs, C. J. and Wynne, J. M. (1999) 'Abuse of children in foster and residential care', *Child Abuse and Neglect,* 23, (12), 1239-1252.

Hogg, M. A. and Abrams, D. (1988) *Social Identifications: A Social Psychology of Intergroup Relations and Group Processes.* London and New York: Routledge.

Holt, R., Grundon, J. and Paxton, R. (1998) 'Specialist assessment in child protection proceedings: problems and possible solutions', *Child Abuse Review,* 7, (4), 266-279.

Horwath, J. (2002) 'Maintaining a focus on the child? First impressions of the framework for the assessment of children in need and their families in cases of child neglect', *Child Abuse Review,* 11, (4), 195-213.

Horwath, J. (2001) *The Child's World - Assessing Children in Need.* London: Jessica Kingsley Publishers Ltd.

Horwath, J. (2000) 'Childcare with gloves on: protecting children and young people in residential care', *British Journal of Social Work,* 30, (2), 179-191.

Horwath, J. and Morrison, T. (2000) 'Identifying and implementing pathways for organisational change - using the framework for the assessment of children in need and their families as a case example.', *Child and Family Social Work,* 5, 245-254.

Horwath, J. and Glennie, S. (1999) 'Inter-agency child protection training: gathering impressions', *Child Abuse Review,* 8, (3), 200-206.

House of Lords. (2004) *Children Bill,* London: Stationery Office.

Howe, D. (1992) *'Theories of Helping, Empowerment and Participation'* in J. Thoburn (ed). *Participation in Practice-Involving Families in Child Protection.* University of East Anglia, Norwich: Social Work Development Unit, University of East Anglia, pp. 39-43.

Hudson, B., Hardy, B., Henwood, M. and Wistow, G. (1999) 'In pursuit of inter-agency collaboration in the public sector: What is the contribution of theory and research?', *Public Management: an International Journal of Research and Theory,* 1, (2), 235-260.

Human Rights Act 1998. (1998) London: The Stationery Office.

Hunt, J., Macleod, A. and Thomas, C. (1999) *The Last Resort: Child Protection, the Courts and the 1989 Children Act.* London: The Stationery Office.

Huxham, C. and Macdonald, D. (1992) 'Introducing collaborative advantage', *Management Decision,* 30, (3), 50-56.

Inter-agency group. (2004) *From Vision to Reality: Transforming outcomes for children and families.* London: LGA Publications.

Iwaniec, D. (1997) 'An overview of emotional maltreatment and failure-to-thrive', *Child Abuse Review,* 6, (5), 370-388.

Iwaniec, D. (1995) *The Emotionally Abused and Neglected Child.* Chichester: Wiley.

Jack, G. (2001) *'Ecological Perspectives in Assessing Children and Families'* in J. Horwath (ed). *The Child's World: Assessing Children in Need.* London: Jessica Kingsley Publishers, .

James, S. L., Halliday, K., Somers, J. and Broderick, N. (2003) 'A survey of non-accidental injury imaging in England, Scotland and Wales', *Clinical Radiology,* 58, (9), 696-701.

Janis, I. L. (1972) *Victims of Groupthink: A Psychological Study of Foreign Policy Decisions and Fiascos.* Boston: Houghton-Mifflin.

Jones, D. P. H. (2001) 'False positives in the field of child maltreatment', *Child Abuse & Neglect,* 25, 1395-1396.

Jones, D. (2001) *'The Assessment of Parental Capacity'* in J Horwarth (ed). *The Child's World: Assessing Children in Need.* London: Jessica Kingsley Publishers.

Jones, J. and Gupta, A. (2003) *'Neglect and its Impact on Child Welfare'* in M. J. Bannon and Y. H. Carter (eds). *Protecting Children From Abuse and Neglect in Primary Care.* Oxford: Oxford University Press.

Jones, L., Nahrstedt, K. and Packard, T. (2002) 'Evaluation of a training curriculum for inter-agency collaboration', *Journal of Community Practice,* 10, (3), 23-40.

131

Jones, J. and Gupta, A. (1998) 'The context of decision-making in cases of child neglect', *Child Abuse Review,* 7, (2), 97.

Jowitt, S. (2003) *Policy and Practice in Child Welfare: Literature Review Series 3. Child Protection and the Decision-Making Process: Assessments of Risk and Systems of Professional Knowledge, Judgement and Beliefs.* NCH: The Bridge Child Care Development Service. Glasbury on Wye: The Bridge Publishing House Ltd.

Kairys, S. W., Alexander, R. C. and Block, R. W. (2001) Shaken baby syndrome: rotational cranial injuries. *Pediatrics.* 108(1) 206-210.

Kavanagh, C. (1982) 'Emotional abuse and mental injury: a critique of the concepts and a recommendation for practice'. *Journal of the American Academy of Child Psychiatry,* 21, 171-177.

Kearney, P., Levin, E. and Rosen, G. (2000) *Alcohol, Drug and Mental Health Problems: Working with Families*. London: National Institute of Social Work.

Kelly, N. and Milner, J. (1996) 'Child protection decision-making', *Child Abuse Review,* 5, (2), 91-102.

Kennedy, M. (1995) '*Perceptions of Abused Disabled Children*' in K. Wilson and A. James (eds). *The Child Protection Handbook.* London: Bailliere Tindall, pp. 127-149.

King, W. and Reid, C. (2003) 'National audit of emergency department child protection procedures', *Emergency Medicine Journal,* 20, (3), 222-224.

Kirkaldy and Crispin (1999) *Home-Start in Scotland – An Evaluation.* Scotland: Home-Start UK.

Kirkland, J. P., Field, B. and Hazel, A. (1996) 'Child protection: the continuing need for training and policies in schools', *Pastoral Care, .*

Knowles, R., Blackburn, M., Zahir, M., Russell, M., Carrier, A. and Nevrkla, E. (1999) 'The implementation of a new parallel child health record', *Child: Care, Health and Development,* 25, (4), 253-266.

Kolbo, J. R. and Strong, E. (1997) 'Multidisciplinary team approaches to the investigation and resolution of child abuse and neglect: a national survey', *Child Maltreatment,* 2, (1), 61-72.

Laming, H. (2003) *The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming.* London: TSO.

Leventhal, J. M. (2000) 'Thinking clearly about evaluations of suspected child abuse', *Clinical Child Psychology and Psychiatry,* 5, (1), 139-147.

Lewis, V. and Creighton, S. J. (1999) 'Parental mental health as a child protection issue: data from the NSPCC national child protection helpline', *Child Abuse Review,* 8, 152-163.

Ling, M. S. and Luker, K. A. (2000) 'Protecting children: intuition and awareness in the work of health visitors', *Journal of Advanced Nursing,* 32, (3), 572-579.

Lloyd, S. and Burman, M. (1996) 'Specialist police units and the joint investigation of child abuse', *Child Abuse Review,* 5, (1), 4-17.

Logan, T.K., Walker, R., Horvath, L.S. and Leukefeld, C. (2003) 'Divorce, custody, and spousal violence: a random sample of circuit court docket records', *Journal of Family Violence*, 18, (5), 269-279.

Lupton, C., Khan, P. and North, N. (2000) 'The role of the general practitioner in child protection', *British Journal of General Practice,* 50, 977-981.

Lupton, C., North, N. and Khan, P. (2001) *Working Together or Pulling Apart?* Bristol: Policy press.

Lupton, C. and Khan, P. (1998) 'The role of health professionals in the UK child protection system: a literature review', *Journal of Interprofessional Care,* 12, (2), 209-221.

Lyons-Ruth, K. (1996) 'Attachment relationships amongst children with aggressive behavior problems: the role of disorganized early attachment patterns.', *Journal of Consulting and Clinical Psychology,* 64, 64-73.

Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect: An Evidence-Based Approach to Planning and Evaluating Interventions.* Chichester: Wiley.

Macdonald G. (2002) '*Child Protection'*. in McNeish D., Newman T. and Roberts H. (eds) *What Works for Children?: Effective Services for Children and Families*. Buckingham: Open University Press.

MacLeod, J. and Nelson, G. (2000) 'Programs for the promotion of family wellness and the prevention of child maltreatment', *Child Abuse and Neglect*, 24, (9), 1127-1149.

Maddocks, A., Griffiths, L. and Antao, V. (1999) 'Detecting child sexual abuse in general practice: a retrospective case-control study from Wales', *Scandinavian Journal of Primary Health Care,* 17, (4), 210-214.

Marchant, R. (2001) *'The Assessment of Children with Complex Needs*' in J. Horwath (ed). *The Child's World: Assessing Children in Need.* London: Jessica Kingsley Publishers, pp. 207-220.

Martins, C. and Gaffan, E. A. (2000) 'Effects of early maternal depression on patterns of infant - mother attachment: a meta-analytic investigation', *Journal of Child Psychology and Psychiatry,* 41, 737-746.

McAuley, C. (1999) *The Family Support Outcomes Study.* Northern Ireland: Northern Health and Social Services Board.

McGee, R. A. and Wolfe, D. A. (1991) *'Between a rock and a hard place. Where do we go from here in defining maltreatment?'* in D. Ciccetti (ed). *Development and Psychopathology.* Cambridge: Cambridge University Press, pp. 119-124.

Morris, J. (1999) 'Disabled children, child protection systems and the children act 1989', *Child Abuse Review,* 8, 91-108.

Morrison, T. (2000) 'Working together to safeguard children: challenges and changes for inter-agency co-ordination in child protection', *Journal of Interprofessional Care,* 14, (4), 363-373.

Mulholland, H. (2003a) 'Nurses can make sure it never happens again', *Nursing Times,* 99, (5), 10-11.

Munro, E. (1999) 'Common errors of reasoning in child protection work', *Child Abuse and Neglect,* 23, (8), 745-758.

Munro, E. (1996) 'Avoidable and unavoidable mistakes in child protection work', *British Journal of Social Work,* 26, 793-808.

Narducci, T. (2003) *Increasing the Effectiveness of the ACPC,* London: NSPCC.

National Clearing House on Child Abuse and Neglect. (2001) *Acts of Omission: An overview of Child Neglect.* London: National Clearing House.

National Clearing House on Child Abuse and Neglect Information and National Adoption Information Clearing House. (2003a) *'Definitions of child abuse and neglect',* London: National Clearing House.

National Clearing House on Child Abuse and Neglect Information and National Adoption Information Clearing House. (2003b) *'Substance abuse and child maltreatment',* London: National Clearing House on Child Abuse, 12.

National Working Group on Child Protection and Disability. (2003) *It Doesn't happen to Disabled Children: Child Protection and Disabled Children.* London: NSPCC.

Oates, R. K. (1996) *The Spectrum of Child abuse: Assessment, Treatment, and Prevention.* New York: Brunner/Mazel Inc.

O'Hagan, K. P. (1995) 'Emotional and psychological abuse: problems of definition', *Child Abuse and Neglect,* 19, (4), 449-461.

Olds, D. L., Henderson, C. R., Tatelbaum, R. and Chamberlin, R. (1986) 'Preventing child abuse and neglect: a randomised trial of nurse home visitation.', *Paediatrics,* 78, 65-78.

Oosterhoorn, R. and Kendrick, A. (2001) 'No sign of harm: issues for disabled children communicating about abuse', *Child Abuse Review,* 10, (4), 243-253.

O'Sullivan, T. (1999) *Decision Making in Social Work.* London: Macmillan.

Owen, C., Barreau, S. and Peart, E. (forthcoming) *A Study of Private Fostering*. Thomas Coram Research Unit, London.

Packman, J. and Hall, C. (1998) *From Care to Accommodation: Support, Protection and Control in Child Care Services*. London: Stationery Office.

Parton, N. (1994) 'Neglect as child protection: the political context and the practical outcomes.', *Children and Society,* 9, 67-89.

Parton, N. and Otway, O. (1995) 'The contemporary state of child protection policy and practice in England and Wales', *Children and Youth Services Review,* 17, (5/6), 599-617.

Paul, A. and Cawson, P. (2002) 'Safeguarding disabled children in residential settings: what we know and what we don't know', *Child Abuse Review,* 11, (5), 262-281.

Philpot, T. (2001) 'A honeypot for abusers', *Nursing Times,* 97, (46), 28-29.

Pithouse, A., Batchelor, C., Crowley, A., Webb, A. and Ward, H. (2004) '*Developing a Multi-Agency Pre-referral Common Assessment Approach to the Identification of Children In Need in the Community. A Report for the Wales Office of Research and Development for Health and Social Care'*. Cardiff: Cardiff University.

Platt, L. (2002) *'Parallel Lives?'*. Child Poverty Action Group, London.

Poblete, X. (2002) '*Overview of Child Abuse and Neglect'* in J. M. Bannon and Y. H. Carter *'Protecting Children from Abuse and Neglect'*. Oxford: Oxford University Press.

Prilleltensky, I. B. and Pierson, L. (1999) *Contributing Factors and Consequences. Promoting Family Wellness and Preventing Child Maltreatment. Fundamentals for Thinking and Action.* Ontario: Wilfrid Laurier University.

Quereshi, T., Berridge, D. and Wenman, H. (2000) *Where to turn? Family support for South Asian communities.* London: National Children's Bureau.

Reder, P. and Duncan, S. (1999) 'Auditing mental health aspects of child protection', *Child Abuse Review,* 8, 147-151.

Reece, R. (1994) *Child Abuse: Medical Diagnosis and Management.* Philadelphia, USA.: Waverley Company.

Rees, G. and Stein, M. (1999) *The Abuse of Adolescents within the Family.* London: NSPCC.

Resnick, M. D. (1984) 'The Social Construction of Disability' in R. W. Blum (ed). *Chronic Illness in Childhood and Adolescence.* Orlando Florida: Grune & Stratton, pp. 29-46.

Robinson, A., Whitehead, S., Wadeson, J. and Price, A. (1999) 'Registering concern: systems of communication', *Community Practitioner,* 72, (4), 91-93.

Rosenberg, D. and Cantwell, H. (1993) 'The consequences of neglect - individual and societal', *Baillieres Clinical Paediatrics,* 1, 185-210.

Royal College of Paediatrics and Child Health. (2004) www.rcph.ac.uk/publications/recent_publications.html.

Royal College of Paediatrics and Child Health. (1999) *Accident and Emergency Services for Children - Report of A Multidisciplinary Working Party.* London: RCPCH.

Rushton, A. and Dance, C. (in press) 'Negative parental treatment of the singled out child: responses to the problem by health visitors, social services departments and child and adolescent mental health services', *Clinical Child Psychology and Psychiatry*, in press.

Sanders, B., Jackson, S. and Thomas, N. (1996a) 'A comparison of child protection local procedures handbooks', *Practice,* 8, (3), 31-44.

Sanders, R., Jackson, S. and Thomas, N. (1996b) 'The police role in the management of child protection services', *Policing and Society,* 6, (2), 87-100.

Scott, J. (1999) *Looking After Children: Audit of Implementation in Year Three (1997-8),* Leicester: University of Leicester.

Sedlak, A. J. and Broadhurst, M. L. A. (1996) 'Executive summary of the third national incidence study of child abuse and neglect', *Administration for Children and Families,* 9, .

Shaw, M. E. (1981) *Group Dynamics: The Psychology of Small Group Behaviour.* New York: McGraw-Hill.

Sibert, J. R., Payne, E. H., Kemp, A. M., Barber, M., Rolfe, K., Morgan, R. J. H., Lyons, R. A. and Butler, I. (2002) 'The incidence of severe physical child abuse in Wales', *Child Abuse and Neglect,* 26, (3), 267-276.

Simpson, C. H., Simpson, R. J., Power, K. G., Salter, A. and Williams, G. (1994) "GP's' and health visitors' participation in child protection case conferences.', *Child Abuse Review,* 3, 211-230.

Smith, S. (1998) 'Child protection: are we going backwards?', *Community Practitioner,* 71, (3), 98-99.

Social Services Inspectorate (2000) *'Excellence not Excuses – Inspection of Services for Ethnic Minority Children and Families.* London: Department of Health.

Social Services Recruitment and Retention Survey (2000) *'A Summary of the Findings.'* London.

Socolar, R. R. S. and Reives, P. (2002) 'Factors that facilitate or impede physicians who perform evaluations for child maltreatment', *Child Maltreatment,* 7, (4), 377-381.

Spencer, D. (2002) 'Paediatric trauma: when it is not an accident', *Accident and Emergency Nursing,* 10, (3), 143-148.

Stanley, N., Manthorpe, J. and Talbot, M. (1998) 'Developing interprofessional learning in child protection at the qualifying level', *Journal of Interprofessional Care,* 12, (1), 33-41.

Starling, S. P. and Boos, S. (2003) 'Core content for residency training in child abuse and neglect', *Child Maltreatment,* 8, (4), 242-247.

Statham, J. (2004a) *Safeguarding children*, CISC Evidence Paper 5. Report to the Children in special circumstances expert working group.

Statham, J. (2004b) *Links between adults' and children's services*, CISC Evidence Paper 4. Report to the Children in special circumstances expert working group.

Stein, M., Rees, G. and Frost, N. (1994) *Running the Risk: Young People on the Streets in Britain Today.* London: Children's Society.

Stevenson, O. (1998) *Neglected Children: Issues and Dilemmas.* Oxford: Blackwell Science.

Stone, B. (1998) 'Child neglect: practitioners' perspectives', *Child Abuse Review,* 7, (2), 87-96.

Sullivan, P. M. and Knutson, J. F. (2000) 'Maltreatment and disabilities: a population-based epidemiological study', *Child Abuse and Neglect,* 24, (10), 1257-1273.

Tajfel, H. and Turner, J. C. (1986) *The Social Identity Theory of Intergroup Behaviour.* Chicago: Nelson-Hall.

Taylor, J. and Daniel, B. (1999) 'Interagency practice in children with non-organic failure to thrive: is there a gap between health and social care?', *Child Abuse Review,* 8, (5), 325-338.

Thoburn, J., Wilding, J. and Watson, J. (2000) *Family Support in Cases of Emotional Maltreatment and Neglect.* London: HMSO.

Tomison, A. M. (1999) *Interagency collaboration and communication in child protection cases: some findings from an Australian case tracking study. Paper presented at the 5th ISPCAN Asian Conference on Child Protection, 26-28 November, Hong Kong.* www.aifs.org.au/institute/pubs/papers/tomison4.html, accessed 23/02.

Tomison, A. M. (1996a) *Child Maltreatment and Mental Disorder.* AIFS, Melbourne: National Child Protection Clearinghouse Discussion Paper No. 3.

Tomison, A. M. (1996b) *Child Maltreatment and Substance Abuse.* AIFS, Melbourne: National Child Protection Clearinghouse Discussion Paper No. 2.

Tomison, A. M. and Tucci, J. (1997) 'Emotional abuse: the hidden form of maltreatment.', *Issues in Child Abuse Prevention,* 8, .

Townsley, R., Abbot, D. and Watson, D. (2003) *Making a Difference: Exploring the Impact of Multi-Agency Working on Disabled Children with Complex Health Needs, their Families and the Professionals who Support them.* Bristol: Policy Press.

Trowell, J., Hodges, S. and Leighton-Laing, J. (1997) 'Emotional abuse: the work of a family centre', *Child Abuse Review,* 6, (5), 357-369.

Turney, D. (2000) 'The feminizing of neglect', *Child & Family Social Work,* 5, (1), 47-56.

Tye, C. and Precey, G. (1999) 'Building bridges: the interface between adult mental health and child protection', *Child Abuse Review,* 8, (3), 164-171.

U. S. Department of Health and Human Services. (2002) *Child Maltreatment 2000; reports from the states to the national child abuse and neglect data systems,* Washington D.C: U.S Government Printing Office.

Utting, W., Department of Health. and Welsh Office. (1997) *People Like Us: The Report of the Review of the Safeguards for Children Living Away from Home.* London: HMSO.

Velleman, R. (1993) *Alcohol and the family.* London: Institute of Alcohol Studies.

Vulliamy, A. P. and Sullivan, R. (2000) 'Reporting child abuse: pediatricians' experiences with the child protection system', *Child Abuse and Neglect,* 24, (11), 1461-1470.

Ward, H. (1995) *Looking After Children: Research into Practice.* London: The Stationery Office.

Ward, H. and Peel, M. (2002) *'An Inter-Agency Approach to Needs Assessment'*, in H. Ward and W. Rose (eds.) *Approaches To Needs Assessment In Children's Services.* London: Jessica Kingsley Publishers Ltd.

Ward, H., Munro, E. R., Dearden, C. and Nicholson, D. (2003) *Outcomes for Looked After Children: Life Pathways and Decision-Making for Very Young Children in Care or Accommodation,* Loughborough: Centre for Child and Family Research.

Ward, H., Holmes, L., Soper, J. and Olsen, R. (2004) *The Costs and Consequences of Placement Choice for Children looked After Away from Home. Final Report to the Department for Education and Skills.* Loughborough: Centre for Child and Family Research.

Waterhouse, R. and Department of Health. (2000) *Lost in Care: Report of the Tribunal of Inquiry into the Abuse of Children in Care in the Former County Council Areas of Gwynnedd and Clwyd Since 1974.* London: The Stationery Office.

Webb, E., Maddocks, A. and Bongilli, J. (2002) 'Effectively protecting black and minority ethnic children from harm: overcoming barriers to the child protection process', *Child Abuse Review,* 11, (6), 394-410.

Weir, A. B., Lynch, E., Hodes, D. T. and Goodhart, C. L. (1997) 'The role of the general practitioner in child protection and family support: a collaborative training model', *Child Abuse Review,* 6, (1), 65-69.

Welbourne, P. (2002) 'Culture, children's rights and child protection', *Child Abuse Review,* 11, (6), 345-358.

Westcott, H.L. and Jones, P.H. (1999) 'Annotation: the abuse of disabled children', *Journal of Child Psychology and Psychiatry*, 40, (4), 497-506.

Williams, A. and Morris, J. (2003) *'Child Protection and Disabled Children at Residential Schools.'* In NSPCC (ed) *'It Doesn't happen to Disabled Children'.* London: NSPCC.

Winnicott, D. (1958) *Collected Papers.* London: Tavistock.

Wright, C. M. and Talbot, E. (1996) 'Screening for failure to thrive - what are we looking for?', *Child: Care, Health and Development,* 22, (4), 223-234.

Zander, A. (1979) 'The psychology of group processes', *Annual Review of Psychology,* 30, 417-451.

Zimbardo, P. G. (1975) *'Transforming Experimental Research into Advocacy for Social Change'* in M. Deutsch and H. A. Hornstein (eds). *Applying Social Psychology.* Hillsdale: Erlbaum, .

Zuravin, S. J. (1999) '*Child neglect: a review of definitions and measurement research*' in *Neglected Children: Research, Policy and Practice.* (ed). Thousand Oaks: Sage, pp. 24-47.