

# THE COSTS AND CONSEQUENCES OF CHILD MALTREATMENT

Literature review for the NSPCC

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# PREFACE

This literature review forms the first stage of a project by the National Institute of Economic and Social Research to estimate the long-term costs and consequences of the maltreatment of children. The main purpose of the review was to establish an evidence base for the estimation of costs. However, much of the work reviewed is of interest to a wider audience, and so is being published as it stands. A caveat is that most of the work on the review took place in 2009. Although there has been some updating, the literature which is drawn upon dates mainly from the mid-1990s to 2009. The second stage relies on data from the recent NSPCC study of the prevalence of child maltreatment in the UK (Radford, L. Corral, S. Bradley, C. Fisher, H. Bassett, C. & Howat, N. (2011) *Child abuse and neglect in the UK today* London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)), and will follow in the coming months.

Particular thanks go to the NSPCC for funding the study, and for the advisory group (Tim Loughton, MP, Professor Rod Morgan, Professor Jennifer Beecham, David Yelland and Professor David Berridge) who provided valuable input.

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## SUMMARY

This report is the first stage of a review of the costs and consequences of child maltreatment. It reviews a wide range of recent literature covering prevalence of different types of maltreatment of children and young people and the impact the maltreatment has on them. There is almost no literature covering costs, either in terms of the costs of the interventions or in terms of the costs of the consequences. Thus, the second stage of the review will combine the information from the literature review with other information about the impact on life chances of some of outcomes which are observed for children who have been maltreated. For example, maltreated children have poorer school performance than non-maltreated children. The effect of this poor performance is likely to be similar to the effect of poor performance among other groups of children who have not been maltreated. The lifetime consequences of maltreatment are not therefore confined to the outcomes of maltreatment as identified in the literature. Rather, they include the consequential impact on their adult lives as well. This consequential impact has costs for the children themselves, for their families, and for the wider society, both in terms of ongoing support costs, and in terms of the costs of the behavioural consequences for a small minority.

## THE PREVALENCE OF MALTREATMENT

A new NSPCC survey on child maltreatment and victimisation in the UK<sup>1</sup> found that 5.9 per cent of children under the age of 11 years and 18.6 per cent of young people between the ages of 11 to 17 years had reported experiences of severe abuse or neglect over their lifetimes<sup>2</sup>. Just over 1 per cent of under 11 year olds and almost 4 per cent of 11 to 17 year olds reported severe maltreatment from a parent or guardian and at least one act of abuse or neglect having happened in the last year. Over 25 per cent of all young adults have experienced severe abuse or neglect at some point in their childhood. In some cases this will have been a single incident, or will have been of short duration. However, for others it will have continued over many years. The outcomes of maltreatment do vary with duration – longer-term abuse or neglect is more damaging than short-term. However, the type of impact is similar for all forms of abuse or neglect.

For children who come to the attention of the authorities the most common form of maltreatment is neglect by a caregiver (accounting for around two-thirds of cases). Child protection authorities have traditionally taken a fragmented approach to children's safety and focused mostly upon abuse or neglect perpetrated by adult caregivers and family members. However, recent research on children's experiences of victimisation has shown that a substantial proportion of the inter-personal victimisation experiences of children and young people are perpetrated by other children and young people and those that experience victimisation by adult caregivers are also much more likely to experience the most frequent and most injurious abuse from other adults and also peers. Thus, it is important that we take into account the overlapping, inter-related and aggravating impact that different types of abuse and victimisation have upon the well being of children.

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1 Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. with Collishaw, S. (2011) *Child abuse and neglect in the UK today* London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)

2 Defined as severe physical violence, emotional abuse, and neglect where an adult or caregiver was the perpetrator and the victim was a young person below the age of 18 years and contact sexual abuse perpetrated by anyone including other young people.



The NSPCC survey of child victimisation found high levels of exposure to domestic violence, this being the most frequently reported adult perpetrated victimisation experience for all age groups (affecting 12 per cent of under 11s, 17.5 per cent of 11 to 17 year olds and 23.7 per cent of 18 to 24 year olds at some point in their childhoods). Neglect was the most frequently reported form of severe lifetime maltreatment by a parent or caregiver affecting 9.8 per cent of 11 to 17s, 9 per cent of 18 to 24s but fewer of those aged under 11 (3.7 per cent). Just over 39 per cent of parents with children aged under 11 and almost 46 per cent of parents with children aged between 11 and 17 said they had used physical punishment towards the child in the past year. The NSPCC survey asked participants to also report on physical violence from adults and caregivers that excluded 'smacking' by a parent. Just under 1 per cent of under 11s and 2.4 per cent of 11 to 17 year olds were reported to have experienced physical violence from a parent or guardian in the past year, while 0.8 per cent of under 11s, 3.7 per cent of 11 to 17 year olds and 5.4 per cent of young adults were reported to have experienced severe physical violence from a parent or guardian during their childhood.

Rates of sexual abuse from any perpetrator, adult or child, vary across age groups, with older children and adults tending to report more. Sexual abuse from any perpetrator was reported to have happened during childhood by 16.5 per cent of 11 to 17 year olds and 24.1 per cent of young adults. Caregivers reported much less sexual abuse happening to under 11s, affecting 1.2 per cent during childhood. Of course caregivers may not be aware of all the abuse under 11s experienced. It is clear that most sexual abuse perpetrators in the NSPCC survey were other young people below the age of 18 years. The rates of sexual abuse by adults were much lower with 2.6 per cent of 11 to 17 year olds and 8.2 per cent of young adults reporting childhood sexual abuse from an adult perpetrator. Caregivers reported just 1.2 per cent of under 11 year olds experiencing childhood sexual abuse. Girls are more likely to experience this form of abuse than boys.

## MALTREATMENT KNOWN TO CHILDREN'S SERVICES

The proportion of children on child protection registers is 31 per 10,000 children in England, 26 in Scotland, 40 per 10,000 in Wales and 57 in Northern Ireland. These rates are relatively low compared with those in other countries. In the United States 121 children per 10,000 were identified as having been maltreated in 2006, and in Australia 142 per 10,000 and in Canada 187 per 10,000.

## KNOWN MALTREATMENT RISK FACTORS

Maltreatment generally occurs when adverse circumstances in relation to the child, the family and the wider social and economic environment coincide. It has no single cause. There is an extensive literature on the social gradient in health, whereby the prevalence of wide range of conditions is lowest in the highest social class and highest among those with lower incomes. Maltreatment also follows the same pattern. This implies that it is as much a public health problem as heart disease, cancer and diabetes.

The risk of maltreatment is higher for a range of circumstances which are often associated with poverty and disadvantage. These include:

- children who are disabled, have health problems or behavioural problems
- those who have young parents
- those who live in large families
- poor parenting skills
- parental mental health problems
- parental substance use
- violence between adult family members
- parents who were themselves abused or neglected as children
- social isolation
- poverty

The evidence related to the risk of maltreatment by ethnic heritage is limited. Studies of parenting practices suggest that there are no significant differences in, for example, the use of physical punishment between different ethnic groups. However, children and young people of black and mixed heritages are over-represented in the child protection system, while children and young people of Asian heritage are under-represented. The over-representation of black and mixed heritage children may be accounted for by their over-representation in poverty rather than because they face an intrinsically higher risk.

## THE CONSEQUENCES OF MALTREATMENT

The longer maltreatment goes on the more adverse the outcomes. At one end, a single incident might be life threatening, but the impact of mild neglect over a period of years could also be substantial.

The pathways by which maltreatment affects children's lives are complex, and not fully understood. In essence the literature suggests that there are five main routes that have been established:

- Physical changes in the developing brain as a consequence of stress or trauma
- Difficulties in forming and maintaining relationships
- Mental health-related responses to stress and trauma, including depression, anxiety, post-traumatic stress disorder and behavioural disorders (and subsequent physical health responses to behaviours such as smoking which are more likely among those with mental health problems).
- The development of adult behaviour patterns based on those observed at home
- The disruption to education and social relationships caused by family disruption experienced as a consequence of maltreatment

Many of the other adverse outcomes observed, such as poor educational performance, offending, substance use or impaired physical health as an adult can be related back to these transmission routes.

Mental health problems are common in children and young people who have been maltreated. Problems include anxiety, depression, post-traumatic stress disorder and conduct disorders. Although these problems often follow maltreatment, they are also likely to reflect some of the other problems that

maltreating families experience, particularly parental mental health and substance use problems. These problems can persist into adulthood, particularly if they remain untreated.

Physical health problems sometimes arise directly from injuries received as a result of abuse. Neglect can also result in immediate physical health problems. However, the most important physical health consequences of maltreatment appear in adults who were maltreated as children. They are more likely to experience a range of physical health problems such as cancer, heart disease and diabetes and to die prematurely from them. To some extent this is likely to be because those who have been maltreated in childhood are more likely to engage in activities such as smoking and alcohol consumption or other risky behaviour which can give rise to physical health problems.

Children and young people who have been maltreated have poorer educational outcomes than other young people. This is likely to be due in part to the stress and mental health problems they have suffered from, but it also reflects the fact that they may have had to move school, which itself has adverse consequences for attainment, even for children who have not been maltreated. Children who have been maltreated are more likely to fall below the attainments of other children in their age group and are also more likely to be absent from school.

Children who have been maltreated can find it difficult to form personal relationships, both as a result of attachment problems and because some of them engage in behaviour which has its roots in their childhood maltreatment which others find difficult to deal with. In particular they are more likely than non-maltreated children to show aggression and violence, both as children and later as adults. Conversely, adults who have been maltreated as children are more likely to experience violent treatment from an intimate partner.

## INTERVENTIONS TO PREVENT MALTREATMENT

The fact that maltreatment has no single cause means that a wide variety of interventions can have the aim of addressing maltreatment, ranging from anti-poverty strategies to improving parents' social networks. Primary prevention interventions are directed at the whole population and have the aim of preventing all types of maltreatment. As well as services such as GPs, health visitors and education they include awareness campaigns and interventions aimed at reducing alcohol use. Secondary prevention interventions are those which are offered to populations that may have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns, and parental or child disabilities. These services aim both to address the risk factors for maltreatment (for example poor parenting skills) and to promote resilience in the face of risks, so that the risk factors do not themselves translate into maltreatment, or if they do, so that the damage caused by the maltreatment is minimised. However, those who receive targeted services are generally at *higher* risk than other families, but that is not the same as implying that they are *high* risk. Most families where there is a combination of risk factors do not maltreat their children. These services include

- Parenting education
- Home visiting programs that provide support and assistance to expecting and new mothers in their homes;

- Parent support that helps parents deal with their everyday stresses and meet the challenges and responsibilities of parenting;
- Family centres offering support, information and referral services
- Tertiary prevention interventions focus on families where maltreatment has already occurred and seek to reduce the negative consequences of the maltreatment and to prevent its recurrence. These interventions may include services such as:
  - Mental health services for children and families affected by maltreatment
  - Intensive social work support
  - Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes
  - Removing parental responsibility and taking children out of the home

Distinctions between primary, secondary, and tertiary prevention, while perhaps useful for some purposes, do not necessarily reflect the way prevention-related services are actually organized and provided on the ground. Rather than sorting prevention initiatives into mutually exclusive categories, prevention is increasingly recognized as a continuum. Moreover, not all interventions can be neatly classified into distinct categories. Many interventions cross the levels. For example parenting skills programmes are available as primary, secondary and tertiary interventions, and all three categories of parents might be present in a single group. The classification essential depends on the target group, and not always necessarily on the nature of the intervention itself. Moreover, some interventions can be viewed as crossing the tiers even with the same target group. Thus, for example, therapeutic interventions for maltreated children can be considered tertiary interventions (as maltreatment has already occurred) and also secondary interventions (aiming to reduce the likelihood that these children will go on to maltreat others).

Although there is a strong consensus among professionals, policymakers and parents that early intervention (that is both early in the life of the child, and early in the development of problems among families with older children) is both desirable and cost-effective there continues to be a paucity of research evidence as to which interventions are most effective in which circumstances.

The majority of interventions that have been described in the literature have not been formally evaluated. Many evaluations rely on parents' or professionals' opinions. Even so, most evaluations of most interventions do not reveal any impact on maltreatment rates (although they are often shown to improve parenting skills, improve family relationships, improve social support networks and boost parents' confidence, which are all valuable outcomes, and which are associated with lower risks of maltreatment). However, this does not necessarily mean that they do not work. A major challenge for evaluation is the fact that given that at a single point in time the proportion of children who are at risk of maltreatment is relatively small. This means that the sample numbers required to measure change in a statistically significant way are much larger than those seen in conventional research studies.

Another challenge is that most service use is voluntary, and the parents who tend to volunteer tend to be those who have low risks of maltreatment. Those who have higher risk profiles (for example drug users) are more likely to be wary of coming forward to use a service that might lead to their children being taken away. This pattern is common across parenting skills, sex abuse education and a wide range of services. Services cannot be effective unless they are used by those who would actually benefit from

them. They are unlikely to be used where the costs of use in terms of time, convenience and risk of provoking intervention are high.

The key universal service available to families with children is health visiting. Although this is associated with improved parenting skills and confidence, it has not been shown to have an effect on maltreatment rates, not least because families at the highest risk are more likely to receive a more intensive service, and this may lead to higher detection rates. The US Nurse Family Partnership programme of intensive home visiting by trained nurses has been shown to be effective in preventing child maltreatment, but only where recipients were disadvantaged white teenage mothers who had limited access to primary health care.

Parenting skills programmes delivered to both low risk and higher risk groups show:

- Reductions in harsh, negative, inconsistent and ineffective parenting and increases in supportive and positive parenting
- Reductions in ineffective commands by parents
- Improvements in parents' self-esteem
- Improvements in parent-child relationships
- Reductions in parental anger and blame of children

Other important secondary interventions are support from social workers, family centres and multi-component interventions such as children's centres. However, this is perhaps where resources are under greatest pressure as both social workers and family centres are under increasing pressure to focus their work on families where maltreatment has already taken place, while children's centres are increasingly focusing on delivering universal services such as day care.

The most effective tertiary interventions seem to be those based on cognitive behavioural therapy, for victims, abusers and non-maltreating parents. However, tertiary interventions tend to operate against a background of established behaviour patterns which can be hard to break. Moreover, the evidence suggests that children who have been the victims of maltreatment are not often offered therapeutic interventions of any kind.

## RESILIENCE

Although substantial numbers of maltreated children experience adverse outcomes, a large proportion appear to be functioning adequately. These children have been labelled as demonstrating resilience. Perhaps the most important message from the literature is that maltreatment does not *necessarily* result in adverse outcomes. Children's lives are not just determined by other people's actions. Rather, they can be active agents in determining their own life courses. The adaptation of individuals to adversity, including maltreatment, results from interactive processes among the resilience factors located within the child, family and community. Resilience can help to prevent maltreatment, by providing a more positive child, family or wider environment. But perhaps more importantly, where maltreatment has occurred, it can improve children's chances of positive adaptation in future.

The promotion of resilience involves a recognition that maltreatment may not be prevented (or may already have taken place). What therefore matters is not the elimination of childhood difficulties, but seeking to ensure that those difficulties that children do experience do not necessarily result in a lifetime of disadvantage. Where factors which are associated with a higher risk of maltreatment are present in families, it may be possible neutralise some of their impact by promoting opportunities, resources and strengths in parents, children and communities.

There are three broad groups of interventions that address these aims:

- Those that aim to reduce the incidence of risk factors such as low birth weight or teenage pregnancy
- Those that aim to improve the factors that mitigate the impact of adversity including better healthcare, education, employment
- Those that aim to strengthen family and community systems in order to support positive development, and positive relationships

Perhaps the most important message from resilience research is that resilience can be damaged (albeit inadvertently) by some interventions. For example, the evidence consistently suggests that one of the most important mechanisms by which children are helped to overcome adversity is the support of friends, family and other significant adults such as teachers. Where children do need to be removed from home for their own protection, their future wellbeing will be helped if they can nevertheless retain contact with people who are important to them, particularly teachers, grandparents and other supportive friends.

## TIMESCALES

The costs of maltreatment occur in the very long term, and are largely borne by those who have been maltreated, in terms of poor health and low earnings. However, the costs of interventions are incurred in the very short term. Taking a conventional approach to cost-effectiveness, where savings to the public purse are looked for over a relatively short timescale, it is unlikely that many interventions will pass conventional cost-effectiveness tests. But that does not mean that they represent poor value for money. Rather it indicates that the time horizon over which costs and benefits are considered needs to be decades rather than months, and it needs to be recognised that it is the victims of maltreatment who largely have to live with the consequences. The prevention of maltreatment needs to be viewed as an investment in the human capital of children, where the returns will come over a lifetime, not in the immediate future.

# INTRODUCTION

The National Institute of Economic and Social Research was commissioned by the NSPCC to undertake a study of the costs and consequences of child maltreatment in the UK.

Establishing the long-term costs to society as a whole, and to maltreated children and their families first of all needs to establish what are the outcomes and achievements of maltreated children and how these compare with what they would have been expected to achieve if they had not been maltreated. The first part of the study has therefore been a review of the relevant literature, and this is the report of that part. The search of the literature produced only a small number of studies that looked either at the costs of maltreatment to the victims and to the rest of society, or at the cost of interventions. It has therefore concentrated on the prevalence of maltreatment and the effectiveness of interventions. In the second stage of the study costs are attached both to the consequences of maltreatment and to the interventions that might prevent it.

There is no universally accepted definition of child maltreatment. One obvious reason for this is that to some extent the boundary between maltreatment and normal parenting behaviour is not fixed. What is acceptable in one country or one era can be regarded as maltreatment in another country or at another time.<sup>3</sup> In addition to this, studies and surveys are conducted for different purposes, and they tend to use a definition that suits the particular purpose. Child maltreatment has been defined by the World Health Organisation as:

*All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power*<sup>4</sup>

For the purposes of this study child maltreatment includes:

- Physical abuse: including hurting or injuring a child, inflicting pain, poisoning, drowning, or smothering.
- Sexual abuse: including direct or indirect sexual exploitation or corruption of children by involving them in inappropriate sexual activities.
- Emotional abuse: repeatedly rejecting children, humiliating them or denying their worth and rights as human beings, witnessing domestic violence
- Neglect: the persistent lack of appropriate care of children, including love, stimulation, safety, nourishment, warmth, education and medical attention.

The study has touched on bullying by other children, but the emphasis has been on the maltreatment of children by adults, as that is where the evidence of the long-term consequences has been best

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<sup>3</sup> Cawson, P., Wattam, C., Brooker, S. and Kelly, G. (2000) *Child Maltreatment in the United Kingdom: a Study of the Prevalence of Abuse and Neglect*. London: NSPCC; Quilgars, D. (2001) *Child Abuse in Bradshaw, J. (ed.) Poverty: The Outcomes for Children*. London: Family Policy Studies Centre.

<sup>4</sup> World Health Organisation (1999) *Report of the consultation on child abuse prevention, 29–31 March 1999*. Geneva, World Health Organization. (document WHO/HSC/PVI/99.1). <http://whqlibdoc.who.int/hq/1999/aaa00302.pdf>; Krug E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B. and Lozano, R. (eds) (2002) *World report on violence and health*. Geneva, World Health Organization. [http://whqlibdoc.who.int/publications/2002/9241545615\\_eng.pdf](http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf)

documented. This also means that there is almost no widely established research information on the consequences of unwanted sexual activity or violence within relationships between young people, which accounts for a large proportion of all reported sexual abuse.

A central problem of defining maltreatment is that normative boundaries are often difficult to draw. Even within a single country at a single point in time finding a universally accepted boundary between maltreatment and acceptable parenting can be challenging.<sup>5</sup> What is the point at which the kinds of accidents that occur in a 'normal' childhood translate into neglect? Variations in parenting practices around issues such as the use of physical punishment, or the age at which children should be left alone at home or allowed out unaccompanied, vary both over time, between different social classes, between different geographical areas and across ethnic groups or religious affiliation.

The review can broadly be divided into two parts. The first part covers the prevalence of maltreatment and the outcomes for maltreated children. The NSPCC's previous work (Cawson et al. 2000) and its recent study (Radford et al. 2011) have made important contributions to this.<sup>6</sup> The second part concentrates on services designed either to prevent maltreatment occurring, or to mitigate its consequences, and the evidence related to service effectiveness. This has not been a systematic review of the type covered by Campbell Collaboration guidelines. The standards of evidence and sample sizes used have varied, reflecting differing research traditions. The emphasis has been on studies that quantify outcomes that could be used in the calculation of costs and benefits in the second stage of the project.

Since many of these interventions have been evaluated in other countries, caution has to be interpreted in assuming that results from one context should automatically apply in another. There is also the issue that because something has not been systematically evaluated does not mean that it is not effective. Most obviously a 'programme' approach, with commissioned services being clearly defined lends itself better to experimental methods of evaluation. This in large part explains why systematic reviews of 'what works' tend to contain very few research studies conducted outside North America. In the UK the term 'knowledge-based practice' tends to be used alongside 'evidence based practice' as in the Social Care Institute for Excellence (SCIE) review of the 'types and quality of knowledge in social care'.<sup>7</sup> There are few UK- authored systematic reviews of interventions following child maltreatment and more examples of 'scoping reviews' or 'research syntheses'. These review the state of the knowledge and include longitudinal and smaller scale process research using qualitative methodologies alongside experimental or quasi-experimental design studies.<sup>8</sup>

The second part of the study calculates the economic costs and consequences of the outcomes for children, families, perpetrators and society generally which were identified during the literature review, and considers the costs and benefits of preventiv

The legislative and organisational system within which the concept of child maltreatment is identified and addressed has obvious and direct implications for the present study. This is because the policy

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5 Smith, M., Boddy, J., Hall, S., Morse, C., Pitt, C., Reid, M. (2004) *A Normative Study of Children's Injuries*. TCRU.

6 Cawson, P., Wattam, C., Brooker, S. and Kelly, G. (2000) *Child Maltreatment in the United Kingdom: a Study of the Prevalence of Abuse and Neglect*. London: NSPCC; Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. with Collishaw, S. (2011) *Child abuse and neglect in the UK today* London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)

7 Pawson, R., Boaz, A., Long, A., Grayson, L., Barnes, C. (2003) *Types and Quality of Social Care Knowledge*. Social Care Institute for Excellence).

8 See, for example, DH (1995) *Child Protection: Messages from Research*; Beecham, J. and Sinclair, I. (2007) *Costs and outcomes in children's social care: messages from research*. London: Jessica Kingsley; Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd.



agenda shapes the services and the skills used to deliver them. The current context has been shaped both by an on-going debate between competing theoretical and practitioner perspectives and by the findings of extensive empirical evaluation of the inputs and outputs of services for children and their families. For the previous government *Every Child Matters*<sup>9</sup> provided a specific policy framework for England and there were similar frameworks in place in Scotland, Wales and Northern Ireland. The purpose was to deliver systems, structures and services, which address the Children Act 1989 requirements to both safeguard and to promote the welfare of children.

In order to ensure better support to parents and carers, earlier intervention and effective protection, there has been a stress within the current policy agenda on better partnership working; more effective preventative strategies with less reliance on statutory intervention; and developing family support and early years service. These outputs are to be achieved through a programme of organisational change, including:

- The improvement and integration of universal services – in early years settings; schools and the health service;
- More specialised help to promote opportunity, prevent problems and act early, and effectively, if and when, problems arise;
- The reconfiguration of services around the child and family in one place, for example children's centres;
- The development of a shared sense of responsibility across agencies for safeguarding children and protecting them from harm;
- Listening to children, young people and their families when assessing and planning service provision, as well as in face-to-face delivery.<sup>10</sup>

If child maltreatment refers to acts of commission or omission by adults or other children both within and outside the family, then a further crucial aspect of the ability of services to address individual needs is the range of different styles of service use. Relevant services, which may reduce the prevalence or reduce the seriousness of the outcomes of child maltreatment, will include preventive, therapeutic and compensatory services.<sup>11</sup> As Garbers et al. (2006) argue, in addition to activity associated with the delivery of the services themselves, different styles of service use exert influence on the relative intensity and/resource implications of activity designed to facilitate the engagement of parents/carers with services. In particular, the families and young people who need the most active encouragement to engage with services may include those who have the most to gain from preventive services. But for these families and young people the costs of delivering preventive services has to take into account the relatively high costs of outreach and encouragement, not just the costs of the preventive services themselves.<sup>12</sup>

The underlying aim of the study is to develop a greater understanding both of the costs of child maltreatment and of the potential savings that might arise from a range of preventive interventions, both

9 DfES (2004) *Every Child Matters-Change for Children*. London. DfES.

10 DfES (2004) *Every Child Matters-Change for Children*. London. DfES.

11 Tanner, K. and Turney D. (2003) What do we know about child neglect? A critical review of the literature. *Child & Family Social Work*. Vol 8, issue 1: 25–34; MacDonald, G. (2002) Child Protection, in McNeish, D., Newman, T., Roberts, H., *What works for children? Effective Services for Children and their Families*. Buckingham: Open University Press; Munro, E. (2002) *Effective Child Protection*. London: Sage Publications.

12 Garbers, C., Allnock, D., Akhurst, S. and Tunstill, J. (2006) Facilitating Access to Services for Children & Families: Lessons from Sure Start Local Programmes. *Child & Family Social Work*, Vol 11, No 4: 287–296.

to inform the NSPCC in its own work, but also to provide additional information to those commissioning services about the nature of the resource and timing trade-offs that they face. It is also likely to be useful to those who are providing and designing services, because it should give them some indication of how to maximise the effectiveness of what they are doing within a given resource constraint.

It is more or less inevitable that the literature reviewed for this study is international, with much of it being from the United States and Canada. Part of the reason for this is that there is a tradition in the United States, and increasingly in Canada, of quantitatively evaluating the outcomes from preventive interventions. This does not mean that preventive interventions have not been independently scrutinised in Britain. They have, but within a different research tradition and with more limited research resources.<sup>13</sup> This has meant that longitudinal research (following the same children over time) or using control or comparison groups (where some do not get access to services in order to measure service effectiveness) has not been a feature of UK social policy research. For the purposes of estimating the costs and benefits of interventions versus no interventions we need indicators not only of *whether* an intervention makes a difference, but also *how much* of a difference it makes. This has meant we have drawn on quantitative evaluations from a range of settings,

While quantitative evaluations are useful for measuring quantified outcomes, they have the disadvantage that they do not explain either *what happened* to children and families or *why* outcomes might have differed. For this reason randomised controlled trials are often referred to as ‘black box’ evaluations. What happens inside the box can be unexplained and undocumented. For medical treatment this may not be a problem as the nature of the treatment is usually known and relatively straightforward (the administration of a particular drug or type of surgery). In the case of social interventions, where the relationship between the service provider and the recipient is often part of the process, not being able to see inside the black box and establish what makes an intervention work is a disadvantage when it comes to replication or dissemination of good practice.<sup>14</sup>

In addition to quantification, the second important reason for using international evidence is that there has recently been a growth in epidemiological information about the physical and mental health of adults who have had adverse events in their childhood, including having been maltreated thanks to large scale studies of members of a large health maintenance organisation in California.<sup>15</sup> While the relationship between child maltreatment and mental health problems is well established, the establishment of a relationship with poor physical health outcomes is new. Moreover, because the Adverse Childhood Experiences study includes both formerly maltreated and non-maltreated adults, it provides a basis for estimating the relative risk of mental and physical health problems among those who have been seriously maltreated compared with those who have not.

More generally, the review seeks to emphasise evidence related to the UK population, and drawn from UK studies, where it is available. International evidence needs to be treated with more caution, both in terms of life chances, and in terms of the outcomes achieved by services operating within a different institutional framework. This caution is particularly relevant in relation to health services, where the universal availability of primary care services via GPs and health visitors makes for a very different framework for comparison than does the United States with its very limited access to non-emergency health care for low income families.

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13 Quinton, D. (2004) *Supporting Parents: Messages from Research*. London. Department of Health; Katz, I. and Pinkerton, J. (eds) (2003) *Evaluating Family Support – Thinking Critically, Thinking Internationally* Chichester: Wiley.

14 Meadows, P. (2007) The methodologies for the evaluation of complex interventions: an ongoing debate. in Belsky, J., Barnes, J. and Melhuish, E. *The National Evaluation of Sure Start: Does area-based early intervention work?*. Bristol: Policy Press.; Pawson, R. and Tilley, N. (1997) *Realistic evaluation*. London: Sage.

15 <http://www.acestudy.org/>

# 1. PREVALENCE OF MALTREATMENT

There are a limited number of sources that give an indication of the extent of maltreatment in the United Kingdom. Information is limited on both annual incidence and lifetime prevalence rates; this distinction is important. Although only a relatively small proportion of children are identified as having experienced maltreatment in any particular year, retrospective studies of adults suggest that a much larger number (approximately 25–42 per cent)<sup>16</sup> have some experience of maltreatment at some stage of their childhood.

Across a range of countries general patterns of maltreatment show that physical abuse is more likely to be experienced by boys; sexual abuse predominately affects girls and is more likely to occur in early adolescence. Additionally, although the majority of sexual abuse takes place either as a result of unwanted sexual contact with another young person, or within the family, this type of maltreatment is more likely than others to involve an adult perpetrator who is not a family member. Bullying is more likely to involve boys than girls, both as victims and perpetrators. Emotional abuse is the least consistently defined category across studies. For example, a large amount of the literature from the US has a separate category for exposure to domestic violence, whereas it more commonly falls within emotional abuse in UK definitions.

There is also not always clear dividing line between emotional abuse and neglect. Australian data show markedly higher rates of emotional abuse and lower rates of neglect than do those in other countries, and this may reflect different definitions. Most importantly, it should be noted that children can often be victims of more than one type of maltreatment. In part this is recognised in the statistics of children in receipt of support from children's social services, but community samples and clinical samples of children and young people receiving treatment tend to show more overlap. For example, sexually abused children are often also physically abused, and many physically abused children are subject to neglect.

Evidence of this is shown in Dong et al's study, part of the Adverse Childhood Experiences Study in California.<sup>17</sup> The authors examined the likelihood of experiencing other forms of maltreatment in individuals who had and had not experienced childhood sexual abuse. Data were collected retrospectively from 17,337 adult health plan members. Of the sample 24.7 per cent (n=9,367) of women and 16.0 per cent of men (n=7,970) had experienced childhood sexual abuse. The results show that women who had experienced childhood sexual abuse, in comparison to women who had not been abused in childhood, were 3.4 times more likely to have experienced emotional abuse; 3 times more likely to have experienced physical abuse; 2.8 times more likely to have experienced emotional neglect, and 2.9 times more likely to have experienced physical neglect. For the men who had experienced childhood sexual abuse in comparison to those that had not, the odds ratios were: 2.5 times more likely to have experienced emotional abuse; twice as likely to have experienced physical abuse; twice as likely to have experienced emotional neglect, and 2.1 times more likely to have experienced physical neglect. Felitti et al. (2001),<sup>18</sup> also drawing on the Adverse Childhood Experiences study, provide evidence of the overlap of abuse

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16 Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C. and Howat, N. (2011) *Child abuse and neglect in the UK today* London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)

17 Dong, M., Anda, R.F., Dube, S.R., Giles, W.H., Felitti, V.J. (2003) The relationship of exposure to childhood sexual abuse to other forms of abuse, neglect, and household dysfunction during childhood. *Child Abuse & Neglect* 27: 625–639.

18 Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, S. (2001) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study in Franey, K., Geffner, R. and Falconer, R. (eds) *The Cost of Child Maltreatment: Who Pays? We all do*. Family Violence & Sexual Assault Institute.

types. In their sample, of the 898 individuals whose first category of abuse was psychological abuse 52 per cent had also experienced physical abuse and 47 per cent had experienced sexual abuse. Of those whose first category of abuse was physical abuse (n=874), 54 per cent had experienced psychological abuse and 44 per cent sexual abuse. Among individuals whose first category of abuse was sexual abuse (n=1,770), 24 per cent had experienced psychological abuse and 22 per cent had experienced physical abuse. Furthermore, it is more than likely neglect and emotional abuse are underlying factors in all other forms of abuse.

Administrative data such as UK data relating to children who have been identified by local authority children's services departments as being at risk of maltreatment, or in receipt of other children in need services, do not include children and young people who have not come to the attention of the authorities. They also exclude cases that fall below intervention thresholds, which include a significant number of neglect cases. Studies of the prevalence of maltreatment within the population of children and young people are methodologically and ethically difficult. Thus, prevalence studies until recently have generally been based on adults' recall of their childhood experiences.

One of the main sources of information is the NSPCC funded *National Survey of Child Safety and Victimization*,<sup>19</sup> published in 2011. This research updated on an earlier study by the NSPCC published in 2000 by increasing the sample of participants and by asking young people themselves about experiences of abuse. The new research involved random probability sampling of households to identify participants for a UK-wide study of children's experiences of victimisation. Interviews were collected from 6196 participant using CASI (computer assisted self interviewing), a method used widely to facilitate reporting in sensitive topics and victimisation surveys. Interviews were conducted with 2160 caregivers of children aged 0 to 10 years, 2275 children aged 11 to 17 years and 1761 young adults aged 18 to 24 years. The research explored young people's experiences of violence and maltreatment by adults and by peers. Caregivers were asked to report on their child's past year and lifetime experiences, young people between the ages of 11 to 17 years reported on their own experiences in the past year and during their lifetime and young adults were asked to report retrospectively on experiences they had before the age of 18 years. The study seeks to widen the knowledge of child maltreatment beyond official figures, which are limited to individuals that have come to the notice of child protection services. It also aims to establish a benchmark for the measurement of child abuse and neglect to enable future observation of trends in the UK and cross nationally.<sup>20</sup>

The NSPCC research was presented to respondents as a survey of children's safety and victimisation experiences. It was conducted shortly after the publicity arising from the murder of baby Peter Connolly and it is possible that public interest in the subject had an impact on participants' willingness to cooperate. The questionnaire was designed to gather information not just on the frequency and impact of victimisation experiences, using standardised measures, but also on the wide range of individual, family, relationship and community risks and protective factors that interact in complex and dynamic ways to affect the wellbeing of children. It is the largest and most comprehensive survey of children's experiences of violence, abuse and neglect ever done in the UK.

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19 Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C. and Howat, N. (2011) *Child abuse and neglect in the UK today* London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)

20 Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C. and Howat, N. (2011) *Child abuse and neglect in the UK today* London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)

A recent alternative source of information about the prevalence of maltreatment, research based on hospital attendances and admissions, has estimated that just over a million children experience physical abuse each year in Britain.<sup>21</sup> Around 379,000 are injured, of whom almost 70,000 require medical attention. Around 2,800 attend accident and emergency departments, with the remainder attending GP surgeries or other facilities. The majority of children attending accident and emergency departments receive outpatient treatment only, but a minority are admitted. While physical abuse injuries account for around 1 per cent of all A&E child attendances, it accounts for a higher proportion of hospital admissions following severe injury: 24 per cent of infants and 5 per cent of children aged 1–4 years severely injured children.<sup>22</sup>

The other main source of data in the United Kingdom has been the individual local authority child protection registers, however these data only cover abuse and neglect and not bullying and as stated previously only deal with children that have come to the notice of protective services.

In April 2008 a new recording system for identifying children in need of safeguarding was introduced (see below). Previously the child protection register was where the names of children at risk of maltreatment were recorded. The current process of placing children on the child protection register and other procedures in place to safeguard children is underpinned by the provisions Children Act 1989 and the Guidance and Regulations of the Act. The introduction of the Act marked a change of emphasis in family support away from only focussing on the risk of harm to a broader responsibility for both *safeguarding* and *promoting* the welfare of children, who have been identified as “children in need”.

Section 17 of the 1989 Children Act defines a child to be in need if:

- he/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority
- his/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- he/she is disabled

In fact efforts to refocus services and interventions in this more holistic way have so far been shown to have had limited impact.<sup>23</sup>

In addition to this, Section 47 of the Act asserts that a local authority has a duty to investigate if a child is suffering or likely to suffer significant harm. Harm is defined in Section 31(9) of the Act as ‘ill-treatment’ or ‘impairment of health or development.’<sup>24</sup> In January 2005 the definition of harm was amended to make clear that it included any impairment of health and development that occurred as a result witnessing ill

21 Woodman, J., Pitt, M., Wentz, R., Taylor, B., Hodes, D., Gilbert, R.E. (2008) Performance of screening tests for child physical abuse in accident and emergency departments. *Health Technology Assessment* 12.

22 Gilbert, R., Widom, C.S., Browne, K., Fergusson, D., Webb, E., Janson, S. (2009) Burden and consequences of child maltreatment in high-income countries. *The Lancet* 373(9657): 68–81.

23 Aldgate, J. and Tunstill, J. (1995) *Making Sense of Section 17: Implementing Services for Children in Need within the 1989 Children Act*. London: HMSO; Colton, M., Drury, C., Williams, M. (1995) *Children in Need: Family Support under the Children Act 1989*. Aldershot: Gower; Tunstill, J. and Aldgate, J. (2000) *Services for Children in Need: from policy to practice*. London: TSO).

24 Brandon, M., Thoburn, J., Lewis, A. and Way, A. (1999) *Safeguarding Children with the Children Act 1989*. London: The Stationery Office.

treatment of another individual.<sup>25</sup> Though the Act did not define 'significant', Section 31(10) specifies that in relation to health and development, whether the harm is significant should be assessed against what can be reasonably expected of the health and development of a similar child.

The Guidance (Vol. 1) gives the dictionary definition of 'considerable, noteworthy or important' and also states that the occurrence of ill-treatment:

*is sufficient proof of harm in itself and it is not necessary to show the impairment of health and development has followed, or is likely to follow* (Vol. 1, para. 3.19)<sup>26</sup>

In practice, these definitions give rise to varying interpretations by local authorities who are responsible for planning and delivering services to children in need. In an attempt to ensure local authorities did not limit their services to child protection cases, the Guidance and Regulations for the Act, Vol. 2<sup>27</sup> specified that the definition of need was purposefully kept broad in order to reinforce the emphasis on preventative support and services for the family. It went on to state that it would not be acceptable for an authority to exclude any of the three categories of need and limit services to children at risk of significant harm.

Also to be considered, are the overlaps between 'significant harm' and 'significant impairment', the thresholds for either court intervention or provision of services, which again allow differing interpretations as to whether services or court intervention are needed.<sup>28</sup> Furthermore, variations amongst the different policies and practices of different local authorities appears to explain, to some extent, differences in assessment rates of referred children across authorities.<sup>29</sup>

Official monitoring of children at continuing risk of harm has been through the child protection register and through child protection plans (CPP). The process whereby a child is added to the child protection register or becomes subject to a child protection plan is that once concerns regarding a child's welfare have been referred to a local authority, a four stage process of assessment, planning, intervention and reviewing are put into place; with initial, and if necessary, core assessments being carried out to determine whether the child is at continuing risk of harm and should be subject to a child protection plan. Since 1<sup>st</sup> April 2008, children at risk of harm are no longer added to a child protection register but are instead recorded in the Integrated Children's System (ICS) and subject to a child protection plan, The ICS builds upon existing practices such as the Looking After Children materials and the Assessment Framework.<sup>30</sup>

The most recent data on referrals, assessments and the number of children subject to a child protection plan for England show that in the year ending 31<sup>st</sup> March 2009, there were: 547,000 referrals, 349,000 initial assessments, 120,600 core assessments and 37,900 children had become subject to a child protection plan, of which 13 per cent of the latter had been previously registered.<sup>31</sup> The most recent

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25 Department for Education and Skills (2006) *Children Act 1989 Report 2004 and 2005*. London: DfES. <http://www.dfes.gov.uk/publications/childrenactreport/docs/EN0761B1ChildrenAct.pdf>

26 Brandon, M., Thoburn, J., Lewis, A. and Way, A. (1999) *Safeguarding Children with the Children Act 1989*. London: The Stationary Office.

27 Department of Health (1991) *The Children Act (1989) Guidance and Regulations. Volumes 2 – Family Support Day – Care Provision for Young Children*. HMSO, London.

28 Brandon, M., Thoburn, J., Lewis, A. and Way, A. (1999) *Safeguarding Children with the Children Act 1989*. London: The Stationary Office.

29 *Children Act 1989 Report 2004 and 2005*. London: Department for Education and Skills. <http://www.dfes.gov.uk/publications/childrenactreport/docs/EN0761B1ChildrenAct.pdf>

30 Department of Health (2007) Fact Sheet: *Integrated Children's System*. London: Department of Health.

31 Department for Children, Schools and Families (2009) *Referrals, Assessments and Children and Young People who are the Subject of a Child Protection Plan or are on Child Protection Registers, England – Year Ending 31 March 2009*. Statistical First Release SFR22/2009.

government estimate of the population aged under 18 in England is just over 11 million.<sup>32</sup> At any one time child protection plans cover approximately 3.1 out of every 1,000 children in England. The figures for Scotland are lower (2.6 per 1,000) while those for Wales (4.0 per 1,000) and Northern Ireland (5.7 per 1,000) are higher.

Most children are only the subject of child protection plans for a relatively short period of time (although some are referred for a second or subsequent time – 13 per cent of the total in the most recent period). As a rough approximation, if each child who is registered for the first time stays on the register for around a year,<sup>33</sup> around 5 per cent of children would have been on the register at some point in their lives by the time they reach the age of eighteen. This represents around one in every eight people who say as adults that they were maltreated as children.

Bullying is not covered by administrative statistics of child protection. The overall incidence of bullying has been difficult to identify. The House of Commons Education and Skills Committee when conducting their enquiry into bullying were told by a number of witnesses that schools did not always record incidences of bullying even if statutory requirements were in place. This may be due to a variety of reasons, such as young people's lack of willingness to report incidents and schools' concerns about their reputations.

Tables 1 and 2 below show the prevalence rates for maltreatment in the United Kingdom from community data and the most recent administrative data related to children at risk of maltreatment respectively.

Table 1 shows figures derived from community samples, notably the recent NSPCC survey. The sample for this study consisted of 6,196 respondents from the general population, of whom 2160 were caregivers of children aged 0 to 10 years, 2275 were children aged 11 to 17 years and 1761 were young adults aged 18 to 24 years at the time of the survey. Data have been weighted to take into account the different sample sizes for each age group surveyed and the proportions of each age group in relation to those that exist in the general UK population at the time.

Respondents were asked about childhood experiences of victimisation using validated questions from the Juvenile Victimization Questionnaire (JVQ) which covers a wide range of interpersonal victimisation including physical violence, neglect, sexual abuse, emotional abuse and witnessing violence by any perpetrator, as well as children's experiences of conventional crime.

Young people aged 11 to 17 years were asked to report on their own experiences during their lifetime and in the past year. Young adults were asked about experiences they had before the age of 18. Up to 39 screener questions on victimisation were asked of each age group. Follow up questions towards the end of the interview asked for more detail on victimisation experiences reported. Young adults were asked some questions that were exactly the same as those asked of young adults in a survey by the NSPCC ten years previously.<sup>34</sup> The findings from the young adults' responses to these questions on neglect are included in Table 1 below. The percentages here in Table 1 show the aggregates for broader types of victimisation based on the proportion of the sample within each of the age groups that had been assessed as falling within the specified category depending on their answers to a series of question. For example,

<sup>32</sup> Office for National Statistics *Mid-Year Population Estimates 2009* Table 4, published 24/06/2010.

<sup>33</sup> Completed durations of children leaving the register are published, and these are grouped into less than 3 months, 3–6 months, 6–12 months, 12–24 months, and more than 24 months. Taking the mid-point of the groups as the average duration for that group would yield an average duration of 10.6 months.

<sup>34</sup> Cawson, P., Wattam, C., Brooker, S. and Kelly, G. (2000) *Child Maltreatment in the United Kingdom: a Study of the Prevalence of Abuse and Neglect*. London: NSPCC.

under the severe physical violence section based on responses to nine questions about physical violence by an adult, in the sample covering 2160 under 11s, 1.2 per cent were assessed as falling into this category for lifetime experiences

The NSPCC study indicates that neglect is the most common maltreatment experiences for children and young people. The most commonly reported experience of victimisation from an adult was witnessing domestic violence.

For direct victimisation by an adult the most commonly reported abuse for under 18s was emotional abuse and being scared by an adult while young adults reported physical violence from an adult or caregiver the most frequent form of abuse.

**Table 1: The prevalence of maltreatment: Community samples (UK)**

Type of maltreatment	Study	Male	Female	All	Data source
<b>Neglect</b>					
<b>All United Kingdom</b>					
Experienced any neglect in childhood, caregiver reports child age 0 to 10 years	Radford, L. Corral, S. Bradley, C. Fisher, H. Bassett, C. & Howat, N. (2011) <i>Child abuse and neglect in the UK today</i> . London: NSPCC <a href="http://www.nspcc.org.uk/childstudy">www.nspcc.org.uk/childstudy</a>	4.9%	5.2%	5%	Survey (N=6196) 2160 caregivers of child aged 0–10 years 2275 youth aged 11 to 17 years 1761 adults aged 18 to 24 years
Experienced any neglect in childhood, child age 11 to 17 years		14.8%	11.8%	13.3%	
Experienced any neglect in childhood, young adult age 18 to 24 years		15.6%	16.4%	16%	
Experienced severe neglect in childhood caregiver reports child age 0 to 10 years		3.3%	4.2%	3.7%	
Experienced severe neglect in childhood youth report age 11 to 17 years		9.9%	9.8%	9.8%	
Experienced severe neglect in childhood, young adult age 18 to 24 years		7%	11%	9%	



Type of maltreatment	Study	Male	Female	All	Data source		
<b>Physical abuse</b>							
<b>All United Kingdom</b>							
Physically violent treatment by anyone in past 12 months, caregiver reports child age 0 to 10 years	Radford, L. Corral, S. Bradley, C. Fisher, H. Bassett, C. & Howat, N. (2011) <i>Child abuse and neglect in the UK today</i> . London: NSPCC www.nspcc.org.uk/childstudy	34%	29.5%	31.8	Survey (N=6196) 2160 caregivers of child aged 0–10 years 2275 youth aged 11 to 17 years 1761 adults aged 18 to 24 years		
Physically violent treatment by anyone in past 12 months youth report age 11 to 17 years		43.2%	28.5%	36%			
Physically violent treatment by anyone in childhood caregiver reports child age 0 to 10 years		40.9%	37.7%	39.3%			
Physically violent treatment by anyone in childhood youth report age 11 to 17 years		72%	58.7%	65.5%			
Physically violent treatment by anyone in childhood young adult age 18 to 24 years		72.7%	55.2%	64.1%			
Severe physical violence by any adult in childhood caregiver reports child age 0 to 10 years		1.3%	1.0%	1.2%			
Severe physical violence by any adult in childhood youth report age 11 to 17 years		6.7%	7.1%	6.9%			
Severe physical violence by any adult in childhood young adult age 18 to 24 years		10.2%	12.9%	11.5%			
Severe physical violence by parent or guardian in childhood, caregiver reports child age 0 to 10 years		0.9%	0.7%	0.8%			
Severe physical violence by parent or guardian in childhood youth report age 11 to 17 years		3.1%	4.4%	3.7%			
Severe physical violence by parent or guardian in childhood young adult age 18 to 24 years		4.0%	6.8%	5.4%			
Physical punishment by a parent or guardian in past year, caregiver reports child age 0 to 10 years			40.9%	37.7%		39.4%	
Physical punishment by a parent or guardian in past year, caregiver reports child age 11 to 17 years			48%	43.6%		45.9%	

Type of maltreatment	Study	Male	Female	All	Data source
<b>Sexual abuse</b>					
<b>All United Kingdom</b>					
All sexual abuse, contact & non contact, by anyone in past 12 months, caregiver reports child age 0 to 10 years	Radford, L. Corral, S. Bradley, C. Fisher, H. Bassett, C. & Howat, N. (2011) <i>Child abuse and neglect in the UK today</i> . London: NSPCC www.nspcc.org.uk/childstudy	0.7%	0.5%	0.6%	Survey (N=6196) 2160 caregivers of child aged 0–10 years 2275 youth aged 11 to 17 years 1761 adults aged 18 to 24 years
<b>All sexual abuse</b> , contact & non contact by anyone in past 12 months youth report age 11 to 17 years		6.8%	12.2%	9.4%	
<b>All sexual abuse, contact and non contact</b> , by anyone in childhood caregiver reports child age 0 to 10 years		1%	1.3%	1.2%	
<b>All sexual abuse</b> , contact and non contact, by anyone in childhood youth report age 11 to 17 years		12.5%	20.8%	16.5%	
<b>All sexual abuse</b> contact and non contact, by anyone in childhood young adult age 18 to 24 years		17.4%	31%	24.1%	
<b>Contact sexual abuse</b> in past 12 months caregiver reports child age 0 to 10 years		-0%	0.4%	0.2%	
<b>Contact sexual abuse</b> in past 12 months youth report age 11 to 17 years		1.2%	2.7%	1.9%	
<b>Contact sexual abuse</b> during childhood, caregiver reports child age 0 to 10 years		0.2%	0.8%	0.5%	
<b>Contact sexual abuse</b> during childhood youth report age 11 to 17 years		2.6%	7%	4.8%	
<b>Contact sexual abuse</b> during childhood young adult age 18 to 24 years		5.1%	17.8%	11.3%	

Type of maltreatment	Study	Male	Female	All	Data source
<b>Emotional abuse and witnessed domestic violence</b>					
<b>All United Kingdom</b>					
<b>Witnessed domestic violence</b> in past 12 months, caregiver reports child age 0 to 10 years	Radford, L. Corral, S. Bradley, C. Fisher, H. Bassett, C. & Howat, N. (2011) <i>Child abuse and neglect in the UK today</i> . London: NSPCC <a href="http://www.nspcc.org.uk/childstudy">www.nspcc.org.uk/childstudy</a>	3.8%	2.6%	3.2%	Survey (N=6196) 2160 caregivers of child aged 0–10 years 2275 youth aged 11 to 17 years 1761 adults aged 18 to 24 years
<b>Witnessed domestic violence</b> in past 12 months youth report age 11 to 17 years		2.1%	2.9%	2.5%	
<b>Witnessed domestic violence</b> in childhood caregiver reports child age 0 to 10 years		10.9%	13.1%	12%	
<b>Witnessed domestic violence</b> in childhood youth report age 11 to 17 years		16.4%	18.7%	17.5%	
<b>Witnessed domestic violence</b> in childhood young adult age 18 to 24 years		19.5%	28%	23.7%	
<b>Emotional abuse by non resident adult</b> in past 12 months, caregiver reports child age 0 to 10 years		1.1%	1.2%	1.2%	
<b>Emotional abuse by non resident adult</b> in past 12 months, youth report age 11 to 17 years		2.3%	1.6%	1.9%	
<b>Emotional abuse by non resident adult</b> in childhood caregiver reports child age 0 to 10 years		2.3%	1.8%	2.1%	
<b>Emotional abuse by non resident adult</b> in childhood youth report age 11 to 17 years		4.6%	3.9%	4.3%	
<b>Emotional abuse non resident adult</b> in childhood young adult age 18 to 24 years		6.2%	4.4%	5.3%	
<b>Emotional abuse by parent or guardian</b> in past 12 months, caregiver reports child age 0 to 10 years		1.7%	2.0%	1.8%	
<b>Emotional abuse by parent or guardian</b> in past 12 months, youth report age 11 to 17 years		2%	4%	3%	

Type of maltreatment	Study	Male	Female	All	Data source
<b>Emotional abuse and witnessed domestic violence</b>					
<b>All United Kingdom</b>					
<b>Emotional abuse parent or guardian</b> in childhood caregiver reports child age 0 to 10 years		3.7%	3.4%	3.6%	
<b>Emotional abuse by parent or guardian</b> in childhood youth report age 11 to 17 years		5.5%	8%	6.8%	
<b>Emotional abuse by parent or guardian</b> in childhood young Caregiver age 18 to 24 years		4.3%	9.6%	6.9%	
<b>Parents Arguing</b> in past 12 months, caregiver reports child age 0 to 10 years		2.4%	1.5%	2.0%	
<b>Parents Arguing</b> in past 12 months, youth report age 11 to 17 years		3.3%	5.6%	4.4%	
<b>Parents Arguing</b> in childhood caregiver reports child age 0 to 10 years		6.3%	6.0%	6.2%	
<b>Parents Arguing</b> in childhood youth report age 11 to 17 years		12.6%	16.4%	14.5%	
<b>Parents Arguing</b> in childhood young Caregiver age 18 to 24 years		14.5%	20.8%	17.6%	

Type of maltreatment	Study	Male	Female	All	Data source
<b>Bullying</b>					
<b>All United Kingdom</b>					
Peer victimisation, past year caregiver report under 11s	Radford, L. Corral, S. Bradley, C. Fisher, H. Bassett, C. & Howat, N. (2011) <i>Child abuse and neglect in the UK today</i> . London: NSPCC www.nspcc.org.uk/childstudy	23%	17.2%	20.2%	
Peer victimisation, past year 11–17 year olds		41.2%	29.1%	35.3%	
Peer victimisation lifetime caregiver report under 11s		30.5%	25.5%	28%	
Peer victimisation, lifetime 11–17 year olds		66%	52.7%	59.5%	
Peer victimisation In childhood 18 to 24year olds		69.6%	56.6%	63.2%	
<b>England</b>					
Been bullied a couple of times in the last four weeks	TellUs2 Questionnaire Summary Sheet, National <sup>35</sup>	—	—	17%	Survey (N=111,325)
Been about once a week in the last four weeks		—	—	4%	
Been bullied two or three times a week in the last four weeks		—	—	3%	
Been bullied most days in the last four weeks		—	—	5%	
<b>Great Britain</b>					
Severely bullied	Bullying in Britain: Testimonies from Teenagers <sup>36</sup>	12%	13%	—	Survey Girls (N=3,000) Boys (N=1,344)
Less severely bullied		42%	47%	—	
Bullied 'mildly' or 'never'		45%	40%	—	
Year 5 pupils who report having been bullied	Tackling Bullying: Listening to the views of children and young people <sup>37</sup>			51%	
Year 8 pupils who report having been bullied	Tackling Bullying: Listening to the views of children and young people <sup>38</sup>			28%	

35 Ofsted (2007) *TellUs2 Questionnaire Summary Sheet National*. Ofsted: London <http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Documents-by-type/Statistics/TellUs2-questionnaire-summary-sheet>

36 Katz, A., Buchanan, A., & Bream, V. (2001) *Bullying in Britain: Testimonies from Teenagers*. Young Voice: East Moseley, Surrey

37 Oliver, C. and Candappa, M. (2003) *Tackling Bullying: Listening to the views of children and young people*. Thomas Coram Research Unit: Institute of Education: London

38 Oliver, C. and Candappa, M. (2003) *Tackling Bullying: Listening to the views of children and young people*. Thomas Coram Research Unit: Institute of Education: London

Type of maltreatment	Study	Male	Female	All	Data source
<b>Bullying</b>					
<b>Great Britain</b>					
11 year olds bullied at school at least once in previous couple of months	Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: A national report from the 2001/2002 survey <sup>39</sup>	41.1	45.4		
13 year olds bullied at school at least once in previous couple of months		38.2	37.6		
15 year olds bullied at school at least once in previous couple of months		24.2	28.1		
11 year olds bullied at school at least twice in past couple of months	Inequalities in young people's health. HSBC international report from the 2005/2006 survey <sup>40</sup>	9	11		
13 year olds bullied at school at least twice in past couple of months		9	12		
15 year olds bullied at school at least twice in past couple of months		8	9		

<sup>39</sup> World Health Organization Europe (2004) *Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey*. WHO Europe: Copenhagen [http://www.euro.who.int/InformationSources/Publications/Catalogue/20040601\\_1](http://www.euro.who.int/InformationSources/Publications/Catalogue/20040601_1)

<sup>40</sup> World Health Organization Europe (2008) *Inequalities in young people's health. HSBC International Report from the 2005/2006 Survey*. WHO Europe: Copenhagen [http://www.euro.who.int/InformationSources/Publications/Catalogue/20080616\\_1](http://www.euro.who.int/InformationSources/Publications/Catalogue/20080616_1)

**Table 2: The prevalence of maltreatment: Administrative statistics (UK)**

Type of maltreatment	Study	per 10,000 (n)	Data source
<b>England</b>			
Neglect	Statistical First Release 22: Referrals, assessment and children and young people who are the subject of a child protection plan, England – Year ending 31 March 2009 <sup>41</sup>	14 (15,800)	CPR
Physical abuse	Statistical First Release 22: Referrals, assessment and children and young people who are the subject of a child protection plan, England – Year ending 31 March 2009	4 (4,400)	CPR
Sexual abuse	Statistical First Release 22: Referrals, assessment and children and young people who are the subject of a child protection plan, England – Year ending 31 March 2009	2 (2,000)	CPR
Emotional abuse	Statistical First Release 22: Referrals, assessment and children and young people who are the subject of a child protection plan, England – Year ending 31 March 2009	8 (9,100)	CPR
Number on CPR per 10,000 population for year ending 31/03/2009	Statistical First Release 22: Referrals, assessment and children and young people who are the subject of a child protection plan, England – Year ending 31 March 2009	31 (34,100)	CPR
Children in Need because of risk of abuse or neglect	Children In Need in England, including their characteristics and further information on children who were the subject of a child protection plan (2009–10 Children in Need census, Final) <sup>42</sup>	135 (148,300)	Census of Children In Need

<sup>41</sup> Department for Education (2009) *Referrals, Assessments and Children and Young People who are the Subject of a Child Protection Plan, England – Year Ending 31 March 2009*. Statistical First Release SFR22/2009

<sup>42</sup> Department for Education (2010) *Children In Need in England, including their characteristics and further information on children who were the subject of a child protection plan (2009–10 Children in Need census, Final)* OSR28/2010. <http://www.education.gov.uk/rsgateway/DB/STR/d000970/osr28-2010.pdf>

Type of maltreatment	Study	per 10,000 (n)	Data source
<b>Scotland</b>			
Physical neglect	Child Protection Statistics 2008/09 <sup>43</sup>	12 (1,249)	CPR as at 31 March 2009; ONS Population statistics, August 2009
Physical injury	Child Protection Statistics 2008/09	5 (554)	
Sexual abuse	Child Protection Statistics 2008/09	2 (190)	
Emotional abuse	Child Protection Statistics 2008/09	7 (678)	
Number on CPR per 10,000 <sup>44</sup>	Child Protection Statistics 2008/09	26 (2,682)	
<b>Wales</b>			
Neglect only	Number of children and young people on Child Protection Register by category of abuse 2008–09 <sup>45</sup>	17 (1120)	CPR for year ending 31/03/2009; ONS Population statistics, August 2009
Physical abuse only		6 (385)	
Sexual abuse only		3 (175)	
Emotional abuse only		10 (645)	
More than one type of abuse		3 (190)	
Number on CPR per 10,000		40 (2510)	
<b>Northern Ireland</b>			
Neglect only	Children Order Statistical Tables for Northern Ireland 2008–09 <sup>46</sup>	16 (706)	CPR as at 31 March 2009; ONS Population statistics, August 2009
Physical abuse only		14 (618)	
Sexual abuse only		6 (242)	
Emotional abuse only		7 (320)	
More than one type of abuse		9 (408)	
Number on CPR per 10,000		57 (2488)	

43 The Scottish Government Statistics (2009) *Child Protection Statistics 2008/09* Statistics Publication Notice: Health and Care Series. <http://www.scotland.gov.uk/Publications/2009/09/28115405/18>

44 Includes failure to thrive and unknown cause, where numbers are too small to publish individually

45 <http://www.statswales.wales.gov.uk/TableViewer/tableView.aspx> Table 024713

46 Department of Health, Social Services and Public Safety (2009) *Children Order Statistical Tables for Northern Ireland (2008/09)*. [http://www.dhsspsni.gov.uk/children\\_order\\_statistical\\_tables\\_for\\_northern\\_ireland\\_\\_2008\\_09\\_final.pdf](http://www.dhsspsni.gov.uk/children_order_statistical_tables_for_northern_ireland__2008_09_final.pdf)



The NSPCC data in the table above is presented to show victimization by any perpetrator, by adults and the overall proportion for each maltreatment type. Neglect was found to be the most prevalent type of maltreatment in the family for all age groups. Five per cent of under 11s, 13.3 per cent of 11–17s and 16 per cent of 18–24s had been neglected at some point in their childhoods. Neglect was measured with age appropriate questions about absence of physical care, educational neglect, poor supervision and monitoring and a caregiver being unresponsive to the child's emotional needs to such an extent that significant harm would be the likely result. Severe neglect was also measured on an age related basis and included questions about severe emotional neglect, lack of supervision or physical care.

In relation to physical violence it can be seen that high rates are reported for experiencing physical violence by any adult or peer. Almost two out of five (39.3 per cent) under 11s, 65.5 per cent of 11–17s and 64.1 per cent of 18–24s reported to have some childhood experience of physical violence. Looking only at severe physical violence by adults, (defined as that which results in hurt or injury, is frequent, involves use of a weapon likely to cause harm, an assault that would be more severe under the criminal law or which the victim defines as an act of violence or a crime,) the rates are lower although the reported frequencies increase with age: 1.2% of caregivers reported severe physical violence by an adult to a child under the age of 11 years, 6.9% of young people aged 11 to 17 years self reported having experiences of severe physical violence from an adult and 11.5% of young adults retrospectively reported this experience before the age of 18 years. Parents or guardians were responsible for approximately half of all the severe physical violence towards children perpetrated by adults.

With regards to sexual abuse, the NSPCC research identified prevalence rates for all sexual abuse (contact and non contact abuse) as well as the prevalence rates for contact sexual abuse. Most child sexual abuse is perpetrated by peers, ie young people under the age of 18 years. 1.2 per cent of the sample of under 11 year olds, 16.5 per cent of those aged 11 to 17 years and 24.1 per cent of young adults were reported to have experienced some form of childhood sexual abuse. Girls above the age of 11 reported rates that were almost double the rates reported by boys. Childhood sexual abuse involving contact, including rapes, was reported by 0.5% of under 11s, 4.8 per cent of 11–17s and 11.3 per cent of 18–24s.

Witnessing domestic violence was analysed separately to overall emotional maltreatment in this research and 12% of under 11 year olds, 17.5% of those aged 11 to 17 years and almost 24 per cent of young adults were reported to have been exposed to parental domestic violence during their childhood. Emotional maltreatment was measured both by questions that asked about whether or not the child had been threatened or scared by an adult or caregiver and by questions asking about the warmth and positivity of the child's relationship with the parent. Not surprisingly rates for emotional maltreatment by a parent or guardian were higher than rates of emotional maltreatment by other adults. Emotional abuse in childhood by a parent or guardian was reported for 3.6 per cent of under 11s, 6.8 per cent of 11–17s and 6.9 per cent of 18–24s whereas rates of emotional abuse from non resident adults were 2.1 per cent for under 11s, 4.3 per cent for 11–17s and 5.3 per cent for 18–24s..

The three studies that discuss bullying contain samples from the general population. The results from the two World Health Organisation reports consist of samples of approximately 1,500 respondents in each of the three age groups. The large difference in the percentages between the two years may be explained to some extent by the fact that the earlier study (2001/2002 survey) asks about bullying that takes place at least once in the previous couple of months, whereas the later one (2005/2006 survey) asks about the occurrence of at least two incidences of bullying in the previous couple of months.

Generally, the picture on bullying is more complex and research on bullying has tended to ignore sexualised violence and to concentrate mostly on physically or psychologically abusive behaviour, particularly linked to schools. Younger children are more likely to report having been physically bullied by another child than older children (although they may also interpret the question differently). The NSPCC research included peer sexual, physical and emotional abuse in school and in other locations whereas many bullying studies do not cover the full range of abusive behaviour and tend to focus only on peer abuse in schools. Victimization by children and peers accounted for the greatest proportion of violence reported in childhood by participants in the NSPCC survey, affecting 28% of under 11s, 59.5% of 11 to 17 year olds and 63.2% of 18 to 24 year olds. This is roughly the same as the proportion of primary school aged children who report having been bullied recently in other surveys. It is generally higher than the rates reported by teenagers (age 13 and above, or year 8 and above) which is between a quarter and a third. The TellUs2 figures are well below and the Bullying in Britain figures are well above the figures reported in the other surveys. Given that these anomalies are in both directions, it seems reasonable to believe that the figures from the other sources are probably representative. About half those who report bullying of any kind typically report repeat or persistent bullying.

Table 2 shows the administrative statistics for England, Scotland, Wales and Northern Ireland for children on the Child Protection Register in 2009. The proportions of children on the register because of each of the different categories of maltreatment have been converted into rates per 10,000 children under 18 using the ONS population estimates for 2009 published in June 2010.<sup>47</sup> The number of children per 10,000 on the Child Protection Register is 31 in England, 26 in Scotland, but 40 in Wales and 57 in Northern Ireland.

In all four countries neglect is the largest category (44 per cent of the total in England, 49 per cent in Scotland and Wales and 32 per cent in Northern Ireland). Physical abuse is the second largest category (15 per cent in England and Wales, 23 per cent in Scotland and 20 per cent in Northern Ireland). Sexual abuse accounts for 7 per cent of registrations in England and Wales, 9 per cent in Scotland and 12 per cent in Northern Ireland.

## INTERNATIONAL MALTREATMENT PREVALENCE RATES

International comparisons of prevalence are obviously affected by different legal frameworks and recording systems, so that statistics are not necessarily strictly comparable. Nevertheless, they provide a useful background.

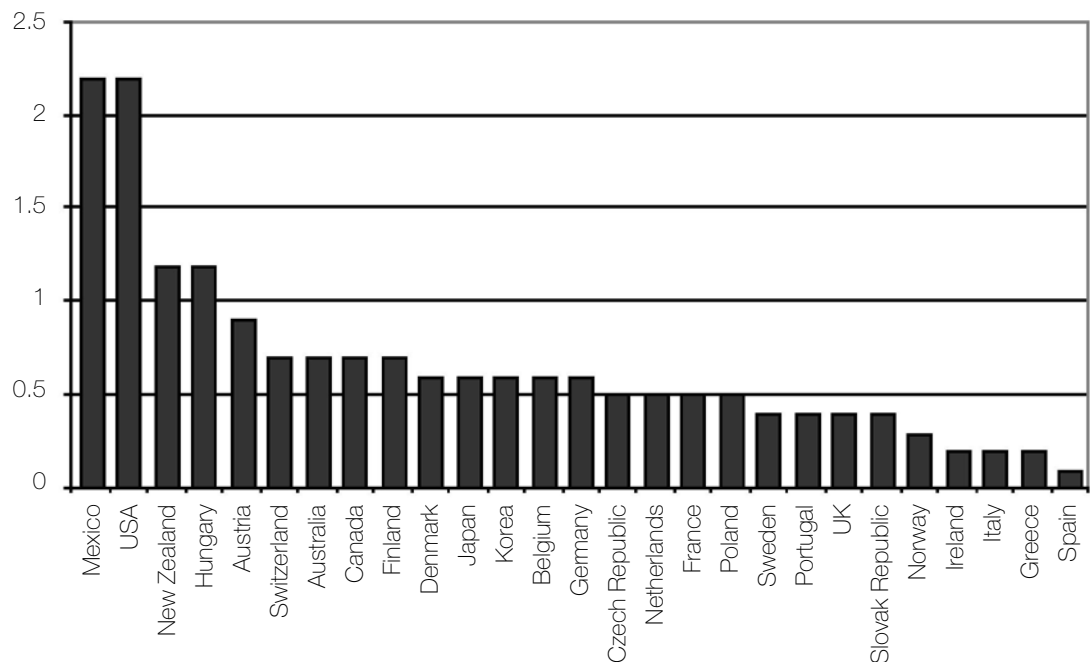
### Administrative statistics

In the United States the proportion of children who are identified as having been maltreated is more than three times the proportion in the UK. According to the most recent statistics, for 2006, 121 children per 10,000 had been maltreated. Neglect accounted for 64 per cent of cases, physical abuse for 16 per cent, sexual abuse for 9 per cent and psychological maltreatment for 7 per cent.<sup>48</sup>

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<sup>47</sup> Office for National Statistics *Mid-Year Population Estimates 2009* published 24/06/2010.

<sup>48</sup> US Department of Health and Human Services, Administration on children, Youth and Families *Child Maltreatment 2006*, Washington DC: US Government Printing Office. <http://www.acf.hhs.gov/programs/cb/pubs/cm06/cm06.pdf>

**Figure 1: Deaths from maltreatment per 100,000 children under fifteen**

Source: UNICEF (2003) *A League Table of Child Maltreatment Deaths in Rich Countries*. Innocenti Report Card Issue No 5 September 2003

In Australia the latest statistics suggest that substantiated maltreatment affects 142 children in every 10,000. This is more than four times the UK rate and is above the US rate. Unusually the most common category of identified maltreatment is emotional abuse (33 per cent of cases) rather than neglect (29 per cent). Physical abuse accounts for 27 per cent of cases and sexual abuse for 11 per cent.<sup>49</sup>

In Canada in 2003 the incidence of substantiated cases of maltreatment is even higher at 187 per 10,000 children. Neglect was the largest category with 34 per cent of cases, followed by physical abuse (23 per cent) and emotional abuse (14 per cent). Sexual abuse accounted for 3 per cent of cases.<sup>50</sup>

While these differences should not be taken at face value, because of differences in legal systems and definitions, nevertheless, statistics of deaths of children from maltreatment show a similar pattern. Figure 1 shows UNICEF statistics of deaths of children under fifteen as a result of maltreatment. The United States has 2.2 per 100,000 children, Canada and Australia have 0.7 and the UK has 0.4.

## Population samples

In the United States the Adverse Childhood Experiences Study has been collecting retrospective information from a sample of adult members of a large health maintenance organisation in California.

<sup>49</sup> Bromfield, L. and Holzer, P. (2008) *A National Approach for Child Protection Project report*. National Child Protection Clearinghouse, Australian Institute of Family Studies. <http://www.aifs.gov.au/institute/pubs/cdsmac/projectreport.pdf>

<sup>50</sup> The Canadian Incidence Study of Reported Child Abuse and Neglect 2003: Final Report, Institute of Education Sciences, Bureau of Justice Statistics. [http://www.phac-aspc.gc.ca/cm-vee/csca-ecve/pdf/childabuse\\_final\\_e.pdf](http://www.phac-aspc.gc.ca/cm-vee/csca-ecve/pdf/childabuse_final_e.pdf)

Table 3 shows the rates at which the sample report having been maltreated in their childhood. More than a quarter of both men and women report having experienced physical abuse. A quarter of women and 16 per cent of men report having been sexually abused and at least 15 per cent report having been neglected at some point during their childhood.

**Table 3: Reported rates of child maltreatment in adults in the Adverse Childhood Experiences (ACE) Study (USA)**

ACE Category	Women (N = 9,367)	Men (N = 7,970)	Total (N = 17,337)
<b>Abuse</b>			
Emotional Abuse	13.1%	7.6%	10.6%
Physical Abuse	27.0%	29.9%	28.3%
Sexual Abuse	24.7%	16.0%	20.7%
<b>Neglect</b>			
Emotional Neglect	16.7%	12.4%	14.8%
Physical Neglect	9.2%	10.7%	9.9%

Source: Middlebrooks JS, and Audage NC. (2008) *The Effects of Childhood Stress on Health Across the Lifespan*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

The prevalence rates for sexual abuse are almost identical to those reported by Finkelhor and colleagues in their national survey of American adults. They found that 27 per cent of women and 16 per cent of men reported having been sexually abused as children.<sup>51</sup> However, the definition of sexual abuse included single incidents of inappropriate behaviour such as indecent exposure as well as more serious or persistent abuse. While recognizing that such incidents can be upsetting for children, the impact on their long-term outcomes is likely to be limited, compared with the outcomes for children who have experienced multiple incidents over a longer period of time.

In Canada there has been one recent retrospective study of adults. The Mental Health Supplement to the Ontario Health Survey was a general population survey involving a random sample of almost 10 000 residents aged 15 years and older.<sup>52</sup> Using a self-administered questionnaire, 31 per cent of males and 21 per cent of females reported a history of child physical abuse. Sexual abuse rates were lower than those in the United States: 4 per cent of males and 13 per cent of females reported having been sexually abused as a child.

51 Finkelhor, D., Hotaling, D., Lewis, I.A. and Smith, C. (1990) Sexual abuse in a national survey of adult men and women: prevalence characteristics, and risk factors. *Child Abuse & Neglect*. 14(1): 19–28.

52 MacMillan, H.L., Fleming, J.E., Trocmé, N., Boyle, M.H., Wong, M., Racine, Y.A., et al. (1997) Prevalence of child physical and sexual abuse in the community: results from the Ontario Health Supplement. *Journal of the American Medical Association*. 278: 131–5.

## RISK FACTORS

Most child maltreatment takes place within the context of the family and the relationships within it. Parenting affects children's social, emotional, and cognitive development. The critical question is therefore: what are the factors that influence the way that parents behave towards their children.

Parenting takes place within the family unit, including the extended family (which might be complex where families are reconstituted). Parents' own histories and their own psychological well-being influences their child caregiving behaviour. So too does the child and his or own characteristics. But the family is not an isolated unit. It is part of the neighbourhood which in turn reflects and relates to the wider society. This wider society can be both a source of stress and a source of support for parents. Belsky (1984)<sup>53</sup> developed the ecological model of parenting behaviour originally put forward by Bronfenbrenner (1979).<sup>54</sup> Belsky stressed that the way parents look after their children is determined by the parents' own characteristics (their psychological functioning and developmental histories), the characteristics of the child, and the broader social context (the relationship between the parents, social support, and labour market and income). He also argued that the relationships are not simple and they influence each other. Thus the influence of parents' developmental histories is mediated by their personalities and psychological functioning. Parents' psychological functioning has both a direct effect on parenting as well as an indirect effect through its impact on the broader context in which parent-child relationships are embedded. The parents' economic and social context has both a direct effect on their parenting behaviour (for example, through the amount of time and level of resource they are able to give to their children) but it also has an indirect effect in that stresses in the work or social sphere can generate stress which adversely affects parents' psychological functioning, or alternatively social support can strengthen psychological functioning, which in turn mitigates the impact of adverse economic circumstances on parent-child relationships.

Thus, broadly speaking the child, the family, the neighbourhood and the wider society have three dimensions which are likely to influence the prevalence of child maltreatment: social and cultural norms and values, social and economic circumstances and relationships, and the support structures and institutions, both informal and formal, available to provide preventive and support services. The UK government has recognised the centrality of this ecological model with the introduction of the Assessment Framework, which requires those working with children to review their needs by looking at the child, the family and the wider environment.<sup>55</sup>

Maltreatment rarely has a single cause. Even where there is a particular trigger, it is the interrelationships between factors operating at different levels which influence whether maltreatment takes place or whether countervailing factors operate to prevent it. These factors differ between countries, between different areas in the same country, and between different groups within society. This means it is unlikely that the prevalence of child maltreatment would be the same across different countries unless they had similar social and economic structures and support systems. Moreover, it is unlikely that a single factor (such as service availability) would account for the differences observed between countries.

For example, parenting styles may vary due to social and cultural factors, adding to the complexity of defining maltreatment. Normative beliefs on physical punishment have been found to vary across

53 Belsky, J. (1984) The determinants of parenting: A process model. *Child Development*, 55, 83–96.

54 Bronfenbrenner, U. (1979) Child maltreatment: An ecological integration. *American Psychologist*, 35, 320–335.

55 Aldgate, J., Jones, D., Rose, W., Jefferey, C. (2006) *The Developing World of the Child*. London: Jessica Kingsley.

cultures; for example, studies have discussed the greater acceptance of corporal punishment in the USA in comparison to Sweden,<sup>56</sup> and the higher approval for the use of physical punishment across different ethnic groups within the same country.<sup>57</sup> Not only does this have implications for the use of physical punishment but it is also likely to result in different levels of reporting from ethnic groups that view certain behaviours as the norm.<sup>58</sup>

It is important to stress that even in families whose combination of circumstances suggests that they are at higher risk of maltreating their children, most children will not be maltreated. It is possible to identify factors that are associated with a higher risk of maltreatment. But these factors need not themselves be causal. They could merely be indicators of an association with an underlying cause. But even if they are causal, they are indicators of increased risk, not predictors. If on average 2 per cent of children are maltreated over a particular period of time (say a year) and a factor is associated with a doubling of the risk, this still means that 96 per cent of children where that risk is present will not be maltreated during that time period.

The literature on the factors associated with an increased risk of maltreatment is large. Meta-analysis of a wide range of studies has identified the issues that emerge consistently from this literature:

- children who are disabled, have health problems or behavioural problems
- early parenthood
- large families
- poor parenting skills
- parental mental health problems
- parental substance use
- violence between adult family members
- parents who were themselves abused or neglected as children
- social isolation
- poverty<sup>59</sup>

Children and young people of black or mixed heritage are over-represented in the child protection system, while children and young people of Asian origin are under-represented.<sup>60</sup> However, this may

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56 Deley, W.W. (1988) Physical punishment of children: Sweden and the USA. *Journal of Comparative Family Studies*, 19(3): 419–431 in Flynn, C.P. (1996) Normative support for corporal punishment: attitudes, correlates and implication. *Aggression and Violent Behavior*, 1(1): 47–55.

57 Ferrari, A.M. (2002) The impact of culture upon child rearing practices and definitions of maltreatment. *Child Abuse & Neglect*, 26: 793–813; Deater-Deckard, K., Dodge, K.A., Bates, J. and Pettit, G. (1996) Physical discipline among African American and European American mother: Links to children's externalizing behaviors. *Developmental Psychology*, 32: 1065–1075.

58 Ibanez, E.S., Borrego Jr, J., Pemberton, J.R. and Terao, S. (2006) *Child Abuse & Neglect*, 30: 1365–1379.

59 Black, D.A., Heyman, R.H. and Smith Slep, A.M. (2001) Risk factors for child physical abuse. *Aggression and Violent Behavior*. 6 (2–3): 121–188; Black, D.A., Smith Slep, A.M. and Heyman, R.H (2001) Risk factors for child psychological abuse. *Aggression and Violent Behavior*. 6 (2–3): 189–201; Schumacher, J.A., Smith Slep, A.M. and Heyman, R.E. (2001), Risk factors for child neglect, *Aggression and Violent Behavior* 6 (2–3): 231–254.

60 Owen, C. and Statham, J. (2009) *Disproportionality in Child Welfare: The Prevalence of Black and Minority Ethnic Children within the 'Looked After' and 'Children in Need' Populations and on Child Protection Registers in England*. DCSF Research Report RR-124; Barn, R. with Ladino, C. and Rogers, R. (2006) *Parenting in multi-racial Britain*. London: NCB; Thoburn T., Chand A., Procter J. (2005) *Child Welfare Services for Minority Ethnic Families: The Research Reviewed*. London: Jessica Kingsley.

not reflect differences in the risk of maltreatment associated with ethnicity *per se*. Families of black and mixed heritage origin are over-represented in poverty, and it may be the other disadvantages that explain their greater presence within the child protection system. Children of black African origin are more likely to be involved in child protection as a result of being left home alone, which is likely to reflect their families' difficulty in accessing affordable childcare.<sup>61</sup> The underlying issue is their economic circumstances. There is some evidence that physical punishment is no more common in minority ethnic families than it is in other families.<sup>62</sup> There is some evidence that children of Asian origin may be under-represented in the official child protection system because of a strong desire to protect family honour by keeping those from outside the family at arm's length.<sup>63</sup>

Many of these factors associated with increased risk of maltreatment are also associated with increased risk of a range of physical and mental health problems, and all are correlated with income. From this perspective, therefore, maltreatment is part of a wider public health problem, where an extensive literature has demonstrated that a range of conditions, many associated with premature death, follow a social gradient, with low incidence in higher income groups and higher incidence in lower income groups.<sup>64</sup> Between 1992 and 1995 deaths of children under the age of 15 in England and Wales in social class I as a result of intentional injury were 2.9 per million, whereas in social class V they were 27.7 per million, with the intermediate groups following a gradient between these two figures.<sup>65</sup>

One of the challenges to estimating the outcomes of maltreatment is the fact that neglect is often difficult to identify, and neglected children do not always come to the attention of the authorities, or where they do, do not always meet the threshold of need that gives them access to services (this issue is discussed more fully in Section 3 below). Because neglect is often not identified, less is known about the range of outcomes for neglected children. Although clinical samples often find that children and young people with problems have been neglected, it is not clear what proportion of all neglected children and young people this group represents.

A key consideration is the interaction between the severity of maltreatment occurrences and the most adverse outcomes of death and serious injury. Work on accidents has shown that strong similarities exist between incidents that were either not reported or were classified as near misses and those that resulted in death or serious injury. Research has identified that for every death or serious injury there are 400 near misses and around 130 less serious incidents. The circumstances around the one death or serious injury are replicated more than 500 times, most of which are unknown either to the authorities, or to management.<sup>66</sup> The different outcomes from similar circumstances were often random rather than being systematically related to the event. This finding has resulted in the conclusion that in order to prevent death and serious injury at work it is necessary to focus on the circumstances that give rise to the much wider range of essentially similar incidents. (The aviation industry has adopted a similar approach.<sup>67</sup>)

61 Bernard, C. and Gupta, A. (2008) Black African children and the child protection system', *British Journal of Social Work* 38 (3): 476–492.

62 Barn, R. with Ladino, C. and Rogers, R. (2006) *Parenting in multi-racial Britain*. London: NCB.

63 NSPCC (2007) Family 'honour' dilemma for British Asians reporting child abuse. Press release 23 March 2007. [http://www.nspcc.org.uk/whatwedo/mediacentre/pressreleases/2007\\_19\\_march\\_family\\_honour\\_dilemma\\_for\\_british\\_asians\\_reporting\\_child\\_abuse\\_wdn43191.html](http://www.nspcc.org.uk/whatwedo/mediacentre/pressreleases/2007_19_march_family_honour_dilemma_for_british_asians_reporting_child_abuse_wdn43191.html)

64 There is a useful review in Marmot MG. (2003) Understanding social inequalities in health. *Perspect Biol Med.* 46(3 Suppl):S9–23.

65 Roberts, I., Li, L., Barker, M. (1998) Trends in intentional injury deaths in children and teenagers (1980–1995) *J Public Health Med.* 20(4): 463–6.

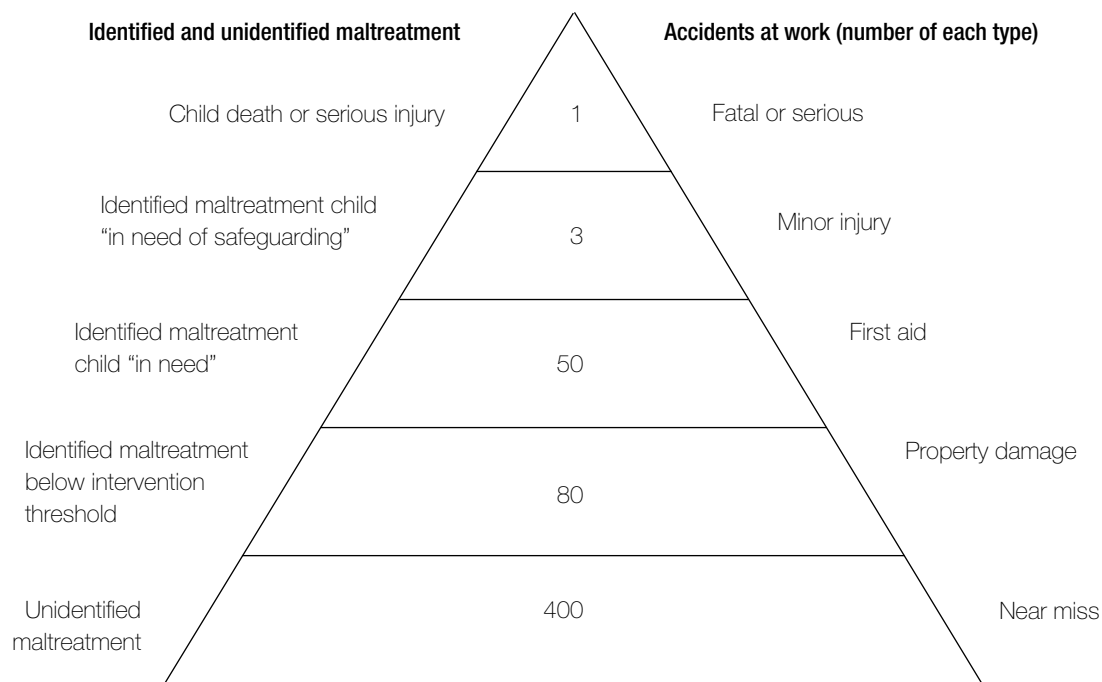
66 Tye, J. (1976) *Accident ratio studies 1974–1975*. British Safety Council.

67 Barach, P. and, Small, S.P. (2000) Reporting and preventing medical mishaps: lessons from non-medical near miss reporting systems. *British Medical Journal* 320: 759–63.

Drawing on this analogy, it may be concluded that to prevent the adverse outcomes associated with the most severe forms of child maltreatment (particularly deaths and serious injuries) it is necessary to identify the wider pool of neglected children from which cases of more severe maltreatment are drawn. This is because the identification of children at the highest risk within the wider population is very difficult, but identification of those with elevated risks due to their circumstances may be easier. However, though physical abuse imparts injury or death there is no doubt that the pervasive nature of chronic neglect and emotional abuse are also immensely destructive

Figure 2 below extends the Tye/Pearson accident triangle to child maltreatment, showing events relevant to maltreatment on the left-hand side of the diagram.

**Figure 2: Identified and unidentified maltreatment**



The prevalence of abuse cannot be discussed without considering the likelihood that experiencing childhood abuse will result in the individual becoming a future perpetrator. This is a commonly held belief, particularly in relation to sexual abuse experienced in childhood. This however, is not true for the majority of victims, and only a significant minority of individuals who sexually abuse children have experienced physical or sexual abuse in their younger years.<sup>68</sup> Dixon et al's (2005)<sup>69</sup> study followed a sample of 4,351 babies up to the age of 13 months over a three year period. Of the children whose parents had been maltreated in childhood, 6.7 per cent had been abused by the age of 13 months, in comparison to 0.4 per cent of children whose parents had not been maltreated. The higher rate of abuse seen among

<sup>68</sup> Jones, D.P.H. (2002) Situations affecting child mental health, in Rutter, M. and Taylor, E. (eds), *Child and Adolescent Psychiatry*. Oxford: Blackwell Science.

<sup>69</sup> Dixon, L., Browne, K. and Hamilton-Giachritsis, C. (2005) Risk Factors of parents abused as children: a mediational analysis of the intergenerational continuity of child maltreatment (Part 1) *Journal of Child Psychology and Psychiatry* 46(1): 47-57.



the children of previously maltreated parents does partially seem to come about through a direct effect. However, it mainly occurs through the fact that maltreatment as a child leads to a higher prevalence of some key risk factors associated with the maltreatment of children. These being: becoming a parent under the age of 21, having a history of mental illness or depression and living with a violent adult. Of these, becoming a parent before the age of 21 accounts for most of the effect.

Renner and Shook Slack (2006)<sup>70</sup> studied a sample of 1,005 high risk group women to examine the relationship between childhood maltreatment and intimate partner violence within and across childhood and adulthood. Their results showed only weak support for the hypothesis that maltreated children are more likely to grow up to maltreat their children. Multinomial analysis showed that several forms of maltreatment are linked with the occurrence of intimate partner violence in adulthood, and with maltreatment of one's own children in adulthood for participants who had also experienced adult intimate partner violence. These results highlight the importance of considering the role of victimisation in adulthood in the intergenerational transmission of maltreatment.

Therefore though it cannot be denied that the excessively negative experiences of maltreatment in childhood result in deleterious outcomes, they are not necessarily a direct pathway to maltreatment of one's own children. There appears to be evidence that when intergenerational maltreatment does occur it appears to be due to poor skills and behaviours developed in part due to maltreatment in childhood.

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<sup>70</sup> Renner, L.M. and Shook Slack, K. (2006) Intimate partner violence and child maltreatment: Understanding intra- and intergenerational connections. *Child Abuse & Neglect* 30: 599–617.

## 2. THE CONSEQUENCES OF MALTREATMENT

Maltreatment can have an adverse impact on children which persists throughout their lives, although not all children experience adverse outcomes, and those who do experience them to different degrees.

The pathways by which maltreatment affects children's lives are complex, and not fully understood. In essence the literature<sup>71</sup> suggests that there are five main routes that have been established:

- Physical changes in the developing brain as a consequence of stress or trauma (a particular issue with very young children)
- Difficulties in forming and maintaining relationships (more common in the case of sexual abuse)
- Mental health-related responses to stress and trauma, including depression, anxiety, post-traumatic stress disorder and behavioural disorders (and subsequent physical health responses to behaviours such as smoking which are more likely among those with mental health problems).
- The development of adult behaviour patterns based on those observed at home, including domestic violence and sexual abuse
- The disruption to education and social relationships caused by family disruption experienced as a consequence of maltreatment (both when children go into care, and when the family move home or an abusive parent moves out of the family home)

Many of the other adverse outcomes observed, such as poor educational performance, offending, substance use or impaired physical health as an adult can be related back to these transmission routes.

Exposure to stress, in the pre-natal and perinatal period, as well as in early childhood, impacts greatly on an individual's cognitive, behavioural and physical development, and thereby influences future outcomes and lifetime trajectories.

Development of the brain's architecture is a cumulative process, where initial basic structures are the foundation for higher functions. This development is shaped by the interrelation between genetics, environment and experience; with the impact of environment and experience directing how genetic inclinations are expressed. Just as a healthy pre-natal environment enables the achievement of full genetic potential, an adverse one may actually alter the genetic plan for the brain which may result in neural circuits function inadequately even in a later healthy environment. Experience refers to the interaction of a child with his or her environment. This begins prior to birth for humans, as the basic architecture of low-level circuits mature at this stage. Experiences following birth play an ever more important role in shaping brain architecture, with healthy and stimulating experiences leading to the achievement of full genetic potential, and persistent deprivation contributing to impaired capabilities. Though the brain has the capacity to adapt throughout life, this ability decreases with age; and the process of developing more advanced skills on a weaker underlying foundation are more problematic and less effective than if building on a proficient underlying structure.<sup>72</sup>

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<sup>71</sup> Kendall-Tackett, K. (2002) The health effects of childhood abuse: four pathways by which abuse can influence health, *Child Abuse & Neglect* 26: 715–729.

<sup>72</sup> National Scientific Council on the Developing Child (2007a) *The Timing and Quality of Early Experiences Combine to Shape Brain Architecture*: Working Paper 5 [http://www.developingchild.net/pubs/wp/Timing\\_Quality\\_Early\\_Experiences.pdf](http://www.developingchild.net/pubs/wp/Timing_Quality_Early_Experiences.pdf)

As stated above, brain architecture and the process of developing skills start from an initial base that provides the support for more advanced circuits and capabilities. In this way, emotional well-being and social competence present a sturdy foundation for nascent cognitive abilities. For example, the cognitive skills developed in language acquisition require the ability to interact socially and to pay attention. Therefore damage to brain architecture, particularly at specific early stages, can lead to far reaching problems in learning, behaviour, and physical and mental health.<sup>73</sup>

One key promoting or damaging factor to development is the presence of stress. Whether the stress is beneficial or detrimental is dependent on its duration and intensity, individual variations in the child's responses to stress, and the degree to which the child receives backing from a supportive adult. Different types of stress lead to differing outcomes. Positive stress includes a range of normal early childhood experiences such as meeting new people, dealing with frustration and coping with discipline. This exposure is a normal part of healthy development and takes place within the context of a supportive relationship, with this relationship being central in helping to reduce cortisol and other stress hormones to a standard level.

A second type of stress, tolerable stress, could lead to disruption of the brain architecture but is mitigated by a supportive relationship that helps the restoration of normal stress levels. Examples of these stressors include death or serious injury of a loved one, a frightening injury or parental divorce. These experiences could have long-term adverse consequences but the brain has the possibility to recover from these situations if they occur for a limited period of time and within a supportive environment.

The third kind of stress, toxic stress, is characterised by severe prolonged activation of the body's stress management systems and crucially, lack of a consistent, supportive, adult relationship that provides protection and facilitates the decrease of stress levels to baseline. Examples of toxic stress include repeated abuse and neglect, persistent substance abuse by parents or the exposure to violence in the family or the community. These conditions bring about continuously high levels of stress hormones and alterations in the levels of central brain chemical resulting in a disturbance to the development of the brain's architecture, which in turn may bring about difficulties in memory, learning and self-regulation. Furthermore, ongoing stimulation of the stress response system may also affect the immune system and other metabolic regulatory mechanisms and result in the permanent lowering of the limits required for activation during an individual's lifetime. Therefore toxic stress in childhood, as well having the potential to inhibit cognitive, behavioural and social functioning can also in the long run impact on stress related physical illnesses, such as hypertension and cardio-vascular disease; and contribute to mental ill health, such as depression and anxiety disorder. In addition, there is a greater likelihood that children who have experienced toxic stress will demonstrate health damaging behaviours and lifestyles.<sup>74</sup>

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<sup>73</sup> National Scientific Council on the Developing Child (2007b) *The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do*. [http://www.developingchild.net/pubs/persp/pdf/Science\\_Early\\_Childhood\\_Development.pdf](http://www.developingchild.net/pubs/persp/pdf/Science_Early_Childhood_Development.pdf)

<sup>74</sup> National Scientific Council on the Developing Child (2007b) *The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do*. [http://www.developingchild.net/pubs/persp/pdf/Science\\_Early\\_Childhood\\_Development.pdf](http://www.developingchild.net/pubs/persp/pdf/Science_Early_Childhood_Development.pdf)

A significant body of extant literature and research provides supporting evidence for the negative consequences of stress and future adaptation.<sup>75</sup> McEwen (2007)<sup>76</sup> outlines how stress and stress hormones produce adaptive and maladaptive consequences on specific regions of the brain in the course of an individual's life. He also states that events that occur early in the life course can influence enduring patterns of emotionality and stress responsiveness and alter the rate of brain and body aging. Teicher et al. (2002)<sup>77</sup> state that extreme early stress and maltreatment bring about a series of events that could potentially alter brain development. Resulting alterations then provide a neurobiological framework whereby early abuse increases the risk of developing negative outcomes such as depression, post-traumatic stress disorder and substance abuse. Felitti et al.,<sup>78</sup> using data from approximately 8,000 people, examine the long-term relationship of deleterious exposures in childhood to health outcomes, and found an association not only with risky health behaviours but also certain disease conditions.

The importance of supportive relationships, as mentioned above, has also been observed in other studies. For example, Higgins and McCabe (2003)<sup>79</sup> state that the family environment, in terms of adaptability and quality of relationships, is a valuable contributor to later adjustment, with the effects of poor relationships, insecurity and fragmentation adding negatively to adult adjustment. Similarly, Kim and Cicchetti (2004)<sup>80</sup> found in their study of mother-child relationship quality and maladjustment, that regardless of a child's maltreatment status, children who had 'secure' relationships with their mothers showed higher levels of self-esteem than those with 'insecure' relationship quality. As self-esteem was found to be related to later child adjustment, by implication the relationship aided the child's adjustment.

The following section catalogues the various adverse outcomes that have been found in relation to maltreatment. It also attempts to ascertain how outcomes differ according to characteristics such as gender or cultural background. It should be noted that strong similarities exist between the outcomes of different forms of maltreatment, which is likely to reflect the fact that many forms of maltreatment can generate toxic stress. It is thus not the particular form of maltreatment that is important in generating the outcome as much as the stress the maltreatment places on the child. Negative outcomes have been found in a wide range of important areas, such as education, mental and physical health and interpersonal relationships.

For the most part, the research outlined below describes outcomes observed in childhood and early adulthood, however the long-term sequelae of maltreatment should not be overlooked, and studies discussing the lifelong consequences of maltreatment, have also been detailed.

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75 Heim, C. and Nemeroff, C. (2001) The role of childhood trauma in the neurobiology of mood and anxiety disorders: Preclinical and clinical trials. *Biological Psychiatry* 49(12): 1023–1039; Teicher, M.H., Andersen, S.L., Polcari, A., Anderson, C.M., Navalta, C.P. and Kim, D.M. (2003) The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience and Biobehavioral Reviews* 27(1–2): 33–44; Grassi-Oliveira, R., Ashy, M. and Stein, L.M. (2008) Psychobiology of childhood maltreatment: effects of allostatic load? *Revista Brasileira de Psiquiatria* 30 (1): 60–68; Watts-English, T., Fortson, B.L., Gibler, N., Hooper, S.R. and De Bellis, M.D. (2006) The psychobiology of maltreatment in childhood. *Journal of Social Issues* 62(4): 717–736; Gunnar, M. and Quevedo, K. (2007) *Annual Review of Psychology* 58: 145–173.

76 McEwen, B.S. (2007) Physiology and neurobiology of stress and adaptation: Central role of the brain. *Physiological Reviews* 87(3): 873–904.

77 Teicher, M.H., Andersen, S.L., Polcare, A., Andersen, C.M. and Navalta, C.P. (2007) Developmental neurobiology of childhood stress and trauma *Psychiatric Clinics of North America* 25(2).

78 Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, S. (2001) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study in Franey, K., Geffner, R. and Falconer, R. (eds) *The Cost of Child Maltreatment: Who Pays? We all do*. Family Violence & Sexual Assault Institute.

79 Higgins, D.J. and McCabe, M.P. (2003) Maltreatment and Family Dysfunction in Childhood and the Subsequent Adjustment in Children and Adults. *Journal of Family Violence* 18(2): 107–120.

80 Kim, J. and Cicchetti, D. (2004) A longitudinal Study of Child Maltreatment, Mother-Child Relationship Quality and Maladjustment: The Role of Self-Esteem and Social Competence. *Journal of Abnormal Child Psychology* 32(4): 341–354.

## HEALTH OUTCOMES

Negative outcomes associated with maltreatment are not confined to those linked with school performance; health outcomes, interpersonal relationships and delinquency have all also been linked with maltreatment. As would be expected both health and social/personal relationships cover a range of issues. For example, health outcomes include mental health, physical health, and health behaviours. Further details are outlined below.

### Mental Ill Health

Mental ill health is relatively common among children who have been maltreated. However, the majority of studies of children with mental health problems are based on clinical populations. Within these populations, particularly those with serious mental health problems, a history of maltreatment is relatively common. However, studies of clinical populations do not reveal the probability that maltreated children will experience mental health problems, compared with the probability of children who have not been maltreated.

Self-reported anxiety and depression has also been associated with being bullied,<sup>81</sup> as have other mental health state such as high neuroticism and suicide ideation.<sup>82</sup>

Mental health problems following childhood maltreatment are not limited to childhood; research has shown that repeat and re-victimisation has been strongly associated to depression in adulthood and maltreatment scales produced from victims' retrospective reports have predicted later reports of trauma symptoms.<sup>83</sup> The Adverse Childhood Experiences Study found that while 17 per cent of adults who had not been maltreated as children had a history of depression, 40 per cent of those who had experienced four or more adverse childhood experiences did.<sup>84</sup> A New Zealand study also found that adult depression was twice as likely among people who had been maltreated as children.<sup>85</sup> The Adverse Childhood Experiences study also found that while 1.1 per cent of adults who had not been maltreated had attempted suicide, 13.4 per cent of those who had experienced four or more incidents of maltreatment had done so.<sup>86</sup> Moreover, this does not take into account the fact that some people will be absent from the sample because they have already committed suicide. A British study of suicidal behaviour found that while only 4 per cent of the population as a whole had ever attempted suicide, 22 per cent of those who had experienced violence in the home during childhood and 26 per cent of those who had been sexually abused had attempted suicide.<sup>87</sup>

81 Bond, L., Carlin, J.B., Thomas, L., Rubin, K. and Patton, G. (2001) Does bullying cause emotional problems? A prospective study of young teenagers. *British Medical Journal*. 323: 480–484.

82 Mynard, H. and Joseph, S. (1997) Bully/victim problems and their association with Eysenck's personality dimensions in 8 to 13 year-olds. *British Journal of Educational Psychology* 67: 51–54.

83 Higgins, D.J. and McCabe, M.P. (2003) Maltreatment and Family Dysfunction in Childhood and the Subsequent Adjustment in Children and Adults. *Journal of Family Violence* 18(2): 107–120.

84 Chapman, D.P., Anda, R.F., Felitti, V.J., Dube, S.R., Edwards, V.J., Whitfield, C.L. (2004) Epidemiology of Adverse Childhood Experiences and Depressive Disorders In a Large Health Maintenance Organization Population. *Journal of Affective Disorders*, 82: 217–225.

85 Danese, A., Moffitt, T.E., Harrington, H.L., Milne, B.J., Polanczyk, G., Pariante, C., Poulton, R., Caspi, A. (2009) Adverse Childhood Experiences and Adult Risk Factors for Age-Related Disease. *Arch Pediatr Adolesc Med*. 163[12]: 1135–1143.

86 Dube, S.R., Anda, R.F., Felitti, V.J., Chapman, D., Williamson, D.F., Giles, W.H. (2001) Childhood abuse, household dysfunction and the risk of attempted suicide throughout life span: findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association*. 286: 3089–3096.

87 Meltzer, H., Lader, D., Corbin, T., Singleton, N., Jenkins, R., Brugha, T. (2000) *Non-fatal suicidal behaviour among adults aged 16 to 74 in Great Britain* London: The Stationery Office.

## Anxiety and Depression

In a longitudinal study that examined the long-term effects of physical abuse in childhood, mothers' reports of anxiety and depression levels in their adolescent children were on average twice as high for those that had experienced maltreatment in comparison to the group of non-abused young people.<sup>88</sup>

Higgins and McCabe (2000)<sup>89</sup> found that repeat victimisation by multiple perpetrators or multi-type re-victimisation, by the same or different perpetrators, was strongly associated with depression in adulthood. Carlyle and Steinman (2007)<sup>90</sup> used data from school-based surveys completed by a census of 6<sup>th</sup> to 12<sup>th</sup> graders in 16 school districts in a large metropolitan area in the United States. Depressive effect was measured by two variables which reported the frequency of feeling happy or depressed, and was found to be positively associated with being bullied. The effect was found to be stronger for girls than boys. Bond et al. (2007)<sup>91</sup> used survey data collected from 12 districts in Melbourne, Australia. The analysis used data from 2,559 students and found that being bullied was significantly associated with self-reported anxiety and depression.

A UK study analysed responses from 904 pupils aged 12–17 in two co-educational schools. School A was a non-selective school based in a socially disadvantaged urban area, and school B was a rural grant maintained school that had a higher than average proportion of high socio-economic status families. Results showed that the frequency of being bullied 'sometimes or more often' was 4.2 per cent with school, gender, anxiety and lying scores all being significant ( $p < .05$ ). The rate of being a bully was 3.4 per cent, with school year, gender, anxiety, lying and depression scores found to be significant ( $p < .05$ ). Children most likely to be bullied were year 8 boys, in school A, with high anxiety and lying scores; least likely to be bullied were girls in year 9, in school B with low anxiety and lying scores. Children who were most likely to be bullies were boys in year 10 who had low anxiety and lying scores but high depression scores. The least likely bullies were girls in year 8 with high anxiety and lying scores and low depression scores.<sup>92</sup> Another study of 331 young people in England found that more than a third of children who had been bullied (40 per cent of the total sample) were suffering from post-traumatic stress disorder.<sup>93</sup>

## Behavioural symptoms

An Australian research project<sup>94</sup> assessed the result of 3 studies which used data collected from self-selected community samples. Study 1 attempted to explore the relationship between maltreatment, family environment, and adjustment amongst children. The sample consisted of 50 self-selected primary carers, of which 48 were biological parents. Study 2 aimed to further examine the relationship between

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88 Lansford, J.E., Dodge, K.A., Pettit, G.S., Bates, J.E., Crozier, J. and Kaplow, J. (2002) A 12-Year Prospective Study of the Long-term Effects of Early Child Physical Maltreatment on Psychological, Behavioral, and Academic Problems in Adolescence. *Archives of Pediatrics & Adolescent Medicine*, 156: 824–830.

89 Higgins, D.J. and McCabe, M.P. (2000) Maltreatment and long-term adjustment of adults. *Child Abuse Review* 9: 6–18.

90 Carlyle, K.E. and Steinman, K.J. (2007) Demographic Differences in the Prevalence, Co-Occurrence, and Correlates of Adolescent Bullying at School. *Journal of School Health* 77(9): 623–629.

91 Bond, L., Carlin, J.B., Thomas, L., Rubin, K. and Patton, G. (2001) Does bullying cause emotional problems? A prospective study of young teenagers. *British Medical Journal*. 323: 480–484.

92 Salmon, G., James, A. and Smith D.M. (1998) Bullying in schools: self reported anxiety, depression, and self esteem in secondary school children. *British Medical Journal* 317: 924–5.

93 Mynard, H., Joseph, S. and Alexander, J. (2000) Peer victimization and posttraumatic stress in adolescents. *Personality and Individual Differences*, 29, 815–821.

94 Higgins, D.J. and McCabe, M.P. (2003) Maltreatment and Family Dysfunction in Childhood and the Subsequent Adjustment in Children and Adults. *Journal of Family Violence* 18(2): 107–120.

maltreatment, family environment and adjustment in adulthood. The sample for this study was made up of 138 adults who retrospectively reported on their experiences of maltreatment. One hundred and nineteen of these respondents were female, and although it was self-selected the majority had been in counselling ( $n=92$ ), and of these 50 stated that their reason for counselling was due to earlier experiences of maltreatment. Study 3 aimed to observe the relationship between child maltreatment, childhood family environment, and current adaptive functioning, particularly in relation to the development of future positive adult functioning. Study 3 involved retesting a subsample of 95 participants from Study 2.

Study 1 found a correlation of 0.51 ( $p<.001$ ) between psychological maltreatment and externalising behaviours as identified by the Child Behavior Checklist (CBCL); a correlation of 0.51 ( $p<.001$ ) between physical abuse and sexual punitiveness (i.e. the frequency that which children are warned, scolded, or punished for engaging in sexual behaviours or being sexually inquisitive); and a correlation of 0.53 between witnessing family violence and self-derogation ( $p<.001$ ). Using multiple regression analyses, the maltreatment scales (sexual abuse, physical abuse, psychological maltreatment, neglect, and witnessing family violence) were all significant predictors of CBCL internalising and externalising behaviours and the Child Sexual Behavior Inventory (a measure of sexual behavioural problems in children aged 2–12 years); though none were unique significant predictors. Study 2, which examined adjustment in adulthood, found that scores on the five maltreatment scales significantly predicted later reports of trauma symptoms, though only psychological maltreatment was a unique predictor. The scores also significantly predicted self-depreciation, with neglect being the only unique predictor. Finally, Study 3 found that on the whole family background characteristics, rather than experience of maltreatment, were predictors of positive adjustment in adulthood; though psychological maltreatment did uniquely predict adaptive functioning.

Dubowitz et al. (2002)<sup>95</sup> examined the relationship between neglect and children's behaviour and development at the ages of 3 and 5. The sample was recruited from three paediatric clinics that provided services to low-income, urban families. Home evaluations that included both mother and child were undertaken when the children were 3 and 5 years old. The study examined psychological, physical and environmental neglect as well as cognitive development. Environmental neglect was defined as living in a neighbourhood categorised by crime, lack of civility and few resources for children and families. As well as the three types of neglect, the analysis used a cumulative neglect index that specified whether the child experienced no neglect, one type of neglect or two or more types.

At age 3, maternal depression was found to be associated with increased internalising and externalising behaviours. Once maternal depression, type of clinic and socio-demographic risk were controlled for psychological neglect was found to be associated with internalising and externalising behaviours. The cumulative neglect index was associated with greater internalising behaviours. At age 5, the sample's cognitive development was noticeably impaired and they also displayed significant problematic externalising behaviours. However, multiple regression analyses did not show any contribution by three neglect factors at age 3 to outcomes at age 5.

Kumpulainen et al's<sup>96</sup> study examined the relationship between bullying and psychiatric symptoms. The study gathered data from 5,813 children born in 1981 in Finland. Of these children 470 (8.1 per cent)

95 Dubowitz, H., Papas, M.A., Black, M.M. and Starr, R.H. (2002) Child Neglect: Outcomes in High-Risk Urban Preschoolers. *Pediatrics* 109(6): 1100–1107.

96 Kumpulainen, K., Räsänen, E., Henttonen, I., Almqvist, F., Kresanov, K., Linna, S-L., Moilanen, I., Piha, J., Puura, K. and Tamminen, T. (1998) Bullying and psychiatric symptoms among elementary school-age children. *Child Abuse & Neglect* 22 (7): 705–717.

were termed as bullies, 441 (7.6 per cent) as bully-victims, i.e. both perpetrated and experienced bullying, and 655 (11.3 per cent) as victims. Approximately five times more boys than girls were reported to be bullies and bully-victims. Of the victims, 40 per cent were bullies themselves, with more than double the number of boys than girls falling into this category. Behavioural indicators were measured by the Rutter Scale for parents, the Rutter Scale for teachers and Kovac's Children's Depression Inventory (CDI). The items on the scales were factorised, resulting in four factors in each Rutter scale and five in the CDI. Examples of factors on the Rutter scales are: externalising behaviour, which represents actions such as disobedience, fights, irritability, temper tantrums; internalising behaviour, which includes behaviours such as worried, fearful, and miserable; hyperactivity, which includes poor concentration, restless, and fidgety. The constituent factors of the CDI are: ineffectiveness, interpersonal problems, anhedonia, negative mood, and negative self-esteem.

Bully-victims were found to have the highest scores on each scale. Gender differences were not seen on the parental Rutter or CDI scales, but were observed in the teacher Rutter scale, with boys attaining higher mean scores. On the Rutter parental scale bully-victims showed the most externalising behaviour and hyperactivity for both boys and girls; girls also scored highly on internalising behaviours. Victims of both genders scored highest on the psychosomatic factor and on the internalising factor for boys. Analysis of the Rutter teacher scale showed that bully-victims of both genders also scored highest on externalising, hyperactivity on the parental scale, and they also had the highest scores for the school refusal factors; victims had the most internalising behaviour and, with male victims scoring relatively highly on hyperactivity. Bullies scored highly on the externalising and hyperactivity factors.

Results from the CDI showed that bully-victims scored highest on interpersonal problems and ineffectiveness, with female bully victims also getting high scores on negative mood. Both male and female victims scored highest on anhedonia and negative self-esteem, male victims also scored highly on negative mood.

The research also looked at psychological disturbance, which was defined by the most common cut-off points on the Rutter scales and in the pilot study of the CDI. Results from the Rutter parental scale of bully-victims showed that approximately 40 per cent of boys and 45 per cent of girls were classified as disturbed; around 20 per cent of victims of both genders were disturbed and 16 per cent of male bullies and 21 per cent of female bullies were classified as disturbed. Much greater proportions were classified as disturbed by teachers, for example, 63 per cent of male bully-victims and 47 per cent of female bully-victims being characterised as disturbed by teachers.

Kim and Cicchetti (2004)<sup>97</sup> examined 345 children (206 maltreated and 139 non-maltreated) in two consecutive years, and found when assessing the effects of maltreatment on the mother-child relationship quality that maltreated children showed greater internalising symptomatology at Time 1 and greater externalising symptomatology at Time 2. Another study<sup>98</sup> that compared 63 maltreated children to matched sample of non-maltreated found victims of childhood sexual abuse to have greater internalising problems as well as sexualised behaviours.

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97 Kim, J. and Cicchetti, D. (2004) A longitudinal Study of Child Maltreatment, Mother-Child Relationship Quality and Maladjustment: The Role of Self-Esteem and Social Competence. *Journal of Abnormal Child Psychology* 32(4): 341-354.

98 Herbert et al. (2006) Correlates of behavioural outcomes in sexually abused children. *Journal of Family Violence* 21: 287-299.



As well as the behaviours described above, maltreatment has also been found to impact on self-esteem and life satisfaction. For example, Higgins and McCabe (2000)<sup>99</sup> found that individuals who had experienced 1–2 types of maltreatment had better self-esteem than those who had experienced 3–5 types, as measured by the Rosenberg scale.

Gruber and Fineran (2007)<sup>100</sup> surveyed 369 middle and 199 high school girls to measure their experiences of bullying and sexual harassment and their overall health and well-being; the latter included self-esteem and life satisfaction. Items from the bullying questions were factorised to produce two scales labelled Ridicule and Intimidation. Ridicule included items such as ‘upset you for fun’, ‘made fun of you’ and ‘picked on you’; example of Intimidation items are ‘scared you’, ‘pushed, shoved, slapped, or kicked you’ and ‘threatened to hurt or hurt you’.

The authors found that the frequency of bullying and sexual harassment increased from middle school to high school with high school girls having significantly worse outcomes in mental health, physical health, life satisfaction and substance abuse. However, it was also found that high school girls in general have worse outcomes even if they have not experienced sexual harassment and bullying and in fact analysis of t-test results showed that bullying has a greater impact on middle school girls’ health than on that of high school girls. Intimidation was related to self-esteem and life satisfaction, as well as mental and physical health and substance abuse for middle school girls, but only trauma for high school girls. Ridicule was related to self-esteem, life satisfaction, mental health, physical health and trauma for middle school girls and self-esteem and trauma for high school girls.

Mynard and Joseph (1997)<sup>101</sup> assessed the personality dimensions of 179 children from two schools in England. A large proportion, 49 per cent in total, were involved in bullying as either bullies (11 per cent), victims (20 per cent) or bully/victims (18 per cent). The children were assessed through the Self-Perception Profile for Children (SPPC) which measures: scholastic competence, social acceptance, athletic competence, physical appearance, behavioural conduct and global self-worth. The children also completed the Junior Eysenck Personality Questionnaire (EPQ) which contained the following scales: Extraversion, Neuroticism, Psychoticism, and Lie. The results did not find any differences between girls and boys in either being perpetrators or victims of bullying. Higher scores on bullying and victimisation scales were associated with lower scores on scholastic competence, social acceptance, behavioural conduct and global self-worth, victims were also associated with lower scores on athletic competence and physical appearance. Results from EPQ indicated that both bullies and victims may be best characterised by high neuroticism. Other serious mental health conditions such as depression and suicide ideation were also recorded.

### *Suicide Ideation*

Holt et al. (2007)<sup>102</sup> considered the impact of multiple types of victimisation as opposed to fewer or no victimisation experiences. The types of victimisation looked at included: bullying, conventional crime,

<sup>99</sup> Higgins, D.J. and McCabe, M.P (2000) Maltreatment and long-term adjustment of adults. *Child Abuse Review* 9: 6–18.

<sup>100</sup> Gruber, J.E. and Fineran, S. (2007) The Impact of Bullying and Sexual Harassment on Middle and High School Girls. *Violence Against Women* (2007) 13(6): 627–643.

<sup>101</sup> Mynard, H. and Joseph, S. (1997) Bully/victim problems and their association with Eysenck’s personality dimensions in 8 to 13 year-olds. *British Journal of Educational Psychology* 67: 51–54.

<sup>102</sup> Holt, M.K., Finkelhor, D., Kaufman Kantor, G. (2007) Multiple victimization experiences of urban elementary school students: Associations with psychosocial functioning and academic performance. *Child Abuse & Neglect*. 31: 503–515.

physical and sexual abuse and witnessing and indirect victimisation. As hypothesised by the authors, children who were multiple victims reported greater levels of distress than the 'primarily peer victims' and 'minimal victims' groups. With regards to suicide ideation, 'multiple victims; and 'primarily peer victims' groups had a significantly higher percentage than 'minimal victims'. A Dutch study considered the relationship between direct and indirect bullying and the resulting psychosocial health of boys and girls; the research analysed data from 4,721 questionnaires. For both genders, an association was found between 'sometimes' and 'frequently being bullied directly' and depression and suicide ideation. However, after multivariate analysis, this association no longer held for boys but did remain significant for girls. Girls who had 'sometimes' or 'frequently been bullied directly', had odds ratios of 1.50 and 3.29 respectively for depression, and odds ratios of 1.72 and 2.62 respectively for suicide ideation. Of the girls that had reported being bullied directly, 42.6 per cent reported depression, in comparison to 6.4 per cent of girls who were almost never bullied. Depression and suicide ideation were also associated with indirect bullying; this relationship remained significant for both boys and girls in multivariate analyses.<sup>103</sup>

In the NSPCC research on child maltreatment and victimisation, researchers explored statistical associations between experiences of victimisation, maltreatment and severe maltreatment with emotional wellbeing (measured by age appropriate validated measures of trauma impact), including self harming behaviour and suicidal ideation. Throughout childhood and adolescence, child maltreatment was associated with poorer emotional wellbeing, independently of any other types of victimisation experienced. Sexual abuse and victimisation by a peer or sibling appeared to exert their strongest effects on mental health during adolescence. Children who experienced victimisation from a number of different perpetrators ('polyvictimised' children) had higher levels of trauma related symptoms than those with fewer or no maltreatment or victimisation experiences.<sup>104</sup>

## Physical Health

The link to physical health outcomes has been less widely researched than that of mental health outcomes. In relation to physical health, as well as research that suggests that some physical symptoms can occur at school age, more radically the association between childhood maltreatment and disease conditions in adulthood has also been the focus of recent investigation.

### Health Problems in Childhood

Williams et al. (1996)<sup>105</sup> analysed data from the Newham 8-plus health survey to ascertain the association between bullying in primary schools and health symptoms. The survey started in 1988 and gathers data by inviting all children in year 4 (aged 8–9) in mainstream schools in Newham to attend a health interview with a school nurse. The authors used responses from the 1992–1993 academic year, which produced sample of 2,848 individuals who had responses in the required variables. The analysis found an association between bullying and having more than usual headaches or stomach aches, with bullied children being 2.4 times more likely to have a headache or a stomach ache once a week or more. An Australian study that assessed the relationship between being bullied early in secondary school with later

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<sup>103</sup> van der Wal, M.F., de Wit, C.A.M. and Hirasing, R.A. (2003) Psychosocial Health Among Young Victims and Offenders of Direct and Indirect Bullying. *Pediatrics* 111(6): 1312–1317.

<sup>104</sup> Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. with Collishaw, S. (2011) *Child abuse and neglect in the UK today* London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)

<sup>105</sup> Williams, K., Chambers, M., Logan, S. and Robinson, D. (1996) Association of common health symptoms with bullying in primary school children. *British Medical Journal* 313: 17–19.

outcomes found that being bullied early in secondary school was predictive of poorer physical health for both genders later in secondary school, taking into account health status at the first time period, being bullied at the later time period and gender.<sup>106</sup>

### *Health Problems in Adulthood*

As discussed earlier, Felitti et al's (2001)<sup>107</sup> work looks at the impact of negative exposures in childhood on leading causes of death in the United States. The study examined childhood exposure by summing three categorisations of abuse: psychological, physical and contact sexual abuse, and four categories of exposure to household dysfunction, one of which was violent treatment of mother or stepmother. Health outcomes were assessed firstly in terms of 10 risk factors that feature in the leading causes of morbidity and mortality in the United States, of which examples are severe obesity, drug use or depressed mood. In addition, the analysis examined the relationship between childhood exposures and disease conditions that are amongst the six leading causes of mortality in the United States.

The findings show a strong relationship between the number of childhood exposures and the number of risk factors that are a principal cause of death in adults. For example, 56 per cent of individuals that did not have any childhood exposures also did not have any of the ten health risk factors, whereas only 14 per cent of individuals who had experienced four or more exposures did not have any risk factors. People with four or more exposure were found to have greater odds ratios of having the disease conditions examined, ranging from 1.6 for diabetes to 3.9 for chronic bronchitis or emphysema. Finally, using logistic regression, a significant dose-response relationship was found between the number of childhood exposure and the ten risk factors assessed ( $p < .001$ ) and between exposures and the following disease conditions ( $p < .05$ ): ischemic heart disease, cancer, chronic bronchitis or emphysema, history of hepatitis or jaundice, skeletal fractures and poor self-rated health.

Draper et al. (2008)<sup>108</sup> investigated the association between childhood physical and sexual abuse with physical and mental health outcomes in older age. Study participants were adults aged 60 and over under the care of general practitioners who were participating in the Depression and Early Prevention of Suicide in General Practice (DEPS-GP). DEPS-GP yielded a substantial sample of approximately 21,800 individuals who had sufficiently complete responses to enable analysis. Individuals were classified as having physical health problems if they reported having three or more medical conditions associated with older age; some of the conditions listed are: arthritis, diabetes mellitus, hypertension, heart failure, stroke, or angina pectoris, and osteoporosis. Information was also collected on risky health behaviours, such as cigarette smoking and alcohol consumption.

The authors found that both types of abuse were significantly associated with a greater risk of having three or more medical conditions. Myocardial infarction and stroke were associated with physical or sexual abuse for women (odds ratio = 1.21), and women who had experienced both types of abuse (odds ratio = 1.19). Multivariate analysis was also carried out; the level of physical health was defined using

<sup>106</sup> Rigby, K. (1999), Peer victimisation at school and the health of secondary school students. *British Journal of Educational Psychology* 69: 95–104.

<sup>107</sup> Felitti, V.J., Anda, R.F., Nordenberg, D., Willaimson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, S. (2001) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study in Franey, K., Geffner, R. and Falconer, R. (eds) *The Cost of Child Maltreatment: Who Pays? We all do*. Family Violence & Sexual Assault Institute.

<sup>108</sup> Draper, B., Pfaff, J.J., Pirkis, J., Snowdon, J., Lautenschlager, N.T., Wilson, I. and Almeida, O.P. (2008) Long-Term Effects of Childhood Abuse on the Quality of Life and Health of Older People: Results from the Depression and Early Prevention of Suicide in General Practice Project. *Journal of the American Geriatrics Society*. 56(2): 262–271.

the Medical Outcomes Study 12-item Short Form Survey, Version 2 (SF-12v2) Physical Composite Score (PCS). Poor physical health was defined as having a score that is one standard deviation below that of the population norm-based score. Multivariate analysis models of association that adjusted for age, gender, marital and migrant status, and education showed that individuals who had experienced either of the two types of abuse were 1.7 times more likely to have poor physical health, and those that had experienced both physical and sexual abuse were 2.55 times more likely to have poor physical health. A second model, in addition to the previous controls, also took into account social support, active religious practice, physical activity, ever or current smoking, and harmful or hazardous alcohol use. The model showed a 1.46 times greater likelihood of poor health of individuals who had experienced either form of abuse and a 2.11 times greater likelihood for individuals who had experienced both forms of maltreatment. All odds ratios were significant at  $p < 0.05$ .

With regards to risky health behaviours, individuals who had experienced either type of abuse were more likely to be currently smoking or to have ever smoked cigarettes, and to have current alcohol consumption at potentially harmful levels. Similar results were found by Diaz et al. (2002)<sup>109</sup> in their study of a nationally representative sample of 3,015 girls in grades 5 to 12. Girls in the sample who had experienced both sexual and physical abuse ( $n=160$ ) were 5.9 times more likely to be regular smokers, 3.76 times more likely to consume alcohol regularly, and 3.44 times more likely to have used illicit drugs in the past 30 days, than were non-maltreated girls. Substance abuse was also associated with bullying by Gruber and Fineran (2007)<sup>110</sup> and with adverse childhood experience by Felitti et al. (2001).<sup>111</sup> Felitti et al. also found that adverse childhood experience was associated with risky sexual behaviour; adults who had experienced four or more adverse childhood exposures were 3.2 times more likely to have had 50 or more intercourse partners and 2.5 times more likely to ever had a sexually transmitted disease than individuals who did not have any of the adverse exposures that had been studied. Wilson and Widom's (2008)<sup>112</sup> study followed an original sample of 908 abused and neglected and 667 non-maltreated individuals when they were approximately 29 and 41 years old. The maltreated individuals within the sample were more likely to report risky sexual behaviour; the odds ratios of early sexual contact in relation to the control group were 1.76 times more likely for the neglect group, 2.06 times more likely for the physical abuse group, and 2.17 times more likely for the sexual abuse group. Significant relationships were also found between maltreatment and prostitution, with the three abuse groups being more likely to engage in prostitution than the control group. Odds ratios are 2.45 for the neglect and physical abuse groups and 2.38 for the sexual abuse group.

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109 Diaz, A., Simantov, E., Rickett, V.I. (2002) Effect of Abuse on Health: Results of a National Survey. *Archives of Pediatrics & Adolescent Medicine* 156: 811–817.

110 Gruber, J.E. and Fineran, S. (2007) The Impact of Bullying and Sexual Harassment on Middle and High School Girls. *Violence Against Women* (2007) 13(6): 627–643.

111 Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, S. (2001) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study in Franey, K., Geffner, R. and Falconer, R. (eds) *The Cost of Child Maltreatment: Who Pays? We all do*. Family Violence & Sexual Assault Institute.

112 Wilson, H.W. and Widom, C.S. (2008) An examination of Risky Sexual Behaviour and HIV in Victims of Child Abuse and Neglect: A 30-Year Follow-Up. *Health Psychology*. 27(2): 149–158.

## SCHOOL PERFORMANCE

### Educational attainment

A substantial amount of research provides evidence of an association between maltreatment and lower levels of educational attainment.

For example, one study which examined the academic performance of 324 neglected and/or abused children and 420 non-maltreated children found a significant difference in the grades of neglected and neglected/abused children in comparison to non-maltreated children. For the sample, the average grade for combined current grades in maths and English was 2.19, and for non-maltreated children the grade was 2.35. In comparison the neglect and neglect/abuse group attained 1.97 and 2.00 respectively, both of which were found to be significantly different to the non-maltreated group ( $p < .0001$ ).<sup>113</sup>

Kurtz et al. (1993)<sup>114</sup> looked at the academic performance of physically abused, neglected and non-maltreated children at two points in time. At Time 1, 22 physically abused and 47 neglected children were compared against 70 non-maltreated children; at Time 2, 19 abused, 40 neglected and 60 non-maltreated children were included in the sample. The analysis showed no significant within-group changes between Time 1 and Time 2, but when controlling for time and socio-economic status, the results showed significant differences across the groups. Both groups of maltreated children achieved significantly lower scores for language ( $p < .0082$ ) and maths ( $p < .0022$ ) over time in comparison to non-maltreated children. Children subjected to neglect appeared to be particularly vulnerable to lower achievement. At Time 1, for language skills, the neglected children's scores were at the 29<sup>th</sup> percentile, abused children's were at the 44<sup>th</sup> percentile and for comparison children scores were on the 67<sup>th</sup> percentile. For maths, neglected children's scores positioned them on the 28<sup>th</sup> percentile, abused children's on the 42<sup>nd</sup> percentile and the comparison children on the 73<sup>rd</sup> percentile. Both neglected and abused children's scores were significantly below those of comparison children at both points in time.

Another study assessed the role of residential and school mobility as a mediator between maltreatment and academic performance. Using data on 360 maltreated and 366 non-maltreated children, the authors found that maltreated children moved more frequently than non-maltreated children, with the maltreated children sample averaging twice as many moves. Regression analysis, which predicted mobility as a function of maltreatment controlling for public assistance, age and gender, was carried out. The analysis established that maltreatment was related to significant increases in mobility; and for both English grades and test scores higher levels of mobility were associated with lower attainment.<sup>115</sup>

Negative educational outcomes have been found in children ranging in age from infancy to older adolescents.<sup>116</sup> For example for infants and pre-school children, a longitudinal study found a dramatic decrease in the scores of maltreated children on an infant development scale in relation to non-maltreated children.<sup>117</sup> Another study found that physically neglected children had the lowest scores on standardised

<sup>113</sup> Kendall-Tackett, K.A. and Eckenrode, J. (1996) The effects of neglect on academic achievement and disciplinary problems: A developmental perspective. *Child Abuse & Neglect* 20(3): 161–169.

<sup>114</sup> Kurtz, P.D., Gaudin Jr, J.M., Wodarski, J.S. and Howing, P.T. (1993) Maltreatment and the school-aged child: school performance consequences. *Child Abuse & Neglect* 17: 581–589.

<sup>115</sup> Eckenrode, J. Rowe, E., Laird, M. and Brathwaite (1995) Mobility as a Mediator of the Effects of Child Maltreatment on Academic Performance. *Child Development* 66: 1130–1142.

<sup>116</sup> Hildyard, K.L. and Wolfe, D.A. (2002) Child neglect: developmental issues and outcomes. *Child Abuse & Neglect* 26(6–7): 679–695.

<sup>117</sup> Egeland, B., Sroufe, A. and Erickson, M. (1983) The developmental consequences of different patterns of maltreatment *Child Abuse & Neglect* 7: 459–469.

tests of intellectual functioning and academic achievement in relation to the other maltreatment groups examined.<sup>118</sup> Other examples of neglect being associated with cognitive developmental delays are: Gowen's (1993)<sup>119</sup> study which found that children who had experienced insufficient psychological care, from the age 12 months through to 36 months, achieved lower scores on IQ measures than those that had received adequate psychological care; and Egeland's (1991)<sup>120</sup> research where school-aged children were found to have considerable difficulty coping with the demands of school and achieved lower scores on achievement tests.

Leiter and Johnsen (1997)<sup>121</sup> carried out a longitudinal analysis of school performance. The study collected data on the entire school careers of 967 individuals aged from 5 to 23 years where all the participants had either substantiated or unsubstantiated reports of abuse and neglect. No differentiation could be made between the different types of abuse as the unsubstantiated reports did not provide this information. This study examined declines in school performance taking into consideration the timing and severity of maltreatment. Forty-three per cent of the sample experienced a fall in their grade point average over the academic year. In addition overall severity of maltreatment was also found to be an important contributor, with its influence on the odds of school performance decline being statistically significant over and above the effect of being at risk of maltreatment. With respect to timing, of the individuals who had experienced abuse or neglect, recent maltreatment was significantly associated with falling grades. The authors also found that 24 per cent of the sample were referred to, declared eligible or placed in a special education programme, with involvement in special education programmes increased slowly until age 14, after which there was a faster increase.

Another study<sup>122</sup> looking at long-term academic outcomes compared 413 individuals who had previously been abused and neglected against a matched sample of 286 non-maltreated individuals. The research was conducted in two stages; in the initial stage children who had a substantiated prevalence of abuse and neglect, which had been processed during 1967 to 1971, were matched with non-maltreated children. The children had experienced maltreatment at 11 years or younger. The two groups were matched on age, sex, ethnicity, and approximate family social background. The second phase of the research involved interviewing any individuals who could be traced, approximately 20 years later. This resulted in a sample size of 699 individuals, with abused, neglected and control individuals being represented in equal proportions as were found in the original study. This latter stage gathered data on IQ and reading ability, and from psychiatric assessments.

It should be noted that the whole sample achieved below average results for reading ability and IQ in comparison to published norms. Even so, abused and neglected individuals attained significantly lower scores than non-maltreated children, with a mean score of one standard deviation below the comparison group. For reading ability individuals who had experienced abuse and neglect had scores that were, on average, classified as sixth grade level, whereas the control group, on average, attained eighth level grade scores. Furthermore, over 50 per cent of the abused and neglected children had standard reading

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118 Erickson, M.F., Egeland, B. and Pianta, R. (1989) The effects of maltreatment on the development of young children, in D. Cicchetti and V. Carlson (eds), *Child Maltreatment*: 647–684. New York: Cambridge University Press.

119 Gowen, J. (1993) *Effects of neglect on the early development of children: final report*. Washington, DC: National Clearinghouse on Child Abuse and Neglect, Administration for Children & Families.

120 Egeland, B. (1991) A longitudinal study of high risk families: issues and findings, in R. Starr and D.A. Wolfe (eds), *The effects of child abuse and neglect*: 33–56. New York: Guilford Press.

121 Leiter, J. and Johnsen, M.C. (1997) Child Maltreatment and School Performance Declines: An Event-History Analysis. *American Educational Research Journal* 34(3): 563–589.

122 Perez, C.M. and Widom, C.S. (1994) Childhood Victimization and Long-term Intellectual and Academic Outcomes. *Child Abuse & Neglect* 18(8): 617–633.

ability scores in the deficient range, compared to less than 30 per cent of the non-maltreated children. Multivariate analysis showed that the maltreated children still had lower cognitive functioning in the IQ and reading assessments when age, ethnicity, gender, group and social class had been controlled for.

A study examining the relationship between the timing of academic difficulties and maltreatment status looked at approximately 300 maltreated and non-maltreated children between 5 and 18 years of age. For both English and maths grades, maltreated children were more likely to receive poor grades; when gender and public assistance were controlled for maltreated children were 1.67 times more likely to achieve a poor English grade and 1.53 times more likely to achieve a poor English grade. In relation to timing, kindergarten posed the greatest risk for all children, however maltreated children were 1.75 times more likely to achieve a poor English grade and 1.68 times more likely to achieve a poor maths grade at kindergarten than non-maltreated children.<sup>123</sup>

Another study also assessing the impact of timing of maltreatment discovered that when a differentiation was made between substantiated and unsubstantiated reports the grade point average declined at a greater rate for children with unsubstantiated reports than substantiated, and that these declines were steeper for children where maltreatment was unsubstantiated.<sup>124</sup>

As well as lower academic attainment, maltreatment is associated with several other negative educational outcomes such as school engagement, grade repetition, disciplinary problems and absenteeism. Findings related to these three areas are detailed below.

## School engagement

Zolotor et al. (1999)<sup>125</sup> found that in addition to being associated with lower academic performance, substantiated reports of maltreatment were also related to poorer adaptive functioning at ages 6 and 8. Adaptive functioning was measured by the average scores on the following four items: how hard the child is working, how appropriate the child's behaviour is, how much the child is learning and how happy the child is. Similarly, in Tyler et al's (2008)<sup>126</sup> study, the relationship between neglect and school engagement was moderated by gender, with ever experiencing neglect being related to lower levels of school engagement for girls than boys.

## Grade repetition

Grade repetition does not happen in British schools, although in much of the United States and in the rest of Europe if a child has failed to keep pace in learning with the rest of the class he or she will remain in the same class when the others move on to the next level. As all British children move on, irrespective of whether they have been able to keep up with the others in the year group, this is a measure that is not available in British studies. But it is a useful indicator of under-achievement.

123 Rowe, E. and Eckenrode, J. (1999) The timing of academic difficulties among maltreated and nonmaltreated children. *Child Abuse & Neglect* 23(8): 813–832.

124 Leiter, J. (2007) School performance trajectories after the advent of reported maltreatment. *Children and Youth Services Review* 29: 363–382.

125 Zolotor, A. Kotch, J. Dufort, V., Winsor, J., Catelier, D. and Bou-Saada, I. (1999) School Performance in a Longitudinal Cohort of Children at Risk of Maltreatment. *Maternal & Child Health Journal* 3(1): 19–27.

126 Tyler, K.A., Johnson, K.A. and Brownridge, D.A. (2008) A Longitudinal Study of the Effects of Child Maltreatment on Later Outcomes among High-risk Adolescents *Journal of Youth Adolescence* 37: 506–521.

In one study that consisted of 420 maltreated and 420 non-maltreated children from kindergarten to grade 12, the maltreated children were found to have a higher likelihood of repeating a grade than non-maltreated. Twenty-nine per cent of the entire sample repeated a grade. When separating out maltreated and non-maltreated children the percentages were 38 per cent and 19 per cent respectively, with maltreated children found to be 2.5 times more likely to repeat a grade than non-maltreated.<sup>127</sup> Increased grade repetition was also found to be a consequence of the higher rates of mobility experienced by the sample under study in Eckenrode et al's (1995) research.<sup>128</sup>

Another study found a significant main effect for neglect status, with children who had experienced both abuse and neglect having the highest number of grade repetitions in the sample; the difference in the number of grade repetitions between the abused and neglected children and non-maltreated children was found to be significantly different. Similarly, children who had only experienced neglect also were found to have a significantly higher number of grade repetitions than the control group.<sup>129</sup>

A longitudinal study that interviewed individuals twenty years after initial contact found that 41 per cent of the abused and neglected children had repeated a grade, in comparison to 24 per cent of control children. Both maltreated and non-maltreated children in this study performed below average in reading and IQ tests. This study also found that 58 per cent of the abused and neglected group did not complete high school in comparison to 34 per cent of the control group, with, on average, the control group completing one more year of schooling. The average last grade completed at school for the maltreated children was 10.8 (standard deviation = 1.9) and for the control group it was 12.0 (standard deviation = 2.3).<sup>130</sup>

Rowe and Eckenrode's (1999)<sup>131</sup> results showed that when gender and public assistance were controlled for, maltreated children were 2.04 times more likely than non-maltreated children to repeat a grade in all school years.

In a sample of 967 children who had either substantiated or unsubstantiated recorded reports of maltreatment, 47 per cent had been repeated a grade at least once, with the rate of repetition increasing overall with age, though with a sharper increase after the age 14.<sup>132</sup>

## Absenteeism

Absenteeism has also been associated with maltreatment. The impact of this is long-term impact as it is a predictor of employment and future earnings. In later life having been persistently absent from school is a predictor of lower employment rates and lower earnings, even when the impact of qualifications is

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127 Eckenrode, J., Laird, M. and Doris, J. (1993) School Performance and Disciplinary Problems Among Abused and Neglected Children. *Developmental Psychology* 29(1): 53–62.

128 Eckenrode, J. Rowe, E., Laird, M. and Brathwaite (1995) Mobility as a Mediator of the Effects of Child Maltreatment on Academic Performance. *Child Development* 66: 1130–1142.

129 Kendall-Tackett, K.A. and Eckenrode, J. (1996) The effects of neglect on academic achievement and disciplinary problems: A developmental perspective. *Child Abuse & Neglect* 20(3): 161–169.

130 Perez, C.M. and Widom, C.S. (1994) Childhood Victimization and Long-term Intellectual and Academic Outcomes. *Child Abuse & Neglect* 18(8): 617–633.

131 Kendall-Tackett, K.A. and Eckenrode, J. (1996) The effects of neglect on academic achievement and disciplinary problems: A developmental perspective. *Child Abuse & Neglect* 20(3): 161–169.

132 Leiter, J. and Johnsen, M.C. (1997) Child Maltreatment and School Performance Declines: An Event-History Analysis. *American Educational Research Journal* 34(3): 563–589.



taken into account. In other words, absenteeism both affects qualifications and has a direct impact in addition.<sup>133</sup>

In one study a greater proportion of the abused and neglected children were reported as having truanted (81 per cent compared to 68 per cent). The relatively high numbers for both maltreated and non-maltreated children may be due to the fact that the sample as a whole were less academically competent than comparable national averages.<sup>134</sup> Lansford et al. (2002)<sup>135</sup> in looking at the interactions between maltreatment and ethnicity found that the damaging effects of maltreatment were stronger for minority than white children. Over 47 per cent of the 967 children in Leiter and Johnsen's (1997)<sup>136</sup> study showed increased absenteeism, with the risk of absenteeism increasing sharply after age 14. In a later study, Leiter (2007)<sup>137</sup> found that though absenteeism increases with age regardless of an individual's maltreatment status, even so there were indications that the earlier maltreatment occurs, the greater its impact on the likelihood of absenteeism. Additionally, it appeared that the advent of maltreatment resulted in an increase in absenteeism.

Slade and Wissow (2007)<sup>138</sup> used data from two waves of the National Longitudinal Study of Adolescent Health; the core sample for this study had been designed to be representative of middle and high school students in the United States. The authors concentrated on sibling pairs, resulting in a final sample of 958 students after attrition. Results from the study showed that individuals with higher scores on the maltreatment index as well as being significantly more likely to have a low grade point average and problems completing homework were also marginally associated with having eight or more days' absence from school.

## Disciplinary problems

Not surprisingly, experience of maltreatment has been associated with disciplinary problems. Several studies have shown a greater likelihood of disciplinary problems and exclusions for children who have been maltreated. Results include: a greater likelihood of disciplinary referrals and suspension;<sup>139</sup> more disciplinary problems for neglected and abused children compared with non-maltreated children;<sup>140</sup> 27 per cent of a sample of children with substantiated and unsubstantiated reports of maltreatment exhibiting heightening problems with behaviour and age;<sup>141</sup> and 53 per cent of a sample of 413 maltreated children being expelled or suspended in comparison to 43 per cent of the controls in the study.<sup>142</sup> In the

133 Dolton, P., Makepeace, G., Hutton, S. and Audas, R. (1999) *Making the Grade*, York Publishing Services.

134 Perez, C.M. and Widom, C.S. (1994) Childhood Victimization and Long-term Intellectual and Academic Outcomes. *Child Abuse & Neglect* 18(8): 617–633.

135 Lansford, J.E., Dodge, K.A., Pettit, G.S., Bates, J.E., Crozier, J. and Kaplow, J. (2002) A 12-Year Prospective Study of the Long-term Effects of Early Child Physical Maltreatment on Psychological, Behavioral, and Academic Problems in Adolescence. *Archives of Pediatrics & Adolescent Medicine*, 156: 824–830.

136 Leiter, J. and Johnsen, M.C. (1997) Child Maltreatment and School Performance Declines: An Event-History Analysis. *American Educational Research Journal* 34(3): 563–589.

137 Leiter, J. (2007) School performance trajectories after the advent of reported maltreatment. *Children and Youth Services Review* 29: 363–382.

138 Slade, E.P. and Wissow, L.S. (2007) The influence of childhood maltreatment on adolescents' academic performance. *Economics of Education Review* 26: 604–614.

139 Eckenrode, J., Laird, M. and Doris, J. (1993) School Performance and Disciplinary Problems Among Abused and Neglected Children. *Developmental Psychology* 29(1): 53–62.

140 Kendall-Tackett, K.A. and Eckenrode, J. (1996) The effects of neglect on academic achievement and disciplinary problems: A developmental perspective. *Child Abuse & Neglect* 20(3): 161–169.

141 Leiter, J. and Johnsen, M.C. (1997) Child Maltreatment and School Performance Declines: An Event-History Analysis. *American Educational Research Journal* 34(3): 563–589.

142 Perez, C.M. and Widom, C.S. (1994) Childhood Victimization and Long-term Intellectual and Academic Outcomes. *Child Abuse & Neglect* 18(8): 617–633.

latter study, both the control and maltreated group exhibited lower than average educational attainment. One study found that minority adolescents who had experienced maltreatment were suspended and had more behaviour problems than the minority adolescents who had not been maltreated. For the white adolescents in this study the reverse was true with the maltreated adolescents having less disciplinary and behavioural problems than non-maltreated adolescents. This, however, was not significant.<sup>143</sup>

## SOCIAL INTERACTION

Maltreatment has also been found to have wide ranging effects on how maltreated individuals interact with others; negative outcomes can be seen in personal relationships, aggressive behaviour and victimisation. Difficulties in relationships can arise directly out of attachment difficulties, but also indirectly as a result of behaviour which has its roots in the childhood maltreatment, and which others find difficult to deal with. In particular they are more likely than non-maltreated children to show aggression and violence, both as children and later as adults. Conversely, adults who have been maltreated as children are three times more likely to experience violent treatment from an intimate partner than other adults.<sup>144</sup>

### Interpersonal relationships

Baer and Martinez (2006)<sup>145</sup> conducted a meta-analysis of eight studies that looked at maltreatment status and insecure attachment. The studies were chosen on the following criteria: they consisted of children who experienced different types of maltreatment including malnutrition and failure-to-thrive; they consisted of children aged less than 48 months; they used a similar method to measure attachment; they contained comparison groups and sufficient detail to undertake the meta-analysis. Combining the studies showed that the maltreated group had 319 children with an insecure attachment style and 80 with a secure attachment style. In comparison, the control group had 142 children with an insecure attachment style compared to 250 with a secure one.

An assessment<sup>146</sup> of mother-child pairs, consisting of both maltreated and non-maltreated children, examined the social skills and social competence of the children through the child's own perceptions and social competence as rated by mothers. The effect of social support on social skills and competence were also considered. Maltreatment types included physical abuse, sexual abuse and neglect. The participants were assessed at two points in time, one year apart. At Time 1, 368 mother-child pairs were interviewed, which included 189 maltreated children. At Time 2, 165 mother-pairs, where the child was maltreated and 169 mother-child control pairs were interviewed.

Time 1 results showed that maltreated children tended to have lower assertiveness skills, though the result was not significant ( $p=.057$ ). Self-evaluation of social skills was predicted by support by peers, with higher levels of support leading to improved self-evaluations of social skills. The occurrence of

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143 Lansford, J.E., Dodge, K.A., Pettit, G.S., Bates, J.E., Crozier, J. and Kaplow, J. (2002) A 12-Year Prospective Study of the Long-term Effects of Early Child Physical Maltreatment on Psychological, Behavioral, and Academic Problems in Adolescence. *Archives of Pediatrics & Adolescent Medicine*, 156: 824–830.

144 Milling Kinard, E. (1999) Perceived social skills and social competence in maltreated children. *American Journal of Orthopsychiatry* 69(4): 465–481.

145 Baer, J.C. and Martinez, C.D. (2006) Child maltreatment and insecure attachment: a meta-analysis. *Journal of Reproductive and Infant Psychology* 24(3): 187–197.

146 Milling Kinard, E. (1999) Perceived social skills and social competence in maltreated children. *American Journal of Orthopsychiatry* 69(4): 465–481.

maltreatment significantly predicted maternal ratings of social competence, with maltreated children being rated as less socially able, though maltreatment status did not predict children's own rating of their social competence. Comparison of maltreated and non-maltreated children on clinical levels of social competence showed that maltreated were significantly more likely to be classified with clinical problems ( $p < .003$ ), with 11 (6.7 per cent) of the maltreated children and 1 (.06 per cent) of the non-maltreated children having these difficulties. Additionally, maltreated children were nearly three times more likely than non-maltreated children to not have any close friends and twice as likely to have only one. Mothers rated maltreated children as significantly different to non-maltreated ones in their ability to get along with siblings, peers and parents with maltreated children being rated worse in all three relationships.

At Time 2, having experienced maltreatment was a significant predictor of maternal ratings of social competence but not of children's self-rating. In relation to social networks, similar findings existed at Time 2 as were found at Time 1.

Maughan and Cicchetti (2002)<sup>147</sup> investigated the unique and interactive effects of maltreatment and inter-adult violence in the home on children's emotional regulation. Results showed that maltreated children were approximately 6.3 times more likely to exhibit under-controlled emotional responses and 5.6 times more likely to display over-controlled emotional responses in comparison to non-maltreated children. Under-controlled responses are characterised by heightened and prolonged rates of negative or positive emotional reactivity to simulated angry exchanges between adults, whereas over-controlled responses are seen in lower than usual levels of emotional reactivity.

## Aggressive behaviour

Lansford et al. (2005)<sup>148</sup> cross-national research examined the moderating effect of the normativeness of physical discipline and mothers' use of physical discipline and children's adjustment. Interviews were carried out with 336 mother-child pairs in China, India, Kenya, the Philippines, and Thailand. The results from the research indicated that in cultures where there is a greater perceived normativeness of physical discipline, more frequent use of physical discipline is less strongly associated with adverse child outcomes. However, when children perceive physical discipline to be highly normal, they display higher levels of self-reported aggression, regardless of the levels of physical discipline they experience. Furthermore, even if the use of physical discipline is perceived to be highly normal, children who experienced physical discipline more frequently had higher levels of anxiety as measured by the Child Behavior Checklist. In all countries, regardless of the normativeness of using physical discipline, high physical discipline was associated with more negative outcomes. In another study, mothers reported that adolescents who had experienced early maltreatment had, on average, twice as high levels of aggression in comparison to non-maltreated adolescents.<sup>149</sup>

147 Maughan, A. and Cicchetti, D. (2002) Impact of Child Maltreatment and Interadult Violence on Children's Emotion Regulation Abilities and Socioeconomic Adjustment. *Child Development* 73(5): 1525–1542.

148 Lansford, J.E., Dodge, K.A., Malone, P.S., Bacchini, D., Zelli, A., Chaudhary, N., Manke, B., Chang, L., Oburu, P., Palmérus, K., Pastorelli, C., Bombi, A.S., Tapanya, S., Deater-Deckard, K. and Quinn, N. (2005) Physical Discipline and Children's Adjustment: Cultural Normativeness as a Moderator. *Child Development* 76(6): 1234–1246.

149 Lansford, J.E., Dodge, K.A., Pettit, G.S., Bates, J.E., Crozier, J. and Kaplow, J. (2002) A 12-Year Prospective Study of the Long-term Effects of Early Child Physical Maltreatment on Psychological, Behavioral, and Academic Problems in Adolescence. *Archives of Pediatrics & Adolescent Medicine*, 156: 824–830.

Fang and Corso (2007)<sup>150</sup> used data from Wave I and III of the National Longitudinal Study of Adolescent Health, which examines the health related behaviours of adolescents in grades 7 to 12, and follows their outcomes into young adulthood. The authors looked at the relationship between three types of maltreatment (physical abuse, sexual abuse and neglect) and victimisation and/or perpetration of youth violence and the victimisation and/or perpetration of intimate partner violence. The final sample used in the analysis was 9,368 individuals, of whom 5,179 (55.2 per cent) were female. The study found that child physical abuse and neglect were significant predictors of youth violence perpetration for both males and females. In relation to intimate partner violence, for males direct predictors were youth violence perpetration and childhood sexual abuse, whereas for females, direct predictors were youth violence perpetration, physical abuse and neglect. For both genders, neglect was also found to have a significant indirect effect through youth violence perpetration. Similarly, a study on 36 men that had a history of perpetrating domestic violence found childhood neglect to be a significant predictor of physical spousal abuse, though the small sample size should be noted in this research.<sup>151</sup>

Another study compared children who had been physically abused to children who had experienced other forms of maltreatment and to control children in relation to aggressive or disruptive behaviour problems. Results showed that physically abused children were rated by their peers as showing significantly more aggression and disruptiveness than were non-maltreated children ( $p < .01$ ) and children who had experienced other forms of maltreatment ( $p < .01$ ).<sup>152</sup>

## Victimisation as an Adult

As described above, Fang and Corso (2007) as well as looking at perpetration of youth violence and intimate partner violence, also assessed the relationship between maltreatment and youth violence and/or intimate partner violence victimisation. Analysis of the data showed that childhood neglect was a significant predictor of youth violence victimisation and a significant indirect effect on intimate partner violence victimisation for males. For females, no maltreatment experiences predicted youth violence victimisation or intimate partner violence victimisation.

One study explored how different types of maltreatment and intimate partner violence occur within and across childhood and adulthood for a high-risk group of women. Data were gathered from three waves of the Illinois Family Study, which tracks family who were receiving Temporary Assistance for Needy Families; a sample of 1,005 was used in this analysis. The results from logistic regressions showed that individuals who experienced childhood physical abuse were 2.58 times more likely to experience intimate partner violence in adulthood than those that had not experienced physical abuse. Individuals who had experienced child sexual abuse were 2.99 more likely to experience adult intimate partner violence than those who had not. Childhood physical abuse, sexual abuse, and witnessing intimate partner violence were positively associated with the experiencing intimate partner violence in adulthood.<sup>153</sup>

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150 Fang, X. and Corso, P. (2007) Child Maltreatment, Youth Violence, and Intimate Partner Violence: Developmental Relationships. *American Journal of Preventative Medicine* 33(4): 281–290.

151 Bevan, E. and Higgins, D.J. (2002) Is domestic violence learned? The contribution of five forms of child maltreatment to men's violence and adjustment. *Journal of Family Violence* 17(3): 223–244.

152 Teisl, M. and Cicchetti, D. (2007) Physical Abuse, Cognitive and Emotional Processes, and Aggressive/Disruptive Behavior Problems. *Social Development* 17(1): 1–23.

153 Renner, L.M. and Schook Slack, K. (2006) Intimate partner violence and child maltreatment: Understanding intra- and intergenerational connections. *Child Abuse & Neglect* 30: 599–617.

Schaaf and McCanne (1998)<sup>154</sup> analysed data on child and adult abuse experiences from 322 female college students in a large Midwestern university. Participants ranged in age from 18 to 27, but the mean age of the groups were 18.3 years for individuals who had experienced sexual abuse at childhood and 18.9 for those who had not experienced childhood abuse. Of the 322 participants, 27 (8.4 per cent) had experienced child sexual abuse; 53 (16.5 per cent) had had child physical abuse sequelae, such as welts, cuts, dislocations; 31 (9.6 per cent) had experienced both physical and sexual abuse, and 211 (65.5 per cent) had not experienced abuse in childhood. Adult sexual abuse and victimisation were defined as having occurred after the age of 15. Results from chi-square tests showed that physical abuse group contributed more than twice as many individuals as expected by chance to the adult physical victimisation group; the sexual and physical abuse group contributed more than three times as many participants as expected by chance to the adult sexual and physical victimisation group and one and a half participants as expected by chance to adult sexual victimisation group. Furthermore, victimisation in adulthood was found to be significantly higher in the child physical abuse group for the child combined physical and sexual abuse group compared to the no abuse group. However the childhood sexual abuse group did not differ significantly in adult victimisation rates from the no abuse group.

Tyler et al. (2008)<sup>155</sup> analysed data from 360 individual who had participated in the National Survey of Child and Adolescent Well-being Child Protection Sample. Their results indicate that neglect was still impacting on individuals three years later as adolescents who had experienced neglect were more likely to experience victimisation three years later. Ponce et al. (2004)<sup>156</sup> found in their sample of 433 undergraduates that 6 per cent of the sample had experienced maltreatment as a child, and that this group were significantly more likely to have an acceptance of violence in adult relationships, due to disrupted cognitions, particularly in relation to self-worth and trust in others.

## Delinquency

There is a clear statistical association between maltreatment and offending. The proportion of children and young people in custody who have experienced serious maltreatment is at least twice that in the population as a whole.<sup>157</sup> While this does not imply that maltreatment necessarily *causes* offending, there is evidence that maltreatment is one of the factors that leads children and young people down pathways which make delinquency more likely.<sup>158</sup>

Those who have been maltreated as children are more likely to engage in offending than others in the same age group. While the maltreatment does not necessarily cause the offending (although there can be a direct link in the case of violent offences) it is one of the factors which strongly influences the pathways through life down which people move.

154 Schaaf, K.K. and McCanne, T.R. (1998) Relationship of childhood sexual, physical, and combined sexual and physical abuse to adult victimisation and posttraumatic stress disorder. *Child Abuse & Neglect* 22(11): 1119–1133.

155 Tyler, K.A., Johnson, K.A. and Brownridge, D.A. (2008) A Longitudinal Study of the Effects of Child Maltreatment on Later Outcomes among High-risk Adolescents *Journal of Youth Adolescence* 37: 506–521.

156 Ponce, A.N., Williams, M.K. and Allen, G.J. (2004) Experience of Maltreatment as a child and acceptance of violence in adult intimate relationships: mediating effects of distortions in cognitive schemas, *Violence and Victims* 19(1): 97–108.

157 Day, C., Hibbert, P. and Cadman, S. (2008) *Literature Review into Children Abused and/or Neglected Prior Custody*. Youth Justice Board.

158 Rutter, M., Giller, H. and Hagell, A. (1998) *Anti-social Behaviour by Young People*. Cambridge: Cambridge University Press.

Delinquency has been found to be another key outcome of maltreatment. Gover's (2002)<sup>159</sup> study tried to ascertain whether individuals who had experienced maltreatment as children were more likely to become prolific violent offenders. The results from the study confirmed that childhood maltreatment is an important risk factor in violent offending; however it was found to be mediated by social learning and social control factors related to peers, family and school. Those that associated with delinquent peers, or where the family were involved with crime had a much greater likelihood of becoming violent offenders; whereas, children who had a strong attachment to school were able to counteract the adverse effects of maltreatment.

Ireland et al. (2002)<sup>160</sup> analysed data from the Rochester Youth Development Study, which is a multi-wave panel study of adolescent development. Subjects start at around age 14 and were interviewed every 6 months for 9 consecutive waves; their primary caregivers were interviewed for 8 consecutive waves.

Maltreatment was classified into: childhood only (birth to 11); adolescence only (12–17); persistent i.e. victims during both childhood and adolescence and no substantiated maltreatment. Delinquency data were collected by both self-report and police records.

A consistent significant association was found between maltreatment and delinquency. Maltreated youngsters were found to have higher rates of occasional and chronic offending than never maltreated youth. Timing of maltreatment was also found to be important. With the exception of violent crime in early adolescence, childhood only maltreatment is not significantly associated with any of the measures of delinquency. Contrastingly, adolescent only maltreatment has a contemporaneous effect with all measures of maltreatment in early adolescence and a relationship with arrest, general delinquency, and street crime in later adolescence. Additionally, adolescence and persistent maltreatment were shown to impact on the prevalence of arrests in early and late adolescence. For example, the odds of early adolescent arrest are 3.4 time more likely for adolescent only maltreatment than for no maltreatment individuals, and 3.8 times more likely for persistently maltreated youth than youth that have never been maltreated. Arrest in late adolescence is 3.7 and 4.3 times more likely adolescent only and persistent maltreatment, respectively. In conclusion, the authors found adolescent only maltreatment and persistent maltreatment to be more statistically similar in their effect on delinquency than statistically different.

Research by Stewart et al. (2008)<sup>161</sup> on a cohort of children born in 1983/1984 who had come into contact with either juvenile offending or child protection services described similar findings with regards to the timing of maltreatment. The study analysed data from 5,849 children who had experienced substantiated episodes of maltreatment. Twenty-seven per cent of these children had offended, with the least likely offenders having experienced maltreatment in early years. In the chronically maltreated group, over 50 per cent of those whose maltreatment peaked at 12 years were more likely to offend than other children in other trajectory groups. Thirty-six per cent of those whose maltreatment peaked at transition to primary school offended.

Another American study that looked at the relationship between emotional and behavioural disorders (EBD), maltreatment and delinquency stated that adolescents with EBD who had been involved with child welfare, juvenile justice and the special educational system experience numerous risk factors throughout

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159 Gover, A. (2002) The effects of child maltreatment on violent offending among institutionalised youth. *Violence and Victims*, 17(16): 655–668.

160 Ireland, T.O., Smith, C.A. and Thornberry, T.P. (2002) Developmental issues in the impact of child maltreatment on later delinquency and drug use. *Criminology* 40(2): 359–399.

161 Stewart, A., Livingston, M. and Dennison, S. (2008) Transitions and turning points: Examining the links between child maltreatment and juvenile offending. *Child Abuse & Neglect* 32(1): 51–66.

their childhood. The risk factors, child maltreatment, academic and behavioural problems, high levels of mobility and parental imprisonment are consistently associated with detrimental outcomes, such as delinquency, that extend into adulthood.<sup>162</sup>

Van der Waal et al's (2003)<sup>163</sup> study which assessed data from 4,721 boys and girls found that delinquent behaviour was more common with children who 'sometimes' or 'frequently bullied others directly', these associations persisted in multivariate analysis.

## OUTCOMES BY MALTREATMENT TYPE

Although many studies do not differentiate between maltreatment types, and many have indicated that outcomes are similar across the different types of abuse and neglect, there is some evidence to link specific types of maltreatment to different outcomes.

### Neglect

Evidence suggests that the experience of neglect on its own can impact on social interaction, mental well-being and school performance.

For example, when children were observed in play in a laboratory setting, neglected children tended to be more isolated than the other groups under observation (i.e. abused, abused and neglected, marginally maltreated, and non-maltreated pre-schoolers);<sup>164</sup> neglected pre-schoolers were also found to be more hopeless in a stressful situation than other groups;<sup>165</sup> more confused by others' emotional displays and less able to distinguish between emotions in comparison to non-maltreated and abused children.<sup>166</sup> Psychological neglect was associated with three year olds' internalising and externalising behaviour problems, even after mothers' depression and poverty related socio-demographic risk factors had been accounted for.<sup>167</sup> Neglect also impacts on relationships in later life, with it being found to be a predictor of intimate partner violence.<sup>168</sup>

162 Malmgren, K.W. and Meisel, S.M. (2004) Examining the Link Between Child Maltreatment and Delinquency for Youth with Emotional and Behavioral Disorders. *Child Welfare* 83(2): 175–188.

163 van der Wal, M.F., de Wit, C.A.M. and Hirasig, R.A. (2003) Psychosocial Health Among Young Victims and Offenders of Direct and Indirect Bullying. *Pediatrics* 111(6): 1312–1317.

164 Crittenden, P.M. (1992) in Hildyard, K.L. and Wolfe, D.A. (2002) Child neglect: developmental issues and outcomes. *Child Abuse & Neglect* 26(6–7): 679–695.; Manly, Kim, Rogosch and Cicchetti, in Hildyard, K.L. and Wolfe, D.A. (2002) Child neglect: developmental issues and outcomes. *Child Abuse & Neglect* 26(6–7): 679–695.; Teisl, M. and Cicchetti, D. (2007) Physical Abuse, Cognitive and Emotional Processes, and Aggressive/Disruptive Behavior Problems. *Social Development* 17(1): 1–23.

165 Crittenden, P.M. (1985) in Hildyard, K.L. and Wolfe, D.A. (2002) Child neglect: developmental issues and outcomes. *Child Abuse & Neglect* 26(6–7): 679–695.; Manly, Kim, Rogosch and Cicchetti, in Hildyard, K.L. and Wolfe, D.A. (2002) Child neglect: developmental issues and outcomes. *Child Abuse & Neglect* 26(6–7): 679–695.; Teisl, M. and Cicchetti, D. (2007) Physical Abuse, Cognitive and Emotional Processes, and Aggressive/Disruptive Behavior Problems. *Social Development* 17(1): 1–23.

166 Pollak, S.D., Cicchetti, D., Hornung, K. and Reed, A. (2000) in Hildyard, K.L. and Wolfe, D.A. (2002) Child neglect: developmental issues and outcomes. *Child Abuse & Neglect* 26(6–7): 679–695.; Manly, Kim, Rogosch and Cicchetti, in Hildyard, K.L. and Wolfe, D.A. (2002) Child neglect: developmental issues and outcomes. *Child Abuse & Neglect* 26(6–7): 679–695.; Teisl, M. and Cicchetti, D. (2007) Physical Abuse, Cognitive and Emotional Processes, and Aggressive/Disruptive Behavior Problems. *Social Development* 17(1): 1–23.

167 Dubowitz, H., Papas, M.A., Black, M.M. and Starr, R.H. (2002) Child Neglect: Outcomes in High-Risk Urban Preschoolers. *Pediatrics* 109(6): 1100–1107.

168 Fang, X. and Corso, P. (2007) Child Maltreatment, Youth Violence, and Intimate Partner Violence: Developmental Relationships. *American Journal of Preventative Medicine* 33(4): 281–290.

In relation to school performance, neglect has also been associated with cognitive developmental delays; Erickson et al. (1989)<sup>169</sup> found that physically neglected children obtained the lowest scores in intellectual functioning and academic achievement in relation to other groups of maltreated children. In Gowen's (1993)<sup>170</sup> study, children who had received insufficient psychological care between the ages of one and three obtained lower scores on measures of IQ than children whose care had been adequate. Perez and Widom (1994)<sup>171</sup> examined differences in IQ and reading ability by type of abuse and found that neglect was a unique significant predictor of reading ability and that both neglect and physical abuse were unique significant predictors of IQ.

Neglect also appears to affect school performance through school engagement, with results from Tyler et al's (2008)<sup>172</sup> work showing that experiencing neglect was associated with lower levels of engagement for girls. Similarly, Leiter and Johnsen (1997)<sup>173</sup> found a relationship between neglect and increasing absenteeism and dropping out of school.

## Physical Abuse

Physical abuse is associated with aggressive behaviour. A number of studies have found physically abused children to be more aggressive and disruptive than those who have experienced other forms of maltreatment or have not been maltreated.<sup>174</sup> It has also been linked to intimate partner violence in adulthood, Fang and Corso (2007)<sup>175</sup> found physical abuse to be a direct predictor of violence towards a partner. Conversely it has been associated with victimisation in adulthood, Renner and Shook Slack (2006)<sup>176</sup> found that adults who had been physically abused as children were 2.58 times more likely to experience intimate partner violence and Schaaf and McCanne (1998)<sup>177</sup> found higher rates of adult victimisation in individuals who had experienced physical abuse and combined physical abuse and sexual abuse in contrast to individuals who had not experienced maltreatment in childhood.

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169 Erickson, M.F., Egeland, B. and Pianta, R. (1989) The effects of maltreatment on the development of young children, in D. Cicchetti and V. Carlson (eds), *Child maltreatment* pp. 647–684. New York: Cambridge University Press.

170 Gowen, J. (1993) *Effects of neglect on the early development of children: final report*. Washington, DC: National Clearinghouse on Child Abuse and Neglect, Administration for Children & Families.

171 Perez, C.M. and Widom, C.S. (1994) Childhood Victimization and Long-term Intellectual and Academic Outcomes. *Child Abuse & Neglect* 18(8): 617–633.

172 Tyler, K.A., Johnson, K.A. and Brownridge, D.A. (2008) A Longitudinal Study of the Effects of Child Maltreatment on Later Outcomes among High-risk Adolescents *Journal of Youth Adolescence* 37 pp. 506–521.

173 Leiter, J. and Johnsen, M.C. (1997) Child Maltreatment and School Performance Declines: An Event-History Analysis. *American Educational Research Journal* 34(3): 563–589.

174 Erickson and Egeland in Hildyard, K.L. and Wolfe, D.A. (2002) Child neglect: developmental issues and outcomes. *Child Abuse & Neglect* 26(6–7): 679–695.; Manly, Kim, Rogosch and Cicchetti, in Hildyard, K.L. and Wolfe, D.A. (2002) Child neglect: developmental issues and outcomes. *Child Abuse & Neglect* 26(6–7): 679–695.; Teisl, M. and Cicchetti, D. (2007) Physical Abuse, Cognitive and Emotional Processes, and Aggressive/Disruptive Behavior Problems. *Social Development* 17(1): 1–23.

175 Fang, X. and Corso, P. (2007) Child Maltreatment, Youth Violence, and Intimate Partner Violence: Developmental Relationships. *American Journal of Preventative Medicine* 33(4): 281–290.

176 Renner, L.M. and Shook Slack, K. (2006) Intimate partner violence and child maltreatment: Understanding intra- and intergenerational connections. *Child Abuse & Neglect* 30: 599–617.

177 Schaaf, K.K. and McCanne, T.R. (1998) Relationship of childhood sexual, physical, and combined sexual and physical abuse to adult victimisation and posttraumatic stress disorder. *Child Abuse & Neglect* 22(11): 1119–1133.



## Sexual Abuse

Experience of sexual abuse has been linked to perpetration of intimate partner violence for males<sup>178</sup> and mental and physical health problems. For example, Herbert et al. (2006)<sup>179</sup> found sexual abuse to be linked to greater internalising problems and sexualised behaviours, and Diaz et al. (2002)<sup>180</sup> found that the individuals in their sample who had experienced sexual abuse were 2.47 times more likely to experience moderate to high levels of depression in comparison to their non-abused peers. With regards to physical health, Draper et al. (2008)<sup>181</sup> found sexual abuse victims to be 1.21 times more likely to have a myocardial infarction or a stroke than the non-abused individuals in the study. Additionally, multivariate analysis which controlled for age, gender, marital and migrant status, and education showed that sexually abused individuals were 1.7 times more likely to have poor physical health than the non-abused comparison group in the study.

## Psychological maltreatment

Higgins and McCabe (2003)<sup>182</sup> found that psychological maltreatment was a unique significant predictor of adults' reports of trauma symptoms, positive relationships with others, and purpose in life.

## Bullying

Bullying appears to manifest itself mostly through psychological symptoms. Victimisation has been associated with externalising and internalising behaviours for both genders, and psychosomatic symptoms for males and hyperactivity for females<sup>183</sup>; anxiety and depression<sup>184</sup> and suicide ideation.<sup>185</sup>

Additionally, it has been associated with poor physical health,<sup>186</sup> and in one study bullied children were found to be more likely to experience a stomach ache or headache once or more a week.<sup>187</sup>

178 Fang, X. and Corso, P. (2007) Child Maltreatment, Youth Violence, and Intimate Partner Violence: Developmental Relationships. *American Journal of Preventative Medicine* 33(4): 281–290.

Renner, L.M. and Shook Slack, K. (2006) Intimate partner violence and child maltreatment:

179 Herbert, M., Tremblay, C., Parent, N., Daignault I.V. and Piche, C. (2006) Correlates of behavioural outcomes in sexually abused children. *Journal of Family Violence* 21: 287–299.

180 Diaz, A., Simantov, E., Rickett, V.I. (2002) Effect of Abuse on Health: Results of a National Survey. *Archives of Pediatrics & Adolescent Medicine* 156: 811–817.

181 Draper, B., Pfaff, J.J., Pirkis, J., Snowdon, J., Lautenschlager, N.T., Wilson, I. and Almeida, O.P. (2008) Long-Term Effects of Childhood Abuse on the Quality of Life and Health of Older People: Results from the Depression and Early Prevention of Suicide in General Practice Project. *Journal of the American Geriatrics Society*. 56(2): 262–271

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183 Kumpulainen, K., Räsänen, E., Henttonen, I., Almqvist, F., Kresanov, K., Linna, S-L., Moilanen, I., Piha, J., Puura, K. and Tamminen, T. (1998) Bullying and psychiatric symptoms among elementary school-age children. *Child Abuse & Neglect* 22 (7): 705–717.

184 Carlyle, K.E. and Steinman, K.J. (2007) Demographic Differences in the Prevalence, Co-Occurrence, and Correlates of Adolescent Bullying at School. *Journal of School Health* 77(9): 623–629; Bond, L., Carlin, J.B., Thomas, L., Rubin, K. and Patton, G. (2001) Does bullying cause emotional problems? A prospective study of young teenagers. *British Medical Journal*. 323, pp. 480–484; Salmon, G., James, A. and Smith D.M. (1998) Bullying in schools: self reported anxiety, depression, and self esteem in secondary school children. *British Medical Journal* 317: 924–5.

185 van der Wal, M.F., de Wit, C.A.M. and Hirasing, R.A. (2003) Psychosocial Health Among Young Victims and Offenders of Direct and Indirect Bullying. *Pediatrics* 111(6): 1312–1317.

186 Gruber, J.E. and Fineran, S. (2007) The Impact of Bullying and Sexual Harassment on Middle and High School Girls. *Violence Against Women* (2007) 13(6): 627–643; Rigby, K. (1999), Peer victimisation at school and the health of secondary school students. *British Journal of Educational Psychology* 69: 95–104.

187 Williams, K., Chambers, M., Logan, S. and Robinson, D. (1996) Association of common health symptoms with bullying in primary school children. *British Medical Journal* 313: 17–19.

## THE PROPORTION OF MALTREATED CHILDREN EXPERIENCING NEGATIVE OUTCOMES

The preceding section demonstrated the wide-ranging, detrimental consequences of maltreatment. These findings do not imply that the experience of maltreatment leads to a deterministic pathway of adverse outcomes; however its consequences do impact negatively on a substantial number of individuals. In order to estimate the full cost of maltreatment it is important to establish the proportion of individuals who do experience the various negative outcomes; evidence of which is reported below.

Leiter and Johnsen's study (1997)<sup>188</sup> gives numbers of abused and neglected children who demonstrated school performance declines after maltreatment had occurred. Of their sample of 967 children, who had either substantiated or unsubstantiated reports of maltreatment, just over 43 per cent experienced a decline in grade point average; approximately 49 per cent showed an increase in truancy, approximately 27 per cent exhibited an increase in behavioural problems in elementary grades, and 24 per cent were referred, eligible, or placed in a special educational program. Taken as a whole, between one fifth and half of the sample experienced a decline in each one of the measures examined in the study.

Kumpulainen et al's (1998)<sup>189</sup> research examined the relationship between psychiatric symptoms and bullying. Psychiatric symptoms were measured by three scales: the Rutter Scale for parents, the Rutter Scale for teachers and Kovac's Children's Depression Inventory (CDI). Data were gathered from 5,813 children born in Finland in 1981; within this sample 1,566 of the children were classified as bullies, bully-victims or victims. In assessing psychological disturbance across the three scales the results showed that: 47 per cent of male and 40 per cent of female bullies; 79 per cent of male and 77 per cent of female bully-victims and 49 per cent of male and 40 per cent of female victims were categorised as having psychological disturbances in any of the scales. This can be compared to 16 per cent of male and 11 per cent of female control children who were classified as being psychologically disturbed.

One study looked at adverse childhood exposures in relation to causes of death in adulthood. Exposures included three types of abuse: physical abuse, contact sexual abuse, psychological abuse, and exposure to four types of household dysfunction: substance abuse, mental illness, violent treatment of mother or stepmother, and criminal behaviour. The sample consisted of the 8,056 individuals; of these 52 per cent reported exposure to at least one category and 6.2 per cent reported exposure to 4 or more categories. Of individuals who had experienced one category, 7.9 per cent were current smokers, 7.0 per cent were severely obese, 21.4 per cent reported two or more weeks of depressed mood in the past year and 2.4 per cent reported having attempted suicide. Of the individuals who experienced four or more negative exposures, 16.5 per cent were current smokers, 12.0 per cent were severely obese, 50.7 per cent reported two or more weeks of depressed mood in the past year and 18.3 per cent reported ever having attempted suicide. With regards to health risk factors, of those exposed to one category 5.7 per cent considered themselves to be alcoholics, 11.4 per cent had used illicit drugs, 0.5 per cent had injected drugs, 5.1 per cent had 50 or more intercourse partners, and 8.6 per cent had had a sexually transmitted disease. Of the individuals who had experienced four or more categories of adverse exposure, 16.1 per cent considered they to be alcoholics, 28.4 per cent had used illicit drugs, 3.4 per cent had injected drugs, 6.8 had 50 or

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188 Leiter, J. and Johnsen, M.C. (1997) Child Maltreatment and School Performance Declines: An Event-History Analysis. *American Educational Research Journal* 34(3): 563–589.

189 Kumpulainen, K., Räsänen, E., Henttonen, I., Almqvist, F., Kresanov, K., Linna, S-L., Moilanen, I., Piha, J., Puura, K. and Tamminen, T. (1998) Bullying and psychiatric symptoms among elementary school-age children. *Child Abuse & Neglect* 22 (7): 705–717.

more intercourse partners, and 16.7 had had a sexually transmitted disease. The results indicate a strong dose response to negative exposures.<sup>190</sup>

Rowe and Eckenrode (1999)<sup>191</sup> looked at the relationship between maltreatment and the timing of academic difficulties. Academic performance was measured by marks in English and maths in sixth grade. For English grades, data were available for 313 non-maltreated and 282 maltreated children and for maths grades the sample included 310 non-maltreated and 286 maltreated children. Using discrete-time hazards modelling, survival curves indicate that 35 per cent of non-maltreated and 62 per cent of maltreated children would not complete sixth grade without receiving a poor grade. For maths, it was estimated 45 per cent of non-maltreated and 63 per cent of maltreated children would not complete the sixth grade without receiving a poor grade.

McGloin and Widom (2001)<sup>192</sup> aimed to examine resilience across different time periods and areas of functioning. The original sample for the study consisted of 908 abused or neglected children, where maltreatment had occurred between 1967 and 1971, and 667 matched non-maltreated children. Follow-up interviews took place between 1989 and 1995 with 1,196 individuals, of which 676 had been abused or neglected. The authors assessed resilience across eight domains of functioning and at varying points in time. Comparison of the maltreated and control groups across the eight domains showed a significant difference between the two groups in six of the eight areas, with no significant difference being seen in social activity and substance abuse. A greater number of maltreated than non-maltreated were successful in all the eight areas. Specifically 80.7 per cent of the abuse/neglect group were not successful in the employment measures in comparison 70.4 per cent of the control group; 25.6 per cent of the abuse/neglect group had not had a period of homelessness for at least a month or more compared to 12.3 per cent of the controls; 51.5 per cent of the maltreated group did not graduate from high school compared to 31.5 per cent of the control group; 51.9 per cent of the maltreated group had a psychiatric disorder compared to 39.2 per cent of the control group; 56.5 per cent of the maltreated group had been arrested as a juvenile or adult compared to 42.5 per cent of the controls, and 32.2 of the maltreated group compared to 22.9 per cent of the controls had self-reports of engaging in violent behaviour. Analysis by gender showed that more females than males were successful in seven of the eight functions, the exception being psychiatric disorder.

Lynskey and Fergusson (1997)<sup>193</sup> aimed to determine which factors distinguish the victims of childhood sexual abuse who did not develop psychiatric disorders or adjustment difficulties from the individuals that did develop difficulties. Data for this study were obtained from the Christchurch Health and Development Study, which is a longitudinal study of an unselected birth cohort of 1,265 children born in Christchurch, New Zealand in 1977. This study examined data from 1,025 of the sample at age 18. The analysis divided the sample into four groups, those that had reported no experience of sexual abuse (n=918), those that reported non-contact sexual abuse only (n=24), those that reported contact sexual abuse without intercourse (n=47) and those that reported intercourse (n=36). The disorders assessed

190 Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, S. (2001) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study in Franey, K., Geffner, R. and Falconer, R. (eds) *The Cost of Child Maltreatment: Who Pays? We all do*. Family Violence & Sexual Assault Institute.

191 Rowe, E. and Eckenrode, J. (1999) The timing of academic difficulties among maltreated and nonmaltreated children. *Child Abuse & Neglect* 23(8): 813–832.

192 McGloin, J.M. and Spatz Widom, C. (2001) Resilience among abused and neglected children grown up *Development and Psychopathology* 12: 1021–1038.

193 Lynskey, M.T. and Fergusson, D.M. (1997) Factors protecting against the development of adjustment difficulties in young adults exposed to childhood sexual abuse. *Child Abuse & Neglect* 21(12): 1177–1190.

by the authors were: major depression, anxiety disorder, conduct disorder, alcohol abuse/dependence, other substance abuse/dependence, suicide attempt, and scoring 3+ on the Post-Sexual Abuse Trauma Checklist.

Forty-one per cent of the non-abused young adults had 'any of the disorders' in comparison to 71 per cent of non-contact abused individuals, 77 per cent of contact abused individuals and 78 per cent of individuals whose abuse included intercourse. The most common disorder was major depression, which was reported by 18 per cent of the non-abused participants, 50 per cent of the non-contact abused group, 51 per cent of the contact abused group and 64 per cent of the group where contact included intercourse. The next most common reported disorder was anxiety disorder which was reported by 14 per cent of the non-abused group, 42 per cent of the non-contact group, 40 per cent of the contact without intercourse and 44 per cent of the contact with intercourse group. The least commonly reported disorder was suicide attempt, which was reported by 3 per cent on the non-abused group, 4 per cent of the non-contact abuse group, 9 per cent of the contact abuse group without intercourse and 22 per cent of the contact abuse group with intercourse

Fergusson et al. (2008)<sup>194</sup> examined the association between sexual and physical abuse in childhood and mental ill health. The study also used data from the Christchurch Health and Development Study to examine outcomes at ages 16–18, 18–21, and 21–25; the sample sizes were 1,025 at 16–18, 1,011 at 18–21, and 1,001 at 21–25. With regards to sexual abuse the number of individuals who reported no experience of sexual abuse ranged from 881 to 855 across the three time periods, for non-contact sexual abuse there were 28 individuals across the three periods, for contact sexual abuse without penetration there were 53 individuals when participants were between 18 and 21, and 52 in the youngest and oldest ranges, for sexual abuse which included attempted/completed penetration the numbers in the sample ranged from 63 to 66. In general the percentage of individuals that were classified as having disorders was greater in the younger age group and for individuals who had experienced the most severe type of sexual abuse. The number of disorders was highest for the youngest age group where sexual abuse had included attempted or completed penetration.

The most common disorder for all age groups was major depression. Between the ages of 16 and 18, 42.9 per cent of the non-contact group, 55.8 per cent of the contact group and 57.8 of the attempted/completed penetration group were categorised as having major depression, in contrast to 16.8 per cent of individuals in the same age range who reported no experience of sexual abuse. At ages 18 to 21, 42.9 per cent of the non-contact group, 41.5 per cent of the contact group and 54.0 per cent of the attempted/completed penetration group had major depression in comparison to 19.6 per cent of non-abused individuals. At ages 21 to 25, major depression was experienced by 35.7 per cent of non-contact abused individuals, 44.2 per cent of contact abused individuals, and 40.9 per cent of attempted/completed penetration abused individuals, in comparison to 18.4 per cent of non-abused individuals. The greatest difference between the most severely abused group and other groups was found in the attempted suicide category. For individuals whose abuse had included attempted/completed penetration 20.3, 20.6 and 10.6 per cent in each consecutive time period reported suicide attempts, for other groups, the proportion of individuals who had attempted suicide ranged from 1.5 to 3.6 per cent, with the exception of individuals at the ages of 16 to 18 who had experienced contact abuse in childhood, where 9.6 per cent attempted suicide; though this fell to 1.9 per cent as they aged.

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194 Fergusson, D.M., Boden, J.M. and Horwood, L.J. (2008) Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse & Neglect* 32: 607–619.

With regards to physical abuse, the sample were split into individuals who had no experience or seldom experienced physical punishment/abuse, those who had experienced regular physical punishment/abuse and those that had experienced severe/harsh physical punishment/abuse. The analysis also looked at the results across the three age ranges previously mentioned. Individuals who had experienced severe/harsh abuse had a greater proportion of individuals in each disorder category with the exception of conduct/anti-social personality disorder where a greater per cent of those in the regular abuse group were reported as having a conduct disorder. Major depression, anxiety disorder and suicidal ideation were the most commonly reported disorders.

Collishaw et al. (2007)<sup>195</sup> assessed the relationship between childhood maltreatment and behavioural problems in adolescence and midlife. The data were obtained from the Isle of Wight adolescence study (1968) and follow-up study (1998–2000). A sample of 378 individuals was interviewed in the follow-up, of which 364 answered the question relating to childhood abuse. Forty-four adults retrospectively reported abuse in childhood.

Adolescent psychopathology and peer relations were assessed in 571 individuals in 1968. The results showed a greater proportion of the abused adolescents demonstrated problem behaviour than did their control counterparts. For example, 37.4 per cent of the abuse group were categorised as having minor depression in contrast to 3.7 per cent of the no abuse group; 28.4 per cent of the abuse group reported suicidal ideation in comparison to 4.3 of the controls; 26.6 per cent of the abuse compared to 4.3 per cent of the no abuse group had anxiety disorder; 10.6 per cent of the abuse in contrast 2.7 per cent of the no abuse group had two or more symptoms of conduct disorder and 44.3 per cent of the abuse group compared to 19.8 per cent of the no abuse group had peer relationship problems.

In adulthood, psychiatric disorder was assessed in the following domains: major depressive disorder (37.0 per cent of abuse group compared to 21.1 per cent of non-abuse group); recurrent major depressive disorder (3+ episodes) (20.3 per cent of abuse group compared to 3.3 per cent of non-abuse group); suicidality (planning or attempts) (23.9 per cent of abuse group compared to 7.4 per cent of non-abuse group); suicide attempt (4.9 per cent of abuse group compared to 1.3 per cent of non-abuse group); any anxiety disorder (39.6 per cent of abuse group compared to 21.4 per cent of non-abuse group) post-traumatic stress disorder (19.0 per cent of abuse group compared to 2.2 per cent of non-abuse group); substance abuse/dependence (17.5 per cent of abuse group compared to 4.1 per cent of non-abuse group), and any DSM-IV psychiatric disorder (55.5 per cent of abuse group compared to 36.2 per cent of non-abuse group).

In relation to delinquent behaviour and conduct problems, Stouthamer-Loeber et al. (2001)<sup>196</sup> found that a greater number of maltreated than non-maltreated youth had problem behaviours. The study examined the behaviours of approximately 500 boys who were first assessed in 7<sup>th</sup> grade (ages 12 to 13). By age 18 approximately a quarter of the boys' families had been referred to Children and Youth Services (CYS) and 10 per cent had substantiated cases of maltreatment after investigation by CYS.

Comparison of the maltreated and non-maltreated boys showed that 67.2 per cent of maltreated youths compared to 46.7 per cent of non-maltreated displayed minor aggressive behaviour; 77.0 per cent

<sup>195</sup> Collishaw, S., Pickles, A., Messer, J., Rutter, M., Shearer, C. and Maughan, B. (2007) Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse & Neglect* 31: 211–229.

<sup>196</sup> Stouthamer-Loeber, M., Loeber, R., Lynn Homish, D. and Wei, E. (2001) Maltreatment of boys and the development of disruptive and delinquent behavior. *Development and Psychopathology* 13: 941–955.

maltreated and 42.6 per cent of non-maltreated boys were involved in fights; 50.8 per cent of maltreated and 34.4 per cent of non-maltreated boys were involved with violent behaviour, and 78.7 per cent of maltreated and 53.3 per cent of non-maltreated youth were involved in moderately delinquent behaviour. Additionally, 54 per cent of maltreated compared to 38.5 per cent of non-maltreated youth had at least one petition in court. The numbers of non-maltreated boys demonstrating negative outcomes appears fairly high, however there are some indications that this sample as a whole are disadvantaged, 44.9 per cent lived with a single parent and 36.2 per cent received public assistance.

The NSPCC research found that although experiencing severe maltreatment by a parent or guardian had a stronger statistical association with poor emotional wellbeing than did maltreatment that was less severe, there was not such a clear relationship between severity of parental maltreatment and delinquent behaviour. Sexual abuse and physical violence were both found to be independently associated with delinquency for girls aged 11 to 17. However, physical violence was not for boys. Amongst boys aged 11 to 17 severe maltreatment was more strongly associated with delinquent behaviour than maltreatment that was less severe.<sup>197</sup>

Rogosch and Cicchetti (2004)<sup>198</sup> examined personality organisation in 211 six year old, of which 135 had been maltreated. The children's personality types were assessed using the Five-Factor Model (FFM) or Big Five approach, which determines individuals' extraversion, agreeableness, conscientiousness, neuroticism and openness. Maltreated children were classified as either experiencing: neglect only (20.6 per cent), abuse only (19.8 per cent) or both neglect and abuse (59.8 per cent). Once individual profiles had been determined cluster analysis was carried out to group together individuals with similar profiles. Of the five clusters derived from the analysis, two demonstrated better adaptive functioning. Clusters 1 (n=45) and 2 (n=46) which were labelled 'Gregarious' and 'Reserved' respectively, contained children who had high scores on agreeableness, conscientiousness and openness to experience, and low scores on neuroticism. Differences were found between these two groups on their extraversion scores as indicated by the cluster names. Cluster 3 (n=41), labelled 'Dysphoric' includes children who are average on extraversion/introversion, but exhibit low scores on agreeableness and conscientiousness and openness to new experiences, and high scores on neuroticism.

The prominent distinction for cluster 4 (n=29) were children who obtained low scores on extraversion and high scores on neuroticism. The children in the group appeared to be withdrawn and inhibited; the cluster was labelled 'Overcontrollers'. The final cluster (n=50) showed high levels of extraversion, low agreeableness scores and low to average scores on the remaining three dimensions; this group were labelled 'Undercontrollers'. Greater numbers of non-maltreated children were found in the clusters which demonstrated positive adaptation. The Gregarious cluster consisted of 31.6 per cent of the non-maltreated children and 15.6 per cent of the maltreated. The Reserved cluster consisted of 34.2 per cent of the non-maltreated and 14.8 per cent of the maltreated children. Therefore the two well adapted clusters contained 65.8 per cent of the non-maltreated children in comparison to only 30.4 per cent of the maltreated group. The majority of maltreated children were found in the three less competent clusters (69.6 per cent). The Dysphoric cluster contained 27.4 per cent of the maltreated and 5.3 per cent of the non-maltreated children; the Undercontrollers cluster contained 27.4 per cent of maltreated and 17.1 per cent of non-maltreated. A smaller distinction was found within the Overcontrollers group which was made up of 14.8 per cent of the maltreated and 11.8 per cent of the non-maltreated children.

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197 Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. with Collishaw, S. (2011) *Child abuse and neglect in the UK today* London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)

198 Rogosch, F.A. and Cicchetti, D. (2004) Child Maltreatment and Emergent Personality Organization: Perspectives From the Five-Factor Model. *Journal of Abnormal Child Psychology* 32(2): 123-145.

Jaffee and Gallop's (2007)<sup>199</sup> study assessed social, emotional and academic competence in a nationally representative sample of children who had been involved with child protective services. The data were obtained from the National Survey of Child and Adolescent Well-Being Child Protective Services sample, which consists of a cohort of children who were subject to investigations related to maltreatment between October 1999 and December 2000, participants were aged from less than one year to fourteen years of age when sampled. This study analysed data on children who were eight years or older at wave 1, as children younger than this did not report on their own symptoms of mental health problems. Data were collected from parents, teachers and the children themselves. Psychopathology was assessed using youth report of depression, trauma and substance abuse, and caregiver and teacher's report of internalising and externalising behaviours. School achievement was measured by the Mini Battery of Achievement, a standardised test of academic achievement, and social competence was measured by caregivers and teachers assessment using the Social Skills subscale of the Social Skills Rating System. Children who demonstrated adequate functioning consistently across informants or measures were defined as showing resilience. At wave 1, 60 per cent of the sample did not have positive mental health, 62 per cent were not achieving academically and 54 per cent did not demonstrate social competence. At wave 3 (24 months from baseline), a greater proportion of children were showing adequate functioning, though 55 per cent did not have positive mental health, 56 per cent were not achieving at school, and 54 per cent did not adequate social competence. At wave 4 (36 months from baseline), a greater number of children had adequate functioning in mental health and social competence, with 52 per cent not having positive mental health and 51 per cent not being assessed as socially competent. The number of children with adequate school achievement dropped to 37 per cent. However, much greater numbers of children did not reach adequate levels of achievement when looking at consistency of functioning in all the 3 time periods; 81 per cent were not assessed as having positive mental health, 78 per cent were not achieving at school and 86 per cent were not assessed as socially competent.

Trocmé et al's (2003)<sup>200</sup> study presented findings from the Canadian Incidence Study of Reported Child Maltreatment (CIS). The CIS produced a sample 7,672 child maltreatment investigations from 51 child welfare service areas across Canada. Results from the CIS showed that approximately 10 per cent of substantiated investigations involve documented injuries, whereas observable emotional harm was seen in 40 per cent of substantiated cases and emotional or behavioural problems were noticed in 50 per cent of substantiated cases.

Overall, it is clear that although substantial numbers of maltreated children experience adverse outcomes, a large proportion do appear to be functioning adequately or well; these children have been labelled as demonstrating resilience. Resilience and how to promote it is discussed more fully in Section 6 below.

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<sup>199</sup> Jaffee, S.R. and Gallop, R. (2007) Social, emotional, and academic competence among children who have had contact with child protective services: Prevalence and stability estimates. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 46(6): 757–765.

<sup>200</sup> Trocmé, N.M., Tourigny, M., MacLaurin, B., Fallon, B. (2003) Major findings from the Canadian incidence study of reported child abuse and neglect. *Child Abuse & Neglect*, 27:,1427–1439.

# 3. THE IDENTIFICATION OF MALTREATMENT

## THE CURRENT POLICY CONTEXT

The development, over the last 100 years, of UK provision for vulnerable children, (including those at risk of abuse), is essentially the on-going resolution of a long-standing tension between the role of the *state* and the role of the *family*, as to their rights and responsibilities for the welfare of children, including freedom from abuse.<sup>201</sup> At any one time, the balance struck between the two will vary, but the underlying conflicts remain remarkably consistent, and the legal, operational and organisational challenges they throw up, as intractable. In fact the specific impetus for much children's legislation since the post war period has been a series of high profile deaths and/ or abuse of a child, in particular the death of Maria Colwell,<sup>202</sup> which, it has been argued by many, 'led to a transformation in the way professionals dealt with suspected cases of child abuse', and in particular set in train a specific set of professional practices around professional communication and collaboration.<sup>203</sup> Each subsequent piece of legislation has inevitably reflected the nature and ethos of the analysis of each tragedy, and drawn on the research and policy knowledge available to each current group of 'policy architects.'

The national policy framework in England is in the process of a number of organizational and administrative changes set in train by the Coalition Government which came to power in 2010. One dominant theme articulated by the Coalition Government in respect of child welfare policy is the necessity for sharing responsibility for child and family need across professions, agencies and sectors. The Government, in a very short period of time, across 2010 and 2011, commissioned five parallel enquiries which in total reflect ministers' approaches to understanding and analysing perceived systemic achievements and challenges. The reviews span areas including early years, family justice and child protection.

The changes overlap inevitably with the government's primary economic objective of eliminating the budget deficit within the life span of this Parliament. The 2010 comprehensive spending review (CSR) and consequent financial settlement have implications for both local government and in turn for their commissioned child care service partners. Furthermore in order to ensure these financial targets are realised the budget reductions have been front loaded into the first two years of the parliament and so the years 2010–12 promise to be the most challenging. At a local authority level many have experienced reductions of over 25 per cent.

In addition to economic and fiscal objectives, there are new policy debates around the concept of localism and associated idea of the "Big Society".<sup>204</sup> Proposed change includes a reduction in regulation and prescription by central government, and a review of the current legislative framework for local authorities. By 2011, the requirement for Children's Plans had been removed as well as prescribed organisational structures such as Children's Trusts. This vision reflects many of the themes of the recently published Munro Review of Child Protection<sup>205</sup>. This lays out a model for services based less on

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201 Parton, N. (1997) *Child Protection and Family Support: tensions, contradictions and possibilities*. London Routledge; Tunstill, J. (2000) (ed) *Children and the State: Whose problem?* Cassell London).

202 Department of Health and Social Security (1974) *Report of the Committee of Inquiry into the Care and Supervision Provided in relation to Maria Colwell*. HMSO London.

203 Munroe, E. (2005) What tools do we need to improve identification of child abuse? *Child Abuse Review* 14: 374–388

204 <http://www.communities.gov.uk/localgovernment/decentralisation/localismbill/>

205 <http://www.education.gov.uk/munroreview/>



'prescriptiveness' and an enhanced role for professional discretion and judgement and for local decision making. This theme is also reflected in the Health and Social Care Bill, which, amongst other changes, will reorganise the regulation of social workers.

The Munro Report makes fifteen recommendations in the context of arguing for a shift from an approach which it characterises as an albeit well-intentioned, tick-box culture and consequent loss of focus on the needs of the child. Taken together, the recommendations cover the following key areas:

1. A radical reduction in the amount of central prescription to help professionals move from a compliance culture to a learning culture, where they have more freedom to assess need and provide the right help. Statutory guidance should be revised and the inspection process modified to give a clearer focus on children's needs. Inspection should be unannounced;
2. A change of approach to Serious Case Reviews (SCRs), with learning from the approach taken in sectors such as aviation and healthcare. There should be a stronger focus on understanding the underlying issues that made professionals behave the way they did and what prevented them from being able to properly help and protect children. The current system is too focused on what happened, not why;
3. Reform of social work training and placements with employers and Higher Education Institutions and doing more to prepare social work students for the challenges of child protection work. The work of the Social Work task Force and the Social Work Reform Board should be built upon to improve frontline expertise;
4. Each local authority should designate a Principal Child and Family Social Worker to report the views and experiences of the front line to all levels of management. At national level, a Chief Social Worker should be established to advise the Government on social work practice;
5. Local authorities and their statutory partners should be given a new duty to secure sufficient provision of early help services for children, young people and families, leading to better identification of the help that is needed and resulting in an offer of early help;
6. Affirmation of the importance of clear lines of accountability as set out in the Children Act 2004 and the protection of the roles of Director of Children's Services and Lead Members from additional functions, unless there are exceptional circumstances; and
7. Strengthened monitoring of the effectiveness of help and protection by Local Safeguarding Children Boards, including multi-agency training for safeguarding and child protection.

As indicated above, the Munro Review is one of five coordinated policy reviews, which together represent an important aspect of the Coalition government's vision for child welfare, and have considerable implications for the relationship between preventive and reactive child welfare services, including, from a range of disciplines, addressing the challenge of child maltreatment. (The other reviews in question explore Early Intervention (Allen)<sup>206</sup>, Tackling Poverty (Field)<sup>207</sup>, Early Years (Tickell)<sup>208</sup> and Family Justice (Norgrove)<sup>209</sup>. These five reviews indicate collectively the real possibility that services may well be delivered in a very different environment in coming years. However one strong indication is that, a “

206 <http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf>

207 <http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf>

208 <http://media.education.gov.uk/MediaFiles/B/1/5/%7BB15EFF0D-A4DF-4294-93A1-1E1B88C13F68%7D%20Tickell%20review.pdf>

209 <http://www.justice.gov.uk/downloads/publications/policy/moj/family-justice-review-interim-rep.pdf>

less proceduralised system “ will make greater demands of practitioners in terms of the use of discretion, and that previous systems and structures will look very different by the end of the life of the current Parliament .

A shared philosophy can be discerned across all of the five reviews in terms of their implications for the future design and delivery of child protection and responses to child maltreatment, which are exemplified by Munro’s call for ‘shared responsibility for the provision of early help’<sup>210</sup>.

Like the reviews led by Graham Allen MP, Dame Clare Tickell, and Rt Hon Frank Field MP, this review has noted the growing body of evidence of the effectiveness of early intervention with children and families and shares their view on the importance of providing such help. Preventative services can do more to reduce abuse and neglect than reactive services. Many services and professions help children and families so co-ordinating their work is important to reduce inefficiencies and omissions. The review is recommending the Government place a duty on local authorities and their statutory partners to secure the sufficient provision of local early help services for children, young and people and families. This should lead to the identification of the early help that is needed by a particular child and their family and to the provision of an offer of help where their needs do not match the criteria for receiving children’s social care services.

## The Response of the Government so far

Following appraisal and discussion by a specially convened Implementation Working Group (IWG) which brought together expertise from local authority children’s services, the social work profession, education, police and health services the Government published its response to the Munro Review of Child Protection. This response is being presented as a first step on the process of longer term reform of the child protection system so it can deliver improved outcomes for the most vulnerable children and young people.

The main ‘headline messages’ are as follows:

- The Government agrees that Professor Munro’s 15 recommendations need to be considered in the round and acknowledges that together they represent the opportunity to delivery holistic reform of the child protection system.
- Government will oversee a radical reduction in the amount of regulation through the revision of statutory framework to place greater emphasis on direct work with children, young people and families.
- An amendment to statutory guidance by December 2011 to remove the prescription of timescales and the distinction between core and initial assessments.
- Government supports Professor Munro’s view that the quality of relationships between social workers and children and young people sits at the heart of an effective child protection system and will support and work with the SWRB, the College of Social Work and ADCS to develop the knowledge and skills of the profession.
- Inspection will continue to be important with a new inspection framework that will have at its heart the experiences of children and young people

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210 Executive summary, page 7, Munro.

- There will be greater transparency and coordination of local arrangements to deliver an early help offer to children, young people and families
- Creation of a chief social worker to advise Government on social work practice and the effectiveness of the help being given to children and young people.
- A co-produced work programme between the Department for Education, the Department of Health, NHS bodies, local authorities, professional bodies and practitioners to ensure continued improvement of safeguarding arrangements in health reform.
- Government agrees that in future systems review methodology should be used by LSCBs when serious case reviews are undertaken but believes it is important to plan the transition to new arrangements carefully.

### An earlier perspective: policy and practice structures and systems introduced after 1997

Whilst the preceding section has laid out the developments in train so far, it is important to see them as part of a continually evolving system, so the paragraphs below provide an overview of the system which developed under the previous government. As explained above, this is currently in the process of considerable modification and change. Although, as can be seen, the perennial issues can be identified in legislation and structures, and many of the aspirations of the previous government can be seen to inform the design of the new structures .

As has so frequently been the case in the history of child welfare policy, the previously legislated, and in some cases surviving, provisions derived substantially from the response of a government to minimize the likelihood of repetition of a child's death. In this case the *catalyst* was the death of Victoria Climbié, and the recommendations of the subsequent Laming Inquiry in to the death of Victoria Climbié. The Laming Inquiry<sup>211</sup> had painted a picture of dangerous fragmentation between the key agencies at local level: health, education, police and social services. Government responded by setting in train a widespread programme of organisational reform in children's services, and a set of plans to improve outcomes for all children and young people, including the most disadvantaged, in the Green Paper, *Every Child Matters*.<sup>212</sup> In this paper, five outcomes for children are specified:

- Being healthy
- Staying safe
- Enjoying and achieving
- Making a positive contribution
- Achieving economic well-being

While there are inevitably some organisational variations, as well as different emphases in the legal and policy systems in England, Scotland, Wales and Northern Ireland, these are mainly outweighed by the similarities. Better support to parents and carers, earlier intervention before problems become entrenched and effective protection are highlighted in all four nations. In children's services, for example,

<sup>211</sup> Lord Laming (Chair) (2003) *The Victoria Climbié Inquiry report of an inquiry by Lord Laming*. CM 5730. London: The Stationery Office.

<sup>212</sup> HM Treasury (2003) *Every Child Matters* CM 5860. London. The Stationery Office.

there are many core commonalities between *Every Child Matters* in England, *Getting it right for Every Child* in Scotland, the Welsh Assembly Government's *Childcare Action Plan* and the Children's Policy currently under consultation in Northern Ireland. Most obviously all four demonstrate a drive to improve outcomes for children; and all reflect an aspiration to reduce levels of child poverty and disadvantage.

Although it includes a central commitment to expanding the degree of support available to *all* children, the ECM reforms reflect in particular a long-standing tension between the *recognition and monitoring of child abuse* on the one hand, and the *provision of support for families* on the other. Successive inspection reports have consistently stressed the need to square that circle, the most recent in 2006.<sup>213</sup> A key aim of *Every Child Matters* is to ensure that systems, structures, and services, neither overlook the importance in children's lives of 'safeguarding' nor of 'promoting' their welfare.

## THE IMPACT OF TIERS OF NEED AND THRESHOLDS ON ACCESS TO SERVICES AIMED AT PROMOTING AND SAFEGUARDING THE WELFARE OF CHILDREN

In addition to specific building blocks in the current child protection/safeguarding system, it is important to highlight the on-going debate around the various levels of need at which a range of interventions might be offered on either a voluntary or an involuntary basis; and the way in which they can potentially interact, both positively and negatively with the series of *thresholds into services*, described below. Thresholds act as both gateways and barriers to a wide range of services. It is also worth noting that within the wider children's service system delivery is undertaken by a *multi-disciplinary* workforce. Members of this workforce have different levels of training in child protection.<sup>214</sup>

### Tiers of need

A *tiered model of services* is a central and familiar concept of healthcare provision, where the concepts of primary prevention, secondary prevention, tertiary prevention and quaternary prevention are well embedded.

*Tier 1* services are universal services provided to all citizens who chose to use them (eg GP services, public libraries) or available to all in a particular age group (eg schools for those of compulsory school age) or in a particular need group, eg midwifery services for expectant mothers, Jobcentres for those seeking employment.

*Tier 2* services are targeted at groups or communities where research or experience indicates that there is an additional level of need or vulnerability, but where the choice to use the service remains with the family. For example Sure Start projects were originally sited in areas of known deprivation, with high concentrations of disadvantaged families, but most services were based on the principle of open access to all local families, without the requirement to establish individual need. They did, however, provide some Tier 1 and Tier 3 services. With the establishment of Sure Start Children's Centres in most areas,

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<sup>213</sup> CSCI (2006) *Supporting parents, safeguarding children: meeting the needs of parents with children on the child protection register*. London CSCI.

<sup>214</sup> Joint Chief Inspectors (2005) *The Second Joint Chief Inspectors Report on arrangements to Safeguard Children*. London CSCI.

these have become mainly Tier 1 service providers, but also providing some Tier 2 and Tier 3 services. Other examples of Tier 2 services would be open access community-based services for refugee families, or families with disabled children.

*Tier 3* services (sometimes referred to as ‘targeted’ or ‘referral based’) services are targeted at identified families known to be vulnerable, who may refer themselves or be referred by a worker within a universal service such as a teacher or GP, for a more specialist service. There is usually a needs threshold (legally or administratively established) for access to these services. They aim to prevent identified problems from causing harm to parents or children, but may involve therapy for established difficulties. They are mainly provided within the family home or neighbourhood, but could include, for example, support foster care for disabled children.

*Tier 4* services are ‘remedial’ or ‘rehabilitative’ support and/or therapy services for referred families, and sometimes involve court orders or an element of compulsion (such as a child protection inquiry; a young person convicted of an offence being placed in a treatment foster family; a health service placement in an addiction treatment unit, or a residential unit for a family evicted as a consequence of anti-social behaviour).

Hardiker et al. (1991)<sup>215</sup> laid the foundations for the transfer of these concepts of tiers of service into planning social care services for children. They have been recently deployed in the development/analysis of Public Service Agreements in Safeguarding Children,<sup>216</sup> and they have incorporated in the Framework for the Assessment of Children in Need and their Families,<sup>217</sup> and more recently into the Common Assessment Framework.<sup>218</sup>

The public health literature generally uses a model of three service tiers. In this model remedial services are Tier 3, as are some referral-based intensive Tier 2 services. Tier 2 is a mixture of open access and referred services targeted at groups where higher risk has been identified. Although children’s services in the UK are generally configured in terms of four tiers, much of the literature on services uses the public health framework, so that in Sections 4 and 5 below, the three-tier framework is used.

## Thresholds

The first Joint Chief Inspectors Report into Area Child Protection Committees in 2002, and the follow up report in 2005, both concluded many referring agencies did not see children’s social care as providing an adequate response to safeguard children. In particular concern was expressed about the issue of thresholds, including the lack of overall clarity about them, and especially the absence of shared understanding between different groups of workers. As the 2005 report concluded:

*There remain significant issues about how thresholds are applied by social services in their child protection and family support work.....agencies other than social services are often unclear about how to recognize the signs of abuse or neglect, are uncertain about the thresholds that apply to child*

215 Hardiker, P., Exton, K., Barker, M. (1991) *Policies and Practices in Preventive Child Care*. Aldershot. Avebury.

216 Mesie, J., Gardner, R., Radford, L. (2007) *Towards a Public Service Agreement on Safeguarding*. Research Report No 829. DfES/NSPCC.

217 Department of Health, Department for Education and Employment, Home Office (2000) Framework for the Assessment of Children in Need and their Families. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4003256](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256).

218 Department for Children, Schools and Families (2006) *The Common Assessment Framework and Lead Professional Guidance and Implementation in 2005–06*. London: DCSE.

*protection or do not know to whom they should refer their concerns...largely because of resource pressures, some councils' social services apply inappropriately high thresholds in responding to child protection referrals and in taking action to protect children...because some social services are unable to respond to families requiring support, other agencies do not refer children when concerns about their welfare first emerge. This means that some families are subject to avoidable pressure, children experience preventable abuse or neglect and relationships between social services and other agencies may become strained.<sup>219</sup>*

Each of the following elements in the safeguarding system are therefore inter-dependent with the operation of thresholds within their respective local area/authority/agency .

## What are the main organisational structures currently in place to support identification?

The main proposals of *Every Child Matters* were incorporated into the Children Act 2004, whose clauses seek to achieve reforms in four key areas: early intervention; accountability and co-ordination; supporting parents and carers; and the introduction of a cross-sector workforce. The Act sets out the duty of local agencies to cooperate on delivering children's services which underpins the development of children's trust arrangements. These trusts bring together the local services provided for children and young people into one agency, including local authority services, community health services, and Children's Centres.

Section 11 of the Children Act 2004, supported by statutory guidance,<sup>220</sup> places a duty on key people and bodies to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The bodies covered are:

- Local authorities, including district councils
- The police
- The probation service
- NHS bodies ( Strategic Health authorities, Designated Special Health Authorities, Primary Care trusts; NHS Trusts and NHS Foundation Trusts)
- Connexions Service
- Youth Offending Teams
- Governors/Directors of Prisons & Young Offender Institutions
- Directors of Secure Training Centres
- The British Transport Police

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<sup>219</sup> Joint Chief Inspectors (2005) *The Second Joint Chief Inspectors Report on arrangements to Safeguard Children*. London CSCI.

<sup>220</sup> HM Government (2007) *Statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the children Act 2004*. London DfES.

At the same time the Act puts a duty on all local authorities to establish a *safeguarding children board* (LSCB).<sup>221</sup> Whilst these new Boards are intended to have a wide agenda in respect of the welfare of children in the area, they are to focus particularly on the staying *safe* outcome.

## Referral routes for the assessment of child protection

The main Government guidance in respect of staying safe is *working Together*.<sup>222</sup> This (p35) clarifies the fact that child protection is part of safeguarding and promoting welfare, and refers to the activity that is undertaken to protect specific children who are suffering, or are at risk of suffering, significant harm. Local authorities have a duty to safeguard and promote the welfare of children in need:<sup>223</sup>

*... children who are defined as being in need under S17 of the Children Act 1989, are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired without the provision of services...plus those who are disabled. ...*

However some children will be in need because they are suffering, or are likely to suffer, significant harm. 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, and gives LAs a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or likely to suffer, significant harm. The conclusion that significant harm has or is likely to take place is however by no means straightforward, as several writers have concluded.<sup>224</sup> Indeed the government's own guidance (p36) acknowledges the challenge in making these judgements:

*There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism or bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and /or relatively greater difficulty in helping the child overcome the impact of the maltreatment...*

The guidance highlights the fact that whilst “*significant events*” may play a part, for children whose health and development are neglected, it is the corrosiveness of long term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm...’

## What happens after the referral?

The system for making a referral offers several routes. Where there is a concern around the safeguarding needs of a child, a referral can be made to children's social care services. This might arise from a CAF but could well be made directly from any worker, who has come into contact with a child; or a member of the

<sup>221</sup> HM Government (2007) *Statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the children Act 2004*. London DfES.

<sup>222</sup> HM Government (2006) *Working Together to Safeguard Children: a guide to inter agency working to safeguard and promote the welfare of children*. London DfES.

<sup>223</sup> Tunstall, J. and Aldgate, J. (2000) *Services for Children in Need: from policy to practice*. London: TSO.

<sup>224</sup> Adcock, M. and White, R. (1998) *Significant Harm: its management and outcome*. Surrey. Significant Publications; Munro, E. (2002) *Effective Child Protection*. London: Sage.

public, or indeed a self referral. ( It may arise in the context of a case that is already open to social care, such as a looked-after child; or a child with disabilities; or other children in need cases.

At this stage children's social care will undertake an initial assessment within seven days, to determine whether a further core assessment, including a S47 investigation is required. In terms of the system of thresholds mentioned above, this initial assessment can be seen to represent the first threshold.

It is children's social care services who then decide, in the light of the information they now have available, whether they should convene a Joint Strategy Meeting. This meeting, effectively Threshold 2, will determine if a S47 investigation should be undertaken or not. The agencies involved at this stage are likely to be social care and police, in addition to the referring agency. If the decision is taken to hold a s47 Enquiry, a core assessment will be done. This stage (Threshold 3) determines whether or not there is sufficient evidence of risk to hold a multi-disciplinary child protection conference to which the family are invited.

The outcome of this meeting is a multi disciplinary decision, effectively Threshold 4, on the need for a child protection plan to be developed, and any immediate safeguarding action to be taken. Subsequently a core group will be convened to develop a multi-disciplinary child protection plan, and to oversee the successful achievement of the staying safe outcome. (It is important to note that in spite of the sequential process described above, at any stage in the process, social care has the duty to take any immediate safeguarding action they deem necessary, eg an Emergency Protection Order.)

## ARRANGEMENTS FOR ASSESSING THE NEEDS OF CHILDREN FOR BOTH SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN

The arrangements for assessment at local level have had a number of individual components, some of which are still in the process of development. There is also a very important debate about the appropriate relationship between data *collection*, data *recording*, and the *interpretation of information*. Current policy development described below has put the spotlight on this inter-relationship, and is further highlighted by the inter-agency nature of current policy and future service delivery.

*Every Child Matters* aimed to integrate services for children aged 0–19, with agencies working across professional boundaries using common processes and a common language. To this end, a set of mechanisms have been introduced, or are in the process of being introduced.

Under the previous government, *Contact Point* was developed as a means of helping professionals to find out who else was working with the same child or family, and was effectively an on-line directory holding demographic data and data on links with services.<sup>225</sup> There were very divergent views as to its potential usefulness, including the cost.<sup>226</sup> The coalition government closed the system down in August 2010.

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<sup>225</sup> [www.ecm.gov.uk/contactpoint](http://www.ecm.gov.uk/contactpoint)

<sup>226</sup> Cleaver, H., Barnes, J., Bliss, D., Cleaver, D. (2004) *Developing Identification, Referral and Tracking Systems: An Evaluation of the Processes Undertaken by Trailblazer Authorities*. DiES London; Munroe E. (2005) What tools do we need to improve identification of child abuse? *Child Abuse Review* 14: 374–388.



The *Common Assessment Framework (CAF)* which was introduced within the ECM agenda is intended to underpin access to services, other than child protection services. The CAF and the establishment of the lead professional role were introduced with the intention that practice and services would be determined by the needs of the child rather than professional boundaries; and that children and families would get a more joined up and coordinated service. It is intended that the CAF will be used where children in ordinary settings have additional needs. Its purpose is to help practitioners identify the need for services at an earlier stage of any problem and to comprise a framework within which a range of different sorts of worker, e.g. education, health, social care, housing, etc. can collaborate to meet the needs for services of children and their families. Whilst the intention of the CAF is early intervention and earlier access to preventive services, in some cases the application of the CAF will lead to the identification of a need for child protection services. In many ways the CAF highlights many of the issues around multi-agency working which may impact at a later stage on the identification of maltreatment.<sup>227</sup>

The other recently introduced related aspect of the children's services system is *The Integrated Children's System*. This involves the systematic collecting and recording in respect of information about the child and family. It is intended to complement the CAF by the in-depth assessment required for children who have or may have suffered abuse or neglect, and where an in-depth assessment is necessary or children become looked after. Two evaluations have been commissioned which reached very different conclusions, one positive, one far less so, and which raised questions about the onerous nature of the computer based recording required which puts at risk the time available to engage in face- to-face work with children and families.<sup>228</sup> The system is currently subject to review by Professor Eileen Munro who is due to report on it in 2011.

## ACHIEVING THE STAYING SAFE OUTCOME: KEY ORGANISATIONAL AND WORKFORCE CHALLENGES

In spite of the considerable effort which went e into the implementation of the ECM agenda, and much of it focused on the safeguarding of child welfare, collaboration between agencies around safeguarding has posed challenges for many local authorities, which reflect longstanding tensions between services designed to support *families* and services designed to *protect children*. The Audit Commission /Health Care Commission (2007),<sup>229</sup> concluded that

*Engaging relevant local bodies in tackling unintentional injuries in some circumstances may be particularly challenging....with no clear direction from government, local agencies faced competing demands. Furthermore local work often reflected the preferences of those charged with shaping strategy. For example when directors of public health took a lead, programmes often had a string focus on promoting health. Elsewhere, where directors of children's services led the work, activities often focused on the welfare of children and family relationships... (p6)*

227 Brandon, M., Howe, A., Dagley, V., Salter, C., Warren, C. (2006) What Appears to be Helping or Hindering Practitioners in the Common Assessment Framework and Lead Professional Working? *Child Abuse Review* 15: 396–413.

228 Cleaver, H., Barnes, J., Bliss, D., Cleaver, D. (2004) *Developing Identification, Referral and Tracking Systems: An Evaluation of the Processes Undertaken by Trailblazer Authorities*. DfES London; Shaw, I., Bell, M., Sinclair, I., Sloper, P., Mitchell, W., Dyson, P., Clayden, J. and Rafferty, J. (2009) An exemplary scheme? An evaluation of the Integrated Children's System. *British Journal of Social Work* 39: 613–626.

229 Audit Commission (2007) *Better Safe than Sorry; preventing unintentional injury to children*.

Even if there is some evidence that staff see the concept of *safeguarding as everyone's business* as a helpful one, there are a number of ongoing challenges still to be addressed if new collaborations are to be developed, and old barriers overcome. These include the following issues:

- Clarity and agreement around respective aims and objectives
- Transcending barriers generated by traditional ways of working
- Strategic level commitment
- Clearly identified roles and responsibilities
- New protocols /procedures for assessment, referral, information sharing
- Ensuring robust training strategies
- Using referral systems to build bridges not barriers.

## CONCLUSION

As this brief overview indicates, the key issues in respect of ensuring the timely identification of potential and or actual child maltreatment are complex and have their roots in a range of organizational, professional and workforce issues. However at the end of the day they have very real consequences for the access of children and their parents/carers to safeguarding services. They also carry major implications for the allocation and scale of resources, whether such resources are in workforce capacity including levels of qualification; workforce training and development; or the costs of hardware and software involved in many of the new programmes, such as the ICS.

The dominance of a narrow child protection ethos acts as a disincentive to parents and carers to refer themselves for services, and if they do reduces the likelihood of services being offered at an early stage of problems.

The assumption that all members of the children's workforce can make a confident contribution to the safeguarding of children has still to be proved to be sound, given both the pace of organizational change and the challenges which bedevil cross-agency working.

There are major questions about the adequacy of training for different workforce members to the appropriate level, so they can collaborate in safeguarding activity across agencies. There may be an additional absence of clarity as to the relationship between the various parts of the training and regulatory system, eg Children's Workforce Development Council; Skills for Care; General Social Care Council; OFSTED.

There is growing debate as to the optimum balance to be struck as between data collection and the interpretation of this data. In particular some have suggested a false sense of security is engendered by extensive recording, when the more efficient strategies for the timely identification of abuse are based on the application of high quality professional decision making, and entail relationship-based social work skills.

## 4. INTERVENTIONS

As discussed in Section 2 above, it is rare for the maltreatment of children to have a single cause. Generally it is the outcome of a combination of factors within the child, the family, the neighbourhood and the wider society. This means that a wide variety of interventions can have the aim of addressing maltreatment, ranging from anti-poverty strategies to improving parents' social networks.

### LEVELS OF INTERVENTION

#### Primary prevention

Primary prevention interventions are directed at the whole population and have the aim of preventing all types of maltreatment. As well as services such as primary health care (including GPs and health visitors) and education they include awareness campaigns and interventions aimed at reducing alcohol use.

#### Secondary prevention

Secondary prevention interventions are those which are offered to populations that may have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns, and parental or child disabilities. These services aim both to address the risk factors for maltreatment (for example poor parenting skills) and to promote resilience in the face of risks, so that the risk factors do not themselves translate into maltreatment, or if they do, so that the damage caused by the maltreatment is minimised.

Services may be directed towards individuals, or to communities or neighbourhoods that have a high incidence of any or all of these risk factors. Approaches to prevention programs that focus on higher risk populations might include:

- Parenting education
- Home visiting programs that provide support and assistance to expecting and new mothers in their homes;
- Parent support that helps parents deal with their everyday stresses and meet the challenges and responsibilities of parenting;
- Family centres offering support, information and referral services

#### Tertiary prevention

Tertiary prevention interventions focus on families where maltreatment has already occurred and seek to reduce the negative consequences of the maltreatment and to prevent its recurrence. These interventions may include services such as:

- Mental health services for children and families affected by maltreatment
- Intensive social work support
- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes
- Removing parental responsibility and taking children out of the home

Distinctions between primary, secondary, and tertiary prevention, while perhaps useful for some purposes, do not necessarily reflect the way prevention-related services are actually organized and provided on the ground. Rather than sorting prevention initiatives into mutually exclusive categories, prevention is increasingly recognized as a continuum. Moreover, not all interventions can be neatly classified into distinct categories. Moreover, many interventions cross the levels. For example parenting skills programmes are available as primary, secondary and tertiary interventions, and all three categories of parents might be present in a single group. The classification essential depends on the target group, and not always necessarily on the nature of the intervention itself. Moreover, some interventions can be viewed as crossing the tiers even with the same target group. Thus, for example, therapeutic interventions for maltreated children can be considered tertiary interventions (as maltreatment has already occurred) and also secondary interventions (aiming to reduce the likelihood of that these children will go on to maltreat others).

## THE CONTEXT OF MALTREATMENT

Most physical and emotional maltreatment and neglect happens within the immediate family, so that the emphasis of interventions is with parents/carers and children. Sexual maltreatment is more complex in that it involves a wider group of perpetrators drawn from both within the family and the wider community. It is also more complex in that it involves a combination of factors related to the perpetrator, the family and the community: motive, willingness to act outside social norms of behaviour, the absence or removal of barriers which might prevent such action and undermining the child's resistance. Preventive interventions can therefore be directed at offenders (or potential offenders), at parents, at other adults in regular contact with children such as teachers, and at children themselves.

## PRIMARY INTERVENTIONS

Although there is a strong consensus among professionals, policymakers and parents that early intervention (that is both early in the life of the child, and early in the development of problems among families with older children) is both desirable and cost-effective there continues to be a paucity of research evidence in the area. As such only a handful of models for prevention of child treatment exist<sup>230</sup>, as most describe and measure the effect of treatment rather than prevention of abuse and neglect.<sup>231</sup>

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230 J.R. Lutzker (ed.), (1998) *Handbook of child abuse research and treatment*. NY: Plenum Press; Wolfe, D.A., Edwards, B., Manion, I. and Koverela, C. (1988) Early intervention for parents at risk for child abuse and neglect: A Preliminary report. *Journal of Consulting and Clinical Psychology*, 56: 40–47.

231 Peterson, L., Tremblay, G., Ewigman, B. and Saldana, B. (2003) Multilevel selected primary prevention of child maltreatment. *Journal of Consulting and Clinical Psychology* 71(3): 601–612.

Unlike early specific prevention programmes for physical abuse, sexual abuse and neglect, most community based primary prevention programmes cut across most forms of maltreatment, and typically focus on bringing about overall improvements in developmental outcomes for children and instilling good parenting practices within the context of wider supportive and enabling socio-economic policies.<sup>232</sup> Given the broad focus and pro-active approach, such interventions provide a window for parents to access services without the stigma of being identified as at risk of abuse or neglect. However, research indicates that the most vulnerable parents are among the least likely to take up primary services.<sup>233</sup> Some parents will steer clear of primary services to avoid possible detection of maltreatment.

## Focus on parents

### Health visitors

Health visitors are qualified and registered nurses (or sometimes midwives) who are trained to assess the health needs of individuals, families and the wider community. They aim to promote good health and prevent illness in the community by offering practical help and advice. The role involves visiting people in their homes, in particular new parents and children under five, as well as working with other sections of the community and in clinics.

All parents with a new baby should receive a visit from a health visitor within twelve days of the birth. They should usually see the health visitor in a clinic three times during the first year. By the child's first birthday the health visitor should complete an assessment of the physical, emotional, social and family needs of the child. In addition health visitors provide needs-based (essentially secondary level) support to families who need more than the basic service (sometimes referred to as a "targetted within universal" model).<sup>234</sup> Parents are also able to ask health visitors for advice or support on an ad hoc basis on issues such as feeding, safety, physical and emotional development, or smoking cessation.

Health visitors also run groups dealing with issues such as parenting, baby massage, child development and smoking cessation. They also support families experiencing domestic violence and work in collaboration with other agencies, such as social services, local housing departments, the police, teachers and probation officers.<sup>235</sup>

### Parenting programmes

Parenting education is increasingly widely available.<sup>236</sup> Such courses are increasingly popular among parents. Figures from 1996 estimated that approximately 4 per cent of the parent population had attended a parent education course at some time.<sup>237</sup> While more recently, Paterson et al. (2002) reported

<sup>232</sup> Macmillan, G. (2001) *Effective interventions for Child Abuse and Neglect: An Evidence-based Approach to Planning and Evaluating Intervention*. Wiley: Chichester.

<sup>233</sup> Naughton A. and Heath, A. (2001) Developing an Early Intervention Programme to Prevent Child Maltreatment. *Child Abuse Review*, 10: 85–96.

<sup>234</sup> *National service framework for children, young people and maternity services: core standards*.

<sup>235</sup> Cowley, S., Caan, W., Dowling, S. and Weir, H. (2007) What do health visitors do? A national survey of activities and service. *Public Health*, 121 (11): 869–879.

<sup>236</sup> Pugh, G. and McQuail, S. (1995) *Effective organisation of early childhood services*. London: National Children's Bureau; National Institute for Health and Clinical Excellence (2005) Parent training/education programs in the management of children with conduct disorders: Final Appraisal Determination, National Institute for Health and Clinical Excellence in association with the Social Care Institute for Excellence.

<sup>237</sup> Smith, T. (1996) *Family Centres and Bringing Up Young Children*. London: HSMO.

that 18 per cent of parents had attended a parenting programme and 58 per cent expressed interest in attending in the future.<sup>238</sup>

Parenting programmes are based on assumption that increasing parents' knowledge can bring about behavioural change. They have come into being because there has been growing recognition that being a parent is a difficult task and requires skills that need to be learned. Parent education programmes are run by health visitors, by Children's Centres and by a range of voluntary organisations. They aim to help parents understand their children and their development, to strengthen their relationships with their children, and to find better ways of dealing with difficult behaviour.

Although parenting programmes are often available to any families who volunteer for them, they are also used as secondary interventions with families who are at a higher risk of maltreatment, or even tertiary interventions with families who have a history of maltreatment. They usually focus on appropriate methods of childrearing, improving parental self-esteem and life-skills. Alongside the development of parenting skills, primary interventions are often underpinned by efforts to enhance parents' social support networks and delivered in conjunction with a host of family services such as health care, adult education and training or social services.

There are many programmes, geared towards both new and experienced parents, which are developed and delivered by a wide range of organisations and professionals covering a range of topics and all of varying duration. However, there are four well-developed manualised and generalized parenting programmes whose use is widespread, and whose impacts have been measured: Mellow Parenting (developed in Scotland), Webster-Stratton (also known as Incredible Years, developed in the USA), Triple P<sup>239</sup> (also known as the Positive Parenting Programme, developed in Australia) and Parenting Matters (developed in England). These programmes usually offer group sessions for parents over a period of weeks, and offer a combination of skill development and social support. Parents share their experience and some of the programmes video parent-child interactions and use them as a basis for discussion.

One of the criticisms of these generalized programmes is that the parents who volunteer for them are not those who need support the most, particularly isolated parents who are often unaware of their existence, and who might be reluctant to join a group with unfamiliar people. They generally have white middle class origins and do not always have a fit with the parenting styles of different cultural groups. Dropout rates tend to be quite high.<sup>240</sup>

### *Sexual maltreatment parent education programmes*

Parents have the ability to erect barriers that make it more difficult for potential sexual abusers to succeed. Programmes for parents, often organized by schools in conjunction with programmes for children, typically take the form of two-hour workshops. The aim is to improve awareness and understanding and the ability to speak to children. However, only motivated volunteers tend to take part. In particular,

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238 Patterson, T., Mockford, C., Barlow, J., Pyper, C. and Stewart-Brown, S. (2002) Need and demand for parenting programs in general practice. *Archives of Diseases in Childhood*, 87: 468–471.

239 Sanders, M., Cann, W. and Markie-Dadds, C., (2003) The Triple P-Positive Parenting Programme: A universal population-level approach to the prevention of child abuse, *Child Abuse Review*, 12: 155–171.

240 Spencer, N. (2003) Parenting Programs. *Archives of Disease in Childhood*. 88: 99–100; Tanner, K. and Turney, D. (2006) Therapeutic Interventions with Children who have Experienced Neglect and their Families in the UK in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers.

parents from dysfunctional families, who are often targeted by abusers from outside the family, are much less likely to attend.<sup>241</sup>

Non-offending parents often experience major costs and disruption in their lives if their children are sexually abused either by a partner or by someone from outside the immediate family. On average they have three major costs in the area of relationships, finances, job performance or living arrangements.<sup>242</sup> Thus, interventions with parents have the potential to benefit them directly as well as benefiting their children.

## Focus on children

### *Early years education*

The main purpose of early years education is to help children to prepare for primary school. However, early years education can contribute to resilience by improving both cognitive and social and emotional skills. It also offers the opportunity to spot maltreatment in the early stages and encourage intervention before it becomes entrenched.<sup>243</sup>

### *Sexual maltreatment education programmes*

Interventions are usually school based sessions aimed at children aged 4–10. These interventions are widespread in the United States and elsewhere (they are compulsory in some states). The programmes are based on instructions, films and behavioural training in various combinations. They generally focus on “good” and “bad” touches as discrete events, with an emphasis on strangers. They rarely deal with grooming and the way in which skilled abusers engage in a much more gradual process. They also rarely consider the issue of family dynamics, where the desire of the child for love and affection overcome aversion. They also face the challenge of children who have been taught to do what adults tell them.<sup>244</sup>

241 Tutty, L.M. (1996) Preventive Education: An integrative review. in Bagley, C., Thurston, M. and Tutty, L. (1996) *Understanding and Preventing Child Sexual Abuse*. Volume 1 Children: assessment, social work and clinical issues, and prevention education. Aldershot: Arena.

242 Putnam, F.W. (2003) Ten-year Research Update Review: Child Sexual Abuse. *Journal of the American Academy of Child and Adolescent Psychiatry* 42(3): 269–278.

243 Douglas, J.W.B. (1986) *The home and the school*. London: MacGibbon and Kee; Phillips, D. et al. (1987) Selective Review of Infant Day Care Research: A Cause for Concern?, *Zero to Three*, Vol VII (3), February. pp 18–21; Weissburg, R.P., Caplan, M. and Hawood, R.L. (1991) Promoting competent young people in competence-enhancing environments: A systems-based perspective on primary prevention. *Journal of Consulting and Clinical Psychology*, 59: 830–841; Sylva, K. (1994) The impact of early learning on children’s later development, in C. Ball (ed.) *Start Right: The Importance of Early Learning*, London: RSA; Barnett, W.S. (1995) Long-term effects of early childhood programs on cognitive and school outcomes. *The Future of Children*, 5: 25–50; Armstrong, C. and Hill, M. (2001) *Services for Vulnerable Families with Children aged 0–3 years: Evidence about Effectiveness*. Centre for the Child & Society: Glasgow; Areteraz, K. and Thurston, M. (2006) *Implementing a Webster-Stratton parent and child programme in a school setting: an evaluation of a pilot project: Executive Summary*. The University of Chester; National Evaluation of Sure Start (2008) *The Impact of Sure Start Local Programmes on Three-Year Olds and their Families*. London: NESS.

244 Rispens, J., Aleman, A. and Goudena P. (1997) Prevention of Child Sexual Abuse Victimization: A meta-analysis of school programs. *Child Abuse and Neglect*, 21(10): 975–987. Tutty, L.M. (1996) Preventive Education: An integrative review. in Bagley, C., Thurston, M. and Tutty, L. (1996) *Understanding and Preventing Child Sexual Abuse*. Volume 1 Children: assessment, social work and clinical issues, and prevention education. Aldershot: Arena; Putnam, F.W. (2003) Ten-year Research Update Review: Child Sexual Abuse. *Journal of the American Academy of Child and Adolescent Psychiatry* 42(3): 269–278; Macmillan H.L., MacMillan, J.H., Offord, D.R., Griffith, L. and MacMillan, A. (1993) Primary Prevention of Child Sexual Abuse: A critical review. Part II. *Journal of Child Psychology and Psychiatry* 35(5): 857–876; MacMillan, H.L. with the Canadian Task Force on Preventive Health Care (2000) Preventive health care, 2000 update: prevention of child maltreatment. *Canadian Medical Association Journal*, 163(11): 1451.

## SECONDARY INTERVENTIONS

Secondary interventions are targeted on families or neighbourhoods who have higher rates of the factors which are known to be associated with maltreatment. Most child abuse and neglect prevention programmes, with the exception of child sexual abuse programmes, fall into the category of secondary prevention. The content and methodology of many of these programmes will vary by the type of maltreatment, the context of the prevention effort and the developmental stage of the child. The overarching objective of secondary prevention is to target health and support services at high-risk families through the early identification of characteristics known to be associated with a higher propensity to maltreat children. However, being identified as 'high-risk' does not mean dysfunction or the onset of maltreatment is inevitable. Since the benefit of preventive interventions primarily depends upon being able to identify vulnerable families, knowledge of factors that intersect and interact to increase the risk of maltreatment is important to target services appropriately and avoid stigmatising non-abusing parents.

However, attempts to identify families with a high risk of maltreatment both result in false negatives (about one fifth of abusive parents are not identified) and false positives (many non-abusive parents are identified as having a high risk of maltreatment). This is because although certain characteristics are more common among parents who maltreat their children, the majority of parents who have those characteristics do not do so. The consequence is that more than nine out of ten parents identified as potential abusers are not.<sup>245</sup> A wide-ranging review of structured risk assessment for neglect found that most instruments are able to identify families who are already known to child protection services they are unable to identify those families within a wider population who are not known to child protection services.<sup>246</sup>

Thus, although secondary interventions are targeted at families with a higher risk profile for maltreatment, families that might actually maltreat their children form a small proportion of the group. Targeted interventions for child maltreatment are therefore in many ways not markedly different from universal interventions. The reality is that most recipients of targeted services will have a very small propensity to maltreat their children.

### Focus on the family

#### *Home visiting*

A wide variety of services come under the umbrella of home visiting. At the one end are manualised and thoroughly evaluated programmes delivered by trained nurses, and at the other end are befriending programmes where mothers within the community visit other mothers on an ad hoc basis. Different assumptions may underpin the selection of the identity of the visitor, with programmes such as Home Start placing an emphasis on the value of the visitor/helper having themselves had to meet the challenges of the parenting task.

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245 Barker, W. (1990) Practical and ethical doubts about screening for child abuse. *Health Visitor*, 63(1): 14–17; Caldwell, R.A., Bogat, G.A., Davidson, W.S. (1988) The assessment of child abuse potential and the prevention of child abuse and neglect: a policy analysis. *American Journal of Community Psychology*, 16: 609–24; McCurdy, K. (1995) Risk assessment in child abuse prevention programs. *Social Work Research*, 19: 77–87.

246 Gershater-Molko, R.M., Lutzker, J.R. and Sherman, J.A. (2003) Assessing child neglect. *Aggression and Violent Behavior*, 8(6): 563–585.



The overarching emphasis of home visiting is on improving knowledge of good parenting practice, boosting confidence and improving parenting skills. The underlying assumption of home visiting is that the resources to offset risk factors via social networks are not available. So a home visitor fills the void by targeting the specific needs of the family and provides parents with social support, practical assistance by way of case management and linking parents with other community services, and education about parenting and/or child development. In delivering social support and practical assistance to the family in situ, academics and practitioners have stated home visiting needs to be based upon strong relationships of trust between the home visitor and parents. The development of trusting relationships is believed to be a first step in developing the parent's ability to form and maintain secure relationships with others, including their own children.<sup>247</sup> Based on strong relationships of trust, home visitors are then better able to detect problematic changes in family functioning and adjust their support accordingly.

The best internationally known home visiting programme is perhaps the Nurse-Family Partnership (known as the Family Nurse Partnership in the English pilot currently underway) developed by Professor David Olds. The programme provides nurse home visits to low-income, pregnant women, most of whom are (a) unmarried, (b) teenagers, and (c) are first time mothers. The nurses visit the women approximately once per month during their pregnancy and the first two years of their children's lives. The nurses teach positive health related behaviors, competent care of children, and maternal personal development (family planning, educational achievement, and participation in workforce). The programme stresses the identification and development of strengths.

In Britain, as well as the Family Nurse pilot the universally available health visiting service offers the option of additional targeted services based on need. In a study by Brocklehurst et al. (2004)<sup>248</sup> the programme trained forty health visitors to deliver an intensive home visiting programme to pregnant women who had been identified as 'vulnerable' and experiencing significant environmental and/or psychological difficulties. The home visiting programme aimed to improve maternal and infant health and reduce the risk of poor parenting through problem-solving strategies based on empowering the parent by developing their parenting techniques and encouraging self-efficacy (known as the Parent Partnership Model), along with other methods of improving parent-infant interaction. Women allocated to the intensive home visiting service were visited by the home visitor on a weekly basis beginning from the second trimester of pregnancy onwards for a period of 12 months.

To influence child and maternal health outcomes through post-natal support, specifically the incidence of child injury, maternal depression and maternal smoking, a home visiting intervention trained five home visitors to implement a supportive listening model. The intervention was delivered by assigning a 'special home visitor' to 172 women based in disadvantaged catchment areas and was implemented based on drop-in sessions, monthly visits and/or telephone support over one year from when the infant was aged approximately 10 weeks old. During the monthly visits, the special home visitor focused on listening to the mother and exploring her needs and any issues she wanted to discuss, with access to practical support and information available on request. On average, mothers received ten hours of support (mean length of time per visit was 83 minutes) over seven home visits plus additional support through telephone contact.<sup>249</sup>

247 Barnard, K.E., Morisset, C.E. and Spieker, S.J. (1993) *Preventive interventions: Enhancing parent-infant relationship*, in C. Zeanah (ed.), *Handbook on infant mental health*. New York: Guilford Press; Gomby, D.S., Culross, P.L. and Behrman, R.E. (1999) Home visiting: Recent program evaluations--analysis and recommendations. *The Future of Children*, 9: 4–26.

248 Brocklehurst, N., Barlow, J., Kirkpatrick, S., Davis, H., Stewart-Brown, S. (2004) The contribution of health visitors to supporting vulnerable children and their families at home, *Community Practitioner*, 77(5): 175–179.

249 Wiggins, M., Oakley, A., Roberts, I., Turner, H., Rajan, L., Austerberry, H. et al. (2004) *Postnatal support for Mothers living in disadvantaged areas: A Randomised control Controlled Trial and Economic Evaluation*. Southampton: Health Technology Assessment.

Another type of home visiting programme uses volunteers or what are known as ‘first parent visitors’<sup>250</sup> or ‘community mothers’,<sup>251</sup> These focus on using trained, experienced mothers to provide peer support for first-time mothers related to health care, nutritional improvement and overall child development.

Programmes aim to develop the skills of parents of young children and build up their self-esteem as well educating parents to cope with the problems of child rearing and to find their own solutions and thus reduce their dependence on professionals. Overall, the argument in favour of trained volunteers suggests that parents as home visitors are less threatening and possibly less judgemental than professionals. However the argument against holds that parents place greater reliance and trust in a professionals’ knowledge and experience and parents may be reluctant to discuss sensitive issues with community members for confidentiality reasons.

Home visiting interventions using non-professional experienced mothers from the local community were initially launched in Ireland and rolled out in Dublin in 1983 as a result of limited resources to fund health visitors to deliver home visitation support to parents and families. Based on the basic premise of child development programmes the aim is for experienced mothers in disadvantaged areas to lend support and advice to new parents. Potential community mothers are identified by local public health nurses and are assessed and trained over four weeks by a family development nurse. Each community mother under the guidance of the family development nurse is then assigned and provides support to approximately 5–15 first time parents, whom she visits at home on a monthly basis. The core elements of the programme focus on enabling parents to give them a sense of control of their lives and their parenting aptitude in all areas of child development, health and nutrition; parents are encouraged to set themselves tasks and group work with other parents is encouraged to promote social support.<sup>252</sup>

In addition to the Community Mothers Programme, there are other home-visiting programmes also delivered by volunteer non-professionals. Home Start offers support, friendship and practical assistance to families under stress where there is at least one child aged under 5 years. Families are visited at home by a volunteer who focus on encouraging and augmenting the parents’ strengths, affirming their abilities and encouraging parents to widen their networks of friends and support and to make use of existing community services.<sup>253</sup> Over 2006/7 there were 340 schemes based in rural and urban areas supporting 34,704 white and ethnic minority families in the United Kingdom; of these 22,454 were supported in their homes. Most families are referred by a health visitor (45.7 per cent) though almost 25 per cent of families referred themselves to Home Start. Users of the programme expressed a multitude of needs, the most common were: feeling isolated (66 per cent); parental well-being (64 per cent); and being able to use other services in the area (46 per cent). The support services are provided for as long as the family require.

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250 Barker, W. (1994) *Child Protection: the impact of the Child Development Programme*. Bristol: Early Childhood Development Unit.

251 Johnson, Z., Molloy, B., Scallan, E., Fitzpatrick, P., Rooney, B., Keegan, T. and Byrne, P. (2000) Community Mothers Programme – seven year follow-up of a randomized controlled trial of non-professional intervention in parenting, *Journal of Public Health Medicine* Vol. 22(3): 337–342.

252 Johnson, Z., Molloy, B., Scallan, E., Fitzpatrick, P., Rooney, B., Keegan, T. and Byrne, P. (2000) Community Mothers Programme – seven year follow-up of a randomized controlled trial of non-professional intervention in parenting, *Journal of Public Health Medicine* Vol. 22(3): 337–342.

(Johnson et al., 1993).

253 Gibbons, J. and Thorpe, S. (1989) *Can voluntary projects help vulnerable families? The work of Home-Start*. 5: 517–527.

### Community-based services

Efforts to reduce the prevalence of child abuse and neglect are now an important facet of a number of community-based initiatives. They are based on the recognition that with the introduction of The Children Act 1989, a renewed emphasis on community support and in particular family preservation, so to as to allow children 'in need' and children 'at risk' to remain within the family unit and receive child protection services within their community. As such community-based support or family support is a generic term for a group of interventions all delivered at a local level which are aimed at avoiding or reducing the impact familial and parental stress, enhancing care-giving capacities and strengthening social networks. As Korbin (1981)<sup>254</sup> argues, one of the factors related to the incidence of child maltreatment is the absence of a wider network of kin and community beyond the immediate family concerned with child-care, thus supporting the case for community-based projects. Family support initiatives provide a range of services that promote and safeguard the welfare of families and young children which can be based upon efforts by social workers providing outreach support, delivering parenting programmes or the development of comprehensive family or children resource centres.

The nature and scope of the social work role in respect of family support can be seen to reflect the perennial tension in children and family services between services aimed at promoting and services aimed at safeguarding the welfare of children. The task of refocusing services envisaged by the Children Act 1989<sup>255</sup> continues to pose a major challenge. Although the threshold for the provision of family support services is that a child should be assessed as 'in need', the legislation makes clear that services may be provided to any member of the family of that child. Schedule 2 of the Act, headed 'Local Authority support for children and families' provides further guidance as does The Children Act 1989 Guidance and Regulations, Volume 2. The services to be provided as appropriate are listed and there is a particular emphasis on family centres as an appropriate setting for the provision of family support services. Strenuous efforts by government to 'refocus' children's social services away from a concentration on families where the child was being maltreated, have failed to reduce the threshold for the receipt of family support services.

Local authority social services continue to be most likely to provide services at higher levels of need (Tiers 3 and 4) or services that can be seen as targeted or referred. This is often provision of a specialist nature. Voluntary and multi-sector services tend to develop pockets of expertise which are often located in community based prevention programmes, although increasingly such agencies also operate at Tiers 3 and 4. Increasingly, the social care team providing a service to a 'higher risk' family or a family with complex problems, often involving disability, will comprise a social worker who is accountable for the assessment, the decisions about the provision of services and some aspects of the casework service, working with a family support worker and possibly a welfare rights worker. The family may attend a family centre where they will receive a service from other family support workers. There may also be an inter-agency network or 'core group' providing a range of services, which could include the services or a health visitor assistant or a parent support worker based in the school.<sup>256</sup>

254 Korbin, J. (1981) *Child Abuse and Neglect: Cross-Cultural Perspectives*. Berkeley, CA: University of California Press.

255 Colton, M., Drury, C., Williams, M. (1995) *Children in Need: Family Support under the Children Act 1989*. Aldershot. Avebury; Tunstill, J. and Aldgate, J. (2000) *Services for Children in Need: From Policy to Practice*. London TSO; Thoburn, J., Wilding, J., Watson, J. (2000) *Family Support in Cases of Emotional Maltreatment and Neglect*. London TSO.

256 Statham, J. and Biehal, N. (2004) *Research and Practice Briefings: Children and Families – Supporting Families*. DfES/ Research in Practice/Making Research Count on website:

Social workers themselves are however a key component in the family support system, and family support a key component in the social work task, even if reactive child protection activities predominate:

*It is relatively easy to opt to focus on immediate safety. It is much harder to ensure services protect children... when parents do not receive the help they themselves need, both in their own right, and in order to support them as parents. (CSCI, 2006; p4)<sup>257</sup>*

The family support component of the social work role therefore currently entails a high degree of liaising, networking and co-ordinating of services:

*Social work ... (has been described) as the joined-up profession – a profession that seeks to liaise, to mediate and to negotiate between professions and between the professions and the children and their families.... Social work can be seen as the cement that holds together the service for children and their families, and attempts to ensure that it is connected and forms a coherent whole. (Soper et al., 2006; p12)<sup>258</sup>*

In addition in many local authorities, children's services social workers are seconded into the multi-disciplinary Youth Offending Teams (YOTs) that provide both parenting education, and parenting support on an outreach basis to children at risk of offending, as well as those found guilty of an offence.

The introduction of family centres saw the recognition of a partnership model for parent and child-care services. The family-centred service approach encompasses family support services for families coping with normal parenting stresses and family preservation services designed to help families facing serious problems and possible out-of-home placement.<sup>259</sup> So while some family centres are established to deliver intensive family preservation services for children deemed to be at risk of abuse or of being taken into care to remain at home or return home from foster care, others will offer wider community services designed to assist families with a range of social or health problems.

The main work of family centres, viewed from the perspective of child protection, falls into three groups:

- basic social services, such as day care for young children, summer play schemes, respite care, health care and education and income support
- family support services, such as parent education and support groups to improve relationships within the family (parent-child, between parents and between parents and siblings);
- family preservation services, such as counselling and assistance, to families where a child has been maltreated, or 'community childminding plus' to prevent moving a child into temporary care<sup>260</sup>

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<sup>257</sup> Commission for Social Care Inspection (2006) *Supporting parents, safeguarding children: meeting the needs of parents with children on the child protection register*. London: CSCI.

<sup>258</sup> Soper J., Holmes, L., Hu, X. and D'Souza, E. (2006) *Valuing Changes in Welfare to Individuals and Society Resulting from the Government's Provision of Children's Social Services in England*. Nottingham: Department for Education and Skills (Research Report RW86)

<sup>259</sup> McCroskey, J. and Meezan, W. (1998) Family-Centered Services: Approaches and Effectiveness. *The Future of Children*, 8(1).

<sup>260</sup> Tunstall, J., Aldgate, J. and Hughes, M. (2006) *Improving Children's Services Networks: Lessons from Family Centres*, London, Jessica Kingsley Publishers; Statham, J. and Holtermann, S. (2004) Families on the brink: the effectiveness of family support services, *Child and Family Social Work*, 9: 153–166; D'Ath, E. (1985) *Self-help and Family Centres*. London: National Children's Bureau.

Family centres can be self-referred, open access or families can be referred for support (sometimes both types operate in the same centre) to specialist centres. The respective theoretical underpinning of family centres results in different models: A client model delivers specialist services to clients in family difficulties on the basis of a referral by a social workers; the neighbourhood model offers support services for a wider set of families in the local area; and the community development model is based on universal access with the aim of empowering local people to develop user-led/ needs-based programmes.<sup>261</sup>

The Children Act 1989 classification differs slightly and suggests: therapeutic, community and self-help. Yet despite these various modes survey findings indicated that in at least 70 per cent of family centres child protection was the predominant function, rather than a generic family support or welfare approach. However many experts claim a proactive, non-stigmatising, universal family support approach is more effective than a reactive, targeted, referral based service with a narrow child protection focus.<sup>262</sup>

The specialist referred family centres, otherwise known as client-focused centres, typically work with families where aspects of child protection issues are prevalent and assess how (or if) parenting skills can be strengthened to enable better care for children. The criteria for admission target those families where children are (or likely to become) the subject of care proceedings and the case requires an assessment of whether the child should return home. Families attending these specialist client focused centres tend to be referred by social workers and are from among the lowest income group, with high levels of stress and ill health and the least sources of informal support.<sup>263</sup>

Sure Start Children's Centres are service hubs where children aged under-5 years and their families can receive a network of integrated services and information intended to have a broad and lasting impact on children, their parents and the wider community. The Sure Start Children's Centres programme is an integral part of the Government's 10 year child care strategy and is based upon a model brings together service providers to deliver high-quality integrated services (health, education, family support and child care), particularly in disadvantaged areas, in order to bring about positive outcomes for children, families and their communities, including:

- Improved educational outcomes
- Supporting and enabling parents to access work and training opportunities
- Reduced juvenile delinquency and crime rates
- Improved health outcomes
- Reduction in child poverty

<sup>261</sup> Holman, B. (1988) *Putting Families First*. London: Macmillan.

<sup>262</sup> Tunstall, J., Aldgate, J. and Hughes, M. (2006) *Improving Children's Services Networks: Lessons from Family Centres*, London, Jessica Kingsley Publishers; Armstrong, C. and Hill, M. (2001) *Services for Vulnerable Families with Children aged 0-3 years: Evidence about Effectiveness*. Centre for the Child & Society: Glasgow; Warren, C. (1990) The potential for Parent Advocacy in Family Centres. MPhil thesis. University of Southampton, in Armstrong, C. and Hill, M. (2001) *Services for Vulnerable Families with Children aged 0-3 years: Evidence about Effectiveness*. Centre for the Child & Society: Glasgow.

<sup>263</sup> Pithouse, A., Lindsell, S. and Cheung, M. (1998) *Family Support and Family Centre Services*. Aldershot: Ashgate; Tunstall, J., Aldgate, J. and Hughes, M. (2006) *Improving Children's Services Networks: Lessons from Family Centres*, London, Jessica Kingsley Publishers; Statham, J. and Holtermann, S. (2004) Families on the brink: the effectiveness of family support services, *Child and Family Social Work*, 9: 153-166; Armstrong, C. and Hill, M. (2001) *Services for Vulnerable Families with Children aged 0-3 years: Evidence about Effectiveness*. Centre for the Child & Society: Glasgow; Kirk, R. (1995) Social Support and Early Years Centres, in Hill, M., Kirk, R. and Part, D. (eds) *Supporting Families*. Edinburgh: HSMO; Cannan, C. (1992) *Changing Families, Changing Welfare*. Hemel Hempstead: Harvester Wheatsheaf.

The actual services delivered may vary slightly from area to area and by centre, but will typically include (certainly by 2010) early years' education (by a minimum half-time qualified teacher) and childcare provision; parenting advice and access to specialist family services, ranging from health screening, health visitor services to breast-feeding support; and Jobcentre Plus support to help parents back into work. Early evaluation of the contribution of Sure Start local programmes to the task of safeguarding in the locality suggests a tension between the delivery of the mainstream Sure Start services, and a willingness to address any safeguarding issues which might arise.<sup>264</sup>

In the United States, Child-Parent Centre Programmes are set-up and operate on a broadly similar model to the Sure Start/Head Start Children's Centre Programme. The CPC programme provides educational and family support services to children aged 3 to 9. However, these centres can be distinguished from these and other early education programmes, since they span a longer intervention period (from pre-school to primary school) and eligibility depends on residence in a designated low-income area and an educational need due to poverty and associated factors. The programme emphasises the importance of parental involvement and requires parents to commit to parent-room or classroom based activities for a minimum of ½ day per week or 2 days or month. So while children are participating in classroom activities, the parents take part in activities focused on enhancing parenting skills, vocational skills and social supports as well as parental involvement in the child's education at home and in school. The sum of these activities is expected to reduce the likelihood of child abuse and neglect.<sup>265</sup>

Family Connections (FC) is a multifaceted community-based intervention that works with families in their homes to help them reduce the risk factors associated with neglect, increase protective factors and meet the basic needs of their children. Through the use of home based interventions, home visitors provide support to low-income families where children are at risk of neglect, for example as a result of family stresses, such as unsafe housing, substance abuse, mental health problems or homelessness. Overarching the delivery of the FC programmes are nine guiding practice principles: community outreach, individualised family assessment, tailored intervention, helping alliance, empowerment approaches, strengths perspective, cultural competence, developmental appropriateness and outcomes driven service plans.<sup>266</sup>

Based on these principles, the scheme offers wide-ranging programmes of individually and/or family focused interventions and support where the risk of neglect has been identified. The core components of FC include: (a) emergency assistance/concrete services; (b) home-based family intervention (such as family assessment, outcome-driven service plans, individual and family counselling); (c) service coordination with referrals targeted toward risk (substance abuse treatment) and protective factors (mentoring programme); and (d) multi-family supportive recreational activities (for example, home-based gatherings such as dinner evenings or trips to museums). The scheme also takes account of the wider context of the local neighbourhood by targeting child safety and enhancing well-being outcomes through advocacy initiatives in schools and the community and multifamily events.

Early Intervention and Prevention programmes are typically based upon multi-agency collaboration between schools, extended services and early years' and children services. The underlying principle of such programmes is to work with vulnerable families in a preventative way before they require social

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264 Tunstall, J. and Allnock, D. (2007) *Understanding the Contribution of Sure Start Local Programmes to the Task of Safeguarding Children's Welfare*. London. DfES).

265 Reynolds, A. and Robertson, D. (2003) School-based early intervention and later child maltreatment in the CLS, *Child Development* 74(1): 3–26.

266 DePanfilis, D. and Dubowitz, H. (2005) Family Connections: A Program for Preventing Child Neglect. *Child Maltreatment*, 10(2): 108–123.

services intervention in order to reduce the onset and incidence of abusive and damaging parenting. After an initial assessment by a health visitor, cases of more complex needs triggers a second in-depth assessment and where necessary a family will be referred to an appropriate agency for help and support. Where complex needs are identified, interventions include assistance with parenting issues such as attending a help clinic to do with sleeping, crying, feeding and/or behaviour run by a child psychologists, specialist health visitors and community paediatricians; linking families with parenting support projects; making a referral to family support services; or instigating child protection services.<sup>267</sup>

## Focus on Parents

### *Training for parents*

The quality of parenting skills have a measurable influence for a range of poor outcomes and in particular parenting behaviours have been linked with child maltreatment. A number of studies have shown that maltreating parents are less positive, less supportive and nurturing of their children, and more negative, hostile, and punitive than non-maltreating parents. They tend to react more negatively to ordinary parental challenges such as a crying infant and face greater difficulties in managing more challenging children behaviours because of their own experience of parenting. Broadly speaking, training programmes designed for parents/carers aim to address these problems areas.<sup>268</sup>

Parent training as a secondary intervention is designed to help parents whose children have already developed challenging and difficult behaviour, and for parents who find it difficult to control their emotions when dealing with their children. In some cases the design of interventions maybe geared towards helping parents to understand what they can expect of children of different ages, whilst others will focus on strengthening the child-parent relationship or increasing support networks. There are a variety of approaches, though some models have a stronger evidence base than others. However, despite the evidence supporting a range of positive outcomes, a number of schemes have recorded high non-engagement or drop-out rates; so arguably those most in need may not be assisted.

Given the complex nature of their difficulties, interventions need to recognise that simple time-limited approaches are unlikely to work with families who have complex problems. Furthermore in engaging with those considered to be hard-to-reach, training can often be unattractive to the most disadvantaged families in terms of location, timing and language.

Parenting Programmes can be grouped into three broad categories:

- skills training – behavioural and social-learning based;
- educational – parent effectiveness programmes; and
- those focused on parent-child relationship.

<sup>267</sup> Naughton, A. and Heath, A. (2001) Developing an Early Intervention Programme to Prevent Child Maltreatment. *Child Abuse Review*, 10: 85–96.

<sup>268</sup> Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd; Griest, D.L., Forehand, R., Wells, K.C. and McMahon, R.J. (1980) An examination of differences between non-clinic and behaviour-problem clinic-referred children and their mothers. *Journal of Abnormal Psychology*, 89: 497–500; Patterson, G.R. (1993) Orderly change in a stable world: The antisocial trait as a chimera. *Journal of Consulting and Clinical Psychology*, 61: 911–919; Barlow, J. (1997) Systematic review of the effectiveness of parent-training programmes in improving behaviour problems in children aged 3–10 years. Oxford, Health Services Research Unit: University of Oxford; Frodi, A.M. and Lamb, M.E. Child abusers' responses to infant smiles and cries. *Child Development* Mar. 51(1): 238–41.

Despite the focus on parents, most parenting programmes are in fact geared towards mothers. But fundamentally parenting programmes are focused short-term interventions aimed at helping parents' to manage their children's behaviour through conflict management techniques and developing the parent-child relationship by improving family functioning, maternal mental health, and the emotional and behavioural adjustment of children.<sup>269</sup>

Using multiple methods Peterson et al. (2003) developed a preventative intervention based on seven goals within a time-limited programme (16 weeks) with high risk mothers.<sup>270</sup> The intervention was based upon a curriculum delivered in a group therapy session sought to target parenting adaptive behaviours; developmental awareness; parenting beliefs; parent affect (parental anger); parent role (problem-solving techniques); mother role (positive parent-child interaction) and self-efficacy. A variety of cognitive restructuring techniques such as role playing, Socratic dialogue, modelling and a discussion of barriers to the curriculum were used. In addition, once a week a home visitor who had been trained in covering the intervention goals spent approximately 90 minutes with each mother and individualised the curriculum for her family circumstances. A diary was used for self-observation of discipline techniques and parental emotion and behaviour.<sup>271</sup>

Another time-limited intervention, the Mellow Parenting Programme, is a 14-week centre-based parenting programme designed for families with children under 5 years who are experiencing stress and relationship problems with their children. The programme has roots in child psychiatry, psychology and social work and is delivered within a specialist clinical environment, with training in the programme coordinated through a professional association. It combines parenting support groups (focused on the development of parenting skills) with a mixture of group work, video feedback sessions and workshops. Variants of Mellow Parenting exist for fathers, grandmothers (looking after children often due to death or where the mother is not available due to substance abuse) parents in prison and mellow parenting for post-natal depression and babies at risk. The programme has been evaluated and outcomes have been shown improvements in parent-child relationships and in engaging hard-to-reach families with severe problems which held at an 18-month follow up.<sup>272</sup>

Project Safe Care is a parenting programme for at risk and maltreating parents that addresses the social and family ecology within which maltreatment occurs. The programme works primarily with women who have been referred from a local hospital maternity centre or a social services department as at risk for, or reported for, child abuse and neglect. Based on a 15-session training programme, the model focuses on three areas of intervention 1) home safety 2) infant and child health care 3) bonding and stimulation. The training is delivered on an individual basis with a social worker or nurse in a video format. During these 1:1 sessions parents are given instructions, view modelling of various skills and activities, and practice these skills with feedback from a home visitor. Among the specific components of the programme, parents are taught about avoiding safety hazards, maintaining cleanliness, preventing child illness and trained to increase positive interactions between them and their children.<sup>273</sup>

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269 Barlow, J. (1997) Systematic review of the effectiveness of parent-training programmes in improving behaviour problems in children aged 3–10 years. Oxford, Health Services Research Unit: University of Oxford.

270 Peterson, L., Tremblay, G., Ewigman, B., Saldana, L. (2003) Multilevel selected primary prevention of child maltreatment, *Journal of Consulting and Clinical Psychology*, 71(3): 601–612.

271 Peterson, L., Tremblay, G., Ewigman, B., Saldana, L. (2003) Multilevel selected primary prevention of child maltreatment, *Journal of Consulting and Clinical Psychology*, 71(3): 601–612.

272 Mills, M. and Puckering, C. (2001) *Evaluation of Mellow Parenting. Report to the UK*. London: DH.

273 Taban, N. and Lutzker, J.R. (2001) Consumer Evaluation of an ecobehavioral programme for prevention and intervention of child maltreatment, *Journal of Family Violence* 16(3): 323–330.



The Learning About Myself (LAMS) programme is a psychoeducational support group that meets at a public child protective services agency once a week over 12 weeks. But instead of concentrating solely on improving parenting skills, the model focuses on increasing and enhancing the social networks of families who neglect as well as emphasising the parent as a person, helping them to become more assertive, make better choices and improve their self-esteem. In addressing these key areas the model emphasises and explores various facets of parents' lives – such as their self, attitude, relationships, finances, home, friends, etc – through the use of various group exercises and hands-on activities, such as arts and crafts and role-plays. Taking account of high drop-out and absence rates that other interventions may struggle with amongst target groups, each class stands alone and participants are able to attend on an open-ended basis, attending repeat sessions they may have missed in the past.<sup>274</sup>

The Webster-Stratton parent training programme is a DVD-based social learning parenting model that focuses on strengthening parenting competencies, such as monitoring children, implementing positive discipline, instilling confidence in parents, and encouraging parental involvement in their child's education to promote scholastic achievement and reduce behavioural problems. Using these social learning techniques and structure, the PARTNERS Project delivered a parenting programme based on a cognitive behavioural design to families within Head Start Centres. The programme comprised of eight sessions covering topics such as playing and helping a child to learn, handling misbehaviour and using effective praise and encouragement.

Balancing Employment and Parenting (BEAP) was a community-based prevention programme aimed at low-income families, which focused on improving parenting skills, increasing the chances of finding employment and preventing child maltreatment. The premise and design of BEAP was to reduce the incidence of child maltreatment by addressing factors contributing to child abuse and neglect, including family stress, depression, substance abuse, inadequate knowledge about child development, and inadequate social support systems.

Through 90 minute culturally-specific education group sessions the programme sought to increase awareness and understanding about how stress influences parental attitudes and behaviours; the developmental needs of children; the role culture plays in parenting techniques and approaches; how to maintain good health; the role of substance abuse as it relates to depression, violence, and HIV/AIDS; and alternative parenting strategies and techniques. The BEAP Program also aimed to increase the parents' awareness and knowledge about how to access community services; increase their sense of personal control and self-esteem; reduce reported alcohol- and drug-related problems; and decrease stress and depression. Programme participants are typically families with young children in receipt of Temporary Assistance to Needy Families (TANF) and enrolled in Head Start or other pre-school programmes.

### *Help with substance abuse for parents*

In the UK there are estimated to be between 250,000 and 350,000 dependent children living with parental drug misuse, and 920,000 living with parental alcohol misuse. Parental substance misuse can cause considerable harm and children of substance abusers are at risk from emotional and physical neglect as they grow up.<sup>275</sup> According to the US National Centre for Addiction and Substance Abuse

<sup>274</sup> Berry, M., Charlson, R., Dawson, K., (2003) Promising practices in understanding and treating child neglect, *Child and Family Social Work*, 8: 13–24.

<sup>275</sup> Gorin, S. (2004) *Understanding what children say: Children's experiences of domestic violence, parental substance misuse and parental health problems*. York: Joseph Rowntree Foundation.

(CASA) parents who use illicit drugs or abuse alcohol are three times more likely to abuse their children and four times more likely to neglect them.<sup>276</sup> As a result, these children also risk developing emotional and social problems later in life and an increased risk of suffering from physical injuries, illnesses (such as depression, conduct disorders or anxiety) and academic failure.

The shortage of drug treatment programs for pregnant women and women with infants has been identified as a significant issue. One promising solution has been to develop programmes specifically for women/mothers that focus on the family as whole, which embed drug and alcohol treatment within framework of support for other issues e.g. therapy to deal their experiences of maltreatment, abusive relationships, poor self-esteem and anxiety; parenting and family skills; stable housing arrangements and employment. Such family rehabilitation/preservation programmes that run parallel with drug treatment are able to target areas that usually remain unaddressed in typical drug treatment models.<sup>277</sup>

The New York City Family Rehabilitation Program is initially very home-based and home visits are made at least a few times a week for the first month and thereafter participants are visited once a week. Such programmes are centred on role modelling and education on home management, child care, health and safety and parenting skills. Through a case worker, parents are supported through the drug abuse treatment and helped to maintain a safe home environment for the children. The drug abuse component of the programme makes provision for women with young children through on-site child care and support groups for extended family members. Atypical features of this model are not only the combination of counselling with vocational, educational and mental health services, but also the attempt to include significant male figures and extended family in the treatment process. Typically, participants remain on the programme for about a year.<sup>278</sup>

### *Help with mental health problems for parents*

Child neglect can be a consequence of parental mental illness when certain symptoms such as depression, low self-esteem, poor concentration, disassociation and a sense of hopelessness exist in a mother. Despite knowledge of the association between mental health as a risk factor for child maltreatment, many parents are not receiving treatment at all; and those receiving treatment often do not get their needs addressed holistically within the system. But equally the stigma associated with mental illness acts as a barrier to services and can deter parents from revealing too much about their family life to service providers. In particular, parents may fear that disclosure of their mental health issues may result in the loss of custody of their children. Thus service providers need to consider stereotypes that associate parents with mental health issues with bad parenting and also take account of their holistic needs as parents.<sup>279</sup>

Mothers with mental health problems feel the need to have their parenting needs addressed alongside their health needs. As conclude, parents with severe mental health issues may require intensive support,

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<sup>276</sup> National Centre for Addiction and Substance Abuse (2005) *Family Matters: Substance Abuse and The American Family*. CASA: Columbia University.

<sup>277</sup> Magura, S. and Laudet, A.B. (1996) Parental substance abuse and child maltreatment: Review and implications for intervention, *Children and Youth Services Review* 18(3): 193–220.

<sup>278</sup> Magura, S. and Laudet, A.B. (1996) Parental substance abuse and child maltreatment: Review and implications for intervention, *Children and Youth Services Review* 18(3): 193–220.

<sup>279</sup> Nicholson, J. et al. (1998) as cited in: Alakus, C., Conwell, R., Gilbert, M., Buist, A. and Castle, D. (2007) The needs of parents with a mental illness who have young children: An Australian perspective on service delivery options. *International Journal of Social Psychiatry*, 53(4): 333–339; Nicholson and Biebel (2002) as cited in: Alakus, C., Conwell, R., Gilbert, M., Buist, A. and Castle, D. (2007) The needs of parents with a mental illness who have young children: An Australian perspective on service delivery options. *International Journal of Social Psychiatry*, 53(4): 333–339.

and the best support will be comprehensive, integrated and home-based wherever possible. Community mental health programmes, for instance, may involve group and individual therapy, parents' skills training, coordination and referral to community support services and day care.<sup>280</sup>

By using parenting programmes as a basis for incorporating a programme for parents with mental illnesses, a Triple-P Level 4 programme was modified to include a 6-week parenting and mental illness group programme. The pilot programme was based on four core sessions of the Triple-P programme and then moved onto two sessions that explored the impact of their mental health problem on their parenting. The six group sessions lasted 2.5–3 hours each. Supplementing the group sessions were four weekly individual home visits which focused on implementing new skills and strategies and the possibility of developing a family safety plan if appropriate. Overall the evaluation of the pilot suggests the programme produce positive outcomes in children's behaviour and parenting practices.<sup>281</sup>

### Anger management training

In families characterised by high levels of aggressive behaviour, teaching parents how to recognise triggers and signs of losing control through anger management training can be helpful. By equipping parents with impulse or anger control techniques, usually in conjunction with child management skills, they can break the cycle of threats, aggressive behaviour and punishment. The training typically uses a combination of relaxation techniques (e.g. deep breathing) and cognitive restructuring (e.g. rejecting the idea that the child is doing something to annoy the parent) and problem-solving (e.g. find another way to address a particular problem).<sup>282</sup>

### Improving parents' social networks

Social isolation has been identified as the single most common characteristic of maltreating families. The lack of social support has been found to be a strong indicator of emotional stress and depression and to characterise families in all maltreatment categories.<sup>283</sup> Communities with lower rates of maltreatment tend to have more developed informal systems of social support and mothers with high levels of support often report the lowest levels of emotional stress and depression. Clearly then agencies, both within the voluntary sector and those that already deliver formal support services, have a key role to play in developing both formal and informal networks. The transition of many family centres from open access/self-referral projects impacts on access by parents.<sup>284</sup> Sure Start programmes often overlook the need for robust outreach strategies to engage ambivalent parents and reduce isolation.<sup>285</sup>

280 Basset, H., Lampe, J. and Lloyd, C. (1999) as cited in Alakus, C., Conwell, R., Gilbert, M., Buist, A. and Castle, D. (2007) The needs of parents with a mental illness who have young children: An Australian perspective on service delivery options. *International Journal of Social Psychiatry*, 53(4): 333–339; Brunette and Dean (2002).

281 Phelan, R., Lee, L., Howe, D. and Walter, G. (2006) Parenting and Mental Illness: A pilot programme for parents. *Australasian Psychiatry*, 14(4): 399–402.

282 Nomellini, S. and Katz, R.C. (1983) as cited in: MacDonald, G. (2001) *Effective interventions for Child Abuse and Neglect: An Evidence-based Approach to Planning and Evaluating Intervention*. Wiley: Chichester; Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd.

283 Erickson, M.F. and Egeland, B. (2002) as cited in: Scannapieco, M. and Connell-Carrick, K. (2005) *Understanding Child Maltreatment*. OUP: Oxford.

284 Tunstill, J., Aldgate, J. and Hughes, M. (2006) *Improving Children's Services Networks: Lessons from Family Centres*, London, Jessica Kingsley Publishers.

285 Garbers, C., Allnock, D., Akhurst, S. and Tunstill, J. (2006) Facilitating Access to Services for Children & Families: Lessons from Sure Start Local Programmes. *Child & Family Social Work*, 11(4): 287–296.

Developing networks of supportive relationships for those who lack them have generally been integrated within models that blend both concrete services with therapeutic interventions. With the development of the Family Connections programme, service providers built in a social support component whereby families were encouraged to participate in recreational activities, such as trips to the local museum or boat rides, with other families. To ensure networks and social connections were maintained and nurtured, the programme sent out newsletters to families with details about free or low-cost family events and activities.<sup>286</sup>

The New Parent Infant Network is another example of a community support programme based on befriending new parents and providing support through the early phases of parenting; the network also facilitates access to a wider range of support services. The programme specifically targets vulnerable women under stress where there is a danger of family breakdown. In targeting vulnerable women, the network particularly seeks to support women with young children and who suffer with depression, social isolation and poverty.<sup>287</sup> The majority of referrals come from health visitors, GPs, and Social Workers, although there are a few self-referrals. The scheme differs from others in that it runs groups for fathers as well.

The scheme is largely delivered in a community setting, though there is an initial home visit. Following this the mother is matched with a volunteer 'befriender'. Most of the work with vulnerable parents is a mixture of therapy, training in a personal development programme and social involvement in therapeutic social groups. The NEWPIN family centres provide on-site access to crèches and playroom facilities for children; centres are also used as drop-in centres for support and advice. Based on two evaluations of NEWPIN, both studies broadly concluded that mothers that made use of the service had benefited; however this should be read against the backdrop that participation rates, even amongst those parents who had been referred were low.

Amongst mothers who had participated for at least 7–12 months, the most notable benefits accrued by mothers were a better ability to anticipate a child's needs, show more warmth and sensitivity towards the child and more effective control.<sup>288</sup> Based on qualitative evaluations, a small group of users indicated that the opportunity to meet other women was important and the personal development training was helpful.

## Focus on Children and Young People

### *Sexual maltreatment prevention*

Around one in a thousand young people aged 12–17 display sexually abusive behaviour (either against children or against people of their own age or older). Young people who are likely to sexually assault children include those who are developmentally impaired (around half have learning difficulties), who are socially isolated, and those who have themselves been sexually abused as children (up to 80 per cent).

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<sup>286</sup> DePanfilis, D. and Dubowitz, H. (2005) Family Connections: A program for preventing child neglect. *Child Maltreatment*, 10: 2.

<sup>287</sup> Oakley, A., Rigby, D., Rajan, L. and Turner, H. (1996) Supporting vulnerable families: an evaluation of NEWPIN. *Health Visitor*, 68: 188–191.

<sup>288</sup> Smith, T. (1999) Neighbourhood and Preventative Strategies with Children and Families: What works? *Children and Society* 13(4): 265–277.

However, only 12 per cent of male victims of abuse go on to become abusers themselves before the age of 20. A smaller group are well socialised, with high IQs and few family problems.<sup>289</sup>

Services aim to:

- Help young people to understand and take responsibility for the behaviour and develop strategies and coping skills to avoid abusing
- Help promote the physical, social and emotional wellbeing of young people who have themselves been abused
- Engage parents and carers in acknowledging what the child has done and to provide supportive family context for change.<sup>290</sup>

## TERTIARY INTERVENTIONS

Tertiary interventions target families in which child maltreatment has already occurred and been identified or reported to external agencies. The central aim of tertiary interventions is to reduce the negative impact of maltreatment and reduce the likelihood of abuse recurring. Tertiary interventions cover a range of different strategies that are monitoring, punitive, supportive and therapeutic in their approach towards perpetrators or victims. For perpetrators, who in most cases will be the parent, the aim will be either to punish (e.g. custodial sentence or losing custody of children), monitoring (e.g. signing the sex offenders register) or therapeutic (e.g. for the non-offending parent or to reduce the risk of further abuse). For abused children, treatment aims to ameliorate the traumatic effects of abuse, to promote their healthy growth and functioning and work towards diminishing the risk they will, in turn, maltreat their own children.

To achieve such aims requires the development of effective child protection services based on clear evidence that beneficial outcomes for children and families arise from interventions. However, a consistent problem in service development has been the dearth of robust impact evaluations establishing the effectiveness and outcomes of tertiary interventions. Although completed evaluations often seemingly show a range of positive outcomes, these have to be weighed up against the methodological problems that accompany many of them, such as small sample sizes, high drop-out rates and inadequate outcome measures, which can often make it difficult to conclude anything other than most tertiary interventions are rarely thoroughly evaluated and where services have been evaluated most are likely to be methodologically weak.<sup>291</sup>

289 Whittle N., Bailey, S. and Kurtz, Z. (2007) *The Needs of Young People who Display Sexually Harmful Behaviours and the Effectiveness of Interventions and Service Approaches to Meet these Needs and to Prevent Sexually Abusive and Criminal Behaviour*. Department of Health Victims of Violence and Abuse Prevention Programme; Hinden, B., Biebel, K., Nicholson, J., Henry, A. and Stier, L. (2002) *Steps Toward Evidence-Based Practices for Parents with Mental Illness and their Families*. US Department of Health and Human Services .<http://www1.nmha.org/children/evidenceBasedPractices.pdf>

290 Whittle, N., Bailey, S. and Kurtz, Z. (2007) *The Needs of Young People who Display Sexually Harmful Behaviours and the Effectiveness of Interventions and Service Approaches to Meet these Needs and to Prevent Sexually Abusive and Criminal Behaviour*. Department of Health Victims of Violence and Abuse Prevention Programme.

291 Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: John Wiley & Sons Ltd; McNeish, D. and Newman, T. (1996) as cited in: Armstrong, C. and Hill, M. (2001) *Services for Vulnerable Families with Children aged 0–3 years: Evidence about Effectiveness*. Centre for the Child & Society: Glasgow.

It is also worth noting that there is a significant degree of overlap between secondary and tertiary interventions, and many of the interventions targeted at families at risk of child abuse and neglect are also used with families with a history of maltreatment.

## Addressing Child Abuse and Neglect

In the case of physical and sexual abuse, the emphasis in UK practice has been on placing the child victim in a safe place away from the perpetrator, to ensure the child does not continue to be abused. In the case of neglect the reverse response is prevalent, that is the standard practice is for the child to remain with the family and for support to be provided.<sup>292</sup> Given a coherent national approach to tertiary intervention is lacking, the provision of subsequent therapeutic support to address trauma remains limited and dependent upon local arrangements and available facilities.<sup>293</sup>

## Care Arrangements

Foster family placements are the most common form of substitute care option in UK. There are different types of foster care depending on the needs of both the child and their family. These include short-term care for just a few days or weeks (e.g. while plans are made for the child's future), to long-term placements (e.g. to provide a safe environment for the child and also as an alternative to adoption), as well as care for disabled children or children with behavioural problems. Based on 2007 figures, around 71 per cent of children in care are in foster families, approximately 27 per cent are placed in children's homes (including hostels and secure units) and 23 per cent are placed in the community; according to these recent figures 60,000 children are being looked after by foster carers mainly because of abuse and neglect issues.<sup>294</sup>

The average duration of the final period of care that children looked after had before being adopted (where this was applicable) in 2007 was 2 years 8 months. This has changed little over the past 5 years.

It is now common practice when looking to place children in a safe environment away from their birth family, to first and foremost establish the suitability of placing a child in the care of relatives. By placing a child within their extended family, the individual is able to retain family contact and remain within the traditions and culture of their family, and avoid the trauma of placement with unfamiliar people at a time of general upheaval and distress.<sup>295</sup> When compared to non-relative foster care, evaluation data has shown that children typically remain in the care of their relatives for longer, hence providing long-term stability. However, it appears that often less support is made available to family carers than for professional foster carers, including social services support. But without a proper infrastructure of support, such as formal family support services, the responsibility of looking after a child can be a source of stress to families and relative caregivers, especially where children have severe problems.

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292 Tanner, K. and Turney, D. (2003) "What do we know about child neglect? A critical review of the literature and its application to social work practice." *Child & Family Social Work*, 8: 25–34.

293 Bentovim, A. (2006) Therapeutic interventions with children who have experienced sexual and physical abuse in the UK, in McAuley, C., Pecora, P. and Rose, W. (eds), *Enhancing the well-being of children and families through effective interventions*. London: Jessica Kingsley Publishers.

294 Department for Children, Schools and Families (2007) *Cost benefit analysis of interventions with parents*. DCSF: London.

295 Berrick, J.D., Barth, R.P. and Needell, B. (1994) A Comparison of Kinship Foster Homes and Foster Family Homes: Implications for Kinship Foster Care as Family Preservation. *Children and Youth Services Review* 16: 33–63.

Over the last few years, the amount of residential care has decreased significantly. However, despite the comparatively small numbers of children involved, children who are placed in residential care are often among the most difficult cases. Where children are placed in residential care, namely when local authorities have made a court order or parents have voluntarily requested this, the care system now provides 'community homes'. It is thought that in comparison to other forms of substitute care, residential services can often offer specialist additional support.

Typically, decisions to admit children into community homes are triggered where the child has suffered abuse or where family relationships have broken down. However, quite often the main reason for assigning residential care is the nature of a child's social and personal problems, since it can be difficult to find foster carers for difficult adolescents. Even so, empirical evidence suggests the selection for residential care is guided by the preferences of young people. For instance, when a young person prefers residential care to fostering and where residential care would enable siblings to stay together.

Community homes usually have up to six residents and are marked by a high staffing ratio (about 56 hrs per resident per week) and high costs (£61k p.a.). However, despite the investment in skilled staff there are serious problems: harsh discipline; abuse by staff; suicidal tendencies and delinquency among residents; but more important is the lack of belief that residential care has anything to contribute.

### *Therapeutic Services*

The shortage of therapeutic services for abused children to help them overcome the short- and long-term effects of abuse is of great concern. For example, one research study estimated that 90% of children in the social services areas considered who had experienced sexual abuse received no substantial support.<sup>296</sup> At present, service provision is somewhat patchy. So while in some areas therapeutic services may be making a contribution to reducing the harm to children, in other locations children may not have access to any suitable services at all. Where children do receive therapeutic services, treatment models generally combine individual and group support in a safe community-based and out-of-home environment.<sup>297</sup>

Children's symptoms are similar and cut across whatever type of abuse they have experienced. The main symptoms can be broadly described as: internalising (e.g. PTSD, depression, anxiety) and externalising (e.g. behavioural problems). Based on extensive treatment research, Cognitive Behavioural Therapy has come to be the preferred approach amongst specialists in dealing with a range of different internalising behaviours. Given research suggests that children suffer multiple forms of trauma regardless of the type of traumatic experience, CBT, as a treatment model, has been developed to target specific symptom clusters, the developmental level of the child and the severity of the abuse, rather than the type of maltreatment experiences.

CBT treatment models can be delivered in a group or based on individual one-to-one therapy. Of these models, Trauma-focused Cognitive Behavioural Therapy (TF-CBT) has been found to be the most effective in improving trauma symptoms such as PTSD and depressive symptoms in all comparative trials of treatment models. Other than these symptoms the model also targets anxiety, trauma-related shame, and trauma-related cognitions such as self-blame. By using a hybrid treatment model based on cognitive

<sup>296</sup> Baginsky, M. (eds) (2001) *Counselling and support services for young people aged 12–16 who have experienced sexual abuse: a study of the provision in Italy, the Netherlands and the UK*, NSPCC, London.

<sup>297</sup> Dufour, S. and Chamberland, C. (2004) The effectiveness of selected interventions for previous maltreatment: enhancing the well-being of children who live at home. *Child and Family Social Work*, 9: 39–56.

behavioural, inter-personal and family therapy principle the intervention delivers the following types of treatments: parenting skills, activities which enhance parents' ability to talk through the child's trauma, active listening skills, relaxation skills, joint child-parent sessions and addressing future safety issues.

On the whole, intervention programmes were highly structured by the parents themselves and involved 90 minute sessions over 12 individual meetings – 45 minutes with the child 45 minutes with the parent. The content of both groups was generally similar, though therapists would obviously use age-appropriate formats and more interactive behavioural therapy for the child-focused groups. The age-range of evaluated CBT groups was from 5–17 years old and some programmes included components for non-offending parents, in cases of child sexual abuse, as well.<sup>298</sup>

Resilient Peer Treatment is a form of social play therapy that works on developing social interaction skills and positive play with socially withdrawn abused and/or neglected children. The therapy is based on directing interactive and imaginative play between pairs or groups of preschool children in special play areas, with a trained parent volunteer supervising. The underlying theory is that by pairing abused pre-school children with a resilient peer can enhance the social competency of the child victim. Resilient peers/ play friends were selected on the basis of their ability to engage in a high level of positive play.

The intervention involved daily sessions which followed a fairly structured sequence of activities, involving set-up, the adult supervisor spending a few moments with the play buddy to prepare them for the play session and ensuring supportive comments were made to the target child and play buddy about their interactive play. Overall, the intervention was spread over 15 play sessions (three planned session per week) spread over a two-month period. The intervention has been evaluated in a variety of settings such as child study labs, playrooms, classrooms and Head Start centres.

The parent supervisors received training from graduate students and parent members of the research team. Training was based on five sessions covering topics such as the significance of peer play interactions, demonstration of their task in supervising play-groups, and also training in observing pro-social play behaviours.

In promoting resilience in children, research has found that certain 'protective' factors related to personal characteristics, such as good health, access to healthcare, adequate housing and importantly a supportive family environment or at least a warm, positive and supportive relationship with an adult, can help protect children from the effects of maltreatment.<sup>299</sup> Examples of possible supportive adults include (proxy) grandparents, family support workers, teachers, etc.

## Addressing Domestic Violence

Millions of children are exposed to domestic violence every year. The implication of the recent study by the NSPCC of the prevalence of child maltreatment is that around 400,000 children witness domestic violence each year in the UK (3.5 per cent of under 11s and 2.5 per cent of 11 to 17 year olds).<sup>300</sup> US studies estimate that between 3.3 million – 10 million children and adolescents witness intimate partner violence

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<sup>298</sup> Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues*, 62(4): 737–766.

<sup>299</sup> Mrazek, P. and Mrazek, D. (1987) Resilience in child maltreatment victims: A conceptual exploration. *Child Abuse and Neglect*, 11: 357–366.

<sup>300</sup> Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C. and Howat, N. (2011) *Child abuse and neglect in the UK today*. London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)



every year.<sup>301</sup> The effects of exposure to violence can have serious negative effects on children, many of which are consistent with the effects of physical abuse. These effects include behavioural problems, poor academic achievement, symptoms consistent with PTSD, and as adults studies have indicated links with violent and criminal behaviour.<sup>302</sup> Furthermore, studies have also shown that children exposed to domestic violence and child abuse show higher levels of distress.<sup>303</sup>

At present, services designed for the specific needs of violence exposed children are limited and only reach a fraction of those exposed to domestic violence. Many of these services are not designed with violence-exposed children in mind. However through cross-agency collaborations, innovative pilot programs are implemented to offer mental health services to children exposed to domestic violence and improve law enforcement responses to domestic violence incidences in which children are present, although little is known about their effectiveness. Overall, interventions span those that are community based, services that are rooted within the health care and mental health systems, interventions that involve child protective services and the legal system.

A specialist community-based counselling service targeted children who had witnessed violence. The service is accessed through a police referral, rather than through crisis centres or shelters. Initial contact is made with the family within an hour of referral by a trained mental health specialist. After the initial visit families are visited and receive up to about 3–4 sessions a week with the specialist over a 3–4 week period. The specialist provides counselling with referral to further mental health services if required.<sup>304</sup>

Child-Parent Psychotherapy for Family Violence (CPP) is a trauma focused, relationship-based, joint child-parent psychotherapy model that addresses various emotional and behavioural difficulties experienced by young children exposed to domestic violence. The service targets infants, toddlers and preschoolers who display symptoms violence-related trauma and aims to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by exposure to domestic violence. The service is typically delivered by a clinician who has at least a masters' degree; training in CPP lasts a full training year.

The service is based on weekly, one hour sessions over one year/ 50 weeks and is delivered within the home or the clinic. Essential components of CPP are grouped into intervention modalities: use of play and language to promote healthy exploration; unstructured developmental guidance; modelling of appropriate protective behaviours; emotional support and emphatic communication; crisis intervention and case management. Based on a six-month follow-up, an evaluation showed that PTSD symptoms improved and there were general improvements in general behaviour problems and the mother's general distress.

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301 Carter, L., Weithorn, L. and Behrman, R. (1999) Domestic Violence and Children: Analysis and Recommendations. *The Future of Children: Domestic Violence and Children* 9(3): 1–20.

302 Silvern, L., Karyl, J., Waelde, L., Hodges, W.F., Starek, J., Heidt, E. and Min, Kyung (1995) Retrospective reports of parental partner abuse: Relationships to depression, trauma symptoms and self-esteem among college students. *Journal of Family Violence*, 10: 177–202; Maker, A.H., Kimmelmeier, M. and Peterson, C. (1998) Long-term psychological consequences in women of witnessing parental physical conflict and experiencing abuse in childhood. *Journal of Interpersonal Violence* 13: 574–89, as cited in: Carter, L., Weithorn, L. and Behrman, R. (1999) Domestic Violence and Children: Analysis and Recommendations. *The Future of Children: Domestic Violence and Children* 9(3): 1–20.

303 O'Keefe, M. (1995) Predictors of child abuse in maritally violent families. *Journal of Interpersonal Violence* 10: 3–25, as cited in: Carter, L., Weithorn, L. and Behrman, R. (1999) Domestic Violence and Children: Analysis and Recommendations. *The Future of Children: Domestic Violence and Children* 9(3): 1–20.

304 Spilsbury, J.C., Belliston, L., Drotar, D., Drinkard, A., Kretschmar, J., Creeden, R., Flannery, D. and Friedman, S. (2007) Clinically significant trauma symptoms and behavioural problems in a community based sample of children exposed to domestic violence. *Journal of Family Violence*, 22: 487–499.

The Youth Relationships Project is a community-based programme developed to address the need for education and prevention strategies amongst young people to reduce and eliminate violence against women and children. By focusing on adolescent personal relationships the programme aims to educate young people:

- about violence and sexism;
- assist them with developing healthy non-violent relationships; and
- prevent them from becoming violent in their personal relationships.

The program is geared towards 14- to 17-year-olds who have experienced violence in their own families. The children are referred to the programme from active child protection cases, usually by their caseworker. Young people participate in a 18-week programme based on two hour sessions in a group environment to discuss and learn about critical issues related to healthy versus abusive relationships, developing positive relationship and communication skills, develop skills to build healthy relationships, and the chance to participate in a social action project. The groups are facilitated by a male and female co-facilitator.

Cognitive Behavioural Interventions for Trauma in Schools (CBITS) is a school-based early intervention program developed for ethnic minority youth aged 10–14 who have had substantial exposure to violence and who have symptoms of PTSD in the clinical range. The programme is designed to ameliorate trauma symptoms caused by exposure to violence (such as PTSD or depression) and to build coping skills and resilience. The overarching aims of CBITS are therefore threefold: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support. CBITS is delivered in a group format by school based mental health professionals; the clinicians are trained and work from a manual.

Each group has up to 5–8 students who will work collaboratively to address the cause of their symptoms through cognitive techniques and trauma-focused work. In each session, a new set of skills to is taught using didactic presentation, age-appropriate examples, and games. The child then uses these skills to address his or her problems through homework assignments. The program format is 10 child group sessions of approximately an hour in length. In addition to the group, participants receive 1–3 individual sessions, two parent-education sessions, and a teacher informational meeting.<sup>305</sup>

## Addressing Sexual Abuse

It can often be difficult to disentangle problems which children have as a result of the abuse they have experienced and the problems that they already had, which provide part of the explanation as to why they were abused in the first place (e.g. low self-esteem). Moreover, abuse victims are very heterogeneous and their needs are likely to differ by gender, by age, by relationship to abuser, and by the nature and duration of the abuse. It is therefore important that therapy is abuse-specific since although children and young people who have been sexually abused suffer from the same range of mental health conditions as do other young people with problems (e.g. PTSD, depression, anxiety), they often also suffer from problems such as sexualised behaviour which is not common to other children and young people.

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<sup>305</sup> Stein, B.D., Jaycox, L.H., Kataoka, S.H., Wong, M., Tu, W., Eliot, M.N. and Fink, A. (2003) A mental health intervention for school children exposed to violence: A randomized controlled trial. *JAMA*, 290(5): 603–611; Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766.

The range of therapeutic interventions usually includes:

- Education about the nature of sexual abuse
- Facilitation of the expression of feelings related to the abuse
- Identifying and correcting sense of responsibility
- Teaching anxiety management skills
- Developing self-protection skills
- Help with managing problem behaviour<sup>306</sup>

In particular therapeutic interventions for sexually abused children have been rooted within different cognitive-behavioural approaches. Underlying the development of cognitive-behavioural therapy are four different theories of learning which combine to provide an integrated holistic approach that focus particularly on the meaning of events for children and non-offending parents. In essence, the therapy endeavours to identify and address maladaptive cognitions, misattributions, low self-esteem, and more overt behavioural problems such as externalising behaviours, internalising behaviours or sexualised behaviour.

Cognitive behavioral approaches for sexual abuse involve providing victims with psycho-education on sexual abuse, attribution retraining, building coping skills and parent training. Overall treatment models are typically brief, lasting between 8–12 sessions and delivered in both individuals and within group settings.<sup>307</sup> Such approaches are targeted at the child victim, although it is often useful for therapy to include non-abusing parents. In fact studies indicate programmes offering parallel therapy sessions for both parents and children are more beneficial than those programmes that focus on either children or parents. Therefore the rationale for including parents hinges off the fact that family support is important in dealing with the aftermath and disclosure of the abuse and building up resilience against long-term negative consequences.

The trauma-focused cognitive behavioural therapy model has been prioritised by practitioners as having the most promise as an efficacious treatment for trauma-related symptoms, such as anxiety, depression and PTSD.<sup>308</sup> In particular, *trauma-focused* cognitive behavioural therapy (often combined with similar treatment for the non-offending parent) has extensive empirical support as an effective treatment for physically and sexually abused children.<sup>309</sup> However, while the weight of evidence supports TF-CBT as an effective intervention, it is important to note that studies are somewhat undermined by the high

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<sup>306</sup> Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd.

<sup>307</sup> Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766.

<sup>308</sup> James, S. and Mennan, F. (2001) Treatment outcome research: How effective are treatments for abused children? *Child and Adolescent Social Work Journal*, 18: 73–95, as cited in: McAuley, C., Pecora, P.J. and Rose W. (2006) *Enhancing the well-being of children and Families through Effective Interventions: International Evidence for Practice*. London: Jessica Kingsley Publishers.

<sup>309</sup> Putnam, F.W. (2003) Ten-year Research Update Review: Child Sexual Abuse. *Journal of the American Academy of Child and Adolescent Psychiatry* 42(3): 269–278.

drop-out rates that range from 35 per cent<sup>310</sup> to 40 per cent<sup>311</sup> and limited follow-up of assessments with roughly 48 per cent-50 per cent of studies completing all assessments.<sup>312</sup>

The overarching aim of TF-CBT is to increase adaptive functioning and reduce internalising behaviours. By targeting trauma-related symptoms (e.g. PTSD, depression and anxiety) and integrating specific techniques, TF-CBT assists abused children with developing their coping mechanisms (e.g. managing distressing thoughts, feelings and behaviours) and provides their offending caregivers and the larger family system with support to improve parenting skills and family communication. Most of TF-CBT treatment programmes consist of 10–12 treatment sessions, based on attending once a week for 60–90 minute sessions. Parents are seen separately from their children for most of the treatment and receive interventions that parallel those provided to the child. Several joint parent-child sessions are also included to enhance joint-family communication about sexual abuse and other issues.

Children are generally referred for treatment following an investigation conducted by child protection agencies or following a court recommendation. The programme can be delivered in a public health clinic or by therapists in community settings.

Behavioural family therapy is an approach based upon a premise that many factors interact to give rise to a situation in which a child may be at risk of child abuse or neglect, and that many of these factors are located within the family structure, or can be intervened with at this level of the family, and cognitive behavioural approaches are effective interventions. In situations of child maltreatment, family therapy is premised upon achieving three main objectives: to prevent the reoccurrence of maltreatment, with the non-offending parent taking responsibility for protecting the child; for the perpetrator to acknowledge and take responsibility for the abuse; and re-establish an appropriate hierarchy in the family.<sup>313</sup>

To effect change in families, it is important to rely on a combination of family/group approaches based on a wide range of methods, such as individual psychological help, behavioural methods and family therapy (Gaudin, 1993). The family therapy programmes run at Great Ormond Street (Sexual Abuse Team), have integrated two main approaches – family therapy and in some cases adding group therapy to a family therapy treatment programme – within a framework of clear co-operation with social services and criminal welfare. Great importance is attached to an initial assessment of each individual case. Both Bentovim et al. (1988) and Monck et al. (1991) concluded that integrated approaches can lead to small but significant, safe rehabilitation of families following intra-familial sexual abuse.

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310 Celano, M., Hazzard, A., Webb, C., et al. (1996) Treatment of traumagenic beliefs among sexually abused girls and their mothers: an evaluation study. *Journal of Abnormal Child Psychology*, 24, 1-17. As cited in: Ramchandani, P. (2003) Treating psychological symptoms in sexually abused children. *The British Journal of Psychiatry* 183: 484–490

311 Cohen, J.A. and Mannarino, A.P. (1998) Factors that mediate treatment outcome of sexually abused preschool children: Six and 12-month follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(1): 44–51. As cited in: Cohen, J.A. and Mannarino, A.P. (2006) Psychosocial interventions for maltreated and violence-exposed children. *Journal of Social Issues*, 62(4): 737–766.

312 Cohen, J.A. and Mannarino, A.P. (1997) A treatment study for sexually abused preschool children: Outcome during a one-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(9): 1228–1235. As cited in: Cohen, J.A. and Mannarino, A.P. (2006) Psychosocial interventions for maltreated and violence-exposed children. *Journal of Social Issues*, 62(4): 737–766; Cohen, J.A. and Mannarino, A.P. (1998) Factors that mediate treatment outcome of sexually abused preschool children: Six and 12-month follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(1): 44–51. As cited in: Cohen, J.A. and Mannarino, A.P. (2006) Psychosocial interventions for maltreated and violence-exposed children. *Journal of Social Issues*, 62(4): 737–766.

313 Silovsky, J.F. and Hembree-Kigin, T.L. (1994) Family and group treatment for sexually abused children: A review. *Journal of Child Sexual Abuse*, 3(3): 1–20.

Group based cognitive behavioural interventions are used to improve symptoms of depression, anxiety and sexualised behaviour, and boost self-esteem and assertiveness. By providing CBT in a group format, the feelings of isolation and stigma sexually abused children will often experience can be addressed more effectively alongside other abuse victims rather than in individual 1:1 therapy sessions.<sup>314</sup> Sturkie (1992) stated that group-based therapy provides an element of stability and a support network at a time when other elements of their lives may be disrupted and equally the group can also provide a less intrusive and more egalitarian form of support.<sup>315</sup> Sturkie's (1992) identified five different models of group interventions for sexually abused children:

1. Traditional group based therapy with a therapist that plays the role a non-directing facilitator
2. Therapy that focuses on role play and development rather than the problems themselves
3. Therapy within a structured group with a greater degree of organization and direction
4. Group therapies that use art as a mode of expression (e.g. sculpting, painting and drawing).
5. Parallel groups for children and non-offending parents where the same themes are addressed in a structured group.<sup>316</sup>

CBT is also increasingly used with young people, particularly young men, who are showing signs of becoming abusers themselves.

## Breaking the Cycle

By watching and learning from the parents and other adults in the social environment, children learn how to behave both by experiencing how others treat them and how their parents interact with one another. Based on the social learning theory research has evinced that children who either witness persistent parental violence or have been victimised themselves, are at greater risk than other children of repeating this behaviour as adults; young men in particular are can also develop hostile attitudes towards women. In breaking the cycle of inter-generational transmission of abuse, programmes address these issues in a systematic way by focusing on the relational context in which violence can occur.

The Youth Relationships Project aims to prevent violence in close relationships and promote relationships based on trust and equality. The programme entails 18 weekly sessions lasting about 2 hours each. The underlying emphasis is on changing attitudes and behaviour by increasing understanding of power and role in relationship violence; developing skills to build healthy relationships; understanding societal influences which give rise to violent pressures; consolidating learning through social action within the community. Each session is based upon five stages: teach, show, practice, reinforce and apply.

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<sup>314</sup> Reeker, J., Ensing, D. and Elliott, R. (1997) A meta-analytic investigation of group treatment outcomes for sexually abused children. *Child Abuse and Neglect*, 21(7), 669–680.

<sup>315</sup> Sturkie, K. (1992) Group treatment of child sexual abuse victims: A review, in W. O'Donohue and J.H. Geer (eds), *The sexual abuse of children* (pp. 331–364). New York: Human Sciences Press.

<sup>316</sup> Sturkie, K. (1992) Group treatment of child sexual abuse victims: A review, in W. O'Donohue and J.H. Geer (eds), *The sexual abuse of children* (pp. 331–364). New York: Human Sciences Press.

## Focus on Parents

Parental involvement in treatment for child abuse is critical. However working with parents who have been deemed to be abusive or neglectful towards their children interventions can present a number of difficult issues. Interventions often require detailed assessment and monitoring, which may give rise to feelings amongst parents of being watched for incriminating evidence against them. Furthermore, hostility amongst parents as a result of the stigma associated with child protection investigations may lead to reluctant and superficial participation in the intervention process.

## Social Work Support

Much of the discussion around social work support as a secondary intervention is relevant as a tertiary intervention as well. A consideration in identifying the data on social work delivered outcomes is the role played, certainly in the UK, by the child and family area team social worker as the 'general practitioner of the child welfare system'<sup>317</sup> and thereby responsible for the delivery of a flexible casework service. It can be argued therefore that the level of a social worker's success in networking and packaging support services, may militate unfairly against the profession's visibility as an active agent in the delivery of outcomes.

For example, the availability of emotional support has been shown to be associated with lower levels of stress and more competent parenting.<sup>318</sup> A major emphasis in the child maltreatment field and amongst social workers has been on family preservation and ensuring parents have access to comprehensive services in the community so as to ensure that their concrete needs in managing their family are met alongside treatment.<sup>319</sup> For social workers' this has meant that the thrust of their casework with maltreating parents (especially in cases of neglect) has been focused upon increasing parents' sense of personal efficacy and breaking the cycle of dysfunctional relationships between parents and children.<sup>320</sup>

However, in dealing with entrenched dysfunctional patterns of relationships and communication difficulties may mean that in some cases talking and receiving advice is insufficient in introducing positive behaviours. Practitioners may be required to model the sought behaviours, maintain regular contact with parents through supportive telephone calls and regular home visits.<sup>321</sup> In particular, when working on the parent-child relationship, the use of video can be particularly effective as it allows the parents to view their behaviour from the perspective of the child.

Based on this social workers can then engage with parents in devising different ways of interaction with their children using the video as a tool in evaluating the impact of the changes in their attitude and parenting approach.<sup>322</sup> By addressing the destructive nature and effect of maltreatment on child-parent

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317 Thoburn, J. (2007) Social Work with Children and Families in Davies, M. (ed) *The Blackwell Companion to Social Work*. (3rd Edition) Oxford: Blackwell. pp 207–221.

318 Thoburn, J. (1994) *Child Placement: Principles and Practice* (Second Edition). Ashgate; Ghate, D. and Hazel, N. (2002) *Parenting in poor environments: stress, support and coping*. London: Jessica Kingsley Publications Maluccio, A.N., Canali, C. and Vecchiato, T. (eds) (2002) *Assessing Outcomes in Child and Family Services: Comparative Design and Policy Issues*. Aldine Transaction.

319 Tunstill, J. and Aldgate, J. (2000) *Services for Children in Need: from policy to practice*. London: TSO); Gilligan, R. (1999) Children's own social networks and network members: key resources in helping children at risk' in Hill, M. (ed) *Effective Ways of Helping Children*. London Jessica Kingsley.

320 Turney, D.J. and Tanner, K. (2001) Working with neglected children and their families. *Journal of Social Work Practice*, 15 (2): 193–204.

321 Iwaniec, D. (2004) *Children who fail to thrive: A practice guide*. John Wiley and Sons.

322 Iwaniec, D. (2004) *Children who fail to thrive: A practice guide*. John Wiley and Sons.

interactions, it is possible such interventions will promote child attachment and assist in breaking the intergenerational learning of abusive parenting.

### *Cognitive behavioural therapy*

For parents with a history of maltreatment, cognitive behavioural therapy typically combines parenting training, anger management and problem solving, with an overarching emphasis on functioning in a broader social context. Working in group is often an important component of such interventions as is the duration of the programme. A key issue when working with maltreating parents is allowing time to build up trust, since this can take a long time the period of the intervention often needs to be much longer than the standard therapeutic approach (approximately 12 weeks).

In delivering CBT there is often a question of whether it would be better to train social workers to deliver therapy sessions as they are used to working with difficult families, rather than use psychologists or clinicians who have less understanding of maltreating families and their circumstances.<sup>323</sup> Particularly since when using *targeted* behavioural interventions, parents can often feel judged and stigmatised so it can be more effective to focus on addressing their problems rather than their abusive behaviour. Practitioners have suggested it can be effective, when dealing with families in difficult circumstances, to concentrate initially on the problems they feel are the most important and places them under the most stress.<sup>324</sup>

Specific examples of CBT include Abuse-Focused Cognitive Behavioural Therapy (AF-CBT). This branch of CBT is used primarily in the context of physical abuse. By targeting offending parents, the model focuses on the parents' parenting skills, including the increasing the use of positive child management techniques and reducing the likelihood of the parent resorting to harsh and coercive forms of punishment and discipline.<sup>325</sup> Other than child-focused components, the model also addresses external factors/ triggers for abuse located in parents' lives, for instance by providing stress management techniques to address and cope with everyday problems, development of social support plan and skills training to enhance interpersonal and intrapersonal skills. An evaluation by Kolko (1996) found that families receiving family AB-CBT reported significantly greater reductions in parental anger, the use of physical or coercive discipline and therefore a significant decrease in the abuse risk to children.<sup>326</sup>

Cognitive behavioural therapy can also be effective for non-offending parents in the therapy process for sexually abused children has empirical support as an effective mechanism in assisting the child victim overcome externalising behaviour problems and mental health issues. However, in addition to supporting the child victim, CBT can also assist the non-offending parent in coping with their own emotional reactions so as to better support their child; to initiate and maintain open communication with their child about their abusive experiences; and provide the parent with behaviour management skills to handle abuse-related and non-abuse related behavioural difficulties.<sup>327</sup>

<sup>323</sup> Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766.

<sup>324</sup> Reid, J.B., Taplin, P.S. and Lorber, R. (1981) A social interactional approach to the treatment of abusive families, in MacDonald, G. (2001) *Effective interventions for Child Abuse and Neglect: An Evidence-based Approach to Planning and Evaluating Intervention*. Wiley: Chichester.

<sup>325</sup> Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766.

<sup>326</sup> Kolko, D.J. (1996) Individual cognitive-behavioural treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment*, 1: 322–342.

<sup>327</sup> Forrest-Talley, P. (2005) *Handbook for the Treatment of Abused and Neglected Children*. Haworth Press.

The duration of such programmes can vary. Some studies have based their programmes around 12 sessions, however these models can be built upon and extended to last over 12 months. The model developed by Deblinger et al. (1996)<sup>328</sup> was based on between 12–40 sessions, depending on the severity and complexity of the family needs and situation. The sessions lasted about 45 minutes each, in which parents were taught the same therapeutic skills that the therapist was using in the child-only group. After the individual sessions for parents and the child victim, both then participate in a joint session; these extend over a 12 week period with each session lasting about 30 minutes.

In addition to CBT, interventions for non-offending parents have made use of video-based instruction. Mothers of children aged 4–12 years of age, who had been referred to for assessment for sexual abuse, were shown a short video programme about the short- and long-term psychological and behavioural effects of sexual abuse. The programme highlighted the common reactions of parents and suggested methods of dealing both with their own emotions and more importantly how to supportively respond to their children's behaviour and emotions.<sup>329</sup> Based on a 7 day follow up period, limited yet promising results have been achieved whereby mothers have engaged in supportive responses.

## Anger Management

Training for parents who have physically abused their children focuses on alternative methods of self-control. Anger management, stress management groups and multi-systemic therapy have all been evaluated as effective techniques in preventing family violence, increasing control and decreasing stress, which it is hypothesized, will then feed into improved communication within the family. Within the range of cognitive behavioural therapy models, Trauma-Focused CBT often includes a relaxation component which focuses on techniques such as controlled breathing and muscle relaxation as way of decreasing anger and physiological hyperarousal which may trigger abuse and violence.<sup>330</sup>

## Focus on the family

### Multi-dimensional support

The effect of witnessing domestic violence has serious consequences for the subsequent psychosocial and adaptive behaviours of young children. One of the most common syndromes is Oppositional Defiant Disorder (ODD); ODD is generally seen in younger children and involves behaviour described as disruptive and oppositional that is particularly directed towards authority figures, such as parents or teachers. In managing disruptive behaviour, the parental interventions for children with oppositional defiant disorder, Project SUPPORT, was based upon two main components:

- providing instrumental and emotional support as women made the transition from a shelter to an independent home; and
- teaching mothers a set of behaviour management and nurturing skills.

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328 Deblinger, E. Lippmann, J. Steer, R.A. (1996) Treating sexually abused children suffering post-traumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*. 1(4): 310–321, in Cohen, J.A., Mannarino, A.P. and Knudsen, K. (2005) Treating sexually abused children: One year follow-up of a randomized controlled trial. *Child Abuse & Neglect*, 29(2): 165–145.

329 Jinich, S., Litrownik, A.J. (1999) Coping with sexual abuse: development and evaluation of a videotape intervention for nonoffending parents. *Child Abuse and Neglect*, 23(2), 175–90.

330 Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766.



These components were offered in the participants' home and lasted up to 8 months after the women had left the shelter. The intervention was designed to include weekly session of up to 60–90 minutes, with a trained therapist (team of six graduate students enrolled on a doctoral programme and one clinical psychologist). The team received extensive training, in some cases this was a special university course, on providing services to families affected by violence. Based on a two-year follow up, an evaluation concluded the intervention had a significant and lasting impact on children's conduct and additionally mothers were less likely to use aggressive child management techniques or have returned to their abusive partners.<sup>331</sup>

Kids' Club and Preschool Kids' Club are designed to address the needs of abused mothers and their children who many have witnessed violence by providing supportive and empowering forums to foster resilience from inter-parental violence. The clubs are based on both social and cognitive components, with the aim of increasing parenting skills, addressing the needs of both parents and children regarding increasing coping abilities and safety planning skills and decreasing the effects of post-violence stress.<sup>332</sup>

### *Family therapy and Family behavioural therapy*

Family therapy recognises that families are not just collections of individuals but have developed systems where each individual's behaviour is influenced by that of the other members of the group. Well-functioning families have systems that change in response to changes in circumstances (e.g. children reaching adolescence or leaving home). Often the presenting symptom (e.g. a badly behaved child) is not the problem, but a reflection of a more underlying problem (e.g. difficulties in the couple relationship). As such, interventions aimed at the family unit are comprehensive, multi-service or combined interventions. The underlying logic of family therapy is therefore to effect change based on a range of intervention methods and ultimately prevent the reoccurrence of abuse, prevent the breakdown of the couple relationship and the out-of-home placement of the child.

There are a wide variety of approaches, which can be grouped very broadly as behavioural or eco-behavioural. Yet despite the approach used very few models have been subject to evaluation scrutiny though where impact has been measured, effectiveness has proven to be very mixed. Overall, traditional family therapy approaches can prove to be expensive, with up to four practitioners per family and high rates of attrition and non-attendance from therapy. Given the attrition rates point towards the unpopularity of such approaches, especially amongst families with more serious behavioural issues, the overall cost-effectiveness of family therapy programmes has been queried. However, where families have completed the course of therapy, although evaluations have been limited, parents and children have shown reductions in psychiatric symptoms and improvements in family functioning.

Brunk et al. (1987)<sup>333</sup> delivered a model based on eight sessions of multi-systemic family therapy, within the family unit rather than in groups, to teach parenting skills and child behaviour management skills. In addition, families were observed for parent-child interaction during a 10 minute sessions during which

331 Macdonald, Jourilles and Skopp (2006) Reducing conduct problems among children brought to women's shelters: Intervention effects 24 months following termination of services, *Journal of Family Psychology* 20(1): 127–136.

332 Sullivan et al. (2004) Conjoint Interventions for Adult Victims and Children of Domestic Violence: A Program Evaluation, *Research on Social Work Practice*, Vol. 14, No. 3, 163–170; Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766.

333 Brunk, M., Henggeler, S.W. and Whelan, J.P. (1987) Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology*, 55: 171–8.

the parent was instructed to teach their child block designs of increasing difficulty. Evaluations of the therapy model showed significant reductions in parental stress and improvements in child behaviour.

Based on an eco-behavioural approach, Project 12-ways recognised that families have multiple and inter-related problems. The intervention was targeted at non-specified abuse and offered 12 different types of core support as part of an integrated package:

- Parent-child training
- Stress-reduction and assertiveness training
- Self-control (anger management) training
- Basic skills for children with developmental delay
- Leisure time counselling
- Couples counselling
- Alcohol misuse treatment
- Social support
- Job finding training
- Money management
- Health maintenance and nutrition
- Home safety training
- Behavioural management training
- Prevention service

Given the reported rates of attrition from therapeutic intervention, considerable emphasis was placed upon home-based assessment and delivery of services, so as to facilitate the participation of families and ensure that newly acquired skills were maintained and implemented within the family setting.

### *Improving social networks*

Social network interventions aim to address the issues of child maltreatment by providing vulnerable families with increased contact and time with effective social support services. The increased availability of social support is meant to act as a supplement to rather than a substitute for normal casework with families. So for example, as Gaudin et al. (1994) modelled in cases with neglecting families, allocation to a social worker who has responsibility for holistic case management. These workers sought to improve social networks by:

- Encouraging relationships with wider family and work colleagues
- Establishing attendance at mutual aid groups
- Linking with volunteers
- Recruiting neighbours to as informal helpers; and
- Social skills training<sup>334</sup>

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334 Gaudin, J.M. (1993) Effective intervention with neglectful families. *Criminal Justice and Behavior*, 20(1), 66–89.

However, although there have been a range of interventions to help provide families with better social networks, there is no proven link between improving social networks and reducing the probability of maltreatment.<sup>335</sup> In addition, the impact of social support services is mitigated somewhat by the high drop-out rates, which can be attributed to the extreme mobility of many neglectful families.

The Community Parent Education Project is aimed at socially isolated parents who have young children enrolled in Head Start classes (in general about a third of students on HS classes have a history of maltreatment, the rest are from non-abusive homes). The programme is structured around 10 group-training sessions which focus on child development, developing age appropriate expectations and intervention, encouraging positive child-development through praise and setting appropriate limits. The sessions also work on the relationship between stressors and social support by encouraging and helping parents to use Head Start as a means of developing local networks. On average parents attended 7/10 sessions. COPE is designed to be culturally relevant and based within the local community.<sup>336</sup>

## Focus on Abusers

Convicted sex offenders are inevitably only a sub-set of all adults who sexually abuse children. However, most interventions focus on those who have been convicted, not least because it is problematic for those who have not been convicted to volunteer for treatment. The development of offender programmes to address the perpetration of sexual and physical abuse is a small, though significant, part of the child abuse prevention field. While the bulk of the literature focuses on convicted offenders, it is becoming apparent that there have been increasing efforts to rehabilitate young offenders and prevent the occurrence of abuse in those identified to be 'at risk' of offending. So at present interventions aimed at abusers have elements of tertiary practice (prevent recidivism) and also components of secondary practice (targeting potential offenders). At present the main child maltreatment-related offences are those relating to forms of physical and sexual abuse and gross indecency. Convicted sex offenders are inevitably only a sub-set of all adults who sexually abuse children. However, it is generally problematic for those who have not been convicted (or even arrested) to volunteer for any form of treatment. Thus, most interventions focus on those who have been convicted.

Around half of all convicted child sex abusers have been sexually abused themselves as children. Around six out of ten have only abused children within the family, and 84 per cent of these have only abused girls. By contrast those who have only abused children outside the immediate family are as likely to have abused boys as girls (44 per cent boys only, 37 per cent girls only, 20 per cent both). The pattern is similar for those who have abused children both within and outside the family.<sup>337</sup> Across countries around 13–15 per cent of those convicted for sexual offences (against either adults or children) are likely to reoffend within five years.<sup>338</sup> UK figures suggest that without treatment the sexual offence reconviction rate within

335 Stern, S.B. and Smith, C.A. (2002) Understanding the role of the family in adolescent antisocial and delinquent behaviour: Recommendations for research-based interventions, in Dufour, S. and Chamberlain, C. (2003) *The effectiveness of child welfare interventions: A systematic review*. Montreal, QC: Centre of Excellence for Child Welfare.

336 Fantuzzo, J., Stevenson, H., Kabir, S.A., Perry, M.A. (2007) An Investigation of a Community-based intervention for socially isolated parents with a history of child maltreatment, *Journal of Family Violence* 22: 81–89; Dufour, S. and Chamberland, C. (2004) The effectiveness of selected interventions for previous maltreatment: enhancing the well-being of children who live at home. *Child and Family Social Work*. 9: 39–56.

337 Beech, A., Fisher, D. and Beckett, R. (1999) *An Evaluation of the Prison Sex Offender Treatment Programme*. Home Office Occasional Report. [www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf](http://www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf)

338 Hanson, R.K. and Morton-Bourgon, K. (2004) *Predictors of Sexual Recidivism: An Updated Meta-Analysis*. Beech, A., Fisher, D. and Beckett, R. (1999) *An Evaluation of the Prison Sex Offender Treatment Programme*. Home Office Occasional Report. [www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf](http://www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf)

two years is less than 3 per cent (the conviction rate for offences of all kinds is under 5 per cent). This makes it difficult to establish with any degree of statistical reliability any differences between those who have received treatment and those who have not, as the numbers in British studies are relatively small.<sup>339</sup>

The Thematic Inspection of Probation Service work with Sex Offenders<sup>340</sup> suggests that treatment should apply “What Works” principles to work with sex offenders. Therefore treatment should focus on individuals at an acute risk of recidivism and be matched with the learning styles of the offender.

At present three broad types of treatment for sex offenders have been studied, sex offender treatment courses offered in:

- Prisons;
- Residential courses; and
- Probation service-led courses in the community.

Most group-based treatment occurs in prisons whilst most individual therapy is conducted through community forensic psychiatric/psychology services, Regional Secure Units and Special Hospitals. On the whole standard prison-based courses, using cognitive behavioural therapy, last for 86 two-hour sessions. Each group has two leaders drawn from a range of occupations within the prison system, all of whom have undertaken a two-week training programme and were supported afterwards by a treatment manager at each site qualified in forensic psychology.<sup>341</sup> A survey of UK community treatment programmes identified about 63 group programmes and estimated that on average 50 hours of treatment was provided to each offender.<sup>342</sup>

The focus of interventions is on the offender’s motives, on understanding the impact on victims, on recognising that they have distorted ways of thinking, and on learning ways to avoid offending in future.

The Core Programme of the probation-based UK sex offender treatment model comprises of a total of around 86 sessions and generally provides over 160 hours’ treatment hours to cover 20 modules. The primary purposes of the Core Programme are to increase the offender’s motivation to avoid reoffending and to instil the self-management skills necessary to prevent relapse.<sup>343</sup> Once the Core Programme has been completed there are additional supplementary models:

- The extended programme for offenders requiring additional work in other areas. No information about length of treatment length;
- Booster Programme for offenders serving long sentences and who are about to be released. This generally involves about 60 hours’ treatment.

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339 Friendship C., Mann, R. and Beech, A. (2003) *The Prison-based Sex Offender Treatment Programme – an evaluation*. Home Office Research Findings no 205. <http://rds.homeoffice.gov.uk/rds/pdfs2/r205.pdf>

340 (HM Inspectorate of Probation, 1998).

341 Beech, A., Fisher, D. and Beckett, R. (1999) *An Evaluation of the Prison Sex Offender Treatment Programme*. Home Office Occasional Report. [www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf](http://www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf)

342 Barker, M. and Morgan, R. (1993) *Sex Offender: Offenders: A Framework for the Evaluation of Community Based Treatment*, in Perkins, D., Hammond, S., Coles, D. and Bishopp, D. (1998) *Review of Sex Offender Treatment Programmes*. High Security Psychiatric Services Commissioning Board.

343 Beech, A., Erikson, M., Friendship, C. and Ditchfield, J. (2001) A six-year follow-up of men going through probation-based treatment programmes. Home Office Research Findings, 144.

- Thinking Skills Programme to address difficulties with everyday issues and improve problem-solving and decision-making skills. 50 hours of treatment.
- Other programmes have been developed and adapted for offenders with learning difficulties.

The Challenge Project is a community-based, one year, weekly cognitive behavioural treatment programme, for child sexual abusers, implemented in identical group and individual settings. Over a two-year period, all convicted perpetrators of child sexual abuse in South East London were referred to the project for treatment. The model was based upon weekly standardized cognitive-behavioural treatment over a one-year period for participants in the group condition and 9 months for individual therapy. The weekly treatment programme was based on offense-focused, cognitive-behavioural model of therapy based on four modules:

- Disclosure
- The offense cycle
- Relationships
- Victim empathy

Treatment was delivered by therapists, all of whom had a similar level of experience of counselling skills and knowledge of working with sex offenders.<sup>344</sup>

The interest in restorative approaches has been developed and gained renewed interest, particularly in Canada and the U.S., within the policy context of introducing effective alternatives to punitive approaches, such as imprisonment. While harsh sentences and imprisonment are unlikely to be replaced by restorative justice approaches, if for no other reason than voter/public perception of political emphasis in 'getting tough on crime', experiences over the last decade or so have shown there is a need for holistic managed approaches to sexual offender reintegration into the community. Not least because there have been serious shortfalls in therapeutic-orientated service and provision and offender accountability. In remedying this 'crack' in the criminal justice system, restorative justice approaches such as the 'circles of support and accountability' (COSA) have been developed to assist offenders in adjusting to day-to-day life back in the community.

Circles of Support are based on the underlying thinking that sexual offenders once released from prison require support in reintegrating into the community. As such the circles aim to "substantially reduce the risk of future sexual victimisation by assisting and supporting released men with integrating with the community and leading responsible, productive and accountable lives".<sup>345</sup> The programme targets offenders who are about to be released from prison but are still considered to be at a high risk of reoffending. Each COSA is comprised of an inner circle which includes the Core Member (the ex-offender) and about 5 volunteers (Circle Members). In addition there is an outer circle that circle members can rely on for expert advice; the outer circle consists of supportive community-based professionals, such as psychologists, police officers and social service workers.

<sup>344</sup> Craissati, J. and McClurg, G. (1997) The Challenge Project: A treatment programme evaluation for perpetrators of child sexual abuse, *Child Abuse & Neglect* 21(7) 637–648 (Craissati & McClurg, 1997).

<sup>345</sup> Correctional Service of Canada (2002) Circles of Support and Accountability: A guide to training potential volunteers, Training manual 2002. Ottawa.

During the initial phase after release from prison, the core member will be in contact with one primary member of the circle on a daily basis over about 60–90 days, and in contact with the other circle members on a weekly basis. During this initial phase post-release, the circle works with the ex-offender to provide him with support with social and other needs. While it was expected that the circle's involvement in the life of a core member could possibly become long-term and potentially continue for years, evaluations suggest that COSAs have in fact become surrogate families many ex-offenders. All potential inner circle members receive a half-day orientation as part of the screening process and once appointed all members undergo a four-phase training programme which focuses on elements such as skill building and working with ex-offenders.

Although restorative justice programmes for cases of child sexual abuse are a limited practice, evaluations of circles of support and accountability have shown that offenders who participated in the program, which included treatment for the offenders as well as the restorative component, had a lower recidivism rate than matched groups of probationers and inmates. The restorative justice approaches may also yield financial benefits, such as lower offender recidivism rates and also significant savings relative to processing offenders through the mainstream system.<sup>346</sup>

## Focus on adult survivors

The long-term sequelae of child sexual abuse are numerous and varied. While the evidence base addresses the various effects of child sexual abuse through multiple therapeutic approaches and treatment modalities for adult survivors, group therapy has become the primary mode of treatment, either alone or in conjunction with individual psychotherapy.<sup>347</sup>

### *Group psychotherapy for adult survivors of child sexual abuse*

Group treatment is thought to be particularly effective in light of the significant social adjustment and inter-personal problems many adult survivors struggle with; for example Finkelhor and Browne (1985) identify a sense of betrayal, feelings of powerlessness and stigma, and traumatic sexualisation as particularly significant. In this context, group therapy provides a supportive and safe environment for adult survivors to communicate and address their experiences and feelings, and foster a sense of control over their lives.<sup>348</sup>

By using a model based on group psychotherapy, Lau et al. (2007) found that women with a history of sexual abuse as children benefited from both analytic and systemic group therapy. Analytic psychotherapy was longer in duration and involved eight patients meeting for 2.25 hours per sessions on a weekly basis for 12 months. The systemic treatment was short-term and focused, and involved six patients meeting for 2.5 hour sessions on a twice weekly basis (5 hours over two sessions) over 5 months. Each group was led by two qualified therapists with several years of experience. After the sessions, the participants met with a therapist on an individual basis for an hour. Specifically the evaluation concluded that the

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346 FN 321/322. Wilson, R.J., Picheca, J. and Prinzo, M. (2005) *Circles of Support & Accountability: An Evaluation of the Pilot Project in South-Central Ontario*. Correctional Services of Canada: Ottawa.

347 Stalker, C.A. and Fry, R. (1999) A study comparing short-term group and individual therapy with sexually abused women. *Canadian Journal of Psychiatry*, 44: 168–174.

348 Finkelhor, D. and Browne, A. (1986) Initial and long-term effects: A conceptual framework, in Finkelhor, D. (ed.), *A Sourcebook on Child Sexual Maltreatment*, Newbury Park, CA: Sage: 180–198].

treatment response to systemic therapy was better than across all measures as compared to the effects from the analytic model.<sup>349</sup>

### *Breakfree Service for Adult Survivors*

The specialised therapy unit, Breakfree, offered one-to-one abuse-focused care, therapy and support within a community setting to adult survivors of child sexual abuse. The pilot project worked mainly with individuals who had been in regular contact with health service and other agencies but with no apparent effect on the state of their psychological/ mental health and were highly distressed according to psychological scores. The average duration of a counselling session was 1.8 hours based on meeting with a support worker once and sometimes twice a week; though contracts for therapy were negotiated around individual needs and could range from half an hour a week to two two-hour sessions a week.

The scheme employed 12 sessional workers, all of whom received training from specialists in treating adult survivors. The pilot scheme was funded for a 12-month period based on budget of £70, 000 (excluding the costs for the infrastructure). Based on an audit with 116 clients participating in the pilot therapy programme over the course of the year, results demonstrate that the intervention was effective in the short-term and if the benefits accruing to individuals are held in the longer-term, then the cost-effectiveness of the intervention would result in net savings to the NHS.<sup>350</sup>

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349 Lau, M., Kristensen, E. (2007) Outcome of systemic and analytic group psychotherapy for adult women with history of intrafamilial childhood sexual abuse: A randomised controlled study. *Acta Psychiatrica Scandinavica*. 116: 96–104.

350 Smith, D., Pearce, L., Pringle, M. and Caplan, R. (1995) Adults with a history of child sexual abuse: evaluation of a pilot therapy service. *BMJ*, 310: 1175–1178.

## 5. THE EFFECTIVENESS OF INTERVENTIONS

This section reviews the evidence related to the effectiveness of the primary, secondary and tertiary interventions discussed in section 4. Prevention programmes should either reduce risk factors or promote protective factors or both. Thus evaluations can focus on ultimate outcomes (lower rates of child maltreatment being the one of greatest interest here) or they can focus on factors that increase the risk of maltreatment, such as poor parenting practices, or those that promote resilience.

The majority of interventions that have been described in the literature have not been formally evaluated in the sense that they have not established the counterfactual (what would have happened in the absence of the intervention). Many evaluations rely on parents' or professionals' opinions. These evaluations generally show improved parenting skills, better relationships within the family and improved parents' confidence. This reflects a British evaluation tradition which is rooted in real world experience, but in contrast to the American tradition rarely uses randomised controlled trials. In the UK, the term 'knowledge-based practice' tends to be used alongside 'evidence-based practice'. UK reviews of the evidence generally include longitudinal and smaller-scale process research using qualitative methodologies alongside experimental design or quasi-experimental design studies.<sup>351</sup>

Those in the USA and Canada have been evaluated more thoroughly. But care needs to be taken in translating evidence of effectiveness in one context into evidence of potential effectiveness in another. The one intervention which is generally accepted as effective, the Nurse Family Partnership programme of Professor David Olds, has only been shown to be effective in preventing child maltreatment where recipients were visited during infancy as well as during pregnancy, and where the prevalence of domestic violence was low. Of the three NFP trials, only one (in Elmira) measured the impact on maltreatment. This trial comprised white teenage mothers who had limited access to primary health care. Delivery of the programme by people other than nurses, and delivery other than in accordance with the programme manual, or to non-disadvantaged groups has not been shown to be effective.<sup>352</sup>

However, it is important to exercise caution when looking at risk factors. The reason is that there is evidence of an *association* between certain risk factors and the incidence of child maltreatment. But that does not imply that the association is necessarily *causal*. For example, there is an association between social isolation and maltreatment. This might be causal in that those who are more socially isolated are able to evade community surveillance, or may have fewer opportunities to gain advice on child rearing from friends and relatives. But it might be that both the social isolation and the child maltreatment are caused by a third factor such as difficulty in controlling anger. In these latter circumstances interventions that target social isolation per se, may have no impact on child maltreatment because they do not address the underlying risk factor.

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<sup>351</sup> See, for example, Beecham, J. and Sinclair, I. (2007) *Costs and outcomes in children's social care: messages from research*. London: Jessica Kingsley; Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: John Wiley & Sons Ltd.

<sup>352</sup> Eckenrode, J., Ganzel, B., Henderson, C.R., Smith, E., Olds, D.L., Powers, J., Cole, R., Kitzman, H., Sidora, K. (2000) Preventing child abuse and neglect with a program of nurse home visitation: the limiting effects of domestic violence. *Journal of the American Medical Association* 284(11): 1385–91. MacMillan, H.L. with the Canadian Task Force on Preventive Health Care (2000) Preventive health care, 2000 update: prevention of child maltreatment. *Canadian Medical Association Journal* 163 (11) 1451.



Many of the evaluations of interventions consider only intermediate outcomes: parental self-esteem and parenting behaviour being common. Very few measure the impact on child maltreatment directly or through indicators such as referrals to child protection services. In reality relatively few interventions are evaluated using methods that compare the outcomes for those using the service (or a variant of the service) with the outcomes for those who do not. This need not involve randomised controlled trials (RCTs) although these do often provide strong evidence. Administrative records or other comparison methods can also be revealing. The lack of soundly based evaluations for many interventions is one of the challenges in measuring effectiveness.

It is also important to note that many of the interventions only have the prevention of maltreatment as a subsidiary aim. For example, parent training typically addresses child conduct disorder much more frequently than it does maltreatment. The prevention of maltreatment comes about because of improved parent-child relationships and family functioning.

## PRIMARY INTERVENTIONS

Some of the most important, but frequently ignored primary interventions are universal services available to all families. The importance of the role of universal services in addressing the prevention of child maltreatment lies in the fact that parents who maltreat their children are not necessarily substantively different from other parents. Parenting styles and attitudes lie on a spectrum, and although where maltreatment results in physical injury it clearly falls into the abusive end of the spectrum, many parents engage occasionally in the kind of behaviour found in maltreating parents.

Relatively few United Kingdom primary prevention initiatives have been evaluated within a systematic framework and even fewer have been subject to a robust scientific review by way of a randomised control trial (RCT). Where evaluations have been carried out, it is clear that the concept of 'effectiveness' has been open to a variety of interpretations and very rarely subject to objective standardised criteria. Most U.K. studies have generally been based on the parents' perception of whether their parenting abilities and competencies have been influenced by the intervention or whether the parents consider their child to have benefited from the intervention.<sup>353</sup>

Internationally as well, most primary preventive interventions do not use reduction in child abuse and neglect as an outcome indicator. While most studies on primary prevention are able to demonstrate to varying degrees both short and long-term positive outcomes for vulnerable children, overall very few evaluations have been able to show that participation in preventive interventions is independently linked to lower rates of child maltreatment.<sup>354</sup>

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<sup>353</sup> Macdonald, G. and Roberts, H. (1995) *What works in the early years: effective interventions for children and their families in health, social welfare, education and child protection*. Barking: Barnardo's; Pugh, G. De'Ath, E. and Smith, C. (1994) *Confident Parents: Confident Children*. London: National Children's Bureau; Oakley, A., Rigby, D., Rajan, L. and Turner, H. (1996) *Supporting vulnerable families: an evaluation of NEWPIN*. *Health Visitor*, 68: 188–191. Oliver, C. and Smith, M. (2000) *The Effectiveness of Early Interventions*. Perspectives on Education Policy 10. London: Institute of Education; McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers.

<sup>354</sup> Finkelhor, D., Asdigian, N. and DziubaLeatherman, J. (1995) Victimization prevention programs for children: A follow-up. *American Journal of Public Health*. 85(2): 1684–1689; Reppucci, N.D., Woolard, J.L. and Fried, C.S. (1999) Social, community and preventative interventions. *Annual Review of Psychology*. 50: 387–418.

The other key point about the effectiveness of universal (as opposed to targeted) services, is that they need to be used. The use of universal services in Britain is generally voluntary. Families can choose to use them or not, as it suits them. This means that families at risk of neglecting or abusing their children need to be willing to allow service providers to help them. Services may be very effective as a method of preventing abuse and neglect but they will fail if those who are at risk of abuse or neglect choose not to use them. A constant thread running through the evidence is that services are often used only by those who volunteer to come forward. Families with chaotic lifestyles, those where parents have little knowledge of the help or support available to them, and those who are hostile to officialdom in all its forms are least likely to volunteer. Ensuring that services are accessed is a key part of ensuring that services are effective. Part of the attraction of universally available services is that using these services is the norm (and not using them might encourage closer scrutiny of a family and its circumstances). However, even within an umbrella of universality, some families will inevitably require a more active encouragement and outreach approach on the part of the service provider.<sup>355</sup>

## Focus on the family

### Health visitors

Health visitors provide one of the key universal services available to all families with young children. A systematic review<sup>356</sup> of the effectiveness of health visiting concluded that there was insufficient evidence on the impact of health visitors on the incidence of child abuse and neglect, not least because families where child abuse or neglect are suspected usually receive more intensive visiting and abuse or neglect may be more likely to be identified. Thus families receiving more intensive health visitor support might appear to have higher rates of abuse.

However, there was evidence that health visitors do lead to improved outcomes which are associated with lower levels of abuse and neglect. These include:

- improvements in parenting skills
- amelioration of some child behavioural problems
- a reduction in the frequency of unintentional injury
- improvements in the detection and management of postnatal depression
- enhancement of the quality of social support to mothers

Most of the studies they reviewed were from other countries (including Canada, the USA, Australia, Bermuda and Ireland) but one<sup>357</sup> British study found that among parents of children with psychological problems intensive health visiting led to a more engaged and warm parenting style as measured by the HOME index (mean change 5.37 compared with – 2.08 for children aged 0–3).

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<sup>355</sup> Garbers, C., Allnock, D., Akhurst, S. and Tunstill, J. (2006) Facilitating Access to Services for Children & Families: Lessons from Sure Start Local Programmes. *Child & Family Social Work*, 11(4): 287–296.

<sup>356</sup> Elkan, R., Kendrick, D., Hewitt, M., Robinson, J.J.A., Tolley, K., Blair, M., Dewey, 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 2000* Vol. 4: No. 13.

<sup>357</sup> Davis, H., Spurr, P. (1998) Parent counselling: an evaluation of a community child mental health service. *J Child Psychol Psychiatry* 39: 365–76.

Other qualitative work also supports the notion that health visiting plays an important role in the detection of child abuse and neglect. A study in one disadvantaged area found that 42 per cent of the health visitors working in the area had been the first person to detect maltreatment.<sup>358</sup> Another study found concluded that health visitors generally operate on the assumption that maltreatment is not taking place within a family as long as there is a warm relationship between the parent and child, the parents appear to be co-operative and no other agency has raised any concerns about the family.<sup>359</sup>

The Irish Community Mothers programme focused on using trained, experienced mothers to provide peer support for first-time mothers related to health care, nutritional improvement and overall child development. The evaluation, using a randomised controlled trial design found that at the seven year follow-up parents who had received Community Mothers visits were less likely to use physical punishment. As this is associated with maltreatment it appears that the programme does lead to lower rates of maltreatment.<sup>360</sup>

### Parenting skills programmes

Parents' beliefs and expectations about their relationship with their children and the way they behave towards them are important factors in maltreatment. The underlying causes for their beliefs and behaviour may vary, and may be a response to stress due to poverty or tensions within adult relationships, to mental health or substance use problems or to a lack of knowledge. Parenting difficulties that underpin maltreatment include general social skills, parenting skills, impulse control and stress management. Helping parents avoid turning underlying sources of stress into a family environment conducive to maltreatment is one of the aims underlying parenting skills programmes.<sup>361</sup>

These programmes work on the principle that improving parents' knowledge of how children can be expected to behave, how to manage behaviour generally and how to negotiate their relationships with their children is an effective way of changing the behaviour of parents who would otherwise neglect or maltreat their children.

Although such programmes are widely available, their participants are generally volunteers who have put themselves forward. Their impact on the incidence of maltreatment is likely to be dependent on their ability to attract, engage and retain parents whose relationship with and treatment of their children is potentially problematic. They tend to be more attractive to middle class parents, and less attractive to those who are isolated, have poor self-esteem or multiple problems.<sup>362</sup>

There are many such programmes, developed by a wide range of organisations and individuals. However, there are four well-developed manualised programmes whose use is widespread, and whose impacts have been measured: Mellow Parenting (developed in Scotland), Webster-Stratton (also known as Incredible

358 Gilardi, J. (1991) Child protection in a south London district. *Health Visitor*, 64(7): 225–7.

359 Dingwall, R. (1983) Child abuse – the real questions. *Nursing Times*, 79(25): 67–8.

360 Johnson, Z., Molloy, B., Scallan, E., Fitzpatrick, P., Rooney, B., Keegan, T. and Byrne, P. (2000) Community Mothers Programme – seven year follow-up of a randomized controlled trial of non-professional intervention in parenting, *Journal of Public Health Medicine* Vol. 22(3): 337–342.

361 Azar, S.T., Povilaitis, T.Y., Lauretti, A.F. and Pouquette, C.L. (1998) The current status of etiological theories in intrafamilial child maltreatment, in J.R. Lutzker (ed.), *Handbook of Child Abuse Research and Treatment*: 3–30. New York: Plenum Press; Azar, S.T., Nix, R.L. and Makin-Byrd, K.N. (2005) Parenting schemas and the process of change. *Journal of Marital and Family Therapy*, 31(1), 45–58.

362 Tanner, K. and Turney, D. (2006) Therapeutic Interventions with Children who have Experienced Neglect and their Families in the UK in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers.

Years, developed in the USA), Triple P (also known as the Positive Parenting Programme developed in Australia) and Parenting Matters (developed in England). The programmes usually offer group sessions for parents over a period of weeks, and offer a combination of skill development and social support. Parents share their experience and some of the programmes video parent-child interactions and use them as a basis for discussion.

Evaluations have shown that these interventions lead to:

- Reductions in harsh, negative, inconsistent and ineffective parenting and increases in supportive and positive parenting (Webster-Stratton)<sup>363</sup>
- Reductions in ineffective commands by parents (Webster-Stratton)<sup>364</sup>
- Improvements in parents' self-esteem (Parenting Matters; Mellow Parenting)<sup>365</sup>
- Improvements in parent-child relationships (Mellow Parenting, Parenting Matters, Triple P)<sup>366</sup>
- Reductions in parental anger and blame of children (Triple P)<sup>367</sup>
- Evaluations of other programmes tend to show similar effects.<sup>368</sup>

The recent series of articles in the *Lancet*,<sup>369</sup> especially that on interventions by MacMillan et al. concluded that parenting education programmes (including the 'manualised' programmes developed and evaluated in the USA (Webster Stratton) or Australia (PPP) (discussed above) have been demonstrated to be effective at the Tier 2 level of need, but not in cases where problems have become more entrenched or are more acute. This echoes the findings of an earlier meta-analysis of a wide range of preventive interventions in families where maltreatment had already taken place.<sup>370</sup> There is as yet no evidence that these programmes are effective in preventing further harm once children have been maltreated or neglected. Utting et al. (2007) point to some of the reasons why this may be the case, and particularly highlight that few studies included in systematic reviews report on non-starters and non-completers:

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363 Baydar, N., Reid, M.J. and Webster-Stratton, C. (2003) The role of mental health factors and program engagement in the effectiveness of a preventative parenting program for head start mothers. *Child Development*, 74(5), 1433–1453.

364 Scott, S., Spender, Q., Doolan, M., Jacobs, B. and Aspland, H. (2001) Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice. *British Medical Journal* 323(7306): 194–8.

365 Tanner, K. and Turney, D. (2006) Therapeutic Interventions with Children who have Experienced Neglect and their Families in the UK in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers

366 Tanner, K. and Turney, D. (2006) Therapeutic Interventions with Children who have Experienced Neglect and their Families in the UK in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers; Puckering, C., Evans, J., Maddox, H., Mills, M. and Cox, A.D. (1996) Taking control: A single case study of Mellow Parenting. *Clinical Child Psychology and Psychiatry* 1, 539–550; Zubrick, S.R., Ward, K.A., Silburn, S.R., Lawrence, D., Williams, A.A., Blair, E., Robertson, D. and Sanders, M.R. (2005) Prevention of Child Behavior Problems Through Universal Implementation of a Group Behavioral Family Intervention, *Prevention Science* 2005 6(4): 287–304; Sanders, Matthew R., Pidgeon, Aileen M., Gravestock, Fred, Connors, Mark D., Brown, Samantha and Young, Ross W. (2004) Does parental attributional retraining and anger management enhance the effects of the triple P-positive parenting program with parents at risk of child maltreatment?. *Behavior Therapy*, 35 3: 513–535.

367 Sanders, Matthew R., Pidgeon, Aileen M., Gravestock, Fred, Connors, Mark D., Brown, Samantha and Young, Ross W. (2004) Does parental attributional retraining and anger management enhance the effects of the triple P-positive parenting program with parents at risk of child maltreatment?. *Behavior Therapy*, 35 3: 513–535.

368 Taban, N. and Lutzker, J.R. (2001) Consumer Evaluation of an ecobehavioral programme for prevention and intervention of child maltreatment, *Journal of Family Violence* 16 (3) 323–330.

369 *Lancet Child Maltreatment Series*, Dec 2008.

370 Geeraert, L., Noortgate, W., Grietens, H. and Onghena, P. (2004) The Effects of Early Prevention Programs for Families with Young Children at Risk for Physical Child Abuse and Neglect: A Meta-Analysis. *Child Maltreatment* 9: 277–291.

*Even the most effective and evidenced programmes do not work for all people under all conditions.....What little evidence exists suggests that within a 'treated' population it is generally the most needy, most challenging families and young people who are least helped by these programmes.*<sup>371</sup> (p84)

### Sexual maltreatment interventions for parents

Much of the evaluation effort for sexual maltreatment prevention programmes is focused on programmes aimed at children. However, parents have the ability to erect barriers that make it more difficult for potential abusers to succeed. Programmes for parents (typically two-hour workshops) improve awareness and understanding and the ability to speak to children. However, only motivated volunteers tend to take part. In particular, parents from dysfunctional families, who are often targeted by abusers from outside the family, are much less likely to attend.<sup>372</sup>

Non-offending parents often experience major costs and disruption in their lives if their children are sexually abused either by a partner or by someone from outside the immediate family. On average they have three major costs in the area of relationships, finances, job performance or living arrangements.<sup>373</sup> Thus, interventions with parents have the potential to benefit them directly as well as benefiting their children.

### Focus on children

Primary preventive interventions are generally directed at parents (or parents and children together). The main exceptions are early years education (which has a role in improving resilience) and interventions which aim to provide children with greater awareness of and skills to combat sexual maltreatment.

### Early years education

The provision of early years education may increase the resilience of children by improving their cognitive, social and emotional skills.

The Effective Provision of Pre-School Education (EPPE) Project was a five-year longitudinal multi-level project involving a national sample of over 3000 children to investigate the effects of pre-school education on the intellectual and social/ behavioural development of 3–4 years olds. A sample of 'home children' were recruited (who had little or no pre-school experience) to provide comparison on outcome measures with the pre-school group. Key findings were that pre-school attendance improved all children's cognitive development and aspects of social behaviour, such as independence, concentration, cooperation, conformity and relationships with other children (peer sociability). The comparison group

<sup>371</sup> Utting, D. Monteiro H. and Ghate, D. (2007) *Interventions for children at risk of developing antisocial personality disorder*. Report to the Department of Health and Prime Minister's Strategy Unit.

<sup>372</sup> Tutty, LM (1996) Preventive Education: An integrative review. in Bagley, C., Thurston, M. and Tutty, L. (1996) *Understanding and Preventing Child Sexual Abuse*. Volume 1 Children: assessment, social work and clinical issues, and prevention education. Aldershot: Arena; Hebert, M., Lavoie, F. and Parent, N. (2002) An assessment of outcomes following parents' participation in a child abuse prevention program, *Violence and Victims* 17(3): 355–372.

<sup>373</sup> Putnam, F.W. (2003) Ten-year Research Update Review: Child Sexual Abuse. *Journal of the American Academy of Child and Adolescent Psychiatry* 42(3): 269–278.

of children with no (or limited) pre-school experience had poorer cognitive attainment, sociability and concentration when they start school.<sup>374</sup>

### Preventing sexual maltreatment

Interventions are usually school based sessions aimed at children aged 4–10. These interventions are widespread in the United States and elsewhere (they are compulsory in some states) and have been extensively evaluated.

Recent overviews of these evaluations have concluded that although they usually increase children's knowledge and sometimes have an impact on skill levels, they have no discernible impact either on the rate at which children are sexually abused and there is only limited evidence to suggest that they increase children's willingness to disclose previous abuse. Even where knowledge has improved, there is some evidence of decay over subsequent months.<sup>375</sup>

## SECONDARY INTERVENTIONS

Secondary interventions are those which are directed towards families with characteristics which make them have a higher propensity to maltreat their children. These include low income, social isolation, poor housing conditions, low educational attainment, parental health problems, children with disabilities, parents with relationship problems. However, most of the families with these characteristics do not maltreat their children. Thus, these factors are indicators of increased risk, but they are not good predictors, not least because only a minority of children are maltreated. Thus although secondary interventions are usually targeted at *higher* risk populations, most recipients of these services are unlikely to maltreat their children. This means that in *economic* terms there are high levels of *deadweight* within the target population of parents. It also presents serious measurement difficulties for evaluations.

The evidence suggests that the rate of false positives for attempting to identify families for targeting may be as high as 95 per cent.<sup>376</sup> In other words, for every one hundred families receiving a targeted intervention, 95 would not have maltreated their children even without the intervention. If the maltreatment rate among the remaining 5 per cent was reduced by 20 per cent by the programme, this would result in a reduction in the maltreatment rate from 5 per cent to 4 per cent. To detect this reliably would require a both treatment and control samples of 2325 children, ie a total of nearly 5,000. Most evaluations of

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374 Sylva, K., Melhuish, E.C., Sammons, P., Siraj-Blatchford, I. and Taggart, B. (2004), *The Effective Provision of Pre-School Education (EPPE) Project: Technical Paper 12 – The Final Report: Effective Pre-School Education*. London: DfES / Institute of Education, University of London.

375 Rispens, J., Aleman, A. and Goudena P. (1997) Prevention of Child Sexual Abuse Victimization: A meta-analysis of school programs. *Child Abuse and Neglect* 21(10): 975–987. Tutty, LM (1996) Preventive Education: An integrative review. in Bagley, C., Thurston, M. and Tutty, L. (1996) *Understanding and Preventing Child Sexual Abuse*. Volume 1 Children: assessment, social work and clinical issues, and prevention education. Aldershot: Arena; Putnam, F.W. (2003) Ten-year Research Update Review: Child Sexual Abuse. *Journal of the American Academy of Child and Adolescent Psychiatry* 42(3): 269–278; Macmillan H.L., MacMillan, J.H., Offord, D.R., Griffith, L. and MacMillan, A. (1993) Primary Prevention of Child Sexual Abuse: A critical review. Part II. *Journal of Child Psychology and Psychiatry* 35(5): 857–876; MacMillan, H.L. with the Canadian Task Force on Preventive Health Care (2000) Preventive health care, 2000 update: prevention of child maltreatment. *Canadian Medical Association Journal* 163 (11) 1451.

376 Barker, W. (1990) Practical and ethical doubts about screening for child abuse. *Health Visitor* 63(1): 14–17; Caldwell, R.A., Bogat, G.A., Davidson WS (1988) The assessment of child abuse potential and the prevention of child abuse and neglect: a policy analysis. *American Journal of Community Psychology* 16: 609–24; McCurdy, K. (1995) Risk assessment in child abuse prevention programs. *Social Work Research*. 19: 77–87.

secondary interventions have samples of less than two hundred. Many have fewer than a hundred. Thus, interventions *may* be effective, but we have no means of being sure that they are.

## Focus on the family

### *Home visiting services*

Home visiting programmes emphasise the role of improving parents' knowledge of good parenting practice, boosting their confidence, building on their strengths and improving parenting skills and behaviour. The underlying assumption is often that resources to address these issues via social networks are not available, so the visitor (who may be a professional or someone from the local community) fills the void. Home visitors are usually trained to enable parents to make contact with other more specialist sources of help if necessary, although some professional home visitors provide services directly.

A meta-analysis of evaluation data from sixty home visiting programmes found that parenting behaviour and attitudes generally improved as a result of home visiting programmes. Children enrolled in home visiting programmes generally fared better than those in the control group. Within the set of child outcomes – health care, maternal self-sufficiency and maternal self-help yielded effect sizes significantly greater than zero. However, there was no discernible impact on either the incidence of child abuse or on child stress.<sup>377</sup>

One of the difficulties of drawing conclusions for Britain from US-based home visiting studies is that parents in the US do not have access to universal health visiting services. Thus, the support provided by the home visitor is being compared with no organised support. In Britain parents have access to health visitors and evaluations comparing more intensive or additional home visiting (First Parent and Home Start in particular) with standard health visiting have found few substantive differences in either child or parent outcomes. The most recent evaluation of Home Start (unusually for a UK evaluation using a comparison group design) found that parents had less stress and better social support, and children's development was better, but the Home Start parents used more services than the comparison parents, and there were no net savings in the short term.<sup>378</sup> In many ways this illustrates the challenge facing those developing interventions. Home Start *might* make a major difference to children's life chances, and with long-term follow up might have benefits that significantly exceed the costs, but in the short-term planning environment it does not appear to be cost-effective.

There was, however, some evidence to suggest that programmes that used para-professionals as home visitors had a greater impact on child abuse than either those using nurses or those using volunteers.<sup>379</sup> Individual studies raise issues favouring different groups. Health professionals tend to be better at referring parents to specialist services. Members of the community can encourage greater empathy and openness, but can also raise issues of confidentiality and privacy.<sup>380</sup> However, other evidence suggests

377 Sweet, M.A. and Appelbaum, M.I. (2004) Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children, *Child Development* 75(5): 1435–1456.

378 McAuley, C., Knapp, M., Beecham, J., McCurry, N. and Slead M. (2004) *Young families under stress: Outcomes and costs of Home-Start support*. York: Joseph Rowntree Foundation; Emond, A. Pollock, J., Deave, T., Bonnell, S., Peter, T.J. and Harvey, I. (2002) An Evaluation of the First Parent health visitor scheme. *Archives of Disease in Childhood* 86: 150–157

379 Sweet, M.A. and Appelbaum, M.I. (2004) Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children, *Child Development* 75(5): 1435–1456.

380 Olds, D. and Kitzman, H. (1993) Review of Research on Home Visiting. *The Future of Children* 3(4): 51–92.

that it is the quality of the relationship between the parent (almost always the mother) and the visitor that matters, not whether the visitor is a professional or a parent.<sup>381</sup>

The most often cited home visiting scheme is the Nurse-Family Partnership developed by Professor David Olds of the University of Denver. This was implemented in three sites: Elmira, Memphis and Denver. The follow-up process differed between sites. Long-term follow up of mothers in Elmira showed that the incidence of verified maltreatment was significantly reduced (an average of 29 per cent of mothers compared with 51 per cent in the control group). The effect was most pronounced for poor teenage mothers.<sup>382</sup> There were no similar effects in either the Memphis or the Denver trials, although there were fewer injuries to Memphis children.<sup>383</sup>

An earlier meta-analysis of nineteen home visiting programmes had found only small improvements in parenting measures, but did find a reduction of around 4 percentage points in reports to child protection services.<sup>384</sup> There is therefore limited support for the idea that home visiting programmes do reduce child maltreatment, although the effect is not necessarily large. These programmes, do, however, have other positive outcomes for both parents and children, so their impact on child maltreatment is not their only justification. Moreover, they offer the opportunity for earlier detection of maltreatment, particularly neglect. However, the increased surveillance of families, leading to earlier detection of child maltreatment, means that several studies (for example Kaniuk et al. 2004, Emond et al. 2002) find higher rates of reported maltreatment among families who have received the intervention compared with comparison families.<sup>385</sup> This is likely to reflect improved *detection* of maltreatment, rather than a higher *incidence* of maltreatment among intervention families.

Other evaluations provide some support for the idea that within the relationship developed via intensive home visiting it is possible to improve parents' understanding and parenting practice, and to build parents' confidence. These can in turn contribute to better family relationships and potentially reduce rates of maltreatment as children become older. In comparison to routine health visiting, home visiting was perceived as allowing health visitors to work more to a preventive model of care vs. 'crisis management'. This approach allowed visitors to focus on change, focus on the family needs and relationship building and understand the decision making process of families.<sup>386</sup>

Overall, outside the Nurse-Family Partnership, which targets a specific group – disadvantaged first-time teenage mothers – the evidence to support home visiting schemes beyond universal health visiting is

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381 Morrell, C.J., Siby, H., Stewart, P., Walters, S. and Morgan, A. (2000) Costs and effectiveness of community postnatal support workers: Randomised control trial. *British Medical Journal* 321: 593–8.

382 Olds, D.L., Eckenrode, J., Henderson, C.R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L.M. and Luckey, D. (1997) Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: 15-Year Follow-up of a Randomized Trial." *Journal of the American Medical Association*, 278 (8): 637–643.

383 Kitzman, H., Olds, D.L., Henderson, C.R. Jr, Hanks, C., Cole, R., Tatelbaum, R., et al. (1997) Effect of prenatal and infant home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: a randomized controlled trial. *Journal of the American Medical Association*. 278: 644–52.

384 Guterman, N. (1999) Enrollment strategies in early home visitation to prevent physical child abuse and neglect and the 'universal versus targeted' debate: A meta analysis of population-based and screening-based programs. *Child Abuse & Neglect* 23 (9), 863–890.

385 Kaniuk, J., Steele, M. and Hodges, J. (2004) Report on a longitudinal research project, exploring the development of attachments between older, hard-to-place children and their adopters over the first two years of placement. *Adoption and Fostering Journal* 28(2): 61–67.

386 Brocklehurst, N., Barlow, J., Kirkpatrick, S., Davis, H., Stewart-Brown, S. (2004) The contribution of health visitors to supporting vulnerable children and their families at home, *Community Practitioner* 77(5) 175–179; Johnson, Z., Molloy, B., Scallan, E., Fitzpatrick, P., Rooney, B., Keegan, T. and Byrne, P. (2000) Community Mothers Programme – seven year follow-up of a randomized controlled trial of non-professional intervention in parenting, *Journal of Public Health Medicine* Vol. 22(3): 337–342.



limited. A randomised controlled trial of the Nurse Family Partnership is currently underway in England, and this will provide evidence as to how effective it is in the context of a universal health service.

### *Support from social workers.*

Section 3 discusses the legislative and practice context in which social workers engage with children and families in Britain. Social work with families has focused mainly, but not exclusively, on individuals and at a point where problems are either apparent or acute. Although boundaries are blurred, this means that social workers are concentrating on providing tertiary rather than secondary services. At this level, support is designed to assist individual families to overcome particular difficulties. A recent review of the evidence related to outcomes from preventive work with families from mainstream social workers found that there is a dearth of evidence about what they are achieving.<sup>387</sup> Others have reached the same conclusion.<sup>388</sup>

Although some evidence was collected in previous decades, there have been few recent attempts to examine what social workers are currently doing, and the extent to which they fulfil the role of facilitating access for vulnerable children and families to universal and preventive services.<sup>389</sup>

An important issue for the present review is the extent to which early interventions by social workers achieve savings in later, more intensive and more expensive service provision such as foster care or residential care.

### *Multi-faceted community-based family support services*

Children's Centres (previously Sure Start local programmes) are the most widespread secondary prevention service available in the UK. Although some centres provide services for older children such as after school clubs, services are generally targeted at families with children under school age. There are also some examples of similar services operating in other countries for example the Chicago Child-Parent Centers.<sup>390</sup>

Evaluation of multi-dimensional community-based programmes with a mixture of objectives is a challenge, which is not readily addressed by standard evaluation methods, particularly randomised controlled trials. From the late 1980s onwards, evaluators of social programmes recognised the need to develop approaches to the evaluation of social programmes that both provided rigour in measuring outcomes. The important issues are:

- If the intervention makes a difference, how or why does it do so?
- If the intervention makes a difference on average, is this difference larger for, or confined to, certain sub-groups within the population, and are there any groups for whom the impact is negative?

<sup>387</sup> Walker, M. (2006) *The statutory social worker's role in prevention and early intervention with children*. Edinburgh: Scottish Executive.

<sup>388</sup> Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd.

<sup>389</sup> Department of Health, Dartington Social Research Unit (1995) *Child protection: messages from research*. London Her Majesty's Stationary Office (HMSO).

<sup>390</sup> Reynolds, A. and Robertson, D. (2003) School-based early intervention and later child maltreatment in the CLS, *Child Development* 74(1): 3–26.

- Will it make a difference to a wider group of people if implemented more widely?
- Is the number of potential beneficiaries large or small?<sup>391</sup>

The evaluation of Sure Start local programmes is ongoing, and will compare outcomes at age 5 for children living in Sure Start areas with the outcomes for children living in disadvantaged areas without Sure Start local programmes. At age 3 the parents in the Sure Start areas had a lower incidence of negative parenting and better home learning environments. Children had more positive social behaviour and better self-regulation. The impact on the most disadvantaged families was similar to the impact on other families.<sup>392</sup> While these are not direct measures of child maltreatment, they are consistently associated with lower rates of maltreatment.

The National Evaluation of Sure Start also provided an important opportunity to explore the way in which local services are designed to meet the needs of children for services which can both safeguard and promote their welfare. A key theme to emerge from the national data collected by the Implementation Module between 2001–4, was the challenge for Sure Start local programmes of establishing a working relationship between their own family support activity and the work of the social services departments in the local authorities in which they were located. In the 20 Implementation Module case studies, issues identified by SSLP staff respondents had included:

- Tensions between preventive and protective roles – programmes were anxious to maintain their current capacity for preventive work and almost all programmes took steps to actively distance themselves from perceived pressure from social services to take on aspects of the latter's work;
- Skilled workforce shortages;
- The need for training and support of staff – all Programme Managers highlighted the importance of supervision and support for their outreach and family workers around domestic violence, child neglect, and child protection work.<sup>393</sup>

The themed study on safeguarding, undertaken between 2005–7 explored the ways in which, SSLPs and social service departments were collaborating to safeguard children's welfare, including identifying the concerns about individual children, which were likely to trigger a referral to social services departments, from SSLPs, and the nature of referrals from social services departments to SSLPs. Data was collected at programme level and, in four local authorities, across the local authority against a template of the following good practice indicators:

- Clarity and agreement around respective aims and objectives
- Transcending barriers generated by traditional ways of working
- Strategic level commitment
- Clearly identified roles and responsibilities
- Protocols and procedures for information sharing

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<sup>391</sup> Meadows, P. (2007) The methodologies for the evaluation of complex interventions: an ongoing debate in Belsky, J., Barnes, J. and Melhuish, E. (eds) *The National Evaluation of Sure Start: Does area-based early intervention work?*: 65–78. Bristol: Policy Press.

<sup>392</sup> NESS (2008) *The Impact of Sure Start Local Programmes on Three Year Olds and Their Families*. National Evaluation of Sure Start Report NESS/FR/2008/27.

<sup>393</sup> Tunstall, J., Meadows, P., Allnock, D., Akhurst, S., Chrysanthou, J., Garbers, C., Morley, A. and Van de Velde, T. (2005b) *Implementing Sure Start Local Programmes: An in-depth study*. DfES: London).

- Co-location of services
- A robust training strategy
- Using referral systems to build bridges, not barriers.

Statham and Holtermann (2004) evaluated a family support project in Wales using a before and after design. Families had a high level of need and were at risk of family breakdown. The services are centred around supporting children within their own families, thus averting the need to be accommodated by the local authority. The services were offered to families via a referral by social workers or health professionals, such as a health visitor. The services provided included day care, summer play schemes, respite care for children with disabilities, and emotional and practical support for families provided by parent support workers.

Families with a high level of need who were receiving support from social services improved over a 3 month period, but those with the most severe needs or those referred because of financial problems or substance abuse deteriorated. Those living with both partners fared better after 3 months than those not. The study was not able to find statistically significant associations between the types of service provided, their cost and improvements shown by the two main indicators.<sup>394</sup>

### Family Centres

Traditionally family centres have been open access and have aimed to offer holistic packages of support to parents and children of all ages as a family unit. Some are operated by voluntary organisations; others are part of children's social care services. Their aim is to strengthen parenting skills, offer supportive interventions and help improve relationships within the family. There has been a tendency in recent years for access to be via referral, usually from social services, but occasionally from other groups such as health visitors. The consequence of this is that although family centres have traditionally formed part of secondary (Tier 2–3) services they are now tending towards the provision of tertiary (Tiers 3–4) services.<sup>395</sup>

There is little hard evidence that family centres improve outcomes for children and parents. This is essentially because the evidence has not been collected, not because the evidence that has been collected is inconclusive. There is a great deal of anecdotal and qualitative evidence for of the popularity of family centres with parents, including parents who have been identified as being at high risk of maltreating their children. They appear to be able to deliver support services in a non-stigmatising way, which makes them particularly attractive to hard-to-reach groups.<sup>396</sup> In a (qualitative) evaluation of family centres in Scotland sixteen out of 26 families referred to increased confidence and improved child behaviour and development. The positive impacts identified by parents in the study were the result of the accumulation and interaction of different services.<sup>397</sup>

<sup>394</sup> Statham, J. and Holtermann, S. (2004) Families on the brink: the effectiveness of family support services. *Child and Family Social Work*, 9 153–166.

<sup>395</sup> Tunstill, J., Aldgate, J., Hughes, M. (2007) *Improving Children's Services Networks: lessons from family centres*. Jessica Kingsley Publishers.

<sup>396</sup> Tunstill, J., Aldgate, J., Hughes, M. (2007) *Improving Children's Services Networks: lessons from family centres*. Jessica Kingsley Publishers; Statham, J. and Biehal, N. (2005) *Supporting families*. Research in Practice; Tisdall, K., Wallace, J., McGregor, E., Millen, D. and Bell, A. (2005) *Seamless services, smoother lives*. Children in Scotland.

<sup>397</sup> Tisdall, K., Wallace, J., McGregor, E., Millen, D. and Bell, A. (2005) *Seamless services, smoother lives*. Children in Scotland.

## Focus on parents

### *Training for parents*

The training for parents who have been identified as being at higher risk of maltreating their children is often essentially the same as that available as a primary self-referral intervention. However, with targeted families the emphasis is on children who have already developed challenging behaviour, and for parents who find it difficult to control their emotions when dealing with their children. The challenges confronting parenting training as a primary intervention (in particular the middle class bias in terms of style and content) but also issues of location and timing, are magnified with the secondary intervention target group.

- Circumstances in which parenting programmes appear to be less successful are:
- Poor parental adjustment or depression
- Maternal stress
- Maternal social isolation
- Relationship problems between parents
- Problems are severe or of long standing
- Parents fail to appreciate the deviance of their children's behaviour
- Parents find that the content appears to blame them
- Parents find the setting uncomfortable<sup>398</sup>

Families who have complex problems may need intervention over a longer time scale than the standard 8–15 weekly group sessions offered by most parenting classes. Broadly speaking, parenting interventions to prevent abuse and neglect that use didactic instruction only and have been shown to be ineffective.<sup>399</sup> In contrast models using behavioural techniques such as modelling, practice and feedback, and made use of home visiting, over many months or years have been shown to be more effective, but at very high initial costs.<sup>400</sup>

A number of systematic reviews have shown that parenting programmes can be effective in improving behaviour problems in children less than three years of age, in 3–10 year old children, and in improving maternal psychosocial health in the short term, including reducing anxiety and depression and improving self-esteem. There is also evidence to suggest that they are a cost-effective means of providing support to families compared with interventions that are provided on an individual basis.<sup>401</sup>

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398 Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd ; Webster-Stratton, C. 1998. *Parent Training with Low-income Families: Promoting parental engagement through a collaborative approach* In J.R. Lutzker (ed.), *Handbook of child abuse research and treatment*. NY: Plenum Press.

399 Daro, D. (1988) *Confronting Child Abuse*. New York: The Free Press.

400 Peterson, L., Tremblay, G., Ewigman, B., Saldana, L. (2003) Multilevel selected primary prevention of child maltreatment, *Journal of Consulting and Clinical Psychology*, 71(3): 601–612.

401 Barlow, J. and Parsons, J. (2002) Group-based parent-training programmes for improving emotional and behavioural health adjustment in 0–3 children (Cochrane Review), in *The Cochrane Library*, Issue 2. Oxford: Update Software; Barlow, J. and Stewart-Brown, S. (2000) Review article: behaviour problems and parent-training programs. *Journal of Developmental and Behavioral Pediatrics* 21(5): 356–370; Barlow, J., Coren, E. and Stewart-Brown, S. (2002) Meta-analysis of parenting programmes in improving maternal psychosocial health. *British Journal of General Practice*. 52: 223–233.

One of the parent training programmes that have had a positive impact with the at-risk target group is the Incredible Years programme developed by Carolyn Webster-Stratton has been extensively evaluated with a range of populations in a number of countries.<sup>402</sup> The evaluation of a version called PARTNERS delivered to parents of children receiving Head Start in Seattle, most of whom had four or more maltreatment risk indicators found that attendance was good (88 per cent attended at least two-thirds of the sessions and only 12 per cent attended only one). Among the factors which secured successful engagement of parents were using trainers who already had credibility with parents via their roles in Head Start, providing dinner and childcare, and ensuring that the timing and location of the sessions were suitable for parents. The emphasis was on sharing expertise – parents being experts in their own children. The PARTNERS mothers made significantly fewer critical remarks about their children, used less physical punishment, and were more engaged in their children's education. Their children showed more pro-social behaviour. Nine out of ten mothers had positive views of the programme. It was least successful with mother with a history of substance abuse, and to a lesser extent those with a history of mental illness.<sup>403</sup>

Project Safe Care was a 15 session one-to-one training programme delivered by a nurse or social worker focusing on home safety, infant and child health care, bonding and stimulation. Although studies of Project Safe Care have demonstrated significantly fewer reports of child abuse and neglect for families participating in the eco-behavioural treatment model as compared to routine child protection services the treatment effects do not hold over time; follow-up studies show clinical differences between the groups decreasing after the programme had ended. A later evaluation, however, has suggested that where families are at a higher-risk of child abuse and neglect, Project Safe Care can be more effective than family preservation services in reducing the future incidence of child maltreatment reports.<sup>404</sup> In particular, clinical trials have shown positive treatment effects of this model with low-income, high-risk parents of young children.<sup>405</sup> Despite the positive results, the treatment model does not outwardly address parental mental illness, community isolation, poverty or unemployment, which are important areas of intervention when targeting families that neglect.<sup>406</sup>

Another apparently well-designed intervention developed in Texas specifically for at risk parents was Learning About Myself (LAMS). The evaluation used a before/after design, not a comparison or control group. Both client and caseworker ratings are positive. Clients (particularly younger parents) felt they had learnt problem solving skills, developed greater assertiveness and improved their parenting skills. They had increased their social networks by an average of five new friends. A majority felt that they had more control over their lives and more powerful in making decisions. Somewhat fewer caseworkers agreed with these perceived outcomes.<sup>407</sup>

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402 Full details of all the evaluation publications can be found at [www.incredibleyears.com](http://www.incredibleyears.com)

403 Webster-Stratton, C. 1998. Parent Training with Low-income Families: Promoting parental engagement through a collaborative approach In J.R. Lutzker (ed.), *Handbook of child abuse research and treatment*. NY: Plenum Press. [http://www.incredibleyears.com/library/items/parent-training-low-income-families\(chapter\)98.pdf](http://www.incredibleyears.com/library/items/parent-training-low-income-families(chapter)98.pdf)

404 Gershater-Molko, R.M., Lutzker, J.R. and Sherman, J.A., (2002) Intervention in child neglect: an applied behavioural perspective. *Aggression and Violent Behavior* 7(2): 103–124.

405 Lutzker, J.R., Van Hasselt, V.B., Bigelow, K.M., Greene, B.F. and Kessler, M.L. (1998) Child abuse and neglect: Behavioral research, treatment, and theory. *Aggression and Violent Behavior*. 3(2): 181–196.

406 Taban, N. and Lutzker, J.R. (2001) Consumer Evaluation of an ecobehavioral programme for prevention and intervention of child maltreatment, *Journal of Family Violence* 16 (3) 323–330; Berry, M., Charlson, R., Dawson, K., (2003) Promising practices in understanding and treating child neglect, *Child and Family Social Work*, 8: 13–24.

407 Rickard, V. (1998) *The Learning About Myself (LAMS) Program for At-Risk Parents*. Philadelphia: Howarth Press; Berry, M., Charlson, R., Dawson, K., (2003) Promising practices in understanding and treating child neglect, *Child and Family Social Work*, 8: 13–24.

Another programme specifically geared to low income parents with an emphasis on preventing maltreatment was the Balancing Employment and Parenting (BEAP) training course. This is based on the recognition that parenting is particularly stressful for low income parents. It started with fourteen weekly sessions in the parent's home followed by two-hour group sessions held over a four-year period. It was evaluated using before/after design. A third of parents reported a reduction in the severity of their problems, and greater capacity to request further help. A quarter had improved knowledge of appropriate parenting and one in ten reported an increase in knowledge of the impact of alcohol and drug abuse. The programme was modified after feedback from mothers to include more modules about dealing with male partners or children's fathers.<sup>408</sup>

A US parenting programme using cognitive behavioural techniques (geared towards mothers) delivered via a combination of weekly group therapy, a 90 minute home visit, and a diary recording discipline and emotions was evaluated by Peterson et al. (2003).<sup>409</sup> The study used both a before/after and a treatment/control group design. Participants were followed up both immediately after the programme and a year later. The effects of the programme were still evident at the later date. The evaluation found that treatment parents felt their parenting skills had improved, while the control group did not. Those who had gone through the programme also showed a reduction in harsh discipline. Planned ignoring increased for the treatment group over time while decreasing in the control group. General punishment showed greater declines over time for the treatment group compared with the control. Responses to challenging developmentally appropriate situations grew more effective over time for the treatment group, but not for the control group. This reflected the fact that unrealistically high expectations of children declined over time more for the treatment group than it did for the control group, and the treatment group experienced a reduction in reported anger, while the control group reported an increase. Overall, the model was considered to be cost-effective and the positive intervention effects held a year post-treatment.

### *Help with substance abuse for parents*

It can often be difficult to attract parents to volunteer for substance use programmes because of the risk of losing their children. In some US states it is mandatory for drug rehabilitation programmes to report any parents who come forward for treatment to child protection services. Conventional substance use programmes do not cover parenting issues and vice versa. Substance use programmes aimed specifically at parents have only started in the last ten years or so, and the evidence around design and effectiveness remains limited.

A useful review of the evidence by Kerwin (2005)<sup>410</sup> stresses the extent to which mothers who abuse drugs often have low socioeconomic status, lack of social resources and supports, and inadequate or unstable housing. Many have mental health problems and low cognitive ability. These other factors may impact on their parenting skills and the liability to maltreat their children more than their drug use, although there is evidence that drug using mothers are less engaged with their children than other mothers.

Most evaluations have only looked at pilot programmes with small numbers of participants. Many of the evaluations have been qualitative or have used before/after designs. Nevertheless the evidence that is

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408 Thomas JN (2007) Evidence-based Practice can reduce child abuse in low-income communities. *Journal for Specialists in Pediatric Nursing*. 12 (4): 294–296.

409 Peterson, L., Tremblay, G., Ewigman, B., Saldana, L. (2003) Multilevel selected primary prevention of child maltreatment, *Journal of Consulting and Clinical Psychology*, 71(3): 601–612.

410 Kerwin ME. (2005) Collaboration between child welfare and substance-abuse fields: combined treatment programs for mothers. *Journal of Pediatric Psychology*. 30(7): 581–97.

available suggests that solutions that focus on the family as a whole and embed the drug (or alcohol) use elements of the programme with elements that provide other forms of support, for example for housing, respite care for children, transport or employment, and where programmes are of longer duration tend to show the most positive results.<sup>411</sup> Evaluation of the New York City Family Rehabilitation Program suggests that over half (55 per cent) of families achieved positive outcomes, through case closure or a decreased risk of foster care placement, and in 93 per cent of cases children were allowed to remain at home with the programme averting the need for foster care.<sup>412</sup>

The extended family also has a critical role to play in ameliorating the negative effects of parental drug abuse. The level of support varies between occasional input (as not locally resident) and significant involvement, such as care, routine supply of food and of hot meals, taking children home with them for indefinite periods of time, school uniforms and paying for school trips.<sup>413</sup>

### *Help with mental health problems for parents*

Mental health services are not generally integrated with parenting support, even though mental health problems increase the risk of child maltreatment. The few interventions that have been developed have largely been small-scale, local and experimental. There are some suggestions of ways forward, including stress on family rather than individual functioning, integration of services for children and adults and using a strengths-based approach. Even so, parenting behaviour rather than maltreatment *per se* tends to be the most relevant outcome.<sup>414</sup>

### *Improving parents' social networks*

The evidence suggests that communities with lower rates of maltreatment tend to have more developed informal systems of social support. Maltreating families are themselves often socially isolated. It is therefore often concluded that improving social networks is likely to reduce maltreatment. However, this is an example of a factor which might be an association rather than a causal relationship (in other words social isolation is a symptom of the underlying issues associated with maltreatment). Nevertheless there have been interventions specifically designed to promote social support.

For example the COPE parent training program in Pennsylvania was for socially isolated parents with children in Head Start classes (one-third of whom had a history of maltreatment, the rest with no such history). The programme comprised ten group training sessions focusing on the relationship between stress and social support, and helping parents to use Head Start as a means of developing local networks.

411 Kerwin ME. (2005) Collaboration between child welfare and substance-abuse fields: combined treatment programs for mothers. *Journal of Pediatric Psychology*. 30(7): 581–97. Magura, S. and Laudet, A.B. (1996) Parental substance abuse and child maltreatment: Review and implications for intervention, *Children and Youth Services Review* 18 (3): 193–220; Donohue, B., Romero, V. and Hill, H.H. (2006) Treatment of co-occurring child maltreatment and substance abuse. *Aggression and Violent Behavior*. 11(6): 626–640; Niccols, A. and Sword, W. (2005) New Choices for substance-using mothers and their children: Preliminary evaluation. *Journal of Substance Use*, 10 (4), 239–251.

412 Magura, S. and Laudet, A.B. (1996) Parental substance abuse and child maltreatment: Review and implications for intervention, *Children and Youth Services Review* 18 (3): 193–220.

413 Tyler, R., Howard, J., Epinoso, M. and Simpson Doakes, S. (1997) Placement with substance-abusing mothers Vs. Placement with other relatives: Infant outcomes, *Child Abuse & Neglect* 21(4) 337–349.

414 Smith, Marjorie (2004) Parental mental health: disruptions to parenting and outcomes for children. *Child and family social work*. 9 (1): 3–11; Tunnard, J. (2004) *Parental mental health problems: key messages from research, policy and practice*. Research in Practice; Beresford, B., Clarke, S., Gridley, K., Parker, G., Pitman, R., Spiers, G., Light, K. (2008) *Technical report for SCIE Research Review on access, acceptability and outcomes of services/interventions to support parents with mental health problems and their families*. SCIE working paper no 2255.

It was evaluated using a random assignment design. There was a reduction in parental stress but no reduction in maltreatment.<sup>415</sup> A Canadian intervention has produced similar results.<sup>416</sup> One possible explanation for the lack of effect on maltreatment rates is that the improved social networks include other maltreating parents, so that although social relationships might improve, they might not be supportive of behavioural changes.

## Focus on children and young people

### *Sexual maltreatment prevention*

Sexual maltreatment prevention programmes aimed at young people who are showing signs of sexually abusive behaviour have not generally been evaluated using a control/comparison group design because of concerns about the risks of not offering support to young people who might then go on to abuse other children. Many evaluations are based on small numbers, but the services which include helping young people to understand and take responsibility for the behaviour and develop strategies and coping skills to avoid abusing, help promote the physical, social and emotional wellbeing of young people who have themselves been abused and engage parents and carers in acknowledging what the child has done and to provide supportive family context for change are more successful. However, there is currently insufficient evidence on which to base an assessment of costs and benefits.<sup>417</sup>

## TERTIARY INTERVENTIONS

Tertiary interventions take place with parents with a history of maltreatment and with child victims. In the case of the parents the aim is to prevent further maltreatment, and in the case of the children the aim is to reduce the adverse impact.

Tertiary interventions often deal with small groups and are rarely thoroughly evaluated. This means that the evidence to support their use is not strong.<sup>418</sup> A 2004 meta-analysis<sup>419</sup> of the evidence on preventive interventions with parents for physical abuse and neglect concluded that tertiary interventions are less effective than either primary or secondary interventions. While the reasons for this are not entirely clear, the explanation most frequently put forward is that parents who have been identified as maltreating their children often have more established adverse parenting patterns than those who are at risk of maltreatment.

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415 Fantuzzo, J., Stevenson, H., Kabir, S.A., Perry, M.A. (2007) An Investigation of a Community-based intervention for socially isolated parents with a history of child maltreatment, *Journal of Family Violence* 22: 81–89.

416 Lovell, M.L. and Richey, C.A. (1997) The impact of social support skill training on daily interactions among parents at risk for child maltreatment *Children and Youth services review* 19(4): 221–151.

417 Whittle, N., Bailey, S. and Kurtz, Z. (2007) *The Needs of Young People who Display Sexually Harmful Behaviours and the Effectiveness of Interventions and Service Approaches to Meet these Needs and to Prevent Sexually Abusive and Criminal Behaviour*. Department of Health Victims of Violence and Abuse Prevention Programme.

418 Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd.

419 Geeraert, L., Noortgate, W., Grietens, H. and Onghena, P. (2004) The Effects of Early Prevention Programs for Families with Young Children at Risk for Physical Child Abuse and Neglect: A Meta-Analysis. *Child Maltreatment* 9: 277–291.



A review of studies published between 1984 and 2004<sup>420</sup> covering interventions for families where children remain at home after maltreatment (mainly sexual abuse, physical abuse and neglect) found that most evaluations measured knowledge and attitudes and behaviour. However, few measure whether rates of maltreatment were reduced, or whether measured changes persist over time. Most studies use methodologically limited designs and are often small in scale. It is therefore difficult to draw any firm conclusions about their effectiveness.

## Focus on children

Very few of the interventions with children have been properly evaluated so that we can judge whether or not they make a difference to children's lives.<sup>421</sup> Broadly speaking there are two groups of interventions: those where the emphasis has been on placing children in a safe place away from the perpetrator, and those where the emphasis is on therapeutic treatment to mitigate harm. In the UK the emphasis in practice has been on the former and the availability of therapeutic support has been limited.<sup>422</sup>

### Foster care

Foster care placements most common substitute care option in UK. Around two-thirds of looked after children are placed with foster families.

Outcomes for children placed in foster care reflect the complexity of their circumstances before the placement. Thus, although educational outcomes for children in foster care are well below those for other children in the population, the true comparison would be with what their educational outcomes would have been in the absence of the foster care placement. Similarly other outcomes in terms of transition to adulthood are worse than for other young people. They have to cope on their own at a younger age and they are more likely than other young people to experience mental health and social relationship problems. In spite of this many do make successful lives as adults. However, a significant minority, around 30 per cent, get into serious difficulty in adult life.<sup>423</sup>

Success in short-term and intermediate placements comes from more rigorous selection procedures for foster carers, sensitively managed matching and introductions, regular contact between children and their families, more frequent visits by link social workers to foster carers, and greater efforts by social workers in working with the child's family. When short-term and intermediate care is used as a method of family support, foster carers can have an important role in working with parents and children in resolving difficulties. Foster children themselves are positive about their care and its outcomes.<sup>424</sup>

420 Dufour, S. and Chamberland, C. (2004) The effectiveness of selected interventions for previous maltreatment: enhancing the well-being of children who live at home. *Child and Family Social Work*. 9: 39–56.

421 Macdonald, G. (2001, p 194) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd.

422 Bentovim, A. (1995) *Trauma Organised Systems – Sexual, Physical Abuse in Families*. London: Karnac in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers.

423 Wilson, K. et al. (2006) in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers.

424 Sellick, C., Thoburn, J. and Philpot, T. (2004) *What works in adoption and foster care?*. Barnardo's; Wilson in McAuley et al.

Long-term placement with relatives or friends ('kinship care'), and short-term placements that become permanent, have been found to be more successful for the full range of children than placement with families not previously known to the child ('stranger care'). The key to this might be the greater probability of the retention of family contact. However, there is often less support available to family carers than for professional foster carers. For older children, age at placement is key. Beyond the age of 6 months, vulnerability to emotional problems stemming from difficulties with attachment, separation and loss increase with age at placement.<sup>425</sup>

There is some evidence that the physical health of children in foster care improves compared with the health of those who remain at home. Children in foster care have educational attainments far below the population average. In 1999/2000 the proportion of young people in care for at least one year who obtained at least five GCSEs/GNVQs at grades A\*–C in England was 7.3 per cent in 1999/2000. In the most recent year (2005/06) this had increased to 11.8 per cent. The gap between the proportion of looked after children achieving five GCSEs/GNVQs at grades A\*–C and the proportion of all children achieving five GCSE and equivalent at grades A\*–C has changed from 41.9 percentage points in 1999/2000 to 47.4 percentage points in 2005/06. However, the proportion of all young people who achieved five good GCSEs increased from 49.2 per cent to 59.2 per cent over the same period, so that the gap in looked after children's attainment grew.<sup>426</sup> However, longitudinal studies suggest that young people's educational problems pre-dated their entry into foster care.<sup>427</sup>

### Residential care

Around 10 per cent of looked after young people are in residential care. They tend to be young people with more complex and deeply entrenched problems, and older than children in foster care, although sometimes it is a way of keeping siblings together. This both reflects the fact that adolescents often prefer residential care placements to foster care placements, and also the fact that it is often difficult to find foster care placements for teenagers. Residential care, costs around £61,000 a year reflecting high staffing ratios (56 hours per resident per week).

The current perception of residential care is that it is not helping young people. Homes suffer from harsh discipline; abuse by staff; and suicidal tendencies and delinquency among residents. But perhaps more important is the widespread lack of belief (including among staff) that residential care can improve child wellbeing. Effectiveness in residential care appears to need:

- A clear remit and autonomy for the head of the home
- The leadership shown by the head of home, based on appropriate ideas
- Agreement within the staff group and with the head about how the home should be run

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425 Wilson in McAuley et al; Sellick, C., Thoburn, J. and Philpot, T. (2004) *What works in adoption and foster care?*. Barnardo's.

426 Department for Work and Pensions *Opportunity for All Indicators: Indicator 9*. <http://www.dwp.gov.uk/ofa/indicators/indicator-9.asp>

427 Wilson, K. et al. (2006) in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-being of Children and Families through Effective Interventions*. London: Jessica Kingsley.

The evidence about location is mixed. Homes some distance from where children normally live can help to separate them from pressure to take drugs and engage in prostitution. However, this reduces contact with their families, which is one of the indicators of better outcomes.<sup>428</sup>

### Therapeutic services

Therapeutic interventions for children and young people who have experienced maltreatment fall into two broad groups: interventions designed to treat mental health problems with a clinical basis, and interventions which aim to provide children with enhanced social support outside the family.

Children's mental health symptoms are similar whatever type of maltreatment they have experienced. The main groups of symptoms are internalising (post traumatic stress disorder, depression and anxiety) and externalising (ie behavioural problems). Cognitive behavioural therapy (CBT) has become the preferred approach to dealing with internalizing disorders. It can be either group-based or individual and usually takes place in a safe out of home setting within the community. Psychotherapy can also be used in the case of young people who have been sexually abused.<sup>429</sup>

For children who have experienced sexual abuse it can often be difficult to disentangle problems which they have as a result of the abuse they have received and the problems that they already had which provide part of the explanation as to why they were abused in the first place (eg low self-esteem). Moreover, abuse victims are very heterogeneous and their needs are likely to differ by gender, by age, by relationship to abuser, and by the nature and duration of the abuse. The exact nature of the therapy usually varies depending on the kind of abuse young people have experienced. Although children and young people who have been sexually abused suffer from the same range of mental health conditions as do other young people with problems, they often also suffer from additional problems such as sexualised behaviour.<sup>430</sup>

Therapy usually includes:

- Education about the nature of sexual abuse
- Facilitation of the expression of feelings related to the abuse
- Identifying and correcting sense of responsibility
- Teaching anxiety management skills
- Developing self-protection skills
- Help with managing problem behaviour
- It is often useful for therapy to include non-abusing parents.

<sup>428</sup> Sinclair, I. (2006) Residential Care in the UK in in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers.

<sup>429</sup> Dufour, S. and Chamberland, C. (2004) The effectiveness of selected interventions for previous maltreatment: enhancing the well-being of children who live at home. *Child and Family Social Work*. 9: 39–56; Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766.

<sup>430</sup> Putnam, F.W. (2003) Ten-year Research Update Review: Child Sexual Abuse. *Journal of the American Academy of Child and Adolescent Psychiatry* 42(3): 269–278; Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd ; Bentovim, A. (2006) in Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd; Corcoran, J. (2001) in Macdonald, G. (2001) *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. Chichester, West Sussex: JohnWiley & Sons Ltd.

A London study of psychotherapy (both group and individual) for sexually abused girls aged 6–14 found a reduction in the incidence of depression from 57 per cent to 17 per cent; separation anxiety fell from 58 per cent to 23 per cent, and general anxiety fell from 37 per cent to 17 per cent. There were also improvements in the Post-Traumatic Stress Disorder scale. The individual therapy cost £3195 per head and the group therapy £1949. There were no differences in outcomes between the two groups, indicating that group therapy is more cost-effective.<sup>431</sup>

Social support for maltreated children is based either on play therapy with other children or improving access to supportive adults. Play therapy targets social interaction skills and positive play with socially withdrawn abused and/or neglected children. Fantuzzo et al. (1996)<sup>432</sup> found that treated children showed higher levels of interactive play than children in the control condition and lower levels of solitary play than control children. There was also a significant treatment effect for social skills in terms of both self-control and interpersonal skills. The treatment group also displayed lower levels of both internalizing and externalising behaviour problems. Similar results were reported in a review of effective interventions including earlier studies of play therapy.<sup>433</sup>

Helping children and young people to develop new relationships with supportive adults does not appear to have been subject to evaluation for its effectiveness. However, it is based on the evidence that having access to supportive adults such as grandparents and teachers improves resilience.

There have also been a range of interventions aimed at children who have been exposed to domestic violence, not least because they often show symptoms which are similar to those of children who have been physically or sexually abused, and there is some evidence that they engage in imitative violence themselves and young men may develop hostile attitudes towards women. The sort of cognitive behavioural therapy or psychotherapy interventions used with children who have experienced physical or sexual abuse has been shown to be effective for children who have been exposed to domestic violence. In addition community advocacy and empowerment and cognitive behavioural interventions in schools have also been found to be effective.<sup>434</sup>

## Justice

Bringing perpetrators of abuse to trial can be very helpful to families in coming to terms with the impact that abuse has had on them.<sup>435</sup>

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431 McCrone, O., Weeramanthri, T., Knapp, M., Rushton, A., Trowell, J., Miles, G. and Kolvin, I. (2005) Cost-effectiveness of individual versus group psychotherapy for sexually abused girls, *Child and Adolescent Mental Health* 10 (1): 26–31.

432 Fantuzzo et al. (1996) Community-based resilient peer treatment of withdrawn maltreated preschool children, *Journal of Consulting and Clinical Psychology* 64(6): 1377–1386.

433 Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766.

434 Spilsbury, J.C., Belliston, L., Drotar, D., Drinkard, A., Kretschmar, J., Creeden, R., Flannery, D. and Friedman, S. (2007) Clinically significant trauma symptoms and behavioural problems in a community based sample of children exposed to domestic violence. *Journal of Family Violence*, 22: 487–499; Stein, B.D. Jaycox, L.H. Kataoka, S., Rhodes, H.J. and Vestal, K.D. (2003) Prevalence of Child and Adolescent Exposure to Community Violence. *Clinical Child and Family Psychology Review*. 6(4): 247–264; McMahan, P. et al. (1999) *Child sexual abuse as a public health issue: Recommendations of a expert panel*.

435 Sharland, E., Seal, H., Croucher, M., Aldgate, J. And Jones, D. (1996) *Professional Interventions in Child Sexual Abuse*. London: Her Majesty's Stationary Office (HMSO).

## Focus on parents

Many of the types of support discussed under secondary interventions are also relevant for parents who already have a history of maltreatment. Generally the emphasis of interventions is to help parents see their behaviour from the perspective of the child and break the cycle of dysfunctional relationships.

In addition these interventions there are some more intensive interventions which have been used with parents with a history of maltreatment. The most widely used of these is cognitive behavioural therapy combining parenting training, anger management and problem solving. This type of intervention has been evaluated in the United States and Canada but not extensively in Britain, so that the conclusions about its effectiveness may not necessarily apply. Parents who have received this type of training are less likely to have further episodes of maltreatment and have developed better coping strategies for the problems in their daily lives. However, as an intervention it is expensive (typically lasting for six months or more) as it requires the development of trust before behavioural change can happen. It also helps if the initial focus is on the problems the parents perceive to be the most important rather than those that the referring agency or the therapist sees as most pressing.<sup>436</sup>

Family therapy recognises that families are not just collections of individuals but have developed systems where each individual's behaviour is influenced by that of the other members of the group. However, there are a wide variety of approaches, to family therapy, few of which have been subject to evaluation scrutiny and effectiveness is very mixed. It is expensive (with up to four practitioners working with one family) and has a high rate of drop-out and no-shows.<sup>437</sup>

## Focus on abusers

Four types of treatment for sex offenders in Britain have been studied: the Core sex offender treatment courses offered in some prisons, residential courses, probation service-led courses in the community, and the Challenge Project in South-East London. Standard prison-based courses, using cognitive behavioural therapy, last for 86 two-hour sessions. Each group has two leaders drawn from a range of occupations within the prison system, all of whom have undertaken a two-week training programme.<sup>438</sup>

The interventions focus on the offender's motives, on understanding the impact on victims and on learning ways to avoid offending in future. They thus aim to operate primarily on the first two preconditions, while artificially boosting the third. Those who have less deviant sexual preferences and who have come to terms with their offending were most likely to change their attitudes and to develop their social skills (around 85 per cent had changed attitudes and 59 per cent had improved their social skills as well). Those with more deviant sexual preferences (who were most at risk of re-offending) were least likely to benefit from the intervention (43 per cent had changed their attitudes and 14 per cent had improved social skills as well).<sup>439</sup>

<sup>436</sup> Macdonald; Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766.

<sup>437</sup> Cohen, J. and Mannarino, A. (2006) Psychosocial Interventions for Maltreated and Violence-Exposed Children, *Journal of Social Issues* 62(4): 737–766; Macdonald 177, 182; Dufour, S. and Chamberland, C. (2004) The effectiveness of selected interventions for previous maltreatment: enhancing the well-being of children who live at home. *Child and Family Social Work*. 9: 39–56.

<sup>438</sup> Beech, A., Fisher, D. and Beckett, R. (1999) *An Evaluation of the Prison Sex Offender Treatment Programme*. Home Office Occasional Report. [www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf](http://www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf)

<sup>439</sup> Beech, A., Fisher, D. and Beckett, R. (1999) *An Evaluation of the Prison Sex Offender Treatment Programme*. Home Office Occasional Report. [www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf](http://www.homeoffice.gov.uk/rds/pdfs/occ-step3.pdf)

A review of fourteen evaluations using control or comparison groups found that interventions with sex offenders in prison reduce subsequent reoffending by around a third.<sup>440</sup>

An evaluation of probation-based sex-offender treatment in the community found that the overall reconviction rate within two years was 4 per cent, while the reconviction rate within six years was 15 per cent.

The Challenge Project was a community-based, one year, weekly cognitive behavioural treatment programme, for child sexual abusers, implemented in both group and individual settings in South-East London. There were 43 participants. Five of the participants were convicted of further offences of any kind, including one for possession of child pornography. At follow up half the group had improved their position on the potential child molester scale. Those who took part in group activity had lower rates of denial and greater openness than those who had individual treatment.<sup>441</sup>

## Focus on adult survivors

A Danish evaluation comparing systemic and analytic group psychotherapy for adult survivors of child sexual abuse found that for both groups there were improvements in the severity of symptoms and in global functioning and quality of life in the treatment group. They also experienced fewer flashbacks. The group which received the systemic therapy had significantly better outcomes than the group who received analytic therapy.<sup>442</sup>

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440 Matrix Knowledge Group (2007) *The Economic Case for and Against Prison*. [www.matrixknowledge.co.uk/wp-content/uploads/economic-case-for-and-against-prison.pdf](http://www.matrixknowledge.co.uk/wp-content/uploads/economic-case-for-and-against-prison.pdf)

441 Craissati, J. and McClurg, G. (1997) The Challenge Project: A treatment programme evaluation for perpetrators of child sexual abuse, *Child Abuse & Neglect* 21(7) 637–648.

442 Lau, M., Kristensen, E. (2007) Outcome of systemic and analytic group psychotherapy for adult women with history of intrafamilial childhood sexual abuse: A randomised controlled study. *Acta Psychiatrica Scandinavica*. 116: 96–104.

## 6. RESILIENCE

As indicated in Section 2 above, although substantial numbers of maltreated children experience adverse outcomes, a large proportion do appear to be functioning adequately. These children have been labelled as demonstrating resilience. Perhaps the most important message from the literature is that maltreatment does not *necessarily* result in adverse outcomes. Children's lives are not just determined by other people's actions. Rather, they can be active agents in determining their own life courses.

Masten et al. (1990)<sup>443</sup> define resilience as “the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances”. Resilient children include:

- Those who do not succumb to adversities, despite their high-risk status
- Those who develop coping strategies in situations of chronic stress, for example the children of drug-using or alcoholic parents.
- Those who have suffered extreme trauma, for example through disasters, sudden loss of a close relative, or abuse, and who have recovered and prospered.

Resilience is not a fixed characteristic but something that can be supported and developed. It has been defined by Luthar et al. (2000)<sup>444</sup> as a “dynamic process encompassing positive adaptation within the context of significant adversity”. Masten (2001)<sup>445</sup> describes it as “good outcomes in spite of serious threats to adaptation or development”. Rutter (2006)<sup>446</sup> states that it ‘implies relative resistance to environmental risk experiences, or the overcoming of stress or adversity’. The adaptation of individuals to adversity, including maltreatment, results from interactive processes among the resilience factors located within the child, family and community.<sup>447</sup>

Promoting resilience can therefore play two different roles in improving children's long term outcomes. First, resilience can help to prevent maltreatment, by providing a more positive child, family or wider environment. But perhaps more importantly, where maltreatment has occurred, it can improve children's chances of positive adaptation in future. Hence the importance of resilience factors for outcomes lies not only in their impact on safeguarding a child but also on enabling growth and future development, despite adverse circumstances.<sup>448</sup>

Studies on resilience have identified a number of individual factors or that facilitate positive outcomes. The factors have been described as promoting or protecting factors; promoting factors have a positive effect on both high and low risk groups, whereas protective factors only assist in the positive functioning of

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443 Masten, A.S., Best, K.M. and Garmezy, N. (1990) Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology*, 425–444.

444 Luthar, S.S., Cicchetti, D. and Becker, B. (2000) The Construct of Resilience: A Critical Evaluation and Guidelines for Future Work. *Child Development*, 71(3): 543–562.

445 Masten, A.S. (2001) Ordinary Magic: Resilience Processes in Development. *American Psychologist*, 56(3): 227–238

446 Rutter, M. (2006) The Promotion of Resilience in the Face of Adversity in Families Count: Effects on Child and Adolescent Development in. Clarke-Stewart, A. and Dunn, J. (eds) *Families Count. Effects on Child and Adolescent Development*. Cambridge University Press: New York.

447 Yates, T.M., Masten, A.S. (2004) Fostering the future: Resilience theory and the practice of positive psychology, in Linley, P.A., Joseph, S. (eds) *Positive psychology in practice*. Hoboken, NJ: John Wiley and Sons, 521–539.

448 Newman, T. (2004) *What works in building resilience?*. London: Barnardo's.

high risk groups.<sup>449</sup> Research on resilience has identified factors in the spheres of personal characteristics, family qualities and supportive systems outside the family.

Daniel and Wassell (2002a,b,c)<sup>450</sup> summarised the factors associated with resilience for children and young people of different ages. These are grouped into individual factors, family factors and community factors (domains which echo the ecological model of parenting discussed in Section 1 above).

Individual factors associated with resilience are:

- Having problem solving skills
- Having a sense of self-efficacy
- Being sociable
- Having positive self-esteem
- Independence
- Able to plan
- Empathy with others
- Communication skills
- Intelligence
- Sense of humour
- Hobbies

Family factors associated with resilience are:

- A close bond with at least one person
- Trust
- Lack of separations
- Close grandparents
- Sibling attachment
- Four or fewer children

Wider community factors associated with resilience are:

- Support from friends, neighbours and other adults such as teachers
- Having friends
- Having good experiences at school
- Positive adult role models

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449 Sameroff, A. (2006) Identifying Risk and Protective Factors for Healthy Child Development in Clarke-Stewart, A. and Dunn, J. (eds) *Families Count. Effects on Child and Adolescent Development*. Cambridge University Press: New York

450 Daniel, B. and Wassell, S. (2002) *Assessing and Promoting Resilience in Vulnerable Children I (Early Years)* London: Jessica Kingsley ; Daniel, B. and Wassell, S. (2002) *Assessing and Promoting Resilience in Vulnerable Children II (School Years)* London: Jessica Kingsley; Daniel, B. and Wassell, S. (2002) *Assessing and Promoting Resilience in Vulnerable Children III (Adolescence)* London: Jessica Kingsley.



Other studies have found personal factors promoting resilience to be IQ,<sup>451</sup> positive self-esteem,<sup>452</sup> possessing an easy-going temperament,<sup>453</sup> genetic influences,<sup>454</sup> personal control in problem solving,<sup>455</sup> the feeling of having control in external situations,<sup>456</sup> and absence of self-blame.<sup>457</sup>

Familial factors identified by others include family cohesion,<sup>458</sup> receipt of sensitive and stimulating care,<sup>459</sup> supportive relationship with a non-abusive parent or adult.<sup>460</sup>

Positive attributes outside the family include external support groups,<sup>461</sup> high quality friendships,<sup>462</sup> positive school climate,<sup>463</sup> highly supportive relationship in adulthood with a spouse or partner, and an advantageous neighbourhood by way of moderating the relationship between household stability and resilience.<sup>464</sup>

Factors promoting resilience are both related to each other, and related to the kind of experience that maltreated children might have had. Rutter (2006)<sup>465</sup> in discussing disparities in responses to stress and

451 Herrenkohl, E.C., Herrenkohl, R.C. and Egolf, B.P. (1994) Resilient early-school-age children from maltreating homes: Outcomes in late adolescence. *American Journal of Orthopsychiatry*, 64(2): 301–309; Masten, A.S., Hubbard, J.J., Gest, S.D., Tellegren, A., Garmezy, N. and Ramirez, M. (1999) in Vanderbilt-Adriance, E. and Shaw, D.S. (2008) Conceptualizing and Re-Evaluating Resilience Across Levels or Risk, Time, and Domains of Competence. *Clinical Child and Family Psychology Review*, 11: 30–58; Radke-Yarrow, M. and Sherman, T. (1990) in Herrenkohl et al., 1994 article Resilient Early School-Age Children; Jaffee, S.R., Caspi, A., Moffitt, T.E., Polo-Tomás and Taylor, A. (2007) Individual, family, and neighbourhood factors distinguish resilient from non-resilient maltreated children: A cumulative stressors model. *Child Abuse & Neglect* 31: 231–253.

452 Cichetti, D. and Rogosch, F. (1997) The role of self-organization in the promotion of resilience in maltreated children. *Development and Psychopathology*, 9: 797–815.

453 Kim-Cohen, J. Moffitt, T.E., Caspi, A. and Taylor, A. (2004) in Vanderbilt-Adriance, E. and Shaw, D.S. (2008) Conceptualizing and Re-Evaluating Resilience Across Levels or Risk, Time, and Domains of Competence. *Clinical Child and Family Psychology Review*, 11: 30–58.

454 Caspi A., McClay, J., Moffitt, T., Mill, J., Martin, J., Craig, I.W., et al. (2002) in Vanderbilt-Adriance, E. and Shaw, D.S. (2008) Conceptualizing and Re-Evaluating Resilience Across Levels or Risk, Time, and Domains of Competence. *Clinical Child and Family Psychology Review*, 11: 30–58; Jaffee, S.R., Caspi, A., Moffitt, T.E., Dodge, K.A., Rutter, M., Tayler, A. and Tully, L.A. (2005) Nature x nurture: Genetic vulnerabilities interact with physical maltreatment to promote conduct problems. *Development and Psychopathology*, 17: 67–84.

455 Banyard, V.L. (1999) in O'Dougherty Wright, M., Fopma-Loy, J. and Fischer, S. (2005) Multidimensional assessment of resilience in mothers who are child sexual abuse survivors. *Child Abuse & Neglect*, 29: 1173–1193.

456 Luthar, S.S. (1991) in Haskett, M.E., Nears, K., Sabourin Ward, C., McPherson, A.V. (2006) Diversity in adjustment of maltreated children: Factors associated with resilient functioning. *Clinical Psychology Review*, 26: 796–812.

457 McGee, R.A., Wolfe, D.A. and Wilson, S.K. (1997) in Haskett, M.E., Nears, K., Sabourin Ward, C., McPherson, A.V. (2006) Diversity in adjustment of maltreated children: Factors associated with resilient functioning. *Clinical Psychology Review*, 26: 796–812.

458 Sagy, S. and Dotan, N. (2001) in Haskett, M.E., Nears, K., Sabourin Ward, C., McPherson, A.V. (2006) Diversity in adjustment of maltreated children: Factors associated with resilient functioning. *Clinical Psychology Review*, 26: 796–812

459 Spaccarelli, S. and Kim, S. (1995) Resilience criteria and factors associated with resilience in sexually abused girls. *Child Abuse & Neglect*, 19(9): 1171–1182.

460 Kim Jaffee, S.R. (2007) Sensitive, stimulating caregiving predicts cognitive and behavioral resilience in neurodevelopmentally at-risk infants. *Development and Psychopathology*, 19: 631–647; Runtz, M.G. and Shallow, J.R. (1997) Social support and coping strategies as mediators of adult adjustment following child maltreatment. *Child Abuse & Neglect* 21(2): 221–226.

461 Norring, F. and Walker, R.M.R. (2001) in Wilcox, D.T., Richards, F. and O'Keefe, Z.C. (2004) Resilience and Risk Factors Associated with Experiencing Childhood Sexual Abuse. *Child Abuse Review*, 13: 338–352.

462 Bolger, K.E., Patterson, C.J. and Kupersmidt, J.B. (1998) in Haskett, M.E., Nears, K., Sabourin Ward, C., McPherson, A.V. (2006) Diversity in adjustment of maltreated children: Factors associated with resilient functioning. *Clinical Psychology Review*, 26: 796–812.

463 Perkins, D. and Jones, K. (2004) in Haskett, M.E., Nears, K., Sabourin Ward, C., McPherson, A.V. (2006) Diversity in adjustment of maltreated children: Factors associated with resilient functioning. *Clinical Psychology Review*, 26: 796–812.

464 DuMont, K.A., Spatz Widom, C. and Czaja, S.J. (2007) Predictors of resilience in abused and neglected children grown-up: The role of individual and neighbourhood characteristics. *Child Abuse & Neglect*, 31: 255–274.

465 Rutter, M. (2006) The Promotion of Resilience in the Face of Adversity in Clarke-Stewart, A. and Dunn, J. (eds) *Families Count: Effects on Child and Adolescent Development*. Cambridge: Cambridge University Press.

adversity stated that at least four different areas need to be considered: genetic susceptibilities; the effects of prior experiences; social context and the processing and methods of coping with experiences.

As research on promoting and protecting factors has moved away from examining a single factor in a single domain of functioning there has been an acknowledgement that risks do not usually occur in isolation. Children at risk of some forms of maltreatment are likely to be exposed to a range of other risk factors, such as poverty, low levels of parental education, large family size, maternal mental illness, fragmented social networks, and inadequate neighbourhood amenities. Additionally, chronic maltreatment is also likely to decrease the probability that individuals have developed the facility to adapt successfully and overcome their negative experiences.<sup>466</sup> Research has shown that cumulative risks decrease the probability of resilient functioning with some promoting/protecting factors no longer facilitating success as risks increase.<sup>467</sup> In relation to this, it is also necessary to consider that risks that occur within the family will not necessarily be directed equally to all children in the family.

## INTERVENTIONS TO PROMOTE RESILIENCE

Early research on resilience described resilient children as ‘invincible’ or ‘invulnerable’ implying that these individuals were in some way extraordinary. Thinking on the subject has moved on greatly and now considers a wider range of issues. Encouragingly, Masten<sup>468</sup> describes it as a part of ordinary human adaptation indicating that a majority may have the facility to overcome detrimental experiences with the correct support and services.

The promotion of resilience involves a recognition that maltreatment may not be prevented (or may already have taken place). What therefore matters is not the elimination of childhood difficulties, but seeking to ensure that those difficulties that children do experience do not necessarily result in a lifetime of disadvantage. Where factors which are associated with a higher risk of maltreatment are present in families, it may be possible to neutralise some of their impact by promoting opportunities, resources and strengths in parents, children and communities.<sup>469</sup>

Rutter (1993)<sup>470</sup> argues that the existence of resilience is better understood than the mechanisms by which it can be promoted. However, he identified four processes by which resilience might be improved:

- by altering the child’s perceptions of their circumstances
- by reducing the chain reaction that takes place when risk factors compound each other and multiply

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466 Quinton, D. and Rutter, M. (1976) Early hospital admissions and later disturbances of behaviour: an attempted replication of Douglas’ findings. *Developmental Medicine and Child Neurology* 18 (4), 447–459.

467 Moran, P.B. and Eckenrode, J. (1992) Protective personality characteristics among adolescent victims of maltreatment. *Child Abuse & Neglect*, 16: 743–754; Herrenkohl, E.C., Herrenkohl, R.C. and Egolf, B.P. (1994) Resilient early-school-age children from maltreating homes: Outcomes in late adolescence. *American Journal of Orthopsychiatry*, 64 (2): 301–309; Jaffee, S.R., Caspi, A., Moffitt, T.E., Polo-Tomás and Taylor, A. (2007) Individual, family, and neighbourhood factors distinguish resilient from non-resilient maltreated children: A cumulative stressors model. *Child Abuse & Neglect* 31: 231–253; Sameroff, A. (2006) Identifying Risk and Protective Factors for Healthy Child Development in Clarke-Stewart, A. and Dunn, J. (eds) *Families Count: Effects on Child and Adolescent Development*. Cambridge: Cambridge University Press.

468 Masten, A.S. (2001) Ordinary Magic: Resilience Process in Development. *American Psychologist*, 56(3): 227–238.

469 Garbarino, J., Vorrasi, J.A. and Kostelny, K. (2002) Parenting and Public Policy in Bornstein, M.H. *Handbook of Parenting: Volume 5 Practical Issues in Parenting*. Mahwah NJ: Lawrence Erlbaum Associates.

470 Rutter, M. (1993) Resilience: some conceptual considerations, *Journal of Adolescent Health*, 14: 626–31.

- by helping the child improve self-esteem and self-efficacy
- by creating opportunities for change

Yates and Masten (2004)<sup>471</sup> identified three types of intervention which aim to promote resilience:

- Those that aim to reduce the incidence of risk factors such as low birth weight or teenage pregnancy
- Those that aim to improve the factors that mitigate the impact of adversity including better healthcare, education, employment
- Those that aim to strengthen family and community systems in order to support positive development, and positive relationships

Newman (2004)<sup>472</sup> reviewed the evidence related to effective intervention strategies to promote resilience and developed a list of the key factors for different age groups. Prenatal interventions include those designed to improve maternal nutrition, reduce smoking and alcohol consumption, improve access to antenatal care, improve social support and prevent domestic violence. During infancy good quality housing, parent education and adequate income can also play a role. During the pre-school period high quality education, the availability of alternative caregivers, support from resilient peers and links with community support also contribute. In middle childhood positive school experiences and the promotion of parental engagement with school can be helpful. Structured routines, and a perception by the child that praise and sanctions are being administered fairly are an important means of promoting stability, which is one of the underpinnings of resilience. In abusive settings, the opportunity to maintain or develop attachments to the non-abusive parent, other family member or, otherwise, a reliable unrelated adult are important. In adolescence and early adulthood strong social support networks, the presence of a least one unconditionally supportive parent or parent substitute and a sense of mastery and a belief and one's own efforts can make a difference add to these.

As yet, the evidence about the impact on the outcomes for children who have been maltreated from interventions that promote resilience is limited. Nevertheless, there are some interventions (mainly international) where the evidence is positive.<sup>473</sup> Moreover, perhaps the most important message from resilience research is that resilience can be damaged (albeit inadvertently) by some interventions. For example, the evidence consistently suggests that one of the most important mechanisms by which children are helped to overcome adversity is the support of friends, family and other significant adults such as teachers. Where children do need to be removed from home for their own protection, their future wellbeing will be helped if they can nevertheless retain contact with people who are important to them, particularly teachers, grandparents and other supportive friends.<sup>474</sup>

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471 Yates, T.M., Masten, A.S. (2004) Fostering the future: Resilience theory and the practice of positive psychology, in Linley, P.A., Joseph, S., eds. *Positive psychology in practice*. Hoboken, NJ: John Wiley and Sons; 521–539.

472 Newman, T. (2004) *What works in building resilience?*. London: Barnardo's.

473 Gilligan, R. (2001) *Promoting resilience: A resource guide on working with children in the care system*, London: BAAF; SCIE (2004) *Promoting resilience in fostered children and young people*. Resource Guide no 4.

474 Newman, T. (2004) *What works in building resilience?*. London: Barnardo's.

## 7. CONCLUSION

There are several key conclusions from the literature. The most important is that the damage done to children by maltreatment is not the immediate injuries or illnesses. It is the impact on their mental wellbeing and educational progress which damages their life chances. Maltreated children in adulthood have poor job prospects. They are more likely to engage in damaging behaviour such as smoking, domestic violence (both as perpetrators and as victims) drug and alcohol use. They are more likely to commit crime than those who have not been maltreated as children. They are more likely to suffer from physical illness and to die early, including death by suicide. All these have important economic consequences for the children themselves as adults, but in addition there are consequences for the wider community. There are also consequences for their own children.

The second conclusion is that those developing preventive services face two major challenges. The first is that even *higher risk* families are actually unlikely to maltreat their children. Thus, most interventions will include only a minority of parents whose maltreating behaviour might be changed (although they might become better parents and their children's life chances might improve). It is at least partly for this reason that most interventions show no impact on maltreatment rates. It does not mean there is no impact, but it does mean that impact is difficult to measure, and that in conventional economic terms it is likely to be difficult to demonstrate that services are cost-effective.

In many ways the more promising approach is to focus on ensuring that the community provides an environment where resilience of both parents and children is strengthened and where the incidence of risk factors (such as teenage parenthood) is reduced, and where the institutions that have the capacity to improve life prospects such as schools are improved. These are challenging, and the link with child maltreatment is often indirect, but it is likely to be in these areas where the improvement in children's life chances can be brought about.