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Health Care Workers' Knowledge of Current Child Protection Legislation and Child Discipline Practices

Abstract

The reasonable chastisement of children remains legal despite intensive lobbying by various groups to rule out smacking and despite the physical abuse of children being problematic. All professionals working with children have a duty to safeguard and promote children's welfare. This includes knowledge about child protection legislation and child discipline practices. This study assessed the knowledge of 55 health care professionals working in children's services in one NHS trust in relation to child protection legislation and child discipline practices. The study aimed to establish if workers from more specialist child services (e.g. tiers three and four) demonstrated greater knowledge in these two areas than workers from less specialist services (e.g. tiers one and two) and if experience was positively correlated with knowledge. The results suggest that workers in more specialist children's services demonstrated greater knowledge about child protection legislation. There was no difference found between the two groups of health workers in relation to knowledge about child discipline practices. The number of years' experience was not significantly related to knowledge in either area considered. The results are discussed. Inconsistencies and gaps shown in knowledge across both groups of participants are outlined and the clinical implications are

KEY WORDS: child protection; child discipline; health care workers; child protection legislation

Introduction

The current paper examines the knowledge of Scottish health professionals about child protection legislation and child discipline practices. Scotland was the first part of the UK to introduce legislation covering the physical punishment of children (Criminal Justice (Scotland) Act 2003). This legislation was developed in the context of the continuing physical abuse of children and had as a central aim making a distinction between reasonable physical chastisement and physical abuse. There are a variety of definitions for physical abuse available, however, for the purposes of this paper the NSPCC (2009) defines physical abuse as including:

‘ . . . hitting, shaking, kicking, punching, scalding, suffocating and other ways of inflicting pain or injury to a child. It also includes giving a child harmful substances, such as drugs, alcohol or poison.’

Their recent ‘Full Stop’ campaign (NSPCC, 2007) suggests that at least one child dies every week as a direct result of child abuse. In Scotland in 2002, ten children were the victims of child homicide; half of them were under the age of five (Yarwood, 2004). The death of a child as a result of non accidental injury represents the most extreme act on a large spectrum of behaviour that constitutes child abuse, including emotional, physical and sexual abuse as well as neglect.

During 2000, it was reported that there were legal proceedings against 205 people for non-sexual offences of child abuse (Scottish Executive, 2005). It is difficult to ascertain how widespread nonfatal child abuse actually is in the UK as this relies on accurate identification of abusive situations and consistent reporting of the same. Prevalence rates are therefore likely to be largely under representative. The figures available, however, suggest that seven per cent of children experience serious physical abuse at the hands of their parents or carers, while 16 per cent experience ‘serious maltreatment’ by parents (Cawson *et al.*, 2000).

Reasonable Chastisement

Until the introduction of Section 51 in the Criminal Justice (Scotland) Act 2003, Scottish Law in relation to physical child abuse was based on an 1860 judgment by Chief Justice Cockburn who stated that a parent may ‘for the purpose of correcting what is evil in the child, inflict moderate and reasonable corporal punishment’ (Roberts and Roberts, 2000, p. 259). The defence of reasonable chastisement was established on the basis of this statement and has since been the focus for many anti-smacking lobbyists in their campaign for better children’s rights (Phillips and Alderson, 2003). They argue that children should be afforded the same rights as adults in relation to protection from assault and it should, therefore, be illegal to hit a child in any manner. The implications of outlawing ‘smacking’ in all its forms would be considerable, given that reports suggest that up to 50 per cent of parents in the UK have hit or smacked their child in the last year and that up to eight per cent of parents report using physical punishment weekly or more (Scottish Executive, 2002).

Despite intensive lobbying by professional and charitable organisations (e.g. Children are Unbeatable! Alliance, 2000; Community Practitioners’ and Health Visitors’ Association, 2001), it was voted in parliament in 2003 not to outlaw the physical punishment of children and instead only to outlaw *abusive punishment* as defined by Section 51 in the Criminal

Justice (Scotland) Act 2003. This section of the Act states that if what was done to the child consisted of a blow to the head, shaking or the use of an implement then the court must consider that it was not a justifiable assault and, therefore, illegal. The legislation, however, still allows for the defence of a justifiable assault on a child (e.g. 'smacking') (Stewart-Brown, 2004) and such cases are considered individually taking into account the nature of what was done to the child, the duration and frequency, the effect on the child, the age of the child and the characteristics of the child (Protection of Children (Scotland) Act 2003). This is of some concern, given that the research literature indicates a link between physical punishment and physical abuse (Gershoff, 2002; Newson and Newson, 1989) and the frequency and intensity of physical punishment (Cawson *et al.*, 2000).

Shared Responsibility

Child protection extends beyond ensuring that the legal system reacts and a number of child protection documents which outline proactive measures for identifying and preventing child abuse have been published in Scotland, including the Protection of Children (Scotland) Act 2003, the Children (Scotland) Act 1995 and more recently, Getting it Right for Every Child (Scottish Government, 2008). The documents were designed to help professionals identify children at risk and to work together to protect them. They emphasise the need for all services working with children to share a commitment to safeguard and promote children's welfare, including all NHS bodies. In tandem with this has come the recognition of the benefit of additional training in child protection for health professionals in relation to increasing awareness and improving knowledge (Keys, 2005).

Within health services there exist a number of different disciplines that are in contact with children on a daily basis, all of whom have a responsibility for their welfare and who, therefore, need an awareness of the issues, and possible indicators of child abuse as well as knowledge of child protection procedures (Baginsky, 2003). The potential fine dividing line between physical abuse and reasonable chastisement is one of the issues that those working with children should be aware of to ensure that abusive situations are not overlooked or conceptualised as reasonable chastisement.

Lack of knowledge about child abuse has been highlighted as one of the factors contributing to the under-reporting of abuse (Sege and Flaherty, 2008). It is argued that formal education or training in relation to child abuse helps to improve the identification and reporting of child abuse (Flaherty *et al.*, 2000). Child protection training is a mandatory part of staff induction within the NHS; however, it is unclear whether workers sustain the level of knowledge required to use the training in their daily work with children to help identify and prevent child abuse. It is also unclear what health professionals understand physical abuse to be and whether they conceptualise it as a child protection issue.

Positive Discipline Practices

In addition to knowledge about legislation related to physical punishment, it is also important that staff are aware of positive practice in relation to child discipline in order to promote positive parenting practices and reduce potentially abusive behaviours. One of the most common referrals to child and adolescent mental health services (CAMHS) is children with conduct problems (e.g. conduct disorder, oppositional defiant disorder as defined by DSM-IV) (NICE, 2006), and the relationship between punitive and authoritarian parenting style and child behaviour problems is well established (Darling and Steinberg, 1993). Such is the

strength of this relationship that one of the most effective interventions for conduct problems in children is the utilisation of parenting programmes (Scott, 2008), which, in part, focus on reducing inappropriate child discipline practices and introducing more positive and appropriate ones (e.g. Webster-Stratton, 1994).

Professionals working with children and families are often called upon to advise on parenting practices. An early study found that 90 per cent of paediatricians included advice about discipline 'most of the time' when they were giving anticipatory advice to families (McCormick, 1992). This study suggested that health professionals working with children and families should be knowledgeable about appropriate child discipline practices (Webster-Stratton, 1998), particularly given the complexity involved in advising about the broad range of potential disciplinary practices and the variety of causes of behavioural problems (Howard, 1996). Waterston (2000) suggests that health care professionals working with families who have children with difficult behaviour should be consistent in their advice about child discipline practices, including smacking. It is argued that combining an awareness of child protection legislation with knowledge about inappropriate and appropriate discipline practices would better equip health professionals to contribute to the successful prevention, identification and reporting of child abuse, and the ongoing development of staff knowledge is a key aim of recent policy documents (Scottish Government, 2008).

All health professionals who deliver services to children are expected to undertake child protection training (Welsh Assembly Government, 2004). Different levels of child protection training are recommended according to which tier health care professionals work in, with higher tiers representing more specialist services (Slater, 2005). For example, staff working across tiers three and four, such as paediatricians and staff working in CAMHS, are likely to have particular responsibilities in relation to child protection and are advised to undertake more regular, intense and specialist child protection training than those working in lower tier services, such as school nurses. This would suggest that more specialist staff would have more in-depth knowledge both in relation to child protection but also about appropriate parenting strategies. There has, however, been little research which has explicitly examined this.

Experience

It has been suggested that direct experience is an important part of improving knowledge (Ainscow, 1999). Previous research undertaken in both the health (McKenzie *et al.*, 2004) and education sectors (Johnson and Cartwright, 1991) has shown a positive relationship between the level of direct experience held in an area of work and the level of knowledge demonstrated about the same area of work. Research is lacking in the areas pertinent to this study, in particular demonstrating if a similar relationship exists between experience of working with children and knowledge about child protection and positive discipline practices.

Aim

The aim of this study was to investigate the levels of knowledge demonstrated by a range of health care professionals who work with children in relation to their understanding of child protection legislation and child discipline practices. The study had three main hypotheses:

- That members of more specialist tier three and four child services (e.g. CAMHS staff and paediatricians) would demonstrate a significantly greater knowledge of child protection legislation than less specialised tier one or two services (e.g. school nurses and health visitors).

- That members of more specialist tier three and four child services (e.g. CAMHS staff and paediatricians) would demonstrate a significantly greater knowledge of child discipline practices than less specialised tier one or two services (e.g. school nurses and health visitors).
- That the number of years of experience since qualification would be significantly positively correlated with knowledge of both child protection legislation and knowledge of child discipline practices for all health care professionals, regardless of specialism.

Method

A questionnaire was devised on the basis of information obtained from policy, legislation and evidence-based practice relating to child protection and child discipline procedures. The criteria for included information were:

- The legislation/policy related to Scotland (as this was the area where the study was being conducted).
- The articles were professional consultation documents or good practice guidelines.
- The research papers were published in peer-reviewed journals.

At the time that the study was conducted the most recent Scottish legislation in relation to child protection had not been published.

The questionnaire was in two sections and contained a number of statements, to which participants were asked to respond 'true' or 'false' or 'don't know'. Section one considered current child protection legislation, while section two considered child discipline practices. The questionnaire was piloted with six health care professionals working in the local CAMHS team to examine face and content validity. Feedback was provided verbally. As no suggested changes were made, the questionnaire was unaltered. No formal measures of any other forms of validity or reliability of the questionnaire were undertaken.

Sample

Participants for this study were selected on the basis that they were health care professionals who were working primarily with children at the time of recruitment and were identified via local health centres or CAMHS services in the area where the study was completed and from existing contact information. Tier three and four staff included paediatricians, psychiatrists, community psychiatric nurses and clinical psychologists (including trainee clinical psychologists on placement) whilst tier one and two staff included health visitors and school nurses. Potential participants were sent a pack by post, which included a brief information sheet about the study (covering aims, issues of confidentiality, anonymity and instructions on what to do if they wished to participate), the study questionnaire and a self-addressed envelope. A total of 67 questionnaires were sent out and 55 were returned which equated to an 82 per cent return rate, which far exceeded expectation for a postal return rate (Babbie, 1998).

Ethical Approval

Full ethical approval was not required as the project was determined to be an audit. Participant consent was assumed if they completed and returned the questionnaire.

Results

Overall, the participants had a mean score of 4.55 (sd = 1.3) out of 7 in section one of the questionnaire, with a minimum score of 1 and a maximum of 7. The mean score for section

two was 7 out of 9 (sd = 1.17) with a minimum of 3 and a maximum of 9. This indicates a wide range of knowledge across both groups with neither group demonstrating a full knowledge in relation to child protection legislation and child discipline practices as measured by the questionnaire.

For the purposes of analysis, participants' responses were divided into the following groups based on the specialist nature of their work: group one—tier three and four staff (n = 29); group two—tier one and two staff (n = 26). Responses to each section were analysed separately for each group. The median and range in relation to correct responses for both sections one and two of the questionnaire are outlined in Table 1 according to group.

Knowledge Between Groups

It was predicted that members of higher tier services would demonstrate a significantly greater knowledge of child protection legislation and child discipline practices than lower tier services. A Mann-Whitney U test was conducted between groups one and two in relation to total scores for section one (reflecting knowledge of child protection legislation) and section two (knowledge of child discipline practices). The results indicated that group one participants had significantly higher scores in section one covering knowledge of child protection legislation (U = 262.5, $p < 0.05$, N = 55, one-tailed test), however, no significant differences were found between the groups on section two addressing child discipline practices (U = 352, $p = 0.33$, N = 55, one-tailed test).

Disagreement Between Health Care Staff

Table 2 illustrates the questions with the greatest discrepancy in responses.

Impact of Experience on Knowledge

The number of years since qualification for participants ranged from newly qualified to 36 years. The median number of years since qualification was five years six months.

Experience, Child Protection Legislation and Child Discipline Practices

It was predicted that there would be a significant positive relationship between the number of years since qualification and knowledge about both child protection legislation and child discipline practices. Spearman correlations were conducted to compare years since qualification with the total score on sections one and two of the questionnaire for groups one and two.

Table 1. Descriptive information in relation to the number of correct responses for sections one and two

	Section 1			Section 2		
	Range (0-7)			Range (0-9)		
	Min	Max	Median	Min	Max	Median
Group 1	1	7	5	3	9	7
Group 2	2	7	4	5	9	7

Table 2. Questions indicating the areas where most health staff lacked knowledge

Statement	Correct	Incorrect	Don't Know
1:1 The law protects children from assault to a greater extent than it protects adults (false)	40%	47%	13%
1:2 The law considers physical and abusive punishment to be the same (false)	52%	31%	16%
1:5 It is legal for a parent to shake a child if they are over the age of three (false)	58%	18%	24%
1:6 It is illegal for anyone other than a parent or someone with parental rights to hit a child (true)	64%	20%	16%
2:6 Punishment is a necessary part of discipline (true)	40%	51%	11%

No significant relationships were found between the number of years' experience since qualification and participants' scores on section one ($\rho = 0.154$, $n = 54$, $p = 0.267$, two tailed) or section two of the questionnaire ($\rho = 0.123$, $n = 54$, $p = 0.374$, two tailed).

Discussion

This study aimed to assess the levels of knowledge in a selection of health care professionals in relation to child protection legislation and child discipline practices. These two areas were selected on the basis of the significant roles they have played in the Government's recent drive to protect children from abuse.

Group one (CAMHS workers and paediatricians) had the highest mean scores and the highest minimum scores for both sections one and two in comparison to group two. For section one, this difference between groups was significant and the more specialist workers that made up this group, therefore, had a better knowledge of child protection legislation than group two. No significant difference was found between the two groups in relation to knowledge of child discipline practices. No significant relationship was found between the number of years since qualification and knowledge demonstrated in relation to child protection legislation and child discipline practices, regardless of specialism. Overall, no one question was answered correctly by all participants, indicating that no one group had a perfect knowledge in relation to the statements in the questionnaire about child protection legislation and recommended child discipline practices. The ranges in correct scores also indicated a wide variation in knowledge, with some participants having very low levels of knowledge in both sections, while others achieved individual scores of 100 per cent.

The importance of a shared responsibility in relation to child protection (Baginsky, 2003) means that all groups involved in this study would have perhaps been expected to demonstrate a better and more consistent knowledge in relation to current child protection legislation. For example, Table 2 illustrated that only 40 per cent of participants were appropriately aware that the law protects children from assault to a lesser extent than it protects adults. Forty-seven per cent of participants ($n = 26$) thought that children receive

greater legal protection from assault than they actually do. In addition, participants believed children to be more protected by the legislation than reality. Forty-nine per cent of participants ($n = 27$) did not know that abusive punishment and physical punishment are considered different in the eyes of child protection legislation, which implies that these participants think that the law considers all forms of physical punishment to be abusive and, therefore, illegal. While a substantial percentage of participants (31%) were incorrect in their response to this statement, reflecting a lack of knowledge about child protection legislation, the implication might be a higher rate of reporting and thus detection of abuse. The literature does suggest that physical punishment can lead to abusive punishment, especially when parents are under stress (Newson and Newson, 1989), and that the more often a parent hits, the harder the hits become (Cawson *et al.*, 2000). Almost all physical abuse of children is a result of physical punishment and the most serious injuries and even deaths can begin with actions that are intended to punish a child or to correct his/her behaviour (Gershoff, 2002). It may be, therefore, that if people consider physical and abusive punishment to be the same, that this acts to increase child protection activity.

Just over half of the participants (58%) knew that it is illegal to shake a child, regardless of the age. More worrying perhaps, is the proportion of those who responded incorrectly: almost 20 per cent thought the statement was true and therefore, that it is legal to shake a child if they are over three-years old. Similar concerns may be raised in response to the statement 'It is illegal for anyone other than a parent or someone with parental rights to hit a child'. Twenty per cent of participants thought that this statement was false and therefore, presumably believe that it is legal for someone other than a parent or someone with parental rights to hit a child. This again has implications for the responsibility of health care workers to accurately identify potentially abusive situations (Baginsky, 2003).

The final statement in relation to punishment being a necessary part of discipline received the greatest variance in responses with 40 per cent agreeing, 51 per cent disagreeing and 11 per cent selecting 'Don't know'. This uncertainty is also reflected in the literature. Some researchers (e.g. Howard, 1996) and professional organisations such as the British Psychological Society (BPS) (Rowland and Turner, 2003) argue that punishment can be used as part of a multifaceted approach towards discipline. It is, however, also argued that punishment should not be used as a means of discipline, even if it is supported by more positive disciplinary tactics (e.g. Donellan *et al.*, 1988). It appears that the difference of opinion in the literature is reflected in participants' response to this particular statement, however, on the basis of the BPS' position, the statement used in the questionnaire, 'Punishment is a necessary part of discipline', was considered a true statement. Some participants may have understood the statement in relation to the use of physical punishment rather than punishment generally and this misunderstanding may also have contributed to the varied responses.

Hypothesis one predicted that members of higher tier services would demonstrate a significantly greater knowledge of child protection legislation than lower tier services. Group one scored significantly higher on section one than group two, suggesting a better knowledge about child protection legislation. This was expected due to the more intensive, more regular training that those members of higher tier services are expected to undertake (Slater, 2005) and the more specialist nature of their work in child services.

No significant difference was found between the two groups in relation to knowledge of child discipline practices. There is no evidence that those in different tiers or specialisms have

received a different type of training in relation to child discipline practices as is shown in relation to child protection and this may explain the lack of significant findings. It could be argued that knowledge about child discipline practices is important across the board in child services, regardless of specialism or tier. The results indicate that health care workers demonstrated a reasonable level of knowledge in the area of child discipline practices (mean score was 7 out of 9), however, the range indicated that knowledge was variable (range 3–9). The implications of inconsistent knowledge about appropriate child discipline practices in health care workers working in children's services, regardless of specialism, is important, particularly if they provide advice on behaviour management to parents or carers. Providing consistent and appropriate advice to parents about positive parenting is seen to be important in addressing childhood disorders such as conduct disorder (Scott, 2008) and often forms the basis of parenting programmes (e.g. Webster-Stratton, 1994). The results from this study suggest that this advice may not always be based on sound knowledge and, therefore, there may be implications for the impact on actual practice.

The study also considered the impact of experience and area of work on knowledge. Unlike previous research, which has shown that experience can have a positive impact on knowledge and practice (Hastings *et al.*, 1995; Johnson and Cartwright, 1991; McKenzie *et al.*, 2004), this study failed to demonstrate any relationship between years of experience and knowledge. In relation to section one, the child protection legislation was only revised in 2003 and, therefore, the maximum experience of working with the new legislation is, in effect, three years. This may help explain the non-significant result for section one, however, there are less obvious explanations for the non-significant result for section two. Further research would be needed in order to ascertain if this was a consistent finding in this area.

Limitations

Due to a lack of pre-existing measures, a non-standardised questionnaire was developed for the purposes of the study, raising issues of validity and reliability. This was addressed to some extent by initial piloting of the questionnaire and ensuring that all items were drawn from policy documents, the research literature and good practice guidelines. Additional measures of reliability and validity would have contributed to the development of a more robust questionnaire. Consideration of confounding variables such as any previous training completed by the participants, for example, in the areas of child protection and positive parenting, would have been helpful in determining if other factors contributed to the findings of the study. Future research in this area may wish to consider differences in knowledge according to geographical area or NHS board, which was not done in the current study. Investigating the levels of knowledge demonstrated by individual professions within the tier system may also contribute to the current findings. Consideration of these areas would allow more comment to be made about the generalisability of the results. The use of non-parametric tests addressed the issue of a small sample size to some extent, however, the results need to be interpreted with some caution. The small sample size also makes generalising the results difficult, particularly for trusts outside NHS Scotland.

Conclusions

All staff working with children are now expected to take an active role in identifying and preventing child abuse, however, this study would suggest that the levels of health staff knowledge in relation to child protection legislation and child discipline practices vary considerably. This is despite all staff undertaking mandatory child protection training. In particular, there were some alarming findings in relation to what some participants believed

to be legal in regards to the physical punishment of children. This has serious implications for the accurate identification of abuse by health staff in their daily practice, as well as the advice they provide to parents about appropriate child discipline practices. Much more research is needed in this area to help identify which factors contribute to the differences identified in the health care workers' knowledge about child protection and discipline and to identify if their knowledge in these areas is directly related to their practice.

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