AN ANALYSIS OF CHILD ABUSE AND CHILD PROTECTION WORK IN SCOTLAND

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ABSTRACT

Child protection services are one of the most overt forms of state intervention into family life. After reviewing the background of child abuse and child protective services, the thesis provides a critical review of child abuse research and argues for the separation of research on the nature of child abuse behaviour and research into child protection practice and policy. It is argued that definitional issues are central to research in this area and so an analysis of the sub components of the concept of child abuse is provided. It is also argued that descriptive and analytic research into child protection practice can be used to provide feedback on the current largely implicit policies being practiced. A task for early studies is to develop a vocabulary for describing this work that can be applied by further more detailed studies or in future routine management information systems. An exploratory descriptive study of a whole population of cases of child protection for preschool children is presented as a contribution to this process.
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PREFACE

The work reported in this thesis grew out of a study of child protection work funded by the Social Work Services Group of the Scottish Office.

The original purpose of the research was to undertake an evaluation of the efficacy of a specialist interventive service for cases of child abuse. This posed serious methodological problems because there was no information on the selection criteria of cases referred to the special unit or the way in which the cases differed from the total number of cases of child abuse identified by child protective services. More seriously there was virtually no descriptive data on the total population of cases or methods for analysing or classifying child protection work. The research studies that had been undertaken had only studied unspecified sub-samples of cases. Much of this research was attempting to identify the essential nature of child abuse cases. Very little research was focused on child protection practice.

The author therefore re-designed the study to be a longitudinal descriptive study of all new registrations of newly identified cases of child abuse or risk of abuse to pre-school children. The cases were defined by placement on the local authority child abuse register. Unfortunately it was not possible to fully change the agreed design of the study and so the schedule of data collection considered appropriate for the original design was applied to the larger sample involved in the new research design. Only a proportion of the data is collected is included in this thesis.

This thesis contains an account of the history of child abuse work, the nature of child abuse research, and an analysis of the concept of child abuse to provide the background and the justification for the empirical data on child protection presented in later chapters.

The thesis has taken a long time to be completed and during this time I have produced several reports and publications using material from or related to the thesis. These publications include the formal reports of the study to the Scottish Office (Gough et al, 1987, 1989, 1993) and various publications on Scottish child abuse statistics (Gough, 1987, 1988, 1992) and on the methodology and results of child abuse research (Gough, 1993a, 1993b; Gough and Boddy, 1986). My colleagues Dr Andrew Boddy, Mr Norman Dunning, and Dr Fred Stone were the grant holders on the project and provided useful guidance and advice in the
execution of the research study. They were also cited as joint authors on the research reports to the Scottish Office. There had been plans for them to be involved in data collection and analysis, but time constraints prevented this from happening. I am therefore solely responsible for the research presented here.

During the time taken for the completion of the thesis there have been many developments in the study and practice of child abuse. One of these has been a change from a language of child abuse to one of child protective services in order to reflect that interventions are aimed at preventing future abuse. This has resulted in a change of terminology so that lists of children thought to be in need of protective services and previously called child abuse registers are now described as child protection registers. In this thesis both terms are used, though the older term is principally used for describing the situation at the time of data collection and the newer term to describe present circumstances.

Other changes that have taken place during the completion of this thesis include the funding of other research studies on child protection practice by the Department of Health. These studies are currently being completed and although some reference is made to them, it has not been possible to incorporate their findings into this thesis.

The changes in the development of child protection practices may effect the relevance of the study findings and the conclusions and arguments made in the thesis. In the author's view, however, many of the issues raised by the theoretical and research study chapters are still relevant despite these practice changes.

This thesis would not have been possible without the generous help and kindness that I received from many people. Firstly, I want to express my gratitude and appreciation to the families and workers who gave me their time and allowed me access to very sensitive information about themselves and their work. Secondly, I want to thank my supervisor, Dr Margaret Reid, for all her guidance and support over the many years it took me to complete the thesis. I also want to thank Dr Andrew Boddy, Director of the Public Health Research Unit, for his advice, patience, and continued support, and Mrs Irene Young for all her help with typing the many drafts of the thesis.
CHAPTER ONE

BACKGROUND

Historically, children in many cultures have often been seen as possessions of their parents. Even if the children were loved and well cared for, their welfare was usually seen as inseparable from the welfare of the family. In the early 19th century British society began to acknowledge that children had needs and rights separate from the needs and rights of their parents. Despite this the state rarely intervened in families to protect children. The parents' (or rather fathers') power to control and punish their children (and their wives) was sacrosanct and the state usually only acted to protect individual children if the family had clearly broken down (Harding, 1989).

In the late 19th century in Victorian Britain this situation began to change. A variety of charitable societies developed in response to the social problems arising from the great disparity in wealth in the population. Some of these societies were concerned with the rescue of children from maltreating or in other ways 'bad' families (Dingwall et al, 1983) and campaigned for the legal reform to challenge the absolute rights of fathers over their children. These child protection societies combined to form the National Society for the Prevention of Cruelty to Children (NSPCC). The campaign led to the 1889 Prevention of Cruelty to, and Protection of Children Act, which made cruelty to children a clear criminal act. Subsequent acts of parliament have further developed the state's role in protecting children (for example, Children Act, 1948; Children and Young Persons Act, 1969; Children Act, 1989), though the basic premise of this legislation remains that in normal circumstances the family is the best place for children to be raised (Harding, 1989). The state only intervenes and interferes with parental rights where children are being mistreated or are unable to receive a minimum necessary level of care from their own families.

From before the First World War until the 1960's there seemed to be little concern or awareness about child abuse (as it became known), though the charity NSPCC continued its work with extreme cases of child cruelty. Most state intervention was related to general family dysfunction or pathology that might lead to inadequate child care; particular attention being given to family dysfunction as a cause of child delinquency. These family problems were often attributed to poverty and the 1960's saw the rise of political interest in assisting children of poor families escape the
disadvantage of their backgrounds. Central government funded compensatory educational programmes for children in deprived areas and initiated research into how social and economic disadvantage in one generation may be transmitted to the children to become the disadvantaged adults of the next generation in a cycle of disadvantage.

A similar emphasis on prevention was also prevalent in social work. Social work staff of the children's departments of local authorities had the responsibility of assisting families in order to prevent family breakdown. The aim was to help the family and so prevent the need for children to come into the care of the local authorities. The increasing role of the welfare state in supporting families grew further in 1971 when there was a major reorganization and major growth of social work departments.

The Re-Discovery of Child Abuse in the United States

At the same time as these changes in the welfare state and in theories of the cause of family and child problems the social problem of child abuse was re-discovered in the 1950's in the United States. Prior to this the history of child abuse work had been similar in the two countries. Within the United States, a similar rise of charitable philanthropic organization concerned with child safety being formed in the mid to late nineteenth century. The first American organisation for the protection of children was formed in response to the case of Mary Ellen, a girl who was found to have been regularly tied up and beaten by her stepmother. The initial referral for this case was made to the president of a society for the protection of cruelty against animals, who then helped form a similar society for children (Nelson, 1984).

Apart from the work of the charitable associations little attention was given in the United States to the issue of child abuse until the mid 1950's. Interest in child abuse then began to develop due in part to the high level activity of one of the child protection societies, the American Humane Association, and by the discovery of baby battering by American radiologists and paediatricians. Technical advances in radiology (X rays) began to identify many old healed fractures in children's bones. It did not take long for doctors to suppose that parental mistreatment might be responsible for these fractures. The issue did not, however, receive much media attention until after a paediatrician, Henry Kempe, published a well publicised and

Interest grew further with attention from the media and the acceptance of the importance of the problem by the Children's Bureau of the national government. In 1974 the Child Abuse and Prevention Treatment Act became law authorising $85 million spending on national child abuse programmes over four years and establishing the National Center on Child Abuse and Neglect (Nelson, 1984). An important factor in the growth of interest in child abuse was the increase in identified cases. This was assisted by the introduction of mandatory reporting laws in each state in the 1960's. These laws require professionals to inform child protective services of any child that they believe to be the victim of abuse. The laws also protect these professionals from being sued in court (for example, by parents) for making allegations of abuse as long as these allegations were made in good faith. Such laws do not exist in Britain where professionals have a responsibility to report cases to social services but are not legally obliged to do so.

The United States has civil laws allowing intervention in family life and criminal laws for the prosecution of those who mistreat children, but, as in Britain, most cases are dealt without recourse to the law. In the United States these are local child protection services (CPS). Referrals or reports of abuse are made to the local CPS, who then investigate and decide whether the allegations can be substantiated. The process of substantiation has no legal foundation, it is merely a process of eliminating cases where there is little substance to the referral. In 1991 referrals on 2.7 million children (4.2% of all children) were made to protective services and these had an average substantiation rate of 39% (Daro and McCurdy, 1992). Because of the large numbers of cases being referred to child protection services some cases are beginning to be screened out even before investigation (i.e. merely on the basis of the referral information). For substantiated cases child protection workers provide a supportive and protective service which might involve application for legal powers of intervention. There is some data to suggest that the large numbers of substantiated cases result in a minimal service being offered to all but a few of these cases (Daro and McCurdy, 1992). Little, however, is known about the nature of routine protective service work as most research and publications concern the many specialist child abuse treatment facilities. These specialist centres, however, only treat a very small minority of all the child abuse cases identified in the United States each year.
Just as the United States was the first country to 'rediscover' physical abuse of children in the 1950's, it was also the first to give major attention to the separate (if overlapping) problem of sexual abuse in the mid to late 1970's (Finkelhor, 1986). It was not until nearly ten years later in the mid 1980's that substantial numbers of cases of sexual abuse began to be identified in Great Britain. As pioneers in the detection and response to cases of sexual abuse American workers produced the first treatment programmes and clinical literature on this subject. American workers were also at the forefront of experiencing the complex socio-legal problems in child protection practice, particularly the use of litigation in the courts with many lawyers becoming specialists at either prosecuting or defending those prosecuted for alleged sexual abuse crimes (sometimes derogatorily termed 'hired guns'). The many scandals of children being physically and sexually abused in their homes, at school, and in foster care in addition to several high profile and protracted court cases has helped to make the abuse of children headline news. Britain has tried to learn from American experiences (Murray and Gough, 1991), but in many cases has been unable to avoid the types of problems experienced by the American workers.

A major difference between Britain and the United States is the amount of public information on the problems of child abuse available. In America, public, charitable, and commercial organisations produce a plethora of leaflets, video films, television programmes, television advertisements and drama publicising child abuse. These materials are given extra credibility by the support of celebrities. The National Committee for the Prevention of Child Abuse, for example, presents television adverts on child abuse starring a former President's wife, Mrs Barbara Bush. The famous television celebrity, Oprah Winfrey, hosts television specials on sexual abuse, where she reveals that she was also sexually victimised as a child. Included in this high public profile for abuse is the extensive use of preventive educational programmes in schools to warn children about abuse and to provide them with basic information to protect them from becoming victims or to summon assistance if they can not avoid the abuse. Such educational programmes are available in Britain but to a much more limited extent (Gough, 1991).

Development of Child Protection Systems in Britain

The concepts of baby battering and child abuse spread from the United States to Britain, but these ideas did not receive much attention until 1973 when a six year old child, Maria Colwell, was murdered by her step-father. There was considerable publicity and outrage in the media and anger that social workers who were
monitoring the family had not prevented the girl's death. The government set up an inquiry which ultimately led to the creation of central government guidance on the management of child abuse cases. Each local authority social work department included the main elements of the central government guidance within local procedures for child abuse work. These procedures specified the organisational framework and the basic minimum standards of work in these cases. Government also required each area of Britain to create interdisciplinary Area Child Protection Committees composed of senior representatives from each of the relevant professions to ensure good inter professional communication on child abuse issues and the resolution of any local difficulties in the management of child abuse cases.

Since the 1970's there have been many changes to the legislation concerning children and to the central guidance on working with cases of child abuse. Many of these changes have arisen in response to difficulties in applying legislation or problems in practice identified by inquiries into further child abuse tragedies (see Department of Health, 1982, 1991a; Hallett, 1989). Most of these inquiries (of which there have been nearly forty) have arisen from cases where children known to social services have been killed by their parents or the parent's partners, as in the case of Maria Colwell. The inquiries have attempted to ascertain why it was not possible to prevent the children's deaths, the unspoken assumption being that social work and other agencies should have been more interventive. Although these inquiries were based upon implicit criticisms of social work practice and were accompanied by extensive media criticisms of social work as a profession, they have resulted in government increasing the powers and responsibilities of social work child protective services. The inquiries have damaged the public reputation of social work yet ironically contributed to a growth in the roles and responsibilities of social work as an agency.

In the early 1970's and early 1980's there were very few cases of sexual abuse identified despite some discussion of the problem in the literature. Since the mid 1980's the increasing awareness of sexual abuse in the last ten years has led to a massive increase in the identification of such cases. These cases have proved to be highly sensitive and difficult to investigate and manage. In a few instances the difficulties agencies have experienced in investigating sexual abuse referrals has led to government inquiries (for example, in Cleveland, Secretary of State for Social Services, 1988; in Orkney, Secretary of State for Scotland, 1992). The sexual abuse inquiries have arisen where a large number of children have been removed from their families on emergency orders because of suspicions of sexual abuse. The
inquiries have been concerned with whether the professional agencies have intervened too strongly or inappropriately in family life. This is in contrast to the inquiries into the management of cases of physical abuse where social work has been accused of intervening too weakly to protect children.

The widening of the concept of child abuse to include sexual and other forms of abuse and maltreatment and the increased experience of working with these cases has led to changes in detail and in the philosophy of child protection services, though the general organisational arrangements have not changed dramatically. The main changes are:

- the broadening of the concept of abuse from physical violence to also include neglect, failure to thrive, emotional abuse, and sexual abuse.

- the difficulties in responding to cases of suspected sexual abuse have led to new arrangements for co-operation between agencies (particularly between police and social work) in investigating suspicions of abuse, methods of interviewing children during investigations, the medical examination of children for signs of sexual abuse, and the admissibility of different forms of children's evidence in court.

- a change from a terminology of child abuse work to one of child protection in recognition that the main social work task is to protect children in the future. Child protection work is primarily concerned with investigating and planning work for future protection of children at risk rather than simply identifying children who have been victims of abuse.

- a growing awareness of the need to work in partnership with parents and parents' rights to be fully involved and informed in child protection work. For example, to be involved and informed about child abuse investigations and to have rights of appeal and access to children if their children are removed into care.

- a consolidation and revision of the many different pieces of legislation concerning children in the new Children Act, 1989 (see Parton, 1991), and the issuing of new government guidance to the relevant agencies (Department of Health, 1991b). The new legislation and government guidance also incorporates the changes in philosophy towards child protection, partnership with parents, the rights of parents, and the need to only intervene in family life if it is in the child's best interests to do so. Legal intervention should only occur if the child is at risk of 'significant harm'.
Current British Child Protection Systems

There are at least three distinct systems concerned with child protection in Britain. First, there are the procedures and practices within and between each statutory agency. These are the main inter and intra organisational arrangements for investigating and responding to child protection cases. The government issues central guidance as to the basic form and general policy and philosophy of these arrangements, but each geographical area has an inter disciplinary Area Child Protection Committee that publishes more detailed local procedures (as the statutory agency responsible for child protection, social work is in practice often the main instigator of these procedures). The procedures concern internal agency rules for managing cases and do not depend upon the involvement of the courts or of any legal processes, though the roles and responsibilities of the agencies are determined by acts of parliament (for example, Children Act, 1989).

The second child protection system involves the civil law which can be invoked to provide legal protection to children. Social work can apply to the courts for powers to remove the child from immediate dangers, to gain powers of supervision over the family, or to remove the child into foster or residential care. These actions require evidence to convince the courts that on the balance of probabilities the child's interests would be best served by invoking the powers requested by the social work department.

The third system of child protection is the criminal law. Individuals may be prosecuted for crimes such as a physical or sexual assault on a child. This process is undertaken by the police and the prosecution service and focuses on the behaviour of the alleged abuser rather than on the child's need for protection. The criminal courts require the highest level of proof, that it is beyond reasonable doubt that the defendant committed the alleged crimes. As this level of proof is so high and because criminal courts are concerned only with the past rather than future risk it is not surprising that civil courts are much more frequently involved in cases of child protection than criminal courts.

The discussion so far has referred mostly to developments in England and Wales. Scotland has a separate legal system and the Scottish Office issues its own guidance to agencies, though this usually follows English guidance. The main difference in the Scottish legal system lies in the use of Children's Hearings to decide upon the
disposal of cases in the civil child care system. If a child is considered to be in need of care and protection either because he or she is committing crimes or because he or she is at risk of abuse then the case can be referred to the Children's Hearings for legal powers of supervision of the child in the family or the removal of the child to some other form of care. The basis of the referral (the facts of the case) have to be established in court, but this having been done, the Children's Hearings decide upon what should then occur. The Hearing consists of a 'Reporter', a special professional who manages the process, and three non professional but partly trained volunteer 'Panel Members' who together make the decision on disposal in terms of what would be best for the child. These hearings can only make renewable one year orders and can not order permanent changes for the child as in, for example, adoption. In the English system the court decides upon both the facts and upon case disposal. Until recently English cases could be referred through a complex route of different courts, but this complexity has been considerably reduced by the recent Children Act (1989). The Scottish legal system has not needed such consolidation, but a more limited revision is to take place following inadequacies in the system identified by the inquiry into the investigation of a number of suspected cases of sexual abuse in Orkney (Secretary of State for Scotland, 1992). The Scottish Office will then also issue new central guidance to agencies.

In parallel with these developments in government guidance and legislation, voluntary agencies like the NSPCC (and the Royal Scottish Society, RSSPCC, in Scotland) have also developed their work in this area. Previously NSPCC and RSSPCC staff were mostly comprised of local officers or inspectors who investigated cases of suspected child abuse often arising from referrals from the general public. The Social Service Departments created in 1971 had the statutory responsibility to protect children at risk and (although the voluntary child protection agencies had some statutory powers) the NSPCC and RSSPCC have therefore developed other ways of working. They now concentrate on specialised work such as working in depth with a small number of cases or providing expert advice to other professionals. With the increased awareness and publicity about child abuse other charities have also begun to offer child abuse services (for example, National Children's Homes, Barnado's, and the Children's Society).

Management of Individual Cases

Many different agencies may be involved in child protection cases, but local authority social work departments have the most central role. They have the general
responsibility to support children and families and specific responsibilities concerning the investigation and management of cases of child abuse. Social work departments are essentially reactive agencies. Although some argue for a policy of local community social work where workers have close contact with those living in the neighbourhood, the reality is that social work departments are dependent upon referrals from others. These referrals may come directly from the family or other members of the community or from other agencies (Figure 1.1).

In some cases a range of different agencies may be involved before the social work department is informed that there is suspicion of child abuse or the risk of child abuse. All agencies know that they have a responsibility to refer such cases to the social work department, though this does not always happen quickly and sometimes does not happen at all.

Once the social work department is informed about a possible child protection case, then a decision has to be made whether to investigate it. Social work may decide that there is not sufficient information or sufficient concern about the child's welfare to necessitate an investigation or there may be information to suggest that the referral is malicious. If an investigation is considered necessary then an investigation should be undertaken according to local procedural guidelines. These local procedures vary between areas, but they have much in common as they are informed by the central government guidance.

The procedures usually specify that the investigation must involve two social workers to visit the child and family and to speak to other interested parties such as the initiator of the referral and the professional staff already involved with the family. If the initial investigation indicates that there are grounds for concern, then the social workers usually request that the child be medically examined to ensure that the child is well and to ascertain whether there are any signs indicative of abuse. In a few cases medical evidence can clearly indicate maltreatment, for example, cigarette burns or internal damage to the child's genitalia. In most cases, there are other possible (even if unlikely) explanations for the child's physical condition. In these cases medical data can only show if there is damage consistent with abuse or maybe inconsistent with the parental explanations of what has occurred. The greatest controversy has surrounded the use of medical examinations to determine if a child has been sexually abused. In most cases of sexual abuse there will be no signs of physical trauma, but even if such signs exist they are difficult to
diagnose because of the lack of knowledge and expertise about what is normal in children's genitalia (Hegar, 1991).

With investigations of allegations of sexual abuse by the parents, the parents may not be contacted immediately because of the concern that they might destroy evidence or disappear with the child. If the child is considered to be in immediate danger then the workers may apply to a court for an Emergency Protection Order which allows the child to be temporarily removed from the parents. Also, if the parents frustrate the workers attempts to assess the child's health and condition, then the workers can apply to court for a Child Assessment Order (though older children can refuse to consent to being medically examined). In some cases the social work department will hold a Strategy Discussion with other agencies in order to pool information and to decide what action should be taken.

If the initial social work investigation suggests that there is a basis for concern about the child then the procedure is to call a case conference to which the parents and all relevant professionals are invited. It is only recently that efforts have been made to involve parents in these meetings. Previously the non social work professionals were concerned about parents seeing them discussing the adequacy of their parenting with social workers. Doctors and health visitors, for example, often felt that this might jeopardise their relationship with the parents, particularly if they had been involved in the referral of the case to the social work department. Government and social work have attempted to allay the fears of these other professions and to persuade them that it is important to be honest and direct with parents about the allegations and concerns and to involve them in the case conference process. The fears about parental involvement have been somewhat mitigated by the introduction of strategy meetings where professionals can confidentially discuss whether action is necessary without (or before) involving the parents.

If the social work department decides to convene a case conference then this is called an initial child protection case conference. The main decision is whether to place the child's name upon the local child protection register. This should only occur if there are concerns about the future protection of the child and an inter agency plan is formulated to try to ensure that the child is sufficiently protected. Placing the child's name on the register does not in itself protect the child. Its effect is in defining the case as fulfilling the criteria for a child protection case and thus invoking the child protection procedures. These will require at least the following:
- the appointment of a key worker from the social work department.
- a comprehensive assessment of the child and family's situation.
- a written inter agency child protection plan.
- regular review child protection case conferences.

The assessment of the child and family's situation and the formulation of the inter agency plan may take some time to achieve and so may not be available until the first review case conference. A child's name can only be removed from the register by an inter agency case review deciding that the original concerns about the child's safety and protection no longer apply. Exceptions that do not require a review case conference are, (i) when the child moves to another area (and responsibility is transferred to the social work department and other agencies in that area), (ii) when the child reaches adulthood, (iii) if the child dies.

When children are placed on the child protection register they are categorised according to the type of risks at issue. Currently there are four categories are physical injury, neglect, sexual abuse, and emotional abuse.

Normally children are placed under only one category but it is possible for them to placed under two or more. These categories provide a quick indication of the risks to a child, but they also are used for statistical purposes. These register statistics used to be used by some commentators as indicators of the extent of different types of abuse in the community but most now recognise that the statistics do not reflect prevalence for two main reasons. Firstly, registration occurs because of concerns about future risk. It is not a listing of all children known to have been abused. A child will not be placed on the register if there is little risk of recurrence of abuse (for example the person who perpetuated the abuse has left the family or the child is dead). Secondly, only a fraction of all cases of children at risk of abuse come to the attention of authorities and are considered for registration. Child protection register statistics are therefore better seen as an indication of child protection activity by agencies rather than the prevalence of child abuse in the community.

In Britain identified cases of physical abuse are very much more likely to involve the poorest, the least educated adults, and those who suffered poor child care experiences when they were children (Gough et al, 1987). This finding is also true
for sexual abuse, though not to the same extent. This is partly because poorer and less well educated sections of society are less able to avoid the attention of government agencies. In addition, many identified cases are not clear cut extreme cases of abuse or risk of abuse. Typically there may be generalised bruising of unknown origin and it difficult to ascertain the extent that the child is at risk of maltreatment. For this reason, many workers would like to have some form of test or assessment that could clearly indicate the level of risk in a family. Such tests have been devised, and these are able to identify whether there are high levels of risk in a family. The problem is that they are not sufficiently precise to predict in which families maltreatment will actually occur (Dingwall, 1989).

The child protection procedures and child protection register system are internal management processes for ensuring high standards of child protection work. They do not involve the courts, but many of the cases may be subject to court involvement. The most common form of involvement is civil proceedings to ensure the safety of the child or to supervise parental care of the child. Child protection casework often involves the use of temporary or medium term powers of legal involvement. In some of these cases the child will be removed from the parental home to be cared for by others, but this can only occur with the approval of the courts. The main types of order are:

- temporary emergency orders to ensure the immediate safety of a child
- temporary orders to enable assessment of child's psychological and medical condition
- medium term orders providing the social work department with legal powers of supervision over the care of the child in her original home.
- medium term orders providing the social work department with legal powers of supervision of the child's care in a different home. This may be the home of a relative, a foster home, or a residential children's home.
- permanent changes in the responsibility for care of a child as in adoption.
- custody disputes between parents who have separated from each other.
In approximately a half of the cases placed on the register there is some involvement with the civil courts (beyond emergency orders) and in about a third of all cases legal powers of supervision or removal of the child occur. A quarter of the children are taken into formal care, mostly into foster care (Tables 1.1 and 1.2).

**TABLE 1.1**

*Legal Status of Children on English Child Protection Registers, 1991*

<table>
<thead>
<tr>
<th>Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>'In Care' of the Local Authority</td>
<td>26%</td>
</tr>
<tr>
<td>Under Supervision Order</td>
<td>7%</td>
</tr>
<tr>
<td>No legal order</td>
<td>67%</td>
</tr>
</tbody>
</table>

(Department of Health, 1992)

In addition to civil legal proceedings there is also the possibility of criminal proceedings against the alleged perpetrator of abuse. Because of this, social work departments and other agencies have to be careful about the manner in which they collect information whilst investigating a case. During an investigation caring agencies tend to focus on the nature of the child's needs for protection, but the nature and quality of the information they collect will effect whether it is admissible as evidence in court. The police and social work departments therefore require good working relationships to ensure that their methods of investigation do not compromise each other's roles and responsibilities. This is another reason for the recent introduction of strategy meetings before the initial case conference.

**TABLE 1.2**

*Placement of Children 'In Care', England, 1991*

<table>
<thead>
<tr>
<th>Placement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>With parent, relative, friend</td>
<td>30%</td>
</tr>
<tr>
<td>Boarded out (foster care)</td>
<td>53%</td>
</tr>
<tr>
<td>In a community home (children's home)</td>
<td>14%</td>
</tr>
</tbody>
</table>

(Department of Health, 1992)
Finally, there are several methods by which victims of abuse can seek compensation. There are three main methods: suing the perpetrator, a judge ordering a defendant to pay damages when sentencing them for an assault, or claiming from a government compensation fund.

1. It is possible to sue another person for inflicting some damage or harm upon yourself or your property. Some adult women, for example, have successfully sued their father for sexually abusing them as children.

2. If someone is found guilty of an offence of any kind where there is a victim then the Court can order the offender to pay damages to the victim. In practice the sums are small.

3. The government funds a Criminal Injuries Compensation Board that pays substantial sums to those who have been victims of a criminal offence. It is not necessary to find the guilty party, only to prove that it was a criminal offence and the extent that you suffered from this. Child abuse is a criminal offence and therefore claims can be made.
CHAPTER TWO

APPROACHES TO CHILD ABUSE RESEARCH

This chapter reviews the main types of research that have been undertaken in the field of child abuse since its rediscovery in the 1950's. Much of this research has seen child abuse as a syndrome akin to a medical syndrome. The major concern and purpose of research is to understand the aetiology of the syndrome in order to better able to identify or predict instances of abuse and to better ascertain how to intervene to prevent its occurrence and to mitigate its effect. This research has seen the definition of child abuse as a technical issue and not problematic conceptually.

The first section of the chapter reviews this mainstream research on the nature and extent of child abuse. The second section extends this discussion to examine the different levels of analysis at which explanations for the cause of child abuse has been sought.

The maltreatment of children is not a recent phenomena, but the current interest and concern with the subject arose in the 1950's (see Chapter One). In the 1950's and 1960's child abuse was understood according to Kempe's term of the 'battered baby syndrome' (Nelson, 1984). Since Kempe's early writings the concept of abuse has expanded to encompass children older than babies and forms of abuse other than physical battering. Child abuse is used to describe physical, sexual, and emotional abuse or neglect through lack of care to children of all ages. What has not changed is the use of terminology suggesting a syndrome of child abuse or sub syndromes of different types of abuse (Graham et al, 1985).

A syndrome is a characteristic pattern or group of symptoms of a disease. In describing child abuse as a syndrome there is an implicit assumption that there are some characteristic patterns that research can identify. Research aims to describe the nature of the phenomena, a process as an essential first step in understanding the aetiology of the condition and effective methods for its prevention and amelioration. This method of research is often described as 'medical model' research because of the similarity to the methods used to study disease. Features of the medical syndrome including its presentation, its aetiology, and its outcome are described. Although the medical model assumes that there is a syndrome to be characterised by this research, part of the descriptive process is to assess the boundaries of the definition of the syndrome and also to assess whether there are sub-syndromes
within the main syndrome. Some cases may be judged not to be true examples of the syndrome; others may be judged to be members of specific sub-categories of the syndrome. Alternatively, it may be found that there is not one single syndrome, but two or more separate syndromes with different descriptive features, aetiologies, and outcomes.

The medical model of research is well illustrated by the majority of mainstream child abuse research. The research has attempted to identify the extent of child abuse, the characteristic features of cases of abuse, the causes of abuse, predictive factors, and the efficacy of different interventions. The research was initially only concerned with physical abuse, but as awareness began to grow about other forms of maltreatment, research began to include cases of neglect, emotional abuse, failure to thrive, Munchausen syndrome by proxy, and sexual abuse. More recently, research has begun on organised and ritualistic sexual abuse.

EXTENT OF CHILD ABUSE

It is difficult to determine the extent of child abuse for two main reasons. The first is that acts of abuse like acts of domestic violence between adults are likely to occur in the private rather than the public domain (Pahl, 1985). Research into private aspects of individual lives may be considered an inappropriate subject of enquiry by researchers, research funders and ethics committees. In addition, those with information on private matters such as family members and those witnessing or even experiencing such behaviour in a family may be unwilling to provide such data to researchers, particularly if the behaviour is considered unacceptable or even illegal if brought into the public domain. Acts of child maltreatment may not be reported by the abuser or victim and may not be observed by third parties. Even if the maltreatment is witnessed there may be social pressures limiting the its reporting to others, particularly reporting to agencies such as social work with responsibilities and powers to intervene in family life to protect children or the police with powers and responsibilities to enforce the law. For example, a neighbour or even a doctor may not wish to formally report a case of child maltreatment because of the effects of making the report might have on their relationship with the child's parents. The private nature of many cases of child maltreatment and the pressures limiting third party reporting thus also limit the data available on the nature and prevalence of such maltreatment. Even where such data is known to individual government or voluntary agencies, the data may not be fully available to researchers for ethical reasons.
A further difficulty is that the issue of what constitutes an act of abuse or maltreatment is open to debate and requires some degree of agreement before it is possible to count numbers of instances of abuse. According to the medical model of research, the problem of definition is simply one of adopting consistent and appropriate criteria. One purpose of the research is to assess and modify where necessary these criteria so that they properly reflect the nature of the underlying syndrome of child abuse. Some authors have criticised child abuse research for not being sufficiently consistent and rigorous in the definition of cases and so preventing the a proper definition being formulated and refined over time. The criticism is essentially that the research is not being sufficiently scientific and rigorous within its own model of scientific enquiry (Besharov, 1981). More fundamental criticisms of the medical model of research are considered in Chapter Three. An analysis of the concept of child abuse is presented in Chapter Four.

Despite the practical and theoretical limitations in assessing the extent of child maltreatment in the population, attempts have been made to estimate the prevalence and incidence of child maltreatment.

Prevalence

Prevalence refers to the extent that a state of affairs prevails at any one time within a population. Within the medical model it refers to the numbers of individuals in the population who at any one time have experienced the syndrome.

There have been two main methods of estimating the prevalence of child abuse. The first has been to survey normal child care practices of parents. There are few studies in this area. The best known studies in Britain (Newson and Newson, 1976) and in the United States (Straus and Gelles, 1986) both concern physical chastisement and physical abuse. There is little data available describing the social and emotional care and other care of children or the development of sexual knowledge and behaviour of children and families in the population.

The Newson's first study was based on interviews with parents in Nottingham as part of a longitudinal study on child care. The results showed high rates of physical punishment with 75% of parents admitting threatening their seven year olds with an implement such as a belt or a stick. The parents admitted actually using implements to physically chastise 26% of boys and 18% of girls (Newson and Newson, 1976).
In a further study in 1985 the Newsons (1989) found that 63% of mothers admitted to having already smacked their one year old babies.

Gelles and colleagues have undertaken nation wide United States telephone surveys of physical chastisement. They reported high rates of the use of physical force including actions such as slapping and spanking (by 56% of respondents), pushing, grabbing, or shoving (28%), hitting with objects (10%), burning or scalding (0.4%), and threatening children with a knife or gun (0.2%) (Straus and Gelles, 1986). Parents may have believed these techniques to be appropriate and necessary but they were considered as extremes and potentially abusive by the study's authors. Parents may not be honest about their acts of physical punishment towards their children, but Straus and Gelles argue that such bias is likely to be in the direction of under reporting resulting in their data being an under estimate of the extent of parental use of violence.

The second research strategy for prevalence has been to interview adults about their childhood experiences. This approach has been used almost exclusively to estimate the prevalence of sexual abuse by either (i) postal or personally administered questionnaire or (ii) by telephone or face to face interviews. High rates of sexual abuse in the population have been reported in both British (Baker and Duncan, 1985; Kelley et al, 1991) and American (Bagley and McDonald, 1984; Siegal et al, 1987) studies (see Finkelhor, 1991, for a review). The studies report that up to 27% of men and 62% of women were sexually abused as children (Kelley et al, 1991), but Kelley and colleagues (1991) have also shown how these statistics are effected by the breadth of definition used. In their study of college student populations they calculated prevalence for different definitions of abuse. The prevalence rates for any form of sexual victimisation reported was 27% and 59% for men and women respectively, and the rates for sexual genital contact abuse where there was at least a five year age difference between victim and perpetrator were 2% and 4% for men and women respectively. The study by Kelley and colleagues also used multiple probe questions to solicit reports of sexual victimisation. Studies using this approach usually report higher prevalence rates than surveys simply asking one question as to whether the respondent was ever sexually abused as a child (Finkelhor, 1991). Because of the lack of consistency between studies in both the breadth of definition of sexual abuse and the method of eliciting information from respondents, it is not surprising that there are large differences in reported prevalence rates of abuse.
Incidence

Incidence is the frequency of new cases or instances of a situation within a given time period, usually a year. In practice it is extremely difficult to determine this directly and so incidence statistics are usually restricted to incidence of cases reported to child protection agencies.

The major source of data on reported incidence is statistics from agencies. In Britain these cases are the children placed on child protection registers (previously called child abuse registers) by inter agency child protection case conferences. In the United States it is primarily the cases reported to local government child protection services. These reports can be made by any professional or member of the public. These cases are then investigated by child protection service workers and if they believe that the child has been abused or is at high risk of abuse, then the case is described as a substantiated case. United States child abuse case statistics sometimes refer to all referrals and sometimes to only substantiated cases (National Center on Child Abuse and Neglect, 1992). In addition, the National Center on Child Abuse and Neglect has undertaken two broader surveys asking professional staff about all cases of child abuse known to them whether or not these were formally reported to child protection services (National Incidence Studies NIS-1 and NIS-2).

The ability of agency case statistics to reflect the level of child maltreatment occurring in the population are limited in three main ways. First, under reporting because agencies only know about and can only produce statistics on cases that have been drawn to their attention. Secondly, some statistics are based upon extrapolation from particular geographical areas which may not be representative of a whole country or region. Extrapolation can occur because a study did not have the resources to study a large area or because only incomplete data could be gathered. Thirdly, there are wide variations in practice concerning the criteria that agencies adopt in determining that a case should be labelled as abuse or in need of child protection services.

Mention has already been made (under the section on prevalence) of factors that might limit the extent that cases of possible risk or maltreatment are referred to the relevant agencies. The extent of such under reporting is not known and depends upon definitional criteria, but some insight into these differences is offered by comparing the rates of sexual abuse reported by population prevalence studies and child abuse case statistics.
Much fewer cases of sexual abuse are placed on child abuse registers than would be expected from population interview studies on prevalence. Using Kelley et al's (1991) figures of 2% and 4% for direct genital contact childhood sexual abuse and assuming that the duration of abuse was under one year, then one would expect an annual incidence rate of a sixteenth of the birth to sixteen years prevalence rate of 0.19% or 1.9 per thousand. The actual average reported incidence rates for sexual abuse are slightly more than a fifth of this at 0.4 per thousand cases (Department of Health, 1992). The assumption that victims of sexual abuse are only abused for less than one year of their childhoods is very conservative. Siegal et al (1987) reported that 23% of victims identified in their population prevalence study in Los Angeles suffered repeated sexual assault and that this lasted for an average of 4.7 years. These repeated assaults would result in an expected annual incidence rate of 3.47 per thousand, which is over eight times the annual rate of new registrations in England. It may be that sexual abuse is more prevalent in Los Angeles than in England, but the Los Angeles prevalence statistics were actually lower than those reported for England by Baker and Duncan (1985).

Reporting statistics are dependant on referrals being made to agencies, and agency policies and individual professional practice in how these referrals are managed. This is well illustrated in the rise in the number of children placed on child abuse registers because of sexual abuse since the early 1980's. In Strathclyde Region in the early 1980's registrations for sexual abuse were extremely rare with only fifteen cases placed on the register in the six years between 1976 and 1982 (Strathclyde Regional Council, 1983a). By 1987 they accounted for 16% and by 1991 for 24% of all registrations (Gough, 1988, 1992), though there is no evidence from population studies of a marked increase in the prevalence of sexual abuse over this time period. Prevalence studies in the United States have found higher reporting rates of sexual abuse among younger subjects, but with older subjects still reporting high rates of such abuse (see for example, Siegal et al, 1987).

The second problem with the use of child abuse case statistics is the representativeness of samples. In Britain the National Society for the Prevention of Cruelty to Children (NSPCC) were the first to collate child abuse register statistics (Creighton, 1984). The NSPCC data is based on the child protection registers that they run on behalf of approximately twelve local authority social work departments. In the 1980's these registers covered populations making up nearly 10% of the English child population. The NSPCC extrapolated their data on registered cases in
the areas where they ran the child protection in order to calculate incidence rates for the whole of England. This approach has been criticised (Gough et al, 1982; Sharron, 1983) for its assumption that the registration rates of the NSPCC registers are representative of the registration rates of all English registers.

There are two main reasons why the NSPCC registers may not be representative. Firstly, the NSPCC managed particular registers as a result of particular relationships between the NSPCC and local authority social service departments. These departments were in predominantly urban industrial areas such as Manchester, Newcastle, and Leeds, and are not necessarily representative of the English population in terms of the extent of maltreatment of children.

The second problem is that even if the NSPCC areas were representative in terms of incidence, it may be that they are not representative in terms of the proportion of this incidence that is identified by official agencies. The NSPCC may, for example, be particularly effective at identifying cases resulting in higher numbers of reported cases in their areas.

**TABLE 2.1**

Pre-School Registration Rates in Three English Cities in 1975

<table>
<thead>
<tr>
<th></th>
<th>Leeds</th>
<th>Newcastle</th>
<th>Manchester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration Rate per 1000 children under five years</td>
<td>1.0</td>
<td>2.7</td>
<td>2.2</td>
</tr>
</tbody>
</table>

(from Creighton and Outram, 1977)

These arguments against extrapolating data from some geographical areas to others may not be of great concern when incidence statistics are relatively similar between areas. There is, however, considerable geographical variation in rates of registration between registers. In most of their reports the NSPCC do not reveal inter register variation, but Table 2.1 shows the variation in Registration rates for non-accidental injury in under five's in three English cities in 1975 revealing a 2.7 factor variation in the registration rate between the Leeds and Newcastle registers (Creighton and Outram, 1977). Table 2.2 shows the different rates of registration for all types of
child abuse in different areas of Strathclyde Region in 1980 where the East and West district of Glasgow had rates twice as high as in the other two districts and ten times that of Motherwell.

**TABLE 2.2**

Variations in Registration Rates in Glasgow and Motherwell in 1980

<table>
<thead>
<tr>
<th></th>
<th>West</th>
<th>East</th>
<th>S.East</th>
<th>S.West</th>
<th>Motherwell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration Rate</td>
<td>3.1</td>
<td>2.9</td>
<td>1.6</td>
<td>1.4</td>
<td>0.32</td>
</tr>
<tr>
<td>per 1000 children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>under 16 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(from Gough et al, 1982)

Until recently, the only relatively large scale British registration statistics were the NSPCC data based on registers held by them in some English cities that were not necessarily representative of registers as a whole. The first survey of a single large geographical block did not occur until the first Scottish surveys of 1986 and 1987 (Gough, 1988).

Currently data is collected from all of the child protection registers in England (Department of Health, 1992) and Scotland. The English surveys are part of routine annual government statistical returns started in 1989. The Scottish surveys were undertaken by the current author in 1986, 1987, and 1991 (Gough, 1988, 1992) and in 1993 the Scottish Office started collecting data for an annual statistical return. Table 2.3 presents the English and Scottish data and contrasts them with the much higher incidence of identified cases in the United States. These national surveys have confirmed the variation in rates between individual child protection registers. In England in 1991 registration rates varied from 1.4 per thousand children in Trafford in North West England to 16.4 per thousand children in Lambeth in London (Department of Health, 1992). In Scotland in 1990-1991 registration rates varied from 0.6 per thousand in Fife to 6.2 per thousand in Highland Region (Gough, 1992). In the United States there are approximately 16 identified cases per year for every thousand children.
TABLE 2.3
Child Protection Statistics, 1991

<table>
<thead>
<tr>
<th>Abuse</th>
<th>England¹</th>
<th>Scotland²</th>
<th>United States³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>23</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Neglect</td>
<td>15</td>
<td>22</td>
<td>53</td>
</tr>
<tr>
<td>Emotional</td>
<td>6</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Sexual</td>
<td>13</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>Unspecified</td>
<td>47*</td>
<td>17**</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>100</th>
<th>100</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Percentage</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Rate per 1000 Children | 4.2 | 3.4 | 16*** |

* Unspecified cases high as in 1991 registration category of Grave Concern still in use.

** Adjusted figures as in 1991 some local authorities using registration category of At Risk.

*** Estimate calculated from average substantiation rates & confirmed by data from NCCAN, 1992.

1 Cases on registers, Department of Health, 1992.
3 Substantiated referrals, data from 10 states, Daro and McCurdy, 1992.

The surveys in Scotland have indicated that there are also wide differences between registers in the numbers of cases investigated, taken to case conferences, and placed on registers by case conferences. The surveys have shown that there are not only wide variations in registration rates, but also in the way registers are constructed and used. Variation has been reported in the numbers and types of categories or registration available, the proportion of children registered as being at risk rather than considered to have been abused, whether all children in a family are automatically registered rather than just those most at risk, and in the proportion of children reaching different stages of the pathway to registration. These variations in practice constitute the third way in which agency case statistics are limited in their representation of incidence in the population. Some of the relevant aspects of this variation are described in turn.
Proportion of Investigations Case Conferenced and Registered

The process of registration depends upon a series of decisions by families, other members of the public, individual professionals, and agency committees or cases conferences. Little is known about these processes or the proportion of cases screened out at each of the potential decision points in the referral and registration process, but some indication of the variation in this was shown by the 1991 Scottish survey (Gough, 1992). In Tayside, for example, 17.5 per thousand children were formally investigated, whilst the rates for Lothian and Shetland were 5.8 and 1.5 per thousand respectively. However, only 36% of the Tayside investigations resulted in a case conference compared to 63% in Lothian and Shetland. Furthermore, only 54% of the Tayside case conferences placed the child on the register compared to registration rates of 85% and 80% in Lothian and Shetland. The resultant rates of registration in Tayside and Lothian were similar at 3.4 and 3.1 children per thousand, but the rate for Shetland was much lower at 0.8 children per thousand because of the low rate of initial investigations. These figures strongly suggest that the variation in registration rates do not simply reflect decisions concerning registration, but are also affected by the rate of cases that reach this decision making forum.

Categories of registration

Central government provides guidance about the operation of registers including the categories of registration, but not all local authorities used these categories. In 1988 central guidance listed four categories of registration physical abuse, sexual abuse, neglect, and 'at risk', but there were a total of twenty three different categories in operation in the twelve local authorities in Scotland (Gough, 1988). There was also variation in the English register categories, but the national surveys only collected data according to the official central register categories, so the extent of this variation was not apparent. The surveys did probably, however, encourage local authorities to use the national categories.

Proportion of 'At Risk cases'

The first national surveys showed that there was very high variation in the use of the 'at risk' categories on registers (later termed 'Grave Concern' in England). Some regions did not use the category at all, but for others the rate of registration varied from 7% in Tayside to 58% in Highland Region (Gough, 1988). If there is variation
in the criteria of perceived seriousness required for registration then this is likely to be more evident in the 'at risk' rather than the 'believed to have been abused' cases.

The category of 'at risk' was problematic because it did not differentiate the nature of the potential abuse that formed the risk to the child. Also, during the 1980's it became increasingly clear that one of the main purposes of child protection registers was to identify clearly which children were at risk and in need of protection in the future rather than to list the subset of these children who had already been abused. This was clarified further in the English central draft guidance of 1988 which specified that the system of child protection procedures and registration was for children at risk in need of a local authority child protection plan (Department of Health, 1986). All cases were thus at risk cases and the separate category of at risk (grave concern) was removed from central guidance in England in 1988 and in Scotland in 1992.

Registration of Siblings

If several children in a family are abused then all are likely to be placed on the child protection register, but there is variation in practice about registering siblings of an abused or high risk of abuse child. When surveyed local social work departments in Scotland stated that registration would depend upon the risks to each child in each particular case. That siblings make up a high proportion of some child protection registers was indicated by the 1987 Scottish survey where some regions had specific categories for registering of at risk siblings. Such cases made up 43% and 34% of the registers of Borders and Grampian regions respectively (Gough, 1988). In addition, the 1991 Scottish survey reported the number of registrations per family and this varied between an average of 1.7 children per family in Borders and Lothian regions to 2.25 children per family in Strathclyde. As some registered children must come from single parent families, siblings must make up a significant proportion of the total number of registrations.

Turnover of Cases

If child protection register statistics are used to indicate incidence in the population then only the rate of new registrations should be used. Once a child is placed on the register, they then remain there until removed by a subsequent case conference (unless they die, become adult, or are transferred to another areas register). The
length of time on the register will effect the rate of total registrations in an area at any one time.

All of these factors effecting referral and registration of cases influence the consistency of the rate that children appear on child protection registers. Registration rates may be useful indicators of local child protection practices and workloads, but are severely limited in the extent that they reflect incidence of abuse in the population.

CHARACTERISTICS OF CASES

A commonly used technique in child abuse research is to collect data on the features of identified cases in order to characterise the cases and to determine how they differ from other situations or individuals. This strategy has been attempted on many aspects of child abuse cases. For example, researchers have examined the characteristics of abusive parents (Wolfe, 1985; Polansky et al, 1985; Finkelhor, 1986), the characteristics of physically abused (George and Main, 1979) and sexually abused children (Finkelhor, 1986), and the nature of the circumstances immediately preceding instances of physical abuse to children (Kadushin and Martin, 1981). This type of research can be described as taking the perspective of a medical model because of the interest in ascertaining the defining features of the pathology or syndrome or syndromes of child abuse.

The findings of this research have been used to produce check lists of features statistically correlated with the incidence of abuse in order to help professionals identify cases of hidden abuse or those families and situations highly at risk of abuse (Browne and Stevenson, 1983). The research has also been used to suggest possible causative models of abuse to assist in the development of theory and to inform both the prevention and treatment of child abuse cases (Gelles, 1973). More recently, there has been increased emphasis upon the features of the effects of maltreatment on children. For example, there is a debate as to the evidence for a unitary syndrome resulting from sexual abuse. Some authors argue that the characteristics of sexually abused children are of the same form as victims of other traumas as in Post Traumatic Stress Disorder (Wolfe et al, 1989), whilst others argue that there is no evidence for a unitary syndrome (Kendall-Tackett et al, 1993).

There are several problems with these studies. The first is that many do not have proper control groups. It is therefore not possible to tell whether the features
identified are truly more common in cases of abuse than for other children and families. This is illustrated by a study which identified high rates of alcohol use amongst abusive parents in the West of Scotland (Strathclyde, 1982) without providing baseline data on the rates of alcohol consumption amongst families from similar backgrounds. Similarly, many child abuse cases are more common in socially and economically deprived families, but this does not mean that all economically deprived families maltreat their children or that economic factors are necessarily a direct causative factor in abuse.

The second problem with these studies is the reliance on cases identified as abuse by child protection agencies may obscure any common factors that do exist. The lack of consistency between and within local authorities in the identification (referral, investigation, case conference, and registration) of child abuse cases has been described in the previous section of the chapter. Even if there is a homogeneous syndrome or syndromes of child abuse the experimental noise created by this variation in professional practice is likely to mask any such underlying consistency. It is therefore not surprising that there is such conflicting data on the typical features of child abuse cases (Wolfe, 1985) and that research has not been able to reliably distinguish child abusers or child abuse victims from other adults or children.

More worrying is the third problem with these studies, that the variation in case identification that obscures commonalities between the total population of cases (both identified and not identified) may result in the research being more likely to isolate features only existing in identified cases. These features may be common aspects of the identification process rather than anything common to the hypothesised syndrome of abuse. Cases identified by official agencies may not necessarily be representative of all child abuse cases so that the features identified will only characterise those cases that do come to notice. The factors that increase the likelihood of identification will therefore reflect aspects of both the families and of the referral process that brought them to light. If such features are then used to construct risk schedules to aid professionals to identify high risk cases then a circular pattern of identification can occur with factors biasing the reporting of cases becoming an official part of the identification process.
Predictive Factors

One of the main purposes of identifying characteristic features of child abuse cases is in order to identify aspects of the child, parents or the family situations in which abuse might occur. These features might be able to identify hidden cases of abuse or cases of high risk of abuse occurring in the future. 'Featural research' has therefore been used to create lists of risk factors which have then been supplied to health and welfare professionals to aid them in their work (Browne and Stevenson, 1983). However, experimental studies have shown that although the risk features can identify many of the families believed to have abused their children the lists also identify many false positives, that is other families where no abuse is thought to have taken place (Browne and Saqi, 1987). The lists therefore have very limited ability to discriminate abuse and non abuse families (Starr, 1982).

One reason for the lack of discriminative ability of the risk schedules is that all the features carry equal weight. The schedules are mostly scored by simple additions of the number of risk features identified in a family with a specific numbers of features being criteria for labelling as risk of abuse. If the criteria are lowered more false positives are created; if the criteria are heightened more false negatives are created. More recently risk schedules have been developed with features weighted according to how predictive they are of abuse (Browne and Saqi, 1987). For example, evidence of poor parent-child interactions would have a higher rating than low socio-economic status. The criteria of labelling of risk is calculated numerically and can be achieved by a large number of low weighted factors or by a few high weighted factors. Browne and Saqi (1987) argue that the significance of risk features vary geographically and that the calculation of weighting scores must reflect this.

A more fundamental problem undermining the efficacy of risk schedules is the weaknesses interest in featural analysis already discussed. If there is lack of appropriate controls in featural studies and inconsistency in the identification of true incidence of abuse and in other aspects of case mixes then descriptive features and thus risk schedules will be imprecise. Browne and Saqi's (1987) strategy of producing totally weighted factor does make the risk schedules more precise, but this may simply be a more subtle reinforcement of the biases in local reporting practices. The research problem is not simply a technical issue of making risk schedules more precise. The problem is one of criteria for defining cases of child maltreatment.
Causes of Abuse

Another purpose of the study of the common features of cases is to move beyond simple lists of predictive factors to better define the nature of the syndrome. One aspect of this is to inform the development of the theory of the aetiology of the syndrome; to provide a theoretical model to explain how and why the identified features appear together. In child abuse research, however, there have only been limited attempts to provide detailed models. The models that have been proposed contain details of the features that research has indicated are typical of child abuse cases, but the models lack detailed specification of how the features interact together to result in abuse. Typically the models group features by type and then suggest a sequence in which these features might have a causative effect. These are mostly uncontroversial. For example, Gelles (1973) groups features in the following way:

The 'sex, age, and social status of the parent' will influence both 'class and community membership and values' and the extent and type of 'situational stress' they experience;

The parent's 'socialisation experience' will influence both their 'personality and mental health' and the extent and type of 'situational stress' they experience;

'Class and community membership and values'; 'personality and mental health'; and 'situational stress' will all effect 'immediate precipitating situations of abuse', which will effect whether a child abuse event occurs.

Although this and similar models (Helfer and Kempe, 1976; Browne and Saqi, 1987) have virtue as a first step in identifying the processes that need to be explained, the further steps of developing more detailed hypotheses for empirical testing have not been forthcoming. In general, however, most of the theories of cause of maltreatment have not arisen from featural analysis, but from other theories of normal and abnormal human behaviour. These theories apply at many different levels of analysis and these are considered in the second section of the chapter.

Efficacy of Interventions

Many studies have attempted to assess the efficacy of preventive interventions. These interventions may be primary preventions aimed at the general population,
secondary prevention aimed at 'at risk' groups, or tertiary prevention arrived at preventing further instances of abuse or mitigating the effects of abuse that has already occurred. An extensive review of 225 studies has concluded that there was little experimental evidence for the efficacy of interventions (Gough, 1993b). Exceptions were educational programmes to inform children of the danger of sexual abuse, therapeutic programmes for child victims of physical abuse and neglect, and behavioural therapy for adults committing physical or sexual abuse of children.

It is not clear whether the lack of supportive evidence for the majority of interventions is due to a lack of efficacy or due to the methodological weaknesses in the research undertaken. In his review of 225 child abuse intervention studies Gough (1993b) described the two most common methodological weaknesses of the studies. Firstly, the lack of reference to a wider research and practice base on related but non-child abuse work: for example, the research literature and service developments in family support programmes. Secondly, the majority of research studies were limited by methodological problems resulting from a failure to specify their sample, focus, objectives, methods, design, measures and results, and the inter-relationships of these factors (Gough, 1993b).

Despite the methodological weaknesses of many of the studies they provide useful descriptions of the processes involved in the innovative interventions. These descriptions are a by product of studies that were unsuccessfully attempting empirical evaluations of the efficacy of different therapeutic techniques. The studies would have made a greater contribution (been more productive) if the description of process and outcome had been the main initial purpose of the studies.

The empirical evaluation studies that are most successful in fulfilling the accepted criteria of methodological rigour to produce meaningful results are narrowly focused evaluations of specific interventions. Other successful studies were large demonstration projects with sufficient sample sizes to allow multivariate analysis, but these are very expensive to undertake and are beyond the financial resources of many research grant funding bodies.

Gough (1993b) concluded that treatment outcome studies are necessary but should only be attempted with highly specified research designs. As large scale highly controlled research designs are very expensive, smaller studies of individual factors (or small comparative designs) are more easily achieved resulting in an incremental model for developing research knowledge. The study of the efficacy of child abuse
interventions would also be assisted by greater linkage being made between related fields of research. For example, studies of the natural history of childhood adversities in the population, the description of routine child abuse practice and outcome, and non-child abuse health, welfare and educational services, are all highly relevant to the study of child abuse and child protection services.

LEVELS OF ANALYSIS

The discussion of causes of abuse in the previous section was limited to causal models informed by studies attempting to list the characteristic features of the syndrome of child abuse. There are, however, many other theories of cause developed from other studies of human behaviour. Those in child abuse field draw upon a range of theories that cover most of the theories existing within the social sciences and so it is more useful to consider the levels of human or social organisation at which literature has addressed the issue of child abuse (Gough and Boddy, 1986). The classification used here has the following five groups; the analysis of general human physiological or behavioural characteristics; studies of individual differences between humans; research on the characteristics of interaction groups such as communities or neighbours and, lastly, the relevance of the influence of social and political forces. These will each be addressed in turn.

Biological States and Drives

Violent behaviour may result from physiological processes. Analysis at this biological/physiological level is often used in the study of deviant aggressive behaviour. Examples are the physiological basis of criminality or violent behaviour (Hinton, 1981) or the effects of alcohol and other drugs (Taylor, 1983). It is not common to find formal pathological conditions of aggression in the perpetrators of family violence although domestic violence is often associated with high alcohol consumption (Gelles and Cornell, 1990; Pahl, 1985). The alcohol may cause the violent behaviour but many now believe that it is a correlate of other causative factors such as marital discord (Gelles and Cornell, 1990; Pahl, 1985).

Drive theorists from psychology have argued for the existence of an innate aggressive instinct which has to dissipated or released in some way. Behaviourists, however, argue that the use of violence increases rather than decreases the likelihood of further violence (Berkowitz, 1983). Alternatively, others argue that
drives are modified by the environment such as the social behaviour of others (Lorenz, 1966; Snowdon, 1983).

Symons (1979) and Burgess and Garbarino (1983) have applied socio-biological explanations to family violence. If humans have an innate tendency to advance the continuance of their own individual genetic material, then an adult male, for example, would be expected to be relatively hostile to a step-child, while promoting the interests of his biological offspring.

**Individual Differences**

Theories of personality and development seek to explain individual differences within both the normal and abnormal ranges. The range of possible theories includes all personality variables together with individual skills such as impulse control and the ability to cope with stress. These factors can be used to understand the behaviour of perpetrators of aggression as well as victim characteristics such as an unresponsive or disabled child, or an adult with masochistic needs. Research thus studies both 'dangerousness' of adults and the 'vulnerability' of potential child victims.

Environmental factors are also relevant. For example, the experience of stressful life events may create differences between individuals. However, personality and the environments we experience are not independent as people partially chose their own environments (Mischel, 1979).

An important environmental experience is the parenting one receives in childhood. The experience of physical abuse, for example, or the observing of wife battering in childhood may lead to the use or acceptance of these behaviours in adult life. The experience of poor parenting is also thought to be a necessary if not sufficient condition for later serious parenting problems in the next generation (Rutter, 1989).

**Social Interaction and Family Systems**

Skills in intra familial interaction is also relevant to child maltreatment. The existence or lack of these skills may only fully become apparent in exceptional circumstances. People may seem highly skilled within their normal environments but may lack flexibility to adapt to novel or difficult situations. Kadushin and Martin (1981), for example, studied the interactions preceding violent incidents
towards children by parents, and behavioural researchers have examined the ways that certain patterns of interaction can develop into violence (Frude, 1980). Also consistency theories suggest that individuals strive to be consistent in the rationalisation of their behaviour. Perpetrators or observers of abuse may devalue victims because they are victims and must in some way deserve that victimisation resulting in victims being at risk of further violence (Wagstaff, 1982).

The functioning of families as a whole is studied by family therapists (Bentovim et al, 1988) where the focus of interest is in the differences between families on dimensions such as power and dominance (Straus, 1973), adaptability, cohesion and communication (Olson and McCubbin, 1982).

**Communities and Neighbourhoods**

This analysis argues that violence is likely to occur when those with few internal resources live in a situation of environmental poverty (either material or emotional) and with social norms that are more accepting of violence. The importance of the ecological perspective proposed by Garbarino (1976) is that it stresses the neighbourhood as the best level for intervening in these problems. The best preventive strategy would not be aimed at individuals but at supporting the emotional and material resources of local communities in order to diminish the problem of violent and abusive behaviour within families.

**Social and Political Explanations**

Social and political approaches explore the social context in which violence occurs. Authors advocating this approach are often critical of explanations of family violence based on individualistic or pathological models. If violence is regarded as 'the use of force in situations where the community defines the use of force as illegitimate' (Kadushin and Martin, 1981) then the socio-political view is less interested in the deviance of those acts, but in how this line of legitimacy or deviance is drawn and enforced. The concerns are with societal norms, social structure and power, for example in the relationships between men and women, parents and children and the family and the state. Within this general perspective, writers differ from each other in the extent to which they employ a political analysis of the situation. Gelles (1983), for example, proposes an 'exchange' or social control model where individual behaviour is determined by different kinds of rewards and costs. He suggests that structural effects, such as the degree of privacy
and extent of social controls within families, either raise or lower the level of constraint or inhibition towards family violence. Although this approach may be applied in clinical work with families, it is included here because it primarily addresses the way in which power relations and social roles can have consequences for both families and individuals.

More explicit socio-political approaches take a broader view of social norms and controls and the way that they are supported by the reactions of, for example, the police and the legal system (Dobash and Dobash, 1979; Freeman, 1983, 1984) and the health and welfare agencies (Dobash and Dobash, 1979; Maynard, 1985) to family violence. These responses limit the options that are available to abused individuals and lead to political actions and to alternative solutions to problems of family violence. For example, women's refuges that offer women more options with which to respond to marital violence (Schechter, 1982).

There are, in addition, theoretical critiques of individual difference explanations of child abuse that divert attention from underlying structural inequalities in society that encourage abusive behaviour (Hanmer and Leonard, 1985). Therapy for individual or family pathology are seen as reinforcing inequalities, particularly when they 'blame the victim' (Schechter, 1982; Overfield 1982, Wardell, Gillespie, and Leffler, 1983). Ecological theories of impoverished neighbourhoods are also criticised, because although they argue for social change, their basic premise is that there is some fault in the community (Freeman, 1983) or its members that requires treatment or correction.

CONCLUSION

This chapter has reviewed some of the major types of research in child abuse. The first section examined mainstream research which attempts to describe and understand the nature and extent of what is assumed to be a relatively homogeneous phenomena of child abuse. The second section examined the various levels of analysis of the many theories explaining the cause of child abuse.

The next chapter reviews approaches to child abuse that do not assume child abuse to be a homogeneous quasi medical syndrome, but assume instead that the concept of child abuse is socially defined. Evidence for this view and the consequences for the mainstream research described in this chapter are assessed.
CHAPTER THREE

CRITICAL APPROACHES TO CHILD ABUSE RESEARCH

Chapter Two reviewed mainstream research within its own criteria of scientific inquiry, which treats the definition of child abuse as essentially unproblematic (apart from the sociological approaches introduced at the end of Chapter Two). Child abuse is seen as a relatively homogeneous syndrome where it is possible to identify common characteristics of cases in order to understand the aetiology and effects of the problem. This chapter examines research that questions the assumptions of mainstream research and makes definitional issues a central subject of inquiry.

The first section of the chapter examines the research evidence for variation in how child abuse is defined by professionals. The second section discusses the implications of this research for mainstream research. The third section discusses more sociological work which argues that the concept of abuse is social in origin and therefore intrinsically open to variation. The sociological perspective also includes writings on ideological models of social welfare where definitions of child abuse are seen as not only social in context but as being actively used to serve different political purposes.

DEFINITIONAL ISSUES

Three types of study are considered in this section. The first consist of experimental studies that ask respondents to make hypothetical judgements as to what they would or would not consider to be instances of abuse. The second type of studies examine decision making in practice by health and welfare professionals as to what is or is not a case of child abuse. The third consists of research on the incidence of abuse in Britain and the extent of the variation in the rates reported. The consequences of the demonstrated variations in definitions are then discussed.

Experimental studies

The most well known study of professional judgement about what constituted child abuse was undertaken in the United States by Giovannoni and Becerra (1979). They presented a range of health, welfare, and police professional workers with vignettes of child care situations or events. The professionals were asked to indicate which of
these scenarios they considered to be abusive. The respondents were making hypothetical judgements on the basis of limited information which was probably different in quantity and kind to the information available in actual child abuse investigations. The benefit of the vignettes is that the amount and type of information can be controlled and manipulated across respondents and across vignettes so that systematic differences in judgements can be identified.

In their study, Giovannoni and Becerra demonstrated strong agreement between individuals in their judgements about vignettes at the extremes of the continuum, that is scenarios that were thought to be clearly abusive or not abusive. In the middle of the continuum there was more variation in the judgements made. Although there were differences between individuals there were also systematic differences in judgements between different professional groups. Police and social workers rated the vignette scenarios as more serious than paediatricians, who rated the vignettes as more serious than lawyers.

The vignettes were of three types which produced different responses from the four professional groups. For vignettes on parental role failure concerning physical care of a child there was more agreement between paediatricians and lawyers, particularly with vignettes on cleanliness. For vignettes on failure of other caretaker responsibilities such as emotional maltreatment or use of drugs and alcohol there was more agreement between paediatricians and the police and social workers. For vignettes on physical and sexual assaults that transcend child care responsibilities there was considerable disagreement about the point at which a situation was abusive. Police were the most likely to rate a scenario as abusive followed by social workers, paediatricians and then lawyers.

Although professional groups disagreed on the criteria for abuse, they generally agreed on the relative seriousness of different scenarios. All agreed that physical abuse, sexual abuse, and fostering delinquent behaviour were the most serious scenarios. There was also general agreement about the seriousness of other scenarios. These were rated in the following order of seriousness: lack of supervision, emotional maltreatment, parental use of alcohol and drugs, failure to provide for the child, lack of education, bad parental mores. Giovannoni and Becerra also manipulated the degree of negative consequences for the child in the scenarios and found that all professional groups rated vignettes as significantly more serious if there were negative consequences. Although there was general agreement between professional groups concerning relative seriousness there were also some
disagreements. Examples were social workers rating child pornography worse than genital fondling and paediatricians rating medical neglect worse than genital fondling.

In another vignette study, O'Toole and colleagues (1983) asked nurses and physicians to read artificially created records of children seen in hospital accident and emergency departments forms and to indicate whether these were instances of abuse or not. O'Toole et al experimentally manipulated variables of level of injury, race, and socio-economic status of the parents in the vignettes. The results showed that nurses' judgements were affected only by the level of injury, whereas the judgements of the physicians were influenced by injury, race, and socio-economic status. Physicians were more likely to rate cases with poor black parents as instances of abuse. It may be that factors such as race and socio-economic status are used (correctly or incorrectly) as risk factors for a single dimension of seriousness of abuse. Alternately, it may be that the definition of abuse is more complex consisting of multiple rather than a single dimension of seriousness of abuse.

Most vignette studies have manipulated only a few aspects of the vignette scenarios, thus implicitly assuming that seriousness of abuse was a relatively straightforward concept that varied on a single dimension from less to more serious, although Giovannoni and Becerra did introduce the concept of consequences of abuse. Few studies have attempted to explore further sub-dimensions of the concept of abuse.

In a postal study (Stainton Rogers and Stainton Rogers, 1989) respondents were asked to rate their agreement with a range of statements on the definitions, causes, effects, and appropriate social policy on different types of child abuse. A sort methodology was used to determine how the views of the respondents on these different aspects of child abuse correlated together. The authors suggest that respondents views clustered into at least three main types of perspective or accounts for understanding child abuse. The first see children as vulnerable to exploitation and not sufficiently protected from this exploitation by adults. The second account sees child abuse as a more complex social phenomenon. Children are victimised and exploited but can also be exploiters and other factors such as poverty and socialisation must be taken into account. The third account takes a medical and psychiatric model where features of cause and effect can be identified to understand how child abuse occurs and the response of family members to its occurrence and identification. It is likely that respondents having different accounts or
understandings of the concept of abuse would vary in their criteria and thus their judgements about whether specific situations were or were not instances of abuse. The authors stated that the study was not yet complete and did not report on how the respondents' background varied with the type of judgements made.

**Decision making in practice**

Experimental vignette studies have shown that individuals and groups differ in the point at which a situation would be considered abusive, but the studies have not advanced far in examining the important dimensions of such judgements. One limitation has been the restricted number of variables and their interaction considered by the studies. Another limitation is the unknown relation between hypothetical and real life decision making.

The process of case identification (that is, applying definitions in practice) is a complex process of which we know little, but is of crucial importance for two reasons. The first is that it is used to decide whether a particular child or family causes concern and warrants the offer of a service including the use of different procedural and legal systems and the possibility of forceful intervention. If the priority is to protect the needs of the child, then it is necessary to know much more about how such decisions are made and the outcomes they entail for the child and the parents.

The second reason that operational definitions of child abuse are crucial is that research samples for studies of child abuse are most commonly recruited from agency-identified cases. Even if extra research criteria are applied in sample selection, the population from which the sample is selected is defined by the case identification process. The consequence is that research data is dependent on the characteristics of identified cases, without sufficient consideration of the process by which these samples are defined (Boddy and Gough, 1982). This has a biasing effect of unknown quantity on the findings and hence the conclusions of child abuse research. Roger Bacon and Ian Farquar (1983) have argued that differences in agency practice between areas have produced different research samples and is one explanation for inconsistent research findings across the literature.

The different operational definitions of abuse do not occur at only one point in time. For a case to be labelled as abuse a complex sequence of processes must occur where a series of people become aware of a situation and decide that it is of
sufficient gravity to refer the case on to someone else. In very overt and clear cut cases this process may be quite quick and straightforward, but in less clear and less visible cases the process of referral may be slow, indirect, and may not reach the statutory child protection agencies. These agencies might consider the case to be one of abuse but they are only able to do this if others first consider the situation to be of sufficient gravity to bring the case to the child protection agencies' attention. These factors are likely to result in considerable variation between the characteristics of cases within one agency let alone between different agencies or geographical areas. It is therefore necessary to know what variation there is in the referral of cases to and through agencies and the criteria used to identify abuse in cases so referred.

Prior to 1992 a child's name could be placed on a child abuse register as an abused child or as a child at risk (or 'grave concern' in England). Since 1992 the philosophy of the register system is that all the children are registered because they are at future risk, whatever has occurred in the past. Placing a child's name on the register still, however, has significant effects because it invokes local child abuse procedures and so defines the child or family as a 'case' for the system. Both Bacon and Farquar (1983) and Dingwall and colleagues (1983) have shown that the criteria for registration are not applied uniformly and that variations are not simply due to the use of different criteria for 'abuse' but also to the considered needs (or effects) of placement on the register. Also Dingwall and his colleagues (1983) argue that agencies work on a 'rule of optimism' and prefer to take the least coercive line in dealing with parents. Dingwall and colleagues argue that there are various factors that make agencies adopt different stances with different cases.

Bacon and Farquar (1983) undertook a study of decisions to place children's names on a child abuse register. In the first stage of the research they produced standard criteria for registration from the local authority procedures and guidance from central government and the British Association of Social Workers. Bacon and Farquar found that there was a lack of consistency in registration with many cases that did not fit the standard criteria being registered and many fitting the criteria not being registered. In the second stage of the research they attempted to identify the factors most closely associated with decisions to register. The study was not statistically based, but the researchers argued that two factors stood out as having a strong influence on registration decisions. The first was the extent that the professionals felt that they had some measure of control over the family. If they felt lacking in control and yet were anxious about the family then registration was
likely. The second and related factor was the extent that parents were accepting of the service being offered by the agencies.

Dingwall, Eekalaar and Murray (1983) studied professional actions of child protection in hospital accident and emergency departments and found that suspicions of child abuse were usually aroused by doctors' social assessments of families rather than by distinctive features of a child's presenting injuries. A decision to refer the case to the Social Work Department would depend not just upon the worker's definition of abuse and their belief that abuse had occurred, but also upon the quality of their evidence and the perceived effects on them as professionals and the effects on the family of such a referral. Dingwall and colleagues reported that professionals were less likely to refer on cases that were known only to themselves. If cases were known about by other professional staff then an individual professional had a lower threshold for formally referring the case on to the next part of the child protection referral chain.

When cases are referred to social work and a case conference is held, then the case conference decision on whether a child should be placed on the local child protection register will be effected by the definitions of participants and their agency's procedures, the quality and type of evidence available, and cost/benefit assessments of the effects of the different courses of action open to the conference. Dingwall and colleagues concluded that state agencies start with the assumption that parents were able to adequately care for their child and were motivated to do so and that this assumption or 'rule of optimism' was only challenged if there was strong disconfirming evidence. Bruising or other adversities on the child were not necessarily disconfirming evidence even if they were caused by the parents' actions. What was crucial was the parents' perceived moral character concerning their parenting. If they seemed to care for and love their child then lapses from normal standards of parenting would be accepted. Parents accepting that they had behaved incorrectly, were repentant, and eagerly accepted help from the caring agencies were the least likely to be subject to coercive intervention from state agencies.

Professionals may also be concerned about their continuing relationship with the families. Hallett and Stevenson (1980) suggest that such concerns are one reason for the low referral rates of cases to social work from general practitioners. Hallett and Stevenson (1980) also argue that case conference decisions are the product of complicated intra-group processes being acted out by people with very different
professional roles and responsibilities, but concern about continuing relationships with parents may be an important factor in these processes.

Statistics of Identified Cases

The final type of study on definitions is research into the incidence of known cases of child abuse. This research has already been described in Chapter Two. There is extreme variation in numbers of cases identified as abuse or at risk of abuse on British child protection registers and these variations are not surprising considering the factors that can affect case identification. Variation in actual incidence in the population is only one factor. Other factors include variations in visibility of parental care, definitions of what is or is not abusive care of children, and community and professional workers reporting and referring on cases as being suspected child abuse.

CONSEQUENCES FOR MAINSTREAM RESEARCH

Research on child abuse reviewed in Chapter Two was based on the assumption that child abuse was a relatively unproblematic concept. The evidence presented in the first section of this chapter shows that there is a lack of consistency in how definitions are applied. It may be that strict agreed criteria for definitions could be adopted in the research, but most studies rely on agency identified cases defined by a complex route of referral and other actions by members of the public and professional staff. This section considers the consequences of this inconsistency in definition for the different types of mainstream research discussed in Chapter Two.

Prevalence of Abuse

Estimates of prevalence are dependent upon consistency in the definition of abuse. Many population studies use the term 'abuse' in their survey interviews or in the criteria for determining what is a case of abuse. The results of such studies will therefore be dependent upon how the term 'abuse' is interpreted. However, prevalence studies are the studies most likely to adopt detailed objective criteria for what constitutes abuse. Most prevalence studies concern sexual abuse and specify the age range of children, the age difference between perpetrator and victim, and the physical sexual acts involved. There is therefore some possibility for contrasting the definitions applied in practice (Finkelhor, 1991). A more serious problem is that there is considerable variation in how adult respondents are asked about their
childhood experiences in the research interviews making it difficult to assess the extent that different experiences have been elicited by different surveys. (Finkelhor, 1991).

**Incidence of abuse**

Estimates of incidence are usually based on incidence of identified cases. If there is variation in the application of definitions of abuse by professional workers then there is no reason to assume that statistics of numbers of cases identified in different geographical locations or at different historical times are comparable. For example, if identified cases increase or decrease from one year to the next then it can not be assumed that these changes are due to changes in incidence in the population. Similarly geographical variations can not be assumed to be due to variations in the extent of causal factors and thus actual incidence in different locations. Comment has already been made in Chapter Two of extrapolating data from unrepresentative sample statistics to produce national estimates like those published by the NSPSCC.

There are also dangers in contrasting different geographical areas and assuming that variations in identified cases are due to variations in actual incidence. For example, Levinson (1989) argues that there are few cases of physical child abuse in countries such as Japan because such cultures have a more caring and less aggressive attitude toward their children. There probably are many cultural differences between Japan and Britain and the United States that affect the incidence of child maltreatment. However, the extent of such differences can not be revealed by current child abuse statistics on the incidence of identified cases.

In Japan there is no broad based reporting system and statistics are limited to small individual surveys of identified cases. The statistics that are available suggest a rate of only 0.05 cases per thousand children or an eightieth of the rate of the 4 per thousand children on child protection registers in Britain. The extent of this difference might lead one to accept an explanation in terms of cultural differences in child care practices and values. However, an examination of child homicide figures provides a different picture. In Japan, homicides of one to five year old children are reported by health departments as 2.6 per hundred thousand live births compared to 1.4 per hundred thousand in Britain. For children under one year the rates for Japan and for England and Wales are respectively 8.6 and 5.5 per hundred thousand live births (Christoffel and Liu, 1983).
The conclusion from the Japanese homicide statistics might be that physical abuse of children is high in Japan, but that there is little reporting of non-fatal child abuse cases. The reality is that both the child abuse case and the homicide statistics are socially derived and without further information it is not possible to make judgements about relative rates of incidence of abuse in Britain in Japan. The one factor that does seem to be related to higher numbers of cases is the presence of a system for managing and recording cases as abuse. In Britain and America there were few known cases of physical abuse before registration and recording systems were developed. Similarly, sexual abuse cases were not identified in large numbers until a growth of awareness about this issue in the mid to late 1980's and the development of a specific register category of sexual abuse. Prevalence surveys of adult populations, however, suggest that sexual abuse is not a new phenomena even though prevalence rates have been found to be higher in the United States for younger people (Siegal et al, 1987). In Japan, there is a system for recording child homicides and many such cases are recorded, but there is no such system for non-fatal cases of child abuse.

**Features of Cases/Causal Models/Predictive Factors**

Variations in definitions would also add to the problems described in Chapter Two with attempts to isolate distinctive features of cases of abuse. Without consistency in definition there would not be any reason to presuppose consistency of cases or of their constituent features either within or between studies. As previously mentioned (Chapter Two), the lack of consistency would hinder the possibility of discovering features causally related to the abuse. This increases the danger that the factors identified as having the strongest correlation with identified cases will be the factors associated with the process of identification rather than with the context of abuse. Similar arguments apply to attempts to use such features to develop causal models of abuse or predictive features of abuse. The models are developed from the featural research and are dependent on the quality of the results of this research.

**Efficacy of Interventions**

Chapter Two described the way in which most studies of the efficacy of interventions fail to specify their sample criteria or the content of the interventions in any detail. If a lack of consistency in the definition of the term 'abuse' is added to these problems then it is clear that there will be little possibility of comparability of study results.
This brief reference back to the mainstream research described in Chapter Two shows that lack of agreement in what is understood by the term child abuse would add considerably to the already serious methodological problems of these studies. The methodological problems indicated in Chapter Two although serious are essentially technical and open to technical solutions. Problems of variation in definition are more difficult because the definitions are open to continual change. The degree to which this undermines the research depends on the extent of the variation and the potential for it to be controlled by the use of objective descriptive criteria of abuse. The discussion up to this point has assumed that definitions could in principle be clarified and to some extent agreed upon even if this was technically difficult to achieve. The next section examines the argument that the definitions are judgements of social acts and therefore not open to technical prescription.

**SOCIOCLOGICAL PERSPECTIVES**

The mainstream research reviewed in Chapter Two did not question the concept of child abuse as a pathological condition. Child abuse might have social causes but its existence as a quasi medical syndrome was not under question. A criticism of this view is that to decide that a situation is one of child abuse requires interpretation. Child abuse does not exist as an objective fact but relies on judgements of what are or are not unacceptable experiences for children (see Chapter Four for a more detailed discussion). There will be variations between and within societies and across historical time in what is considered unacceptable and therefore in what is considered abusive. For example, there is considerable divergence in views as to the acceptability of different degrees of physical chastisement of young people, and as to who should have the right to carry out such chastisement and in what circumstances. Similarly there are variations between societies in the concept of childhood including how being a child differs from being an adult and the age at which the change from child to adult occurs (Stainton Rogers and Stainton Rogers, 1992).

According to this analysis child abuse is a socially constructed concept (Dingwall et al., 1983, Nelson, 1984, Parton, 1985). This is not to argue that children are not injured by their carers or involved in sexual activity by adults. Rather it is to argue that the ways in which labels are applied have no inherent objective base, but are an expression of moral values by those making such judgements. Sociologists adopting this social constructionist analysis are often interested in studying how the social
constructions are drawn and to describe the implicit value judgements that underlie these constructions (Berger and Luckman, 1967). Public debate can then assess the appropriateness of these values and the consequences of their implementation in practice. Good examples of this approach are the studies by Bacon and Farquar (1983) and Dingwall et al. (1983) on decision making in child protection (see the first section of this chapter).

The social constructionist analysis of child abuse has important consequences for child abuse research. If child abuse cannot be determined solely by a priori objective criteria, but is dependent upon interpretation, then the definitions of abuse applied by researchers are not necessarily the only possible definitions. More importantly it would not be possible to technically specify criteria for definitions if they are dependent upon the interpretations of social acts. Social acts are dependent upon judgements about the social meaning of actions and these are not evident from the particular physical actions involved. A simple example is that the verbal statement 'can you pass the salt' is usually judged to be an indirect request for the salt to be passed rather than a question as to the ability of the listener to pass the salt. Human beings use sophisticated social knowledge to make these interpretations of illocutionary force (intended rather than literal meaning). There may be common mutual understandings about indirect verbal requests and also about the appropriate way to act towards children, but these are fluid, open to negotiation and change, and are difficult to operationalize.

The discussion of the history of child abuse work in Chapter One suggests that different theoretical or operational definitions of child abuse depend upon the ideological context in which these definitions are being adopted. Nelson argues that although maltreatment of children has probably always existed it is only in the last hundred years that the social construct of child abuse as a social problem has arisen (1984, 126). Nelson argues that the concept of abuse was initially based on saving children from deviant situations; deviant families that were not carrying out their role of protecting children. This concept of deviance was continued by the revival of interest in child abuse in the 1950's and 1960's. It was mostly doctors who were initially involved in this revival of interest and, as the behaviour was considered deviant, it was not surprising that it was conceived of as a medical problem open to medical treatment solutions (Nelson, 1984, p17). The socially constructed problem was not controversial and attracted the support of both liberals and those conservatives concerned with the preservation of the traditional roles and power relations of the family. Nelson describes how child abuse became a major issue for
different government agencies and the media in the United States. She describes how the increasing awareness of the extent of maltreatment and the growth of equal rights movements changed child abuse into a wider child welfare and gender rights issues (1984, p127). The development of feminist thought, for example, has not only drawn attention to the existence of sexual abuse, but has created a different social construction of the traditional family. Rather than being a protector of children the family is seen as providing the context for most violations of children's rights (Kitzinger, 1990; MacLeod and Saraga, 1991). Nelson concludes, however, that "the construction of the problem as one of medical deviance has proven extraordinarily durable" (1984, p17).

Models of Welfare

One way of examining the different ideological stances to child abuse is to assess the model of welfare that is being applied.

With the medical model studies are undertaken to examine the nature of the syndrome, its aetiology, and outcome. Many practical interventions are also based on the model. Services are deployed to prevent abuse from occurring or to mitigate its effects after it has occurred. The model distinguishes interventions aimed at the whole population (primary prevention), from interventions aimed at individuals or groups considered to be at risk (secondary prevention), from reactive interventions concerned to prevent unwanted events recurring (tertiary prevention). The main methods of prevention are to destroy the agent causing the syndrome or illness, to reduce contact with the dangerous agent, or treatment to reduce the effects of unavoidable contact.

This can be illustrated by the example of the prevention of the illness of malaria. The protozoa causing the disease is destroyed by destroying the mosquitoes that carry them, killing and controlling the mosquitoes also reduces contact with human beings as do repellent sprays and mosquito nets or simply avoiding living in or travelling to infected parts of the world. Drugs are used to mitigate the effects of any protozoa that do enter the blood stream (Gough, 1993a). In child abuse, the agent could be the perpetrator of the abuse. Health and welfare services might try to influence these individuals so that they did not behave in this way and so were less dangerous to the children. If this were not sufficiently effective they might try to reduce the contact between this agent and children, or to educate the children so that they were able to avoid either those who might be a danger to them or situations in
which this danger might arise. Alternatively, they could be taught skills or coping responses that might help to mitigate the effects of abuse that did occur.

Parton (1985) in examining different models of child abuse describes the medical model as one of medical deficit. The perpetrator is seen as deficient as a human being or, specifically as a parent. Parton (1985) distinguishes the medical model from legal and social welfare models. The social welfare model is similar to the medical model in that there is assumed to be some form of deficit. The difference is the limiting of the explanation for the deficit in terms of social conditions and disadvantages. Parton argues that in the traditional form of this model intervention is based upon a rationale of compassion and rehabilitation. The more radical form of the social welfare model attempts to challenge the inequalities in society that produce such disadvantage. Under the legal model people are not considered to be deficient in abilities. Rather they choose whether to comply with the rules of society and thus they should be held responsible for any transgression of such rules. Prevention includes punishment which aim to deter both initial offending (primary and secondary prevention) and to persuade those caught breaking the rules not to repeat these offences (tertiary prevention).

Parton (1985) also distinguishes accounts of child abuse on the basis of whether the responsibility for the social problem is sought at the individual or collective level. Clearly legal models stress the individual responsibility and the social welfare models stress the responsibility of society. The medical model is often concerned with individuals but can take a broader public health or societal view and promote positive public health (see for example, Giovannoni, 1982; Boddy, 1986).

Hardiker, Exton, and Barker (1991) provide an analysis that combines most of Parton's distinctions. They describe - four models of welfare; residual, institutional, developmental, and radical. The residual model emphasises values of individualism, freedom, and inequality. Every member of society is free to choose what is best for them and what they can achieve within the limits of their abilities and a basic framework of laws. Social and economic inequalities are necessary as a motivational force within this market system. According to this model, welfare intervention is an instrument of last resort when individuals, families, and communities are unable or unwilling to ensure minimum standards are achieved. Within this model, child abuse prevention would be concentrated on upholding the values of the family and community as carers and protectors of children. Intervention by state agencies would be as 'ambulance drivers' for the few residual pathological cases.
The institutional model (Hardiker et al, 1991) espouses more liberal values of a shared consensus of social values within society. As with Parton's (1985) traditional social welfare model, the institutional model accepts that the state may have to intervene to mitigate some of the inequalities produced by market forces. The state therefore takes on the responsibility of intervening in a wider range of families. The state would also be sympathetic to arguments of prevention at the individual and family level - providing people with the educational or psychological resources to avoid social problems.

The developmental model (Hardiker et al, 1991) is not prepared simply to mitigate the effects of social inequality within society, but argues that social change is required. Such change should occur through consensus and the formal political processes of democratic government, welfare services should be one of the mechanisms for change by promoting the interests of the disadvantaged sections of society. Intervention should therefore preferably be at the community and societal rather than the individual level. Welfare services are seen as potentially dangerous in hiding the worst aspects of social problems and reinforcing the inequalities that produced them. The radical model (Hardiker et al, 1991) is similar in arguing for structural change, but does not believe that this can be achieved by consensus through normal political channels. Rather it believes that conflict and radical opposition are necessary to achieve change.

Many researchers and health and welfare professionals working in child abuse and child protection could be described as working predominantly within an institutional model. The model is based upon the view that the state should intervene to assist people disadvantaged by the social system and conceive of this intervention as being applied to individuals and families rather than to changing social structures. This does not imply that these authors are not concerned with structural inequality but that their skills and abilities are in the personal medical, psychological, social welfare, or educational services and their work is directed towards that end.

There are also researchers and practitioners more overtly aligned with the developmental model (see for example, Gil, 1975; Garbarino and Gillham, 1980; Gelles and Cornell, 1990; Violence Against Children Study Group, 1990). Authors advocating the radical model are less likely to use the term child abuse either because they consider the term itself to be based on an analysis that reinforces the social problems that they seek to change or simply because they are more concerned
with macro rather than micro social change. One exception is feminist critiques of mainstream child abuse work that are considered to reinforce the gender inequalities that encourage sexual abuse (for example, Kitzinger, 1990; MacLeod and Saraga, 1991). Another exception are those radical theorists who directly analyse the way in which the concept of child abuse is used politically.

CONCLUSION

This chapter has examined the extent that definitions of child abuse are more problematic than assumed by the mainstream child abuse research. There is evidence that there is considerable variation in how child abuse is defined. The issue is the extent that this can be improved upon to produce more specific criteria. The social constructionist and political analyses suggest that technical solutions are unlikely to be achieved. This issue is addressed again in the next chapter where an analysis is presented of the component parts of the concept of child abuse.
CHAPTER FOUR

THE CONCEPT OF CHILD ABUSE

Previous chapters have shown that there have been two main research traditions in child abuse research. Chapter Two discussed how mainstream research treats definitional issues as unproblematic. This is despite considerable evidence of variations in case identification that produces error into the research designs and seriously distort and limit the relevances of research findings. Chapter Three described other research that questioned the assumption of mainstream research that child abuse was a relatively homogeneous clinical condition. For this research, this variation in case definition was a source of research interest in its own right. All of these approaches to research are restricted by a lack of clarity about definitional issues.

Despite a widespread acknowledgement of difficulties in defining child abuse, and sociological discussion of the way in which the concept is socially constructed, there has been surprisingly little analysis of the concept of child abuse. This chapter argues that there is little disagreement about the general concept of child abuse. The variation is only within two specific sub components of the concept and their interaction. The analysis of these sub components allows an examination of exactly where the variation between individual definitions does occur.

There are several practical benefits that arise from this analysis. Firstly, it can help to clarify case definition for mainstream research studies of child abuse. Greater clarity about definitions will allow these to be more specifically applied in sample recruitment. Secondly, clarification of the dimensions of the concept of abuse can assist research attempting to chart inter and intra personal variations in the way in which different people apply definitions of abuse. Thirdly, the analysis can help to specify what needs to be explained by sociological analysis of the social construction of the concept of child abuse. This is also relevant to the practical application of definitions (i.e. operational definitions) in child protection work. Operational definitions have crucial practical importance in determining who should or should not be categorised and responded to as perpetrators or victims of abuse.

The chapter is in three parts. The first examines the components of definitions, the second applies this analysis to definitions in the literature and the third discusses the application of definitions in practice. Commonly used definitions of child abuse
such as those listed in Table 4.1 are used to discuss the issues addressed in the chapter. The definitions by the Department of Health (1991b) are from Working Together under the Children Act, the central government guidance concerning child protection registers in England.

Table 4.1

Common Definitions of Child Abuse


"Actual or likely physical injury to a child, or failure to prevent physical injury (or suffering) to a child including deliberate poisoning, suffocation and Munchausen' Syndrome by Proxy".


"Any interaction or lack of interaction between a caregiver and a child which results in non accidental harm to the child’s physical or developmental state".

3. Physical Abuse: Gil, 1970

"...intention, non accidental use of physical force, or intentional, non accidental acts of omission, on the part of parent or other caretaker in interaction with a child in his care, aimed at hurting, injuring or destroying that child".


"The persistent or severe neglect of a child, or the failure to protect a child from exposure to any kind of danger, including cold or starvation, or extreme failure to carry out important aspects of care, resulting in the significant impairment of child’s health or development including non organic failure to thrive".


"Child neglect may be defined as a condition in which a caretaker responsible for the child either deliberately or by extraordinary inattentiveness permits the child to experience avoidable present suffering and/or fails to provide one of the ingredients generally deemed essential for developing a person’s physical, intellectual or emotional capacities".


"Actual or likely sexual exploitation of a child or adolescent. The child may be dependent and/or developmentally immature".
7. Sexual Abuse: Schecter and Roberge, 1976

"Sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent, or that violate the social taboos or family roles".

8. Failure to Thrive: Ayoub and Milner, 1985

"Failure to thrive is a physiological growth disorder in which the child demonstrates a weight below the third percentile age. It results from the failure to obtain and/or to utilize the calories required for adequate growth. Environmental failure to thrive (FTT) is a growth without diagnosable organic cause. Its etiology is centred on an omission or disturbance of the interaction within the parent-child relationship".


"Actual or likely severe adverse effect on the emotional and behavioural development of a child caused by persistent or severe emotional ill-treatment or rejection. All abuse involves some emotional ill treatment. This category should be used where it is the main or sole form of abuse".

COMPONENTS OF DEFINITIONS

Everyone is considered to have needs and rights. People are considered to have suffered harm when these needs are not met or their rights are infringed. When it is alleged that a child has been a victim of abuse it is being suggested that the child has suffered harm in some way. The concept of harm is common to all definitions of child abuse, though the definitions may be concerned with different types of harm and may not agree in their criteria as to what sort or degree of different experiences are sufficiently harmful to be considered abuse. For example, definitions of physical abuse are normally concerned with the harm from physical assault on children, but definitions might vary on whether any form of corporal punishment to children was acceptable and so whether it was a form of child abuse or not (Newell, 1989). Similarly, most argue that all sexual relations between adults and children are abusive (Finkelhor, 1979), but some paedophiles believe that children have a right to have sexual relations with adults (Li, 1991). All definitions of child abuse include the concept of harm. The issue here is over what is considered harmful or unacceptable for children and the criteria for determining this. In other words, one major source of variation between definitions is in how that harm is specified.
Children can be harmed by many persons or things in many different situations. These instances of harm are not all described as abuse even if the harm is considerable. Accidents seen as unavoidable are, for example, not usually described as abuse, nor are unavoidable illnesses. For a situation to be seen as abusive involves the second main component of definitions of child abuse, which is the concept of responsibility of agency or cause for the actual or potential harm. Some definitions of abuse specify that this agency is purposeful, for example, parents intended harm to their children. Other definitions of abuse do not require intention. Parents who cause harm to their children through lack of ability or motivation to care for them, would be an example. 'Intention' is therefore a component of some but not all definitions of child abuse. The broader concept that is common to all definitions is the concept of responsibility.

Harm

The concept of harm depends upon concepts of needs and rights and these vary across and within cultures and over time. Even within one society at one point in time there may not be agreement about the needs and rights of individuals. Furthermore, people may believe that different groups have different needs and rights and so have different criteria for harm. That the same experience would be more or less harmful depending, for example, upon age, sex, or racial or religious group. The variation is in both the types of adversity being considered and in the criteria or cut off points for deciding when abuse has occurred.

As the nature of harm is socially constructed, the ways in which it is conceptualised and categorised will also differ. In considering the needs of children, many authors have listed the experiences that they consider that all children are either entitled to (for example, Calam & Franchi, 1987), that children require in order to develop into healthy and well adapted adults or that are harmful to their psycho-social development (for example, Rutter, 1989), or are harmful to their basic human rights (Ennew, 1986). These lists of positive and negative experiences typically consider children’s rights or physical, social, or psychological needs (see examples listed in Table 4.2).

It is not surprising that definitions of child abuse differ in what events, situations, and effects on a child are considered sufficiently adverse to be considered abuse. The definitions in the literature usually specify the negative factors or harm to a child that would be considered abusive. They also sometimes list the needs that
children are thought to positively require. The definitions listed in Table 4.1 demonstrate the relative breadth of harm considered and the criteria for determining the degree at which these adversities become abusive. The harm to children in all five definitions is described in only very general terms and so does not fully reflect the cultural, historical, and individual variation in opinions as to what are necessary, appropriate or inappropriate experiences for children.

Table 4.2

Examples of Positive and Negative Childhood Experiences

a. physical:
positive: food, warmth, clothing.
negative: injury, contracting diseases.

b. socio-emotional/psychological:
positive: to be loved/cared for; to experience mutual caring relationships
negative: psychological effects of childhood sexual experiences.

c. rights:
positive: a child's right to be a child & to receive warm supportive care from adults.
negative: a child's right not to have sexual experiences.

The socially relative nature of what is considered adverse for children is easily demonstrated by the concepts of adult-child relations and sexual abuse. An individual or society may accept adult-child sexual relations as being appropriate, either because they do not consider it to be adverse for the children or because they consider any such adversity to be of less importance than the needs of the adults (Li, 1991). Alternatively it is argued that all adult-child sexual relations are abusive and that children are unable to provide informed consent to such activities (Finkelhor, 1989). The existence of literature from paedophile organisations expounding the virtues of adult-child sexual relations and the illegality of the behaviour advocated by such groups demonstrates the variation of views on this topic within societies.

Variation across societies on the concept of children and sexuality is demonstrated by variation in the age of consent to sexual relations and the age of legal marriage of young teenage children. Even when there is agreement within a society about
what is or is not harmful to children there will still be difficulties in ascertaining the criteria or cut off point at which an adversity becomes sufficiently harmful to be abusive. With physical harm, for example, red marks caused by a parent striking a child on the legs or buttocks with a slipper might or might not be considered as evidence of abuse.

Historical change within a society will effect what is or is not considered harmful to children. These perceptions about harm may also feedback to amplify or mitigate the experience of harm. For example, paedophiles have argued that the stigmatisation of adult - child sexual relations results in a negative reaction to children who have had sexual relations with adults and that it is this reaction by adults rather than the sexual experiences that cause harm to children (Li, 1989, p 159).

Responsibility

The second main component of definitions of child abuse is the attribution of cause or responsibility for any adversity experienced by a child. The list of definitions of child abuse in Table 4.1 contain examples of the types of responsibility commonly considered in interpretations of abuse. In theory, there is no limit to the type of persons or institutions that could be considered responsible for the adversities. For example, a child dying from hypothermia in an unheated flat could be considered the State's responsibility for not providing sufficient resources for the child or family to ensure adequate warmth. Alternatively, the responsibility could be directed at the energy company who disconnected the supply, the extended family or community for not coming to the child's aid, or the parent(s) for not providing for their child. If no person or group could be potentially considered to be to blame, the situation would not normally be considered to be one of abuse. For example, the harm to children from road traffic accidents is not normally considered to be child abuse even though these accidents account for many child deaths. In England and Wales, in 1982, there was a road traffic accident fatality rate of 4.3 per 100,000 children, which compares with a rate of 0.5 suspicious child deaths per 100,000 children recorded by the NSPCC for some parts of England over the same year (Creighton, 1984).

The complexity of these assessments of responsibility can be seen by considering the following four possible interpretations of responsibility in the case of a child 's
experience of the adversity of a mark of bruise from a blow to the face from a parent.

An act of discipline

To some, corporal punishment is an unacceptable method of child care (Newell, 1989). To others it is acceptable under certain circumstances such as age and behaviour of the child, the consequences of not chastising the child, and the force and placement of the blow. The interpretation of which circumstances are or are not acceptable are likely to vary according to perceptions of the actors' intentions and the social context of the disciplining. This will include attitudes towards the roles and responsibilities of parents and children of different ages, and the benefits and costs of different levels and types of physical chastisement as a method of child control or socialization.

A parent might chastise a child in order to make him or her stop a behaviour that was dangerous. However one might question the skill with which this was performed. If the parent was under the influence of alcohol so that skills and maybe tolerance towards the child were reduced then the adequacy of the parent's protective role towards the child might be questioned. Furthermore, it would be necessary to assess the acceptability of the act of discipline independently of the parents' intentions.

An act of aggression

The distinction between an act of discipline or aggression towards children is normally based upon the intentions or other psychological correlates to the behaviour. For example, an observer might view a particular act of corporal punishment on a child to be more of a display of parental aggression than an act of discipline. In British society parental aggression is less likely to be seen as fulfilling the needs of the child and so is more likely to be interpreted as possibly abusive. The manner in which such assessments are made will be similar to those of acts of discipline. A commonly suggested mitigating factor is the effect of alcohol or other drugs that may reduce tolerance to provocation. However, it is possible to question the extent that drugs effect control of aggressive behaviour as the use of the drugs might simply be legitimating violent behaviour (Pahl, 1985). Furthermore, the use of drugs, particularly by those with child care responsibilities, may itself be considered improper and lead to a negative assessment of the parents
and thus the greater attribution of responsibility for any adversities experienced by their children, whether or not they were a consequence of the drug use.

A sexual act

Bruising can arise from actions that have a sexual component. The sexual component may be explicit or may be an aspect of any form of interaction including acts of affection, acts of discipline, and aspects of personal child care such as hygiene or medical care. These interpretations are, again dependent upon the intentions of the actors and the needs that are being attempted to be overtly or implicitly fulfilled. Such interpretations are likely to be affected by society’s attitudes towards different types of personal contact between people of different ages and sex assuming different social roles and responsibilities. Attitudes towards age of consent and sexual maturity, for example, vary considerably between cultures.

An accident

An accident is an unintended and unforeseen negative outcome. Some may argue that however unforeseen or negative the events, the fact that a child is seriously harmed is evidence of parental responsibility and therefore abuse. For others, the responsibility would be mitigated by the degree that the events were unforeseen. There are also the issues of parental motivation and ability. An accident may occur because a parent did not have the ability to realise the risks or they may not have been sufficiently motivated in their care to properly assess the risks. In sum, parental intentions may not always be a sufficient indication of perceived parental responsibility for accidents.

The concept of unintended/unforeseen outcomes can also be applied to circumstances that would not normally be described as accidents. For example, assaults on children by third parties such as strangers or friends of the parent(s). Allowing a child to roam unsupervised in a dangerous inner city area would increase the risk of assault although the parents may not wish harm to come to the child. Similarly, a violent cohabitee could be a risk to children. A parent may be unaware of the risks or may balance these possible increased risks to their children against their emotional need to preserve their relationship with the cohabitee. If the parent feels that the presence of the cohabittee improves his/her functioning then s/he may feel that there is an overall benefit to the children despite the increased risk of injury.
This brief examination of four different social contexts within which a child might receive bruising help to illustrate some of the complexities in the attribution of responsibility necessary for defining a situation as abusive. First, there needs to be an interpretation of the social acts involved, then an assessment of the moral responsibility of the actors for those acts and for their outcomes. These interpretations and assessments are likely to include consideration of at least the following:

1. The causal relationship between behaviour of the person and the adversities experienced by the child (including not actively protecting the child from such experiences).

2. The intentions of the person and the motivation and skill at achieving these intentions.

3. The social acceptability of the acts being performed (including infringement of social or legal rules) notwithstanding the intentions of the person concerned.

4. The social acceptability or moral or social worth of the person concerned—particularly in relation to any child caretaking protective roles.

5. Other factors mitigating or increasing the probability of the person having responsibility for the adversities.

All of these factors are socially defined and can not be defined by specific physical actions. The actions need to be interpreted in the same way that the literal meaning of different utterances can have different illocutionary force to produce different speech acts (Grice, 1975). It has been shown that different listeners often attribute different speech acts to the same utterance (Kreckel, 1981). Similarly, the circumstances in which a child suffers an adversity are open to interpretation and thus also to negotiation. Responsibility is therefore a negotiated rather than an objective feature of child abuse. These variations in interpretations of social acts are in addition to the historical and cultural variations in abstract definitions of abuse already discussed.

Combining Harm and Responsibility

So far, harm and responsibility have been considering separately, but in order to define a situation as abusive requires interpretations of both the actual or potential harm and the responsibility for these circumstances. Vignette studies have shown
that there is little disagreement between respondents on the most severe cases of abuse where harm and responsibility are high. Disagreement arises with the less serious cases (Giovannoni and Becerra, 1979). Concepts of seriousness, however, depend upon the combination of concepts of harm and responsibility.

There are three possible ways in which the two components may act together. They may act independently, they may act additively, or they may interact together. These are considered in turn. The discussion that follows refers to harm and responsibility as if they are concrete dimensions, whereas, of course, they are dependent on how they are conceptualized by the actors involved. This relativity does not diminish the importance of making a conceptual distinction between harm and responsibility and the ways in which they are combined together to make judgements about abuse.

1. Independent model

For a situation to be considered abuse it would be necessary for both the harm and the responsibility to independently reach a criterion level. In this way a situation that only caused a little or no harm would not be abuse however great the responsibility of the person or agency involved for the child receiving that harm. An illustrative example would be parent losing their temper and throwing a punch at their young infant but the punch misses and the infant is unaware of the aggressive attack.

\[ \text{Harm: low, below criterion} \]
\[ \text{Responsibility: high, above criterion} \]
\[ \text{Conclusion: not abuse, as not sufficiently harmful} \]

Similarly, a very high degree of harm would not be considered abuse if the responsibility was low. An illustrative example would be a child being seriously injured or killed whilst fully strapped into a car being driven carefully and responsibly by their parent but that is crashed into by a car driven by a drunk driver.

\[ \text{Harm: high, above criterion} \]
\[ \text{Responsibility: low, below criterion} \]
\[ \text{Conclusion: not abuse, as not sufficient parental responsibility.} \]
If the breadth of responsibility being considered was wider than parental responsibility, then the scenario might be considered abusive. Another driver or the State for its road safety policies or practices might be considered sufficiently responsible for a conclusion of abuse to be reached.

2. Additive Model

In this model the criteria for determining abuse arises from the addition of the two components of harm and responsibility. A small harm not normally considered abusive could be considered abusive if there was a very large degree of perceived responsibility. The previously cited example of a parent throwing a punch at their infant, but missing, might meet the criteria for abuse under this model. Similarly a small degree of responsibility might be considered abusive if there was by chance a very large harm caused. For example, children being burned in a house fire might be considered abuse even if the parents had not put their children at greater risk of danger than other parents.

\[ \text{Harm: small} \]
\[ \text{Responsibility: small} \]
\[ \text{Conclusion: not abuse, as combination of harm & responsibility do not reach criterion.} \]

\[ \text{Harm: small} \]
\[ \text{Responsibility: high} \]
\[ \text{Conclusion: abuse, as combination of harm and responsibility reaches criterion.} \]

\[ \text{Harm: high} \]
\[ \text{Responsibility: small} \]
\[ \text{Conclusion: abuse, as combination of harm and responsibility reaches criterion.} \]

This model is presented graphically in Figure 4.1. The height and angle of the line indicating the additive criterion for defining a situation as one of abuse will vary depending on views about the relative importance of different adversities for children (harm) and different responsibilities for such harm occurring. In Figure 4.1 the line is at 45 degrees indicating an equal effect of harm and responsibility. In practice, harm may be considered more important than responsibility or vice versa. This, of course, begs the question of the calibration of dimensions of harm and responsibility (as discussed at the beginning of this section).
3. Interactive Model

Within this model the components of harm and responsibility combine in an interactive rather than a simple additive way. For example, two different acts may normally be considered to have similar levels of responsibility but may combine differently with a particular type and level of harm with the result that one of the combinations is considered abuse and the other is not. In other words, certain harm and responsibility combinations may be seen as particularly abusive even if other similar combinations are perceived less negatively. In practice such interactive effects reduce to different judgements about relative responsibility.

The combining of assessments of harm with attributions of responsibility is particularly complex in intra familial abuse because of the social roles, responsibilities, and powers of family members to each other. Society expects parents to care for their dependent children and so harm children receive from lack
of care may be considered neglect. Even a child not developing sufficiently without any known organic cause may be labelled as the abuse of failure to thrive.

The responsibility of care also includes powers to decide (within limits of appropriate care) to decide how to raise their children. Physical punishment is a widely accepted method of child management in Britain (Newson and Newson, 1989) and is enshrined in law for parents to use 'reasonable chastisement', but that they should not use 'unnecessary suffering' (Gulbenkian Foundation, 1993, p19). Similarly, the United Convention on the Rights of the Child states that it is difficult to distinguish when an ordinary smack becomes abuse, but such qualifications are not made about laws and regulations about assaults between adults (Gulbenkian Foundation, 1993, p23). There is an assumption that the social context of parental roles in the family differentiate parental from other forms of violence. Similar issues are raised in terms of sexual assault between spouses in a marriage. It is only recently that there have been successful prosecutions for rape in marriage. Prior to this, unless the victim had been physically injured she would not have been considered to have experienced harm, presumably because she did not have the rights presumed to have been infringed by the assault. For sexual abuse of children, however, the situation is very different. The social taboo against incest does not provide a middle ground of acceptable degrees of sexual activity, as there is with 'acceptable' physical punishment.

DEFINITIONS IN THE LITERATURE

Harm and responsibility are the two main components of the definition of child abuse, but consideration of both the boundaries, the cut off criteria, and the interaction of these components produces five main distinctions that need to be addressed in any definition of child abuse:

(a) The types of harm considered.
(b) Criteria for harm to be abusive.
(c) Boundaries of responsibility.
(d) Criteria for the extent of responsibility to be abusive.
(e) Specification of the criteria for interaction between harm and responsibility.

Table 4.3 considers these five aspects of definitions in relation to the five common definitions of different types of child abuse (listed in Table 4.1).
Table 4.3
Specification of Harm & Responsibility in Common Definitions of Child Abuse

(a) Type of Harm: physical injury or suffering including poisoning, suffocation, and experiences arising from false symptoms or reports of illness.
(b) Criteria for Harm: actual or likely harm
(c) Boundaries of Responsibility: not specified
(d) Criteria for Responsibility: not specified but includes failure to prevent harm and deliberate acts
(e) Harm / Responsibility interaction: not specified, but includes combinations of (i) injury or suffering + failure to prevent, (ii) poisoning, suffocation, falsely reporting illness in child + intentional act.

(a) Type of Harm: to the child's physical or developmental state.
(b) Criteria for Harm: Not stated
(c) Boundaries of Responsibility: caregiver, non accidental
(d) Criteria for Responsibility: not specified
(e) Harm / Responsibility interaction: not stated

3. Physical Abuse: Gil, 1970
(a) Type of Harm: physical.
(b) Criteria for Harm: force or acts of omission that hurt, injure, or destroy child
(c) Boundaries of Responsibility: parent or caretaker
(d) Criteria for Responsibility: non accidental/intentional acts of physical force or of omission aimed at hurting, injury or destroying the child. The definition is not specific, but it seems that these acts could be abusive even if they did not achieve their aims of injuring the child.
(e) Harm / Responsibility interaction: not stated
4. **Neglect: Department of Health, 1991**

(a) Type of Harm: cold or starvation, or impairment of the child’s health or development including failure to thrive in the absence of organic causes

(b) Criteria for Harm: that it results in significant impairment

(c) Boundaries of Responsibility: not specifically stated, but implication that child’s caregivers

(d) Criteria for Responsibility: includes persistent or severe neglectful acts and extreme failure to care for child

(e) Harm / Responsibility interaction: not stated beyond the harm being as a result of the acts of commission or omission

5. **Neglect: Polansky et al, 1975**

(a) Type of Harm: essential human needs

(b) Criteria for Harm: current suffering; non provision of ingredients generally deemed essential for developing a person’s physical, intellectual or emotional capacities

(c) Boundaries of Responsibility: caretaker

(d) Criteria for Responsibility: deliberate acts of neglect or extraordinary inattention to caretaking responsibilities

(e) Harm / Responsibility interaction: not stated

6. **Failure to Thrive: Ayoub & Milner, 1985**

(a) Type of Harm: Failure to grow and develop not due to non organic causes

(b) Criteria for Harm: a physiological growth disorder in which the child demonstrates a weight below the third percentile age, that is caused by the failure to obtain or utilize the calories required for adequate growth, and has no diagnosable organic cause.

(c) Boundaries of Responsibility: parent - child relationship

(d) Criteria for Responsibility: not specifically stated, but reference made to omission or disturbance of the interaction within the parent child relationship.

(e) Harm / Responsibility interaction: not stated
7. Sexual Abuse: Department of Health, 1991
(a) Type of Harm: not specified beyond being sexual exploitation
(b) Criteria for Harm: actual or likely and exploitative to a child or adolescent
(c) Boundaries of Responsibility: not stated
(d) Criteria for Responsibility: exploitative.
(e) Harm / Responsibility interaction: not stated

8. Sexual Abuse: Schecter and Roberge, 1976
(a) Type of Harm: sexual activity with children
(b) Criteria for Harm: involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend to which they are unable to give informed consent, or that violate the social taboos or family roles
(c) Boundaries of Responsibility: not stated, but probably sexual involvement by all persons knowing the significance of the sexual acts, i.e. most adults
(d) Criteria for Responsibility: not stated
(e) Harm / Responsibility interaction: not stated

(a) Type of Harm: emotional and behavioural development of a child
(b) Criteria for Harm: actual or likely, severe, and adverse
(c) Boundaries of Responsibility: not specified beyond emotional ill treatment or rejection
(d) Criteria for Responsibility: persistent and severe
(e) Harm / Responsibility interaction: not specified beyond adverse effects being caused by the illtreatment/rejection

These examples of common definitions of child abuse in the literature often distinguish the type of harm being considered. They do not, however, specify the details of such harm or the criteria for decoding when such harm would be considered abusive. The Department of Health definition of sexual abuse, for
example, does not define the harm beyond it being sexual and exploitative. The definition does not make it clear whether exploitation refers to the intent of the abuser (responsibility) or the effect on the child (harm). If it is the former, then not all sexual activity with a child would necessarily have exploitative intention and so would not necessarily be considered abuse. If it is the latter (that is harm to the child), then the definition could be very wide if it included children's rights. For example, the commercial use of a photograph could be exploitative even if the child was unaware of it and whether or not this was the initial purpose of the photograph.

There is less variation in the definitions about the boundaries of responsibility. The definitions of child abuse by Helfer, Gil, and Polansky are typical of many definitions in limiting abuse to adversities seen as the responsibility of the child's caretaker. The abuse is therefore intra-familial and is based upon an assessment of parenting responsibility, reflecting the emphasis our society puts upon parents as providers and protectors of children. An issue for those investigating such a referral would be whether those responsible for the care of the child had sufficiently protected their child from such risks. As mothers are still the most common primary caretakers of children they frequently become the focus of such assessments of parenting responsibility, even when the adversity is clearly caused by another person - even another family member.

A common current exception to this limitation to intra-familial abuse is 'child sexual abuse'. A child physically assaulted by a stranger is usually seen as simply a victim of assault, whilst sexual assaults by strangers are often described as sexual abuse as in Schecter and Roberge's definition. In this way sexual abuse can be identified in children who are considered to be adequately parented and protected and so these definitions put less stress on the responsibility of individual parenting.

The Department of Health definitions could include intra and extra familial abuse, but the definitions are primarily concerned with categorising placement of children's names on child protection registers. The registers are only meant for cases where there are continuing unresolved child protection concerns. Unresolved concerns usually involve parental responsibility either in direct cause of harm or in not sufficiently protecting their child from harm from others.

Specification of the concept of responsibility not only limits the general scope of a definition of child abuse but can also make more detailed restrictions as to what constitutes sufficient responsibility for harm to be abusive. This is difficult to
describe operationally. There is no pre-determined or fully agreed way of interpreting the social meaning of human behaviour and, therefore, no necessary agreement in attributing responsibility to individuals, groups, or institutions for adversities experienced by children. Even if the scope of responsibility is limited to parental behaviour there are numerous assessments that have to be made in order to attribute responsibility in individual cases.

The definitions provide very little specification of the type of responsibility within the broad boundaries of who or what could be a responsible agent. Neither do they state how interpretations of harm and responsibility might act together in order to decide that the criteria for abuse 'had or had not been reached.

In practice, not only is there lack of clarity about definitions, but full and clear information on the adversity experienced by the child or the circumstances in which it arose may not be available. Interpretations of social context, responsibility, and abuse are thus even more difficult to achieve. This may lead to widely diverging views as to whether abuse has occurred particularly when there is high adversity as in unexplained cot deaths.

**APPLYING DEFINITIONS**

Definitions are not just theoretical formulations but are applied or operationalized to decide whether particular situations are cases of abuse or of risk of abuse. Chapter Three showed that there is substantial variation in how definitions are operationalized. This is not surprising considering the lack of specification of the criteria of harm and responsibility in most theoretical definitions of abuse. This chapter has shown that these criteria are stated in very general terms and that substantial additional interpretation is necessary for the definition to be operationalized in practice.

It could be argued that the resolution of these issues depends in our society upon legal judgements in the courts. Although this may be ultimately true for some cases, most operational definitions of abuse are made by individuals and agencies in non legal settings. In practice, therefore, legal judgements normally only provide a broad context in which definitions of abuse are applied. The operational definitions will therefore vary according to the views and purposes of those attempting to make these distinctions.
Definitions of abuse are difficult to apply in practice for at least two main reasons. The first problem is in determining the specific criteria of harm, responsibility, and the interaction of the two that will fulfil the purposes of the operational definition. Most of these definitions have considerable practical consequences. The difficulty is that the criteria used by both the interventive agencies and by child abuse researchers are often not explicitly known. Instead each presenting case is considered individually by the decision makers concerned and it requires other research to attempt to discover the criteria that are being applied (and variations in how these criteria are applied). The second problem is that even if there is some clarity as to the criteria to be applied it will often be the case that the details about the circumstances that are producing concern will not be fully known at the time that the decisions were made and hence operational definitions are being applied.

The most common operational definitions are those applied by the community and government agencies to intervene when there is concern about a child's welfare. Chapter One outlined the processes of intervention in child abuse cases and illustrated the main decision points. Two of the most important actions taken by government agencies and the legal system in child abuse cases are placement of a child's name on the local child protection register and civil legal proceedings to place children under the supervision and care of the local authority. For placement on a child protection register and civil child care proceedings require information (or evidence for legal proceedings) that a child is in need of such monitoring or supervision. This is based upon future risk rather than necessarily prior abuse, but the concept of abuse is still important for two reasons. Firstly, prior abuse may be the basis of the concerns about the future care of the child. Secondly, concerns about the future care of the child are concerns that the child will not be properly cared for or will not be sufficiently well protected from the risks likely to occur in the environment in which she will be living. The agencies may use different and less emotive words to describe these future risks but conceptually they are risks of harm occurring to the child through the responsibility (by action or inaction) of the child's caretaker, which is conceptually the same as risk of intra-familial abuse. Operational definitions within the child protection system are therefore operational definitions of risk of abuse sometimes based upon judgements of past and future abuse.

Important operational definition points include:

i) A person in the community alleging that a child is being abused.
ii) Case referred to and investigated by agencies with statutory duties in this area.

iii) Individual agency invokes internal procedures for child protection or for recording the situation as one of child abuse including calling an inter agency case conference.

iv) Placement of a child’s name on a register that invokes local inter-agency child abuse procedures.

v) A court finding a child to be in need of care and protection.

vi) A court finding a person guilty of an offence against a child.

Although defining a case as one of abuse is a binary decision between abuse and not abuse (Hallett and Birchall, 1992, p109) the levels of interventive action are many. However, the processes and purposes of these operational definitions vary substantially and so it is unlikely that they are on a single continuum of 'extent of abuse' from less serious to more serious. It is more likely that different aspects of harm and responsibility and their mode of combination will be salient in the various different child protection systems and in different parts of the same system. Types of harm and responsibility judgements may differ during a child protection investigation, an initial case conference, and a review case conference. However, there may also be many similarities with decisions taken at any one point influencing decisions taken at other points or levels within a system or between systems.

These are largely empirical questions. Currently, there is very little information about how definitions are applied at any one of these levels or of the consequences of these definitions being applied, although such data is beginning to increase (Bacon and Farquar, 1983; Cleaver and Freeman, 1992; Dingwall et al, 1983; Thorpe, 1991; Waterhouse and Carnie, 1992). Without such information it is not possible to further knowledge either about the social construction of abuse of the appropriateness of current responses to child abuse within the social constructions of abuse being applied.

The study reported in the following chapters does not attempt to assess this process of operationally defining cases as one of child abuse. Rather it attempts to describe the cases so defined and their subsequent intervention in one British city.
CHAPTER FIVE

A STUDY OF CHILD PROTECTION

The first four chapters have described the development of research on child abuse and indicated the central problem of a lack of clarity about the meaning of the concept of child abuse. Chapter Two described conventional research which assumed that definitional issues were not problematic. Chapter Three reviewed evidence that there was a problem of definition and examined theoretical critiques of the concept of abuse and its implementation in practice. To clarify these issues, Chapter Four then offered an analysis of the core concepts underlying the macro concept of child abuse.

The conclusions of the first four chapters are that:

1. Mainstream child abuse research has taken a predominantly medical model to determine the nature of the syndrome of child abuse, its incidence, and its causes and effects.

2. Although mainstream research has made some progress its efficacy has been undermined by its assumptions that the concept of child abuse is essentially unproblematic.

3. There is considerable evidence that definitions of child abuse are not applied consistently. In recruiting research samples without paying due heed to these variations in definitions, mainstream research has often not conformed to the methodology of medical model research.

4. Other research demonstrates that definitions of child abuse vary because of the social nature in which they are constructed. The consequence is that even greater rigour in sample definitions would not overcome all the limitations of mainstream medical model research.

5. The underlying components of definitions of child abuse are based upon concepts of harm to children and responsibility for that harm occurring. There is likely to be variation in how these concepts are applied and interact together to result in particular situations being perceived as instances of abuse.
6. Operational definitions of abuse occur when child protection, law enforcement, and other agencies identify a situation as one of abuse or risk of abuse requiring child protection interventions.

Cases are operationally defined by health, welfare, and legal enforcement government agencies. These operational definitions result in case identification which in turn results in agency statistics of child abuse cases. These statistics do not represent the incidence of abuse in the population (however that is defined), but the statistics do reflect the degree of involvement and workload of government agencies. The trouble is these statistics are mostly collated and described as if they represented incidence of a syndrome rather than to provide management information on the practices of child protection services.

**STUDYING PRACTICE**

In most societies parents are given the responsibility for the care of their children and only in exceptional circumstances does the state judge that the level of care and protection requires government agency intervention (Dingwall et al, 1983). The manner and extent of state intervention is important in two basic respects. Firstly, it defines the social policies of the state in respect to monitoring and intervening in family life. Secondly, it has practical consequences for those children and families to whom such intervention is applied. Children, for example, may be removed from their parents by the state, but even the act of placing a child's name on a child abuse register may have serious social and psychological implications for people for whom parenting may be their main activity or role.

As state intervention for child protection does occur, it is important to examine to whom these interventions are applied, the content of such interventions, and the outcome of such interventions. The current study was undertaken to begin to fulfil this purpose. The purpose was not to directly study the process of case referral and the process of case definition. Nor was it aim to assess the efficacy of the interventions. Rather the aim was to begin to chart the natural history of child protection as applied to pre-school cases in one British city in the early to mid 1980’s.

Current policy and procedures on child protection provide many details of actions that should be taken in particular circumstances but are less specific about the policies concerning state intervention in family life. Research on practice is
therefore necessary to examine the implicit policies being carried out by child protection services. Recently, government guidance has become more specific about policies of child protection (for example, about working with parents, Department of Health, 1991), but even here research on practice is necessary to examine how these policies are actually being implemented and to what effect. The description and analysis of such practice can therefore clarify policy and practice issues and allow greater transparency to policy debates on the important social issue of child protection and state intervention in family life. The current study is meant as a contribution to this process. The hope is that it will inform later more detailed studies and eventually the development of routine information systems for managing child protection services.

Although most other research on child abuse is concerned with isolating the aetiology of child abuse or assessing the efficacy of treatment, a few other studies of child protection were undertaken prior to or concurrent with the current study. The work, for example, of Bacon and Farquar (1983), Dingwall and colleagues (1983), and Corby (1987) discussed in Chapter Three. There is also work on inter-professional practice and co-operation in child protection (Hallett and Stevenson, 1980, Hallett and Britoil, 1992), that is not discussed in detail here.

The research by Dingwall and colleagues (1983) and Corby (1987) studied cases that were not necessarily representative of all cases known to an agency. Corby studied 22 cases but without specifying the basis of case selection. Some of the cases were on the child abuse register and some were not. Dingwall and colleagues asked professionals about their work and focused down upon particular events and cases that seemed to illustrate certain aspects of the professionals child protection work. Both studies were therefore able to raise issues about operational definitions of abuse and child protection practice, but were unable to comment on the representativeness of their samples in the total population of agency cases of unknown homogeneity.

The study by Bacon and Farquar did examine a total population of cases, but only addressed the issue of placing children's names on a child abuse register. There was only very limited follow up of cases and their outcome. The outcome of these cases is important in relation to definitional issues for two main reasons. The first is that the predicted and actual consequences of an act will determine its considered appropriateness. Children are placed on child protection registers for a purpose even if these purposes are not always clear or consistent. The predicted and actual effects
of implementing an operational definition of child abuse through registration is therefore a major (even if retrospective) factor in assessing its appropriateness. The second reason that follow up of cases is important is that at some point a child may be removed from a child abuse register. This reversal of the operational definition of abuse (or rather protection from abuse) may reveal aspects of the nature of the original application of the definition; that is the need for labelling as a child protection case and applying child protection services.

The current study examined all the cases that were defined as cases of child protection of pre-school children in one British city. The study describes the families, the services they received and the longitudinal outcome at de-registration or at two years post registration if they had not been removed from the register by this time. The research strategy was not to sample cases but to study the total population of registrations to overcome the possible selection biases in previous research. The aim of the study was to broadly describe a total population of cases longitudinally rather than study a smaller sample in greater detail. The purpose was not only to contribute to debates on research and definitional issues, but to also explore broader issues of the consequences of the implementation of the definition and provide useful management information on the practice of child protection in a major British city in the early to mid 1980's.

Since this study was initiated a number of other studies of child protection work have been funded by the British government. The need for such studies was one of the main recommendations of a Department of Health funded review of the literature on child abuse interventions completed in 1988 (Gough, Taylor, and Boddy, 1988; revised and updated as Gough, 1993b). These new projects were started long after the research presented here and have yet to fully present their findings. It has therefore not been possible to take account of these studies here.

**DESIGN**

The study examined every new registration of a pre-school child that occurred over a fifteen month period and each of these cases was then followed up through Social Work Department documentation until they were removed from the child abuse register, up to a maximum of two years later. As many of the children had been placed upon the abuse register as being at risk of abuse the project collected more detailed data on those cases where a child had actually received an injury that was associated with the decision to register the child. For practical reasons this sub-
sample was restricted to cases recruited in the last twelve months of the fifteen months of sample recruitment. This data included detailed interviews with professional workers directly involved in the cases and interviews with the parents when this could be negotiated.

**TABLE 5.1**

**Study Research Design**

<table>
<thead>
<tr>
<th>Level</th>
<th>Subjects</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>All pre-school registrations</td>
<td>Case conference minutes</td>
</tr>
<tr>
<td></td>
<td>n = 147 families</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Registrations with physical injuries</td>
<td>Interviews (x3) with social workers &amp; health visitors</td>
</tr>
<tr>
<td></td>
<td>n = 55 families</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Level II cases where parents agree to be interviewed</td>
<td>Interviews (x5) with social workers, health visitors, and parents</td>
</tr>
<tr>
<td></td>
<td>n = 38 families (29 for full follow up)</td>
<td></td>
</tr>
</tbody>
</table>

The project is therefore a prospective longitudinal study of a total population of cases, with more detailed data gathered on a sub-sample and even more detailed data on a further sub-sample. The design is summarised in Table 5.1

The cases were studied for as long as they remained on the register with a maximum follow up of two years. The data on these cases were drawn from centralised case reviews and case conference minutes that are held centrally by the Social work Department. In some cases more than one pre-school child from each family was placed upon the child abuse register at the initial case conference. In these cases the child who the main social worker in the case determined to be the child whose welfare was producing the most concern was chosen as an 'index' child to represent the family in the research data. When it was unclear which child was most at risk, the index child was chosen randomly.
The study is particularly concerned with the management of those cases where the registration had been associated with some injury or assault having occurred to the child. These cases formed a sub-sample that were studied in greater depth than the series of cases as a whole.

The more detailed data on this sub-sample was derived from interviewing the key workers from the Social Work Department and Health Visiting up to three times over the two year follow up period. These interviews were attempted whether or not the child's name was still on the register.

The resource implications of collecting interview data at this level made it necessary to limit this sub-sample to cases registered for the last twelve month period within the fifteen months used for Level I. In addition to this restriction the cases had to meet extra criteria of being new registrations of cases of injury to pre-school Caucasian children.

Many children are placed on registers as being either at risk or having actually experienced different forms of abuse. At the time of sample recruitment in 1982 the local register had only two categories, 'Injured' and 'At Risk'. Pilot work showed that actual cases of abuse that were not physical abuse were usually registered 'At Risk' and so did not complicate the composition of the 'Injured' category. On the other hand, children with an injury which produced agency concern were often placed on the 'At Risk' section on the level of evidence and on the consequences of the registration. The observed variation in these practices led to a research criteria based upon the presence of an injury that was stated (by social workers) to be important in the decision to register rather than on the category of registration.

As the interest of the research is upon the process of intervention of new cases, it was felt necessary to concentrate on new registrations and not to include transfers in from other local registers or the addition to the register of one child whose siblings were already registered. The interest was also on pre-school cases and so also excluded at this level were multiple registrations in a family where it was clear that the focus of concern and case discussion was a child over five years of age in that family.

The population of Glasgow contains an ethnic minority of Asian families who may have different child rearing practices or to whom health and welfare agencies react
differently. To avoid the possible extra variation from these factors these relatively few non Caucasian cases were excluded in this level. 

For all the cases in the sub-sample of injured cases (Level II) negotiations were undertaken to see if it would be possible to interview the children's parents. Social Work Departments asked the parents if they minded their name and address being disclosed to the researcher, who would then contact them to explain about the research in more detail and formally asked for their permission to be interviewed. In only two cases did a social worker refuse to approach the parents on the researchers behalf and this decision was respected. In one of the cases, the parent came to hear about the research from another source and telephoned the researcher asking to be interviewed. She was in conflict with the Social Work Department and wanted the opportunity for her story to be told. While sympathising with the parent's request, the researcher had to decline this invitation as it would have transgressed the agreement between the researcher and the local authority Social Work Department.

When it was possible to meet parents and they did agree to be interviewed, then the main caretaker of the child was interviewed up to five times over a two year period. In these cases there were also up to two extra interviews with the professional caseworkers. This produces a further sub-sample creating the nested design with three sample levels each with different data collected. The formal criteria for inclusion at this level were that the relevant parent agreed to being interviewed and that at least the first three interviews were successfully completed, otherwise the case defaulted to Level II. The criteria for each of the three sample levels is summarised below.

**Criteria for Research Sub-Samples**

**Level I**


Child aged less than five years at date of registration.

**Level II**

Criteria for Level I plus:
Child has an injury or was subject to a verified assault and The Social Work Department confirms that this is one of the main concerns leading to registration.

Child is Caucasian and has lived 75% of life in Britain including at least sixteen of the previous eighteen months.

There was not another child in the family already on the register.

If more than one child in the family is registered at the same time, then the child whose welfare is causing the most concern is not over five years of age.

The case is not a geographical transfer in from another local authority Social Work Department.

Child placed on register in last twelve months of fifteen month case recruitment period.

**Level III**

Criteria for Level II plus:

The child's main caretaker in the two weeks prior to registration agrees to be interviewed.

At least the first three parent interviews are successfully completed.

**METHOD**

Different types of data were collected for each of the three sample levels and this is summarised below.

**Level I**

This sample was the total population of newly registered pre-school cases. The data were collected from Social Work Department case conference minutes. These are the official minutes of the meeting were signed by the case conference chair, who was usually the local Social Work Department area team manager and were circulated to all case conference participants with a request to immediately report any errors or misrepresentation in the minutes. Once agreement was reached they represented the official record of the case conference meeting.

The minutes provided information on the child and family; the reasons for the involvement of different agencies; the legal status, the service provision; case
conference attendance; and the main discussions and decisions of the meeting. One of the main decisions at the initial case conference is placement of the child's name on the child abuse register. If this decision was not taken then the case would not be a possible subject for this research and there would not automatically be subsequent case conferences. Later (review) case conferences have the power to remove children's names from the register and thus from the child abuse procedure system.

The case conference based data were collected on each case until the child's removal from the child abuse register up to a maximum of two years post registration. Once the child's name was removed from the register, the case conferences ceased and so there were no minutes to provide data.

The study was allowed full access to copies of the case conference minutes held centrally at the Social Work Department headquarters. Summary data was collected on every case conference minute under the following headings:

- Child's registration number
- Date of case conference
- Reasons for case conference
- Persons invited to / attended case conference
- Social Work Department area team
- Any new incidents, injuries, child protection investigations
- Any changes in specified agency roles
- Resources currently provided
- Legal status of child
- Statements about child's current circumstances
- Statements about main caretaker's current circumstances
- Contents of case conference discussion
- Specified decisions of case conference

The summary data was used for further examining of the data with back reference to the original case conference forms for clarification. Summary data are used as case illustration because it better reflects the data. Interpretative work is necessarily involved in creating summaries, but the extent of this interpretation depends upon the material concerned and the purpose of the summaries. In the present study the purpose was simply to draw together the different statements located in different parts of the case conference documents. This process was at the low end of the dimension of subjective interpretative work. It was judged that the research summaries provided a less interpretative reflection of the contents of these documents than small direct quotes that were out of context of the whole document.
**Level II**

This sample consists of those cases from Level I where the registration was associated with some injury or unknown assault to the child. The data consists of interviews with the main social work and health visiting caseworkers involved in each case. These interviews were performed at 8 months, 13.3 months and 24 months after initial registration, whether the child was still registered or not at these times. Timing sequences were calculated by dividing each month into three ten day sections. These intervals were used in order to provide five equally spaced interviews over the two year period.

The caseworkers were interviewed in their own offices with each interview taking approximately one to one and a half hours. In some complicated cases the interviews took two to three hours, either because of the complexity of the case or because of the professionals wish to discuss the case with a third party. The interviews were tape recorded and summarised on structured forms. The main topics covered in the interviews were:

1. Perception of the incident, the child, and the child’s caretaker and family situation. Plans for service provision.

2. Change of circumstances in family. Any concerns about the child’s caretaking environment, and the causes of these concerns. Any concerns about the service provision.

3. Assessment of possible risks to the child at home or if returned home.

4. Hypothetical ideal outcome for the child and primary caretaker.

5. Assessment of the relevance of the service provision.

**Level III**

This sample consists of those cases from Level II where parents of the registered child agreed to be interviewed. The data consisted of interviews with the original main caretaker of the child plus additional interviews (compared to Level II) with the social work and health visiting professionals.

The interview sequence for the caretakers was at 2.7 months, 8 months 13.3 months, 18.7 months and 24 months after initial registration whether the children were still registered or not. The additional interviews with the professionals took
place at 2.3 and 18.3 months after registration to make up a sequence of five interviews at the same time as the parental interviews.

Most parents did not have telephones and so had to be contacted by letter. When parents had informed the social worker that the researcher could contact them, then the researcher sent a letter suggesting a time that he would visit their home to discuss the research. If the parents did not contact the researcher to change this appointment, the researcher visited at the scheduled time, to discuss the study with parents, and if they agreed to participate in the interviews, to arrange an appointment to return to undertake the first interview. Subsequent interviews at 5 1/3 month intervals were arranged by letter suggesting a time for the researcher to visit and asking to parents to contact him if this were inconvenient.

Each interview took place in the parental home and was addressed to the child's primary caretaker, usually the mother, though in some cases fathers were also present. The interviews were tape recorded and summarised on structured forms. The interviews covered the following main topics:

1. History of child; social history of primary caretaker.

2. Influences on caretaker's parenting styles.


4. Perception of the health and welfare services.

5. Re-assess the initial registration; hopes and realities for the future.

Ethical Issues

All data collected was treated as strictly confidential. Information collected from one source was never passed on to another source. Information collected from social workers was, for example, never passed on to health visitors, or vica versa. Similarly, no information collected from families was passed on to professionals. The only exception to this rule was an agreement with Strathclyde Regional Council that the author should report any situations of extreme risk to children. In these cases the author would explain to the parents that, he had a responsibility to report the situation to the authorities. The necessity to report situations of risk occurred
twice during the study. On both occasions the parents involved accepted the need for the situation to be reported and in neither case was there evidence of any consequences of the report. The Social Work Department were either already aware of the situation or did not consider it of sufficient gravity for action. Alternatively it is possible that they took action unknown to the author, though this is unlikely considering the in depth nature of the study.

**Comparison Group**

A small comparison group of families who did not have children on the child abuse register and who were not necessary receiving a social work service, was also recruited.

A comparison or control group needs to be as similar as possible to the experimental group except in relation to the variable under study; in this case placement on the child protection register. In order to ensure that the comparison group were similar to the experimental group, they were matched on socio demographic variables with registered cases. In addition, some evidence of problems in relationships within the family or problems between the family and outside families or agencies was also required.

The families were matched with the registered cases at Level III on the basis of age of main caretaker, age of child, and socio economic status. The purpose was not to recruit a formal control group, but to identify a comparison group to provide baseline data about the experience and reaction to child and family problems within the community.

The families were recruited with the assistance of health visiting. Each health visitor assisting the project (by being interviewed about a child on the child abuse register who was under their care) was presented with the basic socio demographic details of another subject in the main study. The health visitors then identified everyone on their list who shared the same basic characteristics as the main sample case. The researcher then asked the health visitor which of these families matched on basic socio demographic details also possessed the extra matching details concerning family problems. If no family met these additional matching criteria, then the matching process was repeated for another main subject family until a match was found.
The comparison families were approached by the health visitors to ask if they agreed to meet the researcher and if they did agree then the process of discussing the project and arranging interviews followed the pattern for the main sample. The difference was that the purpose of the research was explained in terms of collecting data on families in general rather than families with children on child abuse registers.

One limitation of matched controls is that although they share common attributes with the research sample the matching process may identify subjects that in other respects are very unlike either the research sample or other subjects in the population. In other words, the process may identify a very unrepresentative group of comparison subjects that do not provide a useful comparison to the research sample. This is what happened in the present study. The families identified by the matching process had attributes concerning their relationships that were of concern to the health visitors assisting with the matching. These concerns mostly related to suspected problems within families who were not forthcoming in their contacts with the health visitors. The majority of the families were in receipt of state benefits but working illegally or involved in criminal activities. The families seemed resourceful at obtaining material possessions and at limiting health visitor interventions in their lives. These families, though interesting in their own right, did not provide a useful comparison to child protection work and so are not described here.
CHAPTER SIX

THE CASES PLACED ON THE REGISTER

The total research population consisted of all 202 children under five years of age (from 147 families) placed on the child abuse register in Glasgow during a 15 month period in 1982-1983. This chapter describes the characteristics of this population. Subsequent chapters describe the service provision and case management from the relevant agencies for this population and the sub-samples described in Chapter Five.

Each child placed on the register was followed up through Social Work Department documentation until they were removed from the register for up to a maximum of two years. As many of the children had been placed on the register as being 'at risk' of abuse, the collection of more detailed data (in sub-samples at Levels II and III) was restricted to all cases where the child had actually received an injury. A further sub-sample was studied where interviews with the parents could be negotiated. This chapter focuses on the first level of study, and describes the presenting characteristics of all the under five year old cases placed upon the register within a fifteen month period.

The chapter discusses case referral, previous Social Work Department involvement, case characteristics, and case type.

CASE REFERRAL

Before a case conference is held, or before a child's name is placed on the register, some organisation or individual must have brought the circumstances of the child to the notice of the relevant agencies. In practice it is the Social Work Department that has responsibility for these procedures though it is possible that some cases of abuse may be managed outside the system of formal procedures by other agencies. The data reported here are restricted to those cases that completed the referral process as far as the initiation of a conference and a decision to enter the child's name on the register.

The referral process may include the involvement of several persons or agencies before the Social Work Department is notified. For the purposes of this research 'first' or 'initial' referrer was defined as the person or agency who first draws the
attention of others to the possibility of abuse. The 'recipient' or 'second' referrer, is the agency to whom this reference was made. For example, if a neighbour told a health visitor of her concern about a child and the health visitor alerted the Social Work Department, then the neighbour would be the first referrer and the health visitor the second. In some cases the first referrer is more difficult to ascertain. In one case in the study a general practitioner referred a child with injuries to a hospital without suggesting the possibility of abuse to the hospital. The doctor in the hospital did consider that the injuries may have been abusive and so carried out a full examination which revealed healing fractures indicative of abuse and the Social Work Department was informed. In this case the hospital doctor was coded as the first referrer or the first person to raise the issue of abuse.

Table 6.1 describes the initial routes of referral of the 147 families whose pre-school children were placed on the register during the period of initial data collection. The principle feature of the table is that for nearly half of the families the initial referral came from the family itself or from neighbours or other members of the community. The largest agency referrals came from the Social Work Department in the city or from geographical transfer in to the Social Work Department. Educational services, particularly nursery schools, were the source of 14% of referrals, hospitals a further 12%. Only a few cases were referred by other professional agencies and only one initial referral originated from a general practitioner.

Although the Social Work Department identified more cases than other agencies it only identified 27 of the 147 families in the sample. The remaining 120 cases (families rather than individual children) were initially identified by the community or non social work agencies and 59% of these were referred directly to the Social Work Department. Forty nine cases were not directly referred on to the Social Work Department and 41 of these (84%) cases identified by members of the family or of the local community. Professional agencies referred most cases on directly to the Social Work Department. Members of the local community did refer 14 of the 33 cases (42%) that they identified to the Social Work Department, but the community more often referred cases to a range of other agencies such as hospitals, police and the Royal Scottish Society for the Prevention of Cruelty to Children (RSSPCC). In three cases community referrals were made to health visitors but only one parent made self referral to a health visitor. No members of the community referred cases to general practitioners but two parents did so. Health visitors were the initial referrer of a 5% of the cases registered but rarely were
## Table 6.1

**Referral Routes**

*Recipient of Referral*

<table>
<thead>
<tr>
<th>First Referrer</th>
<th>Community</th>
<th>Education</th>
<th>Hospital</th>
<th>Health Visitor</th>
<th>Police</th>
<th>RSSPCC</th>
<th>GP</th>
<th>Social Work</th>
<th>Other</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>5</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>28</td>
<td>20.7%</td>
</tr>
<tr>
<td>Community</td>
<td>-</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>-</td>
<td>14</td>
<td>-</td>
<td>33</td>
<td>24.4%</td>
</tr>
<tr>
<td>Education</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>18</td>
<td>-</td>
<td>21</td>
<td>15.6%</td>
</tr>
<tr>
<td>Hospital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>16</td>
<td>-</td>
<td>1</td>
<td>17</td>
<td>12.6%</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8</td>
<td>-</td>
<td>8</td>
<td>5.9%</td>
</tr>
<tr>
<td>Police</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>3</td>
<td>2.2%</td>
</tr>
<tr>
<td>RSSPCC</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>GP</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Social Work</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8</td>
<td>-</td>
<td>8</td>
<td>5.9%</td>
</tr>
<tr>
<td>Review</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>7</td>
<td>5.2%</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>8</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
<td>3</td>
<td>14</td>
<td>6</td>
<td>10</td>
<td>5</td>
<td>3</td>
<td>86</td>
<td>3</td>
<td>135</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Percentage: 3.7% 2.2% 10.4% 4.4% 7.4% 3.7% 2.2% 63.7% 2.2%
rarely referred on cases by families or the community. General practitioners were rarely involved in any part of the referral chain to the Social Work Department.

The type of abuse of concern in the current study varied with the source of the referral. Eighty per cent of self referrals were related to parents' anxieties that they or their partners might cause physical injury to their children. The 63 families where the area of concern was not physical injury were predominantly referred by professional workers. This might be because families did not refer themselves for help for non physical abuse problems, but a more parsimonious explanation is that agencies only invoked formal child abuse procedures (i.e. registration) when concerns about other forms of abuse were raised by professional workers. It might also be that self referrals for other forms of abuse are less clear cut and therefore less likely to be recorded as such in the case documentation.

For the sub-sample of 29 families interviewed for the study (which all involved cases of injured children) it was possible to ascertain the parents' explanations for these injuries. Table 6.2 presents the explanations offered by the parents and indicates which agency or person was the primary referrer; that is, who first overtly raised the possibility of child abuse. In seven cases the parents were at a loss for an explanation and most of these cases were referred by health and educational services that had been concerned about how the injury might have been caused. Health and other agencies also accounted for most of the ten referrals of injuries which were explained as accidental by parents. In contrast, the six cases presented as assaults by cohabitants were referred principally by the mothers or by others in the community. Maternal self-referrals and community referrals also accounted for most of the cases explained by parents as over chastisement or less specific explanations about being unable to cope with the situation in which they were attempting to care for their children.

Twelve of these 29 cases (41%) were self or community referrals, which is a similar proportion to that reported for the total sample. It indicates that there is awareness amongst the families themselves or amongst their friends, neighbours and relatives of concern for the welfare of the children. Two sets of parents felt that the community referrals were malicious but one of these families did accept that they were having problems with the care of their children. In another case of a young marriage that had arisen after a school age pregnancy, the community referral was by the child's grandfather who did not like his daughter's husband and his allegations of abuse resulted in a marital separation. It is not clear whether the
### Table 6.2

Parental Explanation by Primary Referrer

<table>
<thead>
<tr>
<th>Primary Referrer</th>
<th>Health</th>
<th>Education</th>
<th>Police</th>
<th>Social Work</th>
<th>Community</th>
<th>Self</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Explanation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Do not know</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Unknown assailant</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Assault by cohabitant</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Unable to cope</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>29</td>
</tr>
</tbody>
</table>
grandfather's action had a major impact on his daughter's marriage or whether it simply brought forward a break up that would have occurred soon anyway.

The following two case examples abridged from case conference records help to illustrate the way in which referrals were prompted by members of the family or of the community.

The child had a nasty cut in the roof of her mouth. The mother visiting the general practitioner on other business asked the doctor to check whether the child had catarrh which led to the injury being revealed. The general practitioner suggested that the injury should be examined at the accident department of the children's hospital. This only occurred several days later, after a reminder from the health visitor, and the casualty officer at the hospital was the first to question overtly whether the child was being appropriately cared for. They gave the child a full skeletal survey and found evidence of healing multiple fractures and contacted the Social Work Department. The mother then became very distressed and angry although it was later established that the mother was aware that the child's father had inflicted the injuries. (Case 287)

The mother was accompanied by her own mother in attending the local clinic. When the health visitor asked the mother about a few small bruises and marks on the child, the grandmother surreptitiously made face and arm movements to try and convey to the health visitor that something was amiss. (Case 258)

In the few remaining cases the referral to the Social Work Department was unwelcome at least in the early stages of Social Work Department intervention. Later on the majority of families (or at least mothers) were more willing to accept that there had been a problem. They were also more appreciative of the efforts that had been made on their part except in those cases where the children were being removed from the parents on a permanent basis. There was only one exception to this where a family did not cease to object to the basis of Social Work Department intervention and were not prepared to co-operate with the Social Work Department.

PREVIOUS SOCIAL WORK DEPARTMENT INVOLVEMENT

Many of the families had a history of previous involvement with the Social Work Department or the RSSPCC. In at least sixty six families (44%) there had been
prior contact of some kind concerning the children. In 12 families (8%) there had been a previous registration of a child. There was a history of other forms of Social Work Department involvement with the other parent or cohabitant in 28 cases (19%) and with the index child's principal caretaker (usually the mother) during her own childhood in 15 families (10%). No association was found between previous involvement with the Social Work Department and the state of the child at this registration.

The extent of previous Social Work Department contact was even more marked in the sub-sample of 29 families where the parents were interviewed for the study. Only two families had no contact. These contacts were largely a consequence of the extremely deprived backgrounds of the families. The dependence of the families on state benefits and housing meant that many families contacted the Social Work Departments for assistance in negotiating with the departments of housing and social security and with the gas and electricity boards. It is not clear how many of the families had previous Social Work Department contact for other sort of problems, but in at least eleven of the twenty nine cases there had been clear instances of previous concern about the care of their children. Furthermore, nine of the mothers themselves have been in care, but many more had been in trouble for truanting from school and a few had been before Children's Hearing Panels for crimes of theft or assault. The extent that histories of childhood difficulties or of previous concern about parenting was higher in the sample compared to other parents living in the same communities is not known.

The fact that the families experienced a wide range of social problems does not provide any simple strategies for earlier intervention. Most social workers interviewed would have liked to have offered support to families before a crisis, but the realities of case-loads and other resources made this difficult to achieve. Placing a child's name on the child abuse register allowed resources to be allocated because of the primacy of this type of work within the Department. There were however exceptions to this rule where support was invested in families before registration although it did not in fact prevent the events (such as injury of the child) that led to the later referral and registration.

The following three case examples abridged from case conference records help to illustrate the way in which referrals were preceded by known parenting problems and some attempt at prevention of further problems.
The mother went to the Social Work Department for assistance in paying the electricity bill. During the interview the social worker became aware of the mother being particularly short-tempered and unable to control her two young children. The social worker offered support and kept in contact. Some time later the mother went to the health visitor to say that she was not coping and this led to the identification of bruising and registration. (Case 162)

The health visitor realised that the child was not receiving adequate stimulation and was negotiating to involve a home visiting teacher, but this was not followed through because the child abuse referral occurred. (Case 258)

A family receiving intensive support, including several voluntary receptions of the children into care because of the parents not coping, the children failing to thrive and being subject to repeated illness due to suspected poor hygiene. There had also been several instances of bruising from neglect or over-chastisement. Registration occurred after a specific case of bruising to a child's face and information that the husband had six months previously sexually interfered with a neighbour's daughter. The mother's first male partner had been her own stepfather and they had a daughter who was now eleven years old. The mother's second male partner was a friend of her stepfather and this new partner acted as stepfather to the eleven year old girl and as biological father to the three younger children in the family. There had been suggestions that the eleven year old has been in the same bed as her mother and stepfather whilst they had sexual intercourse. (Case 161)

There was another group of cases where support services were provided to prevent problems in caretaking of children. These were cases of new born children where nursing or medical staff had anxieties as to whether the mothers would be able to cope when they went home from the maternity hospital. Complications at birth have often been cited as a risk factor for child abuse (Corby, 1993, p78), because of the frequency of these problems in identified cases of abuse and because of a belief that it disrupted maternal-child bonding that was thought to be a necessary precursor for later mother-child relationships and protective caretaking (Klaus et al, 1972). For these reasons, many Social Work Departments used to include birth history on child abuse case conference forms.
In the last ten years the perceived importance for children of parent-infant bonding has decreased (Sluckin et al, 1983), and this has undermined the theoretical importance of birth complications as a risk factor for child abuse. In addition, some studies have failed to find an association between birth factors and abuse (Leventhal et al, 1984). However, identified child abuse cases still have high incidences of such complications (Corby, 1993, p78). In the current sample, two of the children were very premature and spent the first few weeks in an incubator and a further six children were quite ill during the first few weeks of life. What is uncertain is the extent that the birth complications and illness disrupted the infants' relationships with their parents and increased the risk of abuse. An alternative explanation is that other factors such as the mother's own background had an independent effect on both the birth and on the chances of problems in the care of children. Six parents also reported experiencing postnatal depression but this is difficult to interpret because depressive episodes were such a frequent occurrence for many of the women interviewed.

In five of the twenty-nine cases there were attempts to intervene with support from birth. In only one of these was there birth complications. The child was premature and spent the first few weeks of life in an incubator and this may have provided greater opportunity for staff to observe the mother's behaviour and to raise doubts about how she would cope when the baby was discharged. However, the hospital were also influenced by their knowledge of the husband's psychiatric condition of schizophrenia, which was the only psychiatric diagnosis within the sub-sample at the time of registration. This was one of the two cases where social workers were brought in by the health workers in the hospital.

The following two case examples abridged from case conference records help to illustrate the way in which referrals arose from the birth of a child.

Because of the concerns voiced about the mother and the schizophrenic husband the health visitor and social worker monitored the situation. The mother moved around, staying in different homes, which created anxiety for the health visitor who often could not find her. However, the baby was developing well and the mother was anxious about the child and constantly sought medical attention. The child was received into voluntary care for three weeks because of the mother's alcohol abuse, which had been her reaction to stress since the age of fourteen. On return from care the child was injured when her brother attempted to hit the mother when they were both drunk.
The mother went to the police about this and was herself arrested for being drunk in charge of the child. (Case 242)

A social worker was allocated to the mother at birth because of her care of her newborn infant and because she had 'nerve' troubles. The mother moved in with a new boyfriend and so the Social Work Department lost contact until the community referral. The baby was found with bruises whilst in the care of a friend who was drunk. (Case 277)

In three cases the concerns about the possible care of the new born babies was because of previous or existing work with the families. In one case this was because of the general standards and social history of the mother's own family was known to the Social Work Department because of various problems with her siblings. In the second it was because of the inappropriate care of previous children. The third case involved the birth of a baby to a teenage child in care. These cases are illustrated by the following descriptions abridged from cases conference records:

Social workers advised the mother (to her displeasure) to have an abortion. After the birth the social worker and a homemaker encouraged the mother, who stayed in very poor housing with her father and brother, to move into her own house and to improve her care of the child. This did not occur and the social worker gave an ultimatum that the mother needed to co-operate and work hard or she would have to refer the case to the Reporter. One month later there was a sequence of three sets of bruising to the child over a one week period. At the third set of bruises a Place of Safety Order was taken and the child was never returned home. (Case 247)

The mother was well known to the Social Work Department as she had been in care, had been sent to a young offenders' institution and had lost her two previous children to permanent alternative care. The new baby was received into care at birth and returned to the mother a few weeks later. There were problems of inappropriate housing, alcohol abuse and violence. Bruises were noticed by the health visitor and although the explanation of an accident was accepted as possibly true, the other problems led to the child being placed on the child abuse register. Subsequently, there were repeated incidents of bruising and receptions into care. (Case 278)
The mother was a minor in care of the Social Work Department at the time of birth and was first in a home for mothers and babies and then moved to a supported flat as she came out of care. However, after a few weeks bruises were noticed on the baby and the baby was received into care and never returned. (Case 155)

All the attempts to provide assistance to avert a need for formal child procedures were by definition not successful in this sub-sample that included injured and registered cases. What is not known is the number of families who received such support and which were successful in preventing a worsening in the situation for the mother and the child. This would be important information, because selective preventive strategies can be open to the criticism that they concentrate resources on those who are likely to be unsuccessful anyway. A different strategy would be to concentrate the same resources on those who have slightly less severe problems. This might mean simply widening the whole child protection system. This system of registration and inter agency procedures is meant to be a preventive system; a system for preventing the risks to the children becoming realities.

Although there were some instances where problems were identified in advance and preventive action was taken before registration, the majority of cases did not receive such help because of difficulties in both identification and in resources. This can be illustrated by abridged case descriptions from case conference minutes:

A mother was living in very poor living conditions with four pre-school children and without the support of her husband who moved out whenever there was stress. The mother went to the Social Work Department for financial assistance, but the mother found it difficult to talk to others about her problems and the extent of these problems were not revealed until a community referral was made and the mother admitted over chastising one of the children due to stress she was experiencing. (Case 275)

The child had been admitted to hospital with a fractured skull from the father accidentally dropping her. This had occurred at a time of great stress in the family as the husband's business had failed, he had debts of £4,000 and they had to move to the most deprived and violent part of a council housing scheme despite their middle class ambitions. Months later there were other injuries explained as accidental but the injuries were unusual and led to a fuller
examination, the discovery of other injuries and the reception of the children into care. (Case 287)

There were, however, other cases where the extent of the difficulties were apparent but where the particular Social Work Department team did not wish to take a proactive role. As in, for example, this case summary abridged from case conference notes:

The mother was well known to the Social Work Department because of problems in her own family such as truanting by one of her siblings. There was also a catalogue of minor injuries to the child that came to the attention of the local team. The first investigation resulted in no action; the second investigation resulted in a case conference and the decision to monitor the case, but not to register it; the third investigation resulted in registration. After transfer to a different social work team there was a higher level of involvement and many of the major problems in the family were successfully resolved. (Case 153)

CASE CHARACTERISTICS

The Children

Child abuse registers were developed in response to guidance from central government and were initially restricted to cases of 'non accidental' injury though they have since been extended to include other kinds of abuse (DHSS, 1980, SWSG, 1982). In 1987 the Glasgow register had six categories of registration describing the type of concern about the welfare of the children.

Physical Abuse
Neglect
Failure to Thrive
Sexual Abuse
At Risk Sexual Abuse
At Risk

During the period of sample recruitment the Glasgow register had only two categories of 'injured' and 'at risk' were employed. The 'injured' category was intended for cases in which the child was injured and that this was due to abuse or lack of protection of the child from abuse. The 'at risk' category was intended for
cases in which there was either (a) the suspicion of abuse but a lack of evidence that abuse had occurred or (b) a belief that abuse might occur. In the sample 55 (27%) of the 202 children were registered as 'injured' and the remaining 73% as 'at risk' although 76 (38%) of the children had an injury associated with their being placed in the register. Approximately a third of the index children were under one year of age (Table 6.3) and the sex distribution for all the children was about equal with 106 boys and 92 girls.

**TABLE 6.3**

**Age Distribution of Sample**

<table>
<thead>
<tr>
<th>Age</th>
<th>Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>65</td>
<td>32%</td>
</tr>
<tr>
<td>1 year</td>
<td>36</td>
<td>18%</td>
</tr>
<tr>
<td>2 Years</td>
<td>47</td>
<td>23%</td>
</tr>
<tr>
<td>3 years</td>
<td>26</td>
<td>13%</td>
</tr>
<tr>
<td>4 years</td>
<td>28</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>147</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The categories of injured and at risk were the official categories for placing children's names on the child abuse register. However, attendance at a number of case conferences during pilot work and sample recruitment suggested inconsistencies in categorisation. For example, if a child had injuries and the case conference was worried that this may have been abuse but were unsure then there could be much discussion about which category the children should be placed in. Registration as 'injured' was considered more serious than registration as at risk and could lead to more forceful intervention in the family. Therefore case conferences were often hesitant to register a child as 'injured' if they did not wish a too negative a label to be applied to the family.

The discussions observed in the initial case conferences may have been partly caused by the nature of the register categories. The categories include at least three different concepts of state of the child, the type of abuse of concern to the case conference, and the level of knowledge about whether abuse had already occurred. The author therefore re-categorised the cases according to these three dimensions.
The purpose being to better specify and understand the type of cases being registered.

The first dimension was the actual state of the child at registration: for example, was the child injured or was there evidence of assault, malnourishment or developmental delay? The second dimension was the nature of the concerns about child protection. Were there concerns about physical maltreatment, sexual abuse, neglect, or just general care and protection? Third, what was the nature of this concern? Was it a strong belief that abuse had occurred, or was it suspicion that abuse occurred or varying levels of concern about future risk?

The state of the children at the initial case conference of registration is summarised in Table 6.4 and shows that many children had no injuries. Where there were injuries these were mostly soft tissue bruising and serious injury was uncommon. The possibility of permanent physical handicap was anticipated in four cases representing an estimated population risk of serious injury of 4.6 per 100,000 preschool children per year.

**TABLE 6.4**

State of Children at Registration

<table>
<thead>
<tr>
<th>State</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn</td>
<td>8</td>
<td>4.5</td>
</tr>
<tr>
<td>Bruise</td>
<td>62</td>
<td>31.0</td>
</tr>
<tr>
<td>Fracture</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Risk of disability</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Unkempt</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Malnourished</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Sexual experience</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>None stated</td>
<td>120</td>
<td>56.0</td>
</tr>
</tbody>
</table>

Total 207 100%

(five double codings: bruise and malnourished (x1); bruise and fracture (x1); bruise and burn (x3))
Only 2 cases (1%) were overtly sexual abuse but four more had some suggestions of a sexual abuse component. However, within four years the sexual abuse cases had risen to 15% of registered cases (Gough, 1988) and the officer in charge of the register estimated that at least 40% of cases had a sexual abuse component (P. Greene, personal communication, 1988).

The area of concern and the level of certainty about whether abuse had occurred in each case coded from the case conference minutes is presented in Table 6.5. For 121 children the concern was physical abuse. In over half of these cases the case conference considered there to be 'good evidence' of abuse and only 'suspicion' in a further quarter of the cases. Slightly higher rates of 'good evidence' existed in the cases of neglect and of general care and protection, which are categories more dependent on a general evaluation of child care rather than determining whether particular events took place. There was vagueness about the area of concern in 19% of cases and a lack of specificity about the basis for deciding whether abuse had occurred in a further 9%.

In summary, the registration process highlighted three main groups:

(a) a majority in whom physical abuse was known or suspected;
(b) a smaller group in which there was concern about the general well being of the child or children
(c) a more diffuse group in which some concern was expressed about the potential for adverse experiences.

Children's problems not directly related to abuse were rarely documented in the initial case conference minutes. For only 16% of the 202 children was there any recording of their prior behaviour or health development. The focus tended to be the life style and behaviour of the parents as an indication of the child's significant environment.

The Abuser

The case conference minutes indicated that the main caretaker, nearly always the mother, was considered as the actual or suspected abuser in 21% of the families. In a further 24% the abuser was thought to be the spouse or boyfriend. In 26% of cases the abusing individual was considered to be someone other than the main caretaker or cohabitant. In a large number of cases (29%) the identity of the abuser
Table 6.5

Area of Concern Versus level of Knowledge

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Physical</th>
<th>Sexual</th>
<th>Neglect</th>
<th>General</th>
<th>Other</th>
<th>ot State</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Evidence</td>
<td>60</td>
<td>1</td>
<td>8</td>
<td>34</td>
<td>5</td>
<td>0</td>
<td>81</td>
<td>40.1%</td>
</tr>
<tr>
<td>Suspicion</td>
<td>28</td>
<td>1</td>
<td>5</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>36</td>
<td>17.8%</td>
</tr>
<tr>
<td>Potential (prev. reg.)</td>
<td>17</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>9</td>
<td>36</td>
<td>17.8%</td>
</tr>
<tr>
<td>Potential (other)</td>
<td>44</td>
<td>4</td>
<td>2</td>
<td>18</td>
<td>7</td>
<td>14</td>
<td>67</td>
<td>33.2%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>18</td>
<td>18</td>
<td>8.9%</td>
</tr>
<tr>
<td>Totals</td>
<td>121</td>
<td>6</td>
<td>12</td>
<td>48</td>
<td>10</td>
<td>38</td>
<td>238</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

59.9% 3.0% 5.9% 23.3% 5.0% 18.8% 100.0%
was not known or not stated. As child abuse registrations procedures are rarely involved for risks to children from strangers, it is likely that the abuser was thought to be one within the immediate family. This lack of specificity about the person considered to be a risk to the child was particularly common in the 'at risk' cases.

**TABLE 6.6**

<table>
<thead>
<tr>
<th>Suspected Abuser</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main caretaker</td>
<td>31</td>
<td>21%</td>
</tr>
<tr>
<td>Carer's spouse/boyfriend</td>
<td>5</td>
<td>24%</td>
</tr>
<tr>
<td>Other person</td>
<td>38</td>
<td>26%</td>
</tr>
<tr>
<td>Not stated</td>
<td>43</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>147</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Among the families that could be described as 'nuclear', or where a cohabitant is thought to be present, the child's caretaker was regarded as the abuser in only 9% of cases, and the husband or cohabitant in 37%. In the 52 cases (35% of total) designated 'single parent' or 'single parent with others' the caretaker was considered to be the abuser in 21 cases (40% of single parents) and a boyfriend was suspected in only 5 cases (10% of single parents). Uncertainty and attribution to others was equally distributed between the different household types.

When the main carer was identified as the potential source of risk then this risk was related to either physical abuse (14 cases) or to general care and protection (15 cases). When a boyfriend or cohabitant was identified as a risk then the concern was more often about physical abuse (31 cases) than care and protection (4 cases). Where there were concerns about physical abuse by the main carer then this was usually after the children had been injured (11 out of 14 cases). However, for cases where a boyfriend or cohabitant was identified as a source of risk, the children were usually not injured (13 out of 31 cases). The concern was about potential physical abuse. For many of the cases where the children had been injured it was not clear who in the family had caused these injuries. The case conference and case planning therefore had to proceed in the context of general concerns about child protection from physical abuse, but without a clear idea of the nature of the risks to the child.
Family Relationships

Inter-adult stress was recorded in almost half the families, and, in 17 families, this amounted to violence. There was reference in some 20 others to the poor quality of the adults' lives, and of their limited ability to cope with the stresses of their circumstances.

More than half the case conference minutes made no reference to problems of adult-child interaction. Where this was an issue it was usually expressed in terms of either the skill or motivation of the adults in caring for their children. In only 10% of the cases were there statements about the caretaking qualities of the adults separate from the immediate concern of abuse. When these did occur, they were usually positive statements about the mother's motivation and protective role, with the supposition that such values could not be assumed in the parents of children placed on the register. In general, there was a tendency to focus on parental problems and attitudes rather than to explore in detail the caretaking environment and the physical, intellectual and social development of the children.

TYPE OF CASE PRESENTATION

The discussion so far suggests that the case conference assesses the case according to the state of the child, the area of concern (type of abuse), and the degree of knowledge that the child had been a victim of abuse and then tries to specify aspects the child, the family, and the alleged actual or potential abuser. In practice, the predominant issue for the case conference was the social interpretation of the meaning of the injury or other reason for referral that suggested a child might be in need of placement on the child abuse register and for case management to be subject to child abuse procedures. The cases were therefore re-classified a second time by the author according to the type of case presentation. The emphasis in this classification is on the agencies' responsibilities of ensuring future child protection rather than detailing the type of family or abuse concerned. The cases in the sample have therefore been divided into six descriptive categories arising from the discussion of cases in the case conference minutes. Each is described briefly:

1. Injury or the risk of injury from a violent cohabitant (21%, 31 cases).

2. Injury of uncertain cause (24%, 35 cases).
3. Injury or other adversity but non-abuse explanations accepted (14%, 21 cases).

4. Injury or other adversity but primary concern is about general caretaking (17%, 25 cases).

5. No injury but concern about general caretaking (17%, 15 cases).

6. Previous history of abuse or suspected abuse (13%, 19 cases).

1) Injury or the risk of injury from a violent cohabitant (21% of cases)

In 31 cases the main concern of the case conference was violence from the partner or friend of the main caretaker who was nearly always the mother. Of these 31 cases 13 were primarily concerned with risk or injury to a sibling older than 5 years of age. Eleven of these 13 families were nuclear in form. Referrals came primarily from the parents, or the community (5 cases), with a few cases from the Social Work Department itself (2 cases) or the education department (2 cases). Only 2 of the index children had injuries but 9 of their siblings (over 5 years) were injured or had been assaulted. In 3 cases, sexual abuse was suspected in a sibling or other related child. There had been previous Social Work Department contact in a number of these cases irrespective of the source of the initial referral.

For 18 cases the primary concern was risk or injury to the pre-school registered child. Half these children had an identified bruise or other injury. Although it was not always clear that the cohabitant was responsible for the injuries, the conference was concerned about this violence or violence between the two adults. In ten of the cases there was a belief that the cohabitant had either over-chastised or otherwise assaulted the child or sibling although the children were not always injured.

Referrals came equally from the parents, the community and from the Education Department and nearly all the cases had a history of previous Social Work Department involvement. The difference between the referral pathways was in the existence of injuries in the children. This was rare in the parent and the community referrals but all of the children referred by the Education Department were injured. Another difference was that the previous Social Work Department involvement in the parent referrals was usually child focused and included previous concerns or registration of the children.
2) Injuries of uncertain origin (24% of cases)

There were cases where the children had usually presented with an injury for which a variety of explanations were given. The case conference was often unable to decide exactly what had occurred, but did believe that abuse had taken place, and that there was a risk that it would recur.

Parental explanations included accidents (8 cases), the action of another person (8 cases), and an event of unknown cause (9 cases). At this stage the parents admitted their abuse of the child in only 3 cases. The referral pattern and family type were very similar to the sample as a whole, with the exception that a quarter came from hospitals and that there was a slight over-representation of 'nuclear' families.

3) Injuries, but explanations accepted (14% of cases)

For 21 families, the case conferences were prepared to accept the explanation offered by the parents for the child's injury. In 13 cases this explanation was that an accident had occurred, in 5 that the injury could be attributed to someone outside the family, and in 2 that the marks suggestive of injury were due to natural causes such as illness. The children were nonetheless registered because the incident leading to the conference had revealed other, more general, concerns about the family. For some this was anxiety about protection from further risks, but for others it was a less definite unease about the stresses and problems the family were experiencing. By themselves, problems like these would have been unlikely to have come to the attention of the Social Work Department and to have aroused concern that led to registration.

In this category there were few self-referrals (4 cases) or referrals from the community. The remaining cases arose from the suspicions of various agencies. Again, there were rather more 'nuclear' families than in the series as a whole.

4) Injury / adversity present, but concerns relate to general caretaking (25 cases)

In these families there was some evidence of a specific adversity or injury to a child in the family linked to a concern about the general caretaking provided for the child. The adversity was usually an injury, but in 4 cases there was evidence of an assault on the child, and in one a threat to end its life. One other child was
described as 'unkempt and uncared for'. Many of the families were single parent families (15 cases).

Ten of the referrals came from the community and 7 from the parents themselves. Others were from Education (6 cases), Housing (1 case) and a voluntary agency (1 case). The cases were not obviously different from others in their social work history.

5) No injuries but concerns about general caretaking (17% of cases)

These were families in which there were no known injuries to the children, but where there was concern about the ability of the parents to provide an adequate caretaking environment. Five of the 15 cases involved newly-born children when there was anxiety in the maternity hospital, or amongst social workers already working with the mother, about the care that might be provided when mother and baby were discharged into the community. A further 5 referrals came from the Social Work Department, the RSSPCC or other agencies when other case-work contacts had led them to believe that the children's parenting was inadequate. Four referrals from the community and one from the Police were more specifically concerned with the parents' abuse of alcohol and the neglect of the children. There was only one case of self-referral - from a mother who was finding it difficult to cope.

Seven of these families were headed by a single parent and the remainder were 'nuclear'. Apart from the 5 new births and the fact that there was only one self-referral, there was little to distinguish the referral routes of these cases from those of other categories.

6) A previous history of abuse or suspected abuse (13% of cases)

This category was based on anxieties arising from past history rather than current concerns. Ten of the 19 cases which were placed on the register arose from the transfer of families from Social Work Departments outside the city. Five concerned new babies in families who had previously abused their children, and 2 related to children previously in care and not on the register, who were being returned to their families. The remaining 2 cases came from a review conference on a sibling, and from a community referral.
DISCUSSION

The majority of registered cases, whatever their other characteristics, concerned children with relatively minor injuries and rather unspecific suspicions that child abuse had occurred or was likely to. While cases associated with severe injuries or major problems about the quality of child care create periods of intense concern for professional workers, the main responsibility of workers was towards children who were less than adequately protected in their own homes and probably at risk of abuse, but where there was little reliable proof of either circumstance.

The only other report which details aspects of cases from total groups of cases on registers in Britain is that of the NSPCC which describes the children placed on the twelve child abuse registers they maintain (Creighton, 1984; Creighton and Outram, 1977). In Creighton's reports significantly more boys than girls were registered, and about a quarter of the children were less than a year old. This is in contrast to the much more even spread of cases in terms of gender and age in the current study reported here. These differences in findings may reflect differences in the way that child protection systems operate rather than actual rates of abuse in the population. In the current study there are rather more cases of children aged between birth and six months and aged between two to three years. These statistics may be related to stressful stages in child-care, but may equally reflect the extent of parental contact with professional agencies at these ages.

Single parent families comprise about a third of the cases in both the NSPCC and the present study. This proportion is significantly greater than the 12% of single families reported by the General Household Survey (HMSO, 1984). This may be because single parents are a greater risk to children. For example, they may experience more stress, be more vulnerable to stress, or have partners and friends who are themselves a risk to the children. Alternatively, it may be that professional workers perceive the risk of abuse differently in this group of parents.

In order to identify cases of suspected child abuse as early as possible, it is important for families, neighbours and others in the community to be aware of the relevant agencies, and to be able to approach them. In both the NSPCC series (Creighton, 1984) and the present study roughly half the cases came to light from informal sources; but in this study relatively few (21%) of the parent initiated referrals were directed to the Social Work Department. The initial approaches were to a wide range of agencies.
The Social Work Department was more commonly the second or third step in the chain of referrals for all registered cases. Given that most referrals arose either from the families themselves or the community this is scarcely surprising; 37% of the 49 cases arising in this way were referred to hospitals, general practitioners or health visitors and 18% were referred to the police or the RSSPCC. Hospitals also acted as a second stage referral agency; a third of the cases that did not go directly to the Social Work Departments followed this route.

Against the background of a high proportion of parents' and community referrals, rates of case-finding by general practitioners and health visitors were very low. For general practitioners, an explanation may be that they are reluctant to compromise on-going relationships with their patients by invoking formal investigative procedures. An alternative strategy evident in a few cases was that general practitioners referred children to hospital without explicit reference to the possibility of abuse. One possible explanation is that it allowed doctors to ensure that the child was competently assessed while still preserving their own relationships with the family.

The situation for health visitors may be more complex. Other researchers in Glasgow (McIntosh, 1986) found that mothers frequently perceived health visitors as having a policing role in regard to their caretaking roles and responsibilities. McIntosh argues that this perception was a significant handicap to the health visitors' ability to provide help and support to young mothers and their infants. The reality of this policing role is, perhaps, not borne out in this study by the few cases (5%) initially referred by health visitors, but health visitors provide a routine service to all families with young children and so their individual case-loads will contain only a small proportion of families at risk of abusing their children. Health visitors do refer families to the Social Work Department but the cases may not all be considered as requiring a formal response by the child abuse procedural system (Bruce, 1980; Dingwall et al, 1983; Hallett and Stevenson, 1980). All 8 cases identified by health visitors and placed on the register concerned explicit physical abuse.

A similar perception of the purposes of the register may also apply to nursery school teachers and others in the education service. Almost all the children referred from this source were injured (usually bruised) whereas one might have expected
that, daily contact with young children would have drawn attention to a broader range of children who were in need of care and protection.

In the 1960's the Newsons reported that the use of physical punishment of children was more widespread in lower than upper or middle socio economic groups. In the literature on the physical abuse of children there was initially the view that child abuse could occur in any social class and was not class related (Wolfe, 1985). It is now accepted that low income families do have much higher rates of reported physical abuse (Taitz et al, 1987; Gelles and Cornell, 1990) and that factors such as poor housing and larger than average family size (Straus and Gelles, 1986) are associated with violence towards children. In the NSPCC data for 1982 (Creighton, 1984), 37% of the fathers of registered children were in semi-skilled and unskilled occupations; the corresponding proportion of the general population was 20% in the 1981 Census. In Creighton's analysis of the NSPCC data, fathers of abused children were significantly more likely to be unemployed even controlling for geographical area and social class.

The number of families in which major questions were raised about their capacity to cope with the stress of daily living is almost certainly an underestimate as these were only counted in the data analysis if specifically mentioned in the case conference minutes. The fact that problems in parent/child or adult/child relationships are mentioned in less than half of the cases may reflect a difficulty on the part of conference participants to conceptualise this area of their work. Being precise about the nature and quality of adult-child relationships may be a more demanding task for a case conference than describing the characteristics and behaviour of individual family members.

Case conferences focused on parental problems and attitudes rather than the situation of the children themselves. It is not clear why there should be a lack of interest in defining and monitoring the children's physical growth and development, intellectual and emotional maturity, and capacity to relate to their immediate caretakers and others. There is considerable evidence (Rutter, 1989) that a child's level of functioning can be a strong indicator of their caretaking environment. The lack of reference to these caretaking variables may be because they are not considered important by the agencies concerned or because such observations demand a level of skill and knowledge acquired with specialised experience.
One reason why agencies might focus on parents rather than children is that the agency concern is primarily about future risks which may be assessed in terms of the care and protection that parents can provide. The focus of assessment and casework is thus fixed on parents even if the ultimate concern is the welfare of the child. This leads on to the next chapter which considers the background of the families that have become the attention of this child protection activity by the statutory agencies.
Mainstream research has studied family background in order to identify risk factors for abuse. The interest is in the aetiology of the child abuse. Causal factors are also of importance to child protection; an understanding of how the abuse arose may inform action to try and minimise the likelihood of its repetition.

Family factors are, however, also important for other reasons. Family features not related to abuse or risk to children may influence the likelihood of a family being identified as requiring child protection. Furthermore, a family’s situation is major starting point for agency intervention. Family circumstances will effect the appropriateness and efficacy of different intervention strategies, whether or not these circumstances are related to the causes of the abuse (or risk of) or related to likelihood of case identification. A family’s circumstances also raises issues about cultural differences within society and cultural assumptions about family life and child care.

These issues are briefly examined before the presentation of data on families in the present study. Data is presented on the whole sample, where this is available. This is supplemented with data from the interview sub-sample of twenty nine families (Level III data).

SOCIAL CONTEXT

The four ways in which family circumstances are important to child protection are discussed in turn.

The first is the 'medical' or 'aetiological' approach discussed in Chapter Two, which examines the context of abuse in an attempt to identify the causal factors that led to the abuse. Factors that are frequently associated with known cases of abuse are used to develop causative models of how the abuse occurred (for example, Gelles, 1974) and lists of risk features to aid in the identification of cases (Browne and Saqi, 1988). The features do not have to be restricted to the individual level of analysis. At a micro level Kadushin and Martin (1981) have examined the immediate precursors of abusive incidents. At a broader level Garbarino (1981) has examined the features of local environments such as communities and neighbourhoods. In
practice any aspect of the social context can be examined for its potential contribution to risks to the child. Even if some feature is not a direct or main cause it may still have a contributing factor in being part of the social context in which the incident occurred.

The second approach to contextual factors is their effect upon the identification as a case of abuse referred to in Chapter Three. The idea is that there are many children in the community who could be considered at risk and many children experiencing adversities such as minor injuries. The social processes by which some of these children come to be assessed for risk may be dependent upon social features that do not necessarily represent risk - for example, the physical appearance of parents bringing a child with a bruise to a casualty department (Dingwall, Eekalaar and Murray, 1983). Once considered in this way the social features influencing case identification may act again to reinforce the way in which risk assessment is made. This process would then be confirmed and extended by research that collates features of registered cases to produce lists of risk features to aid future risk identification and assessment (Gough et al., 1982).

A third reason why social context is important is the effect of the families' social context as the starting point for any agency intervention, which includes providing help for the family and ensuring future child protection. The reality of who the client is as a person and the family or other context in which they live is the starting point for Social Work Department intervention. It will determine the ability of the family to change in order to reduce any future risks to the child and is therefore central to the issue of the likely case outcome. The families' social contexts will affect the possibilities for Social Work Department engagement in order to embark on a programme of change jointly with the family. It will also determine the structural factors that might obstruct the potential for such change including a family's vulnerabilities to new adverse events in their lives. For example, the process of case intervention is highly stressful and may itself be an adverse event that the family has to overcome. The issue is whether the family are able to overcome the difficulties that they face and the best methods by which this can be achieved. As a primary concern of Social Work Department intervention is the protection of the child, consideration has to be given to the risk to which the child is subject during the period of intervention as well as the likely success of such strategies.
In this way the social context of the registered cases provides the starting point for any such social intervention of child protection. An assessment of this context is necessary for both planning these interventions and as a baseline for assessing the progress of case plans and for recording case outcomes. The importance of this can be illustrated by referring to the case outcomes for single parents reported in Chapter Nine. It was found that many children were received into care from different families over the study period, but it was predominantly the single parents who lost their children into long term care. It may be that this was inevitable in which case it could be argued that these permanent arrangements should have been secured earlier. Alternatively, it may not have been an inevitable outcome if the services could have better addressed the problems in parenting experienced by these single mothers.

A fourth and related aspect of why it is important to locate the families within their social context is that child abuse work has been predominantly based on a concept of family pathology (Parton, 1985). Although it is clear that families involved in the child protection system often do have a large degree of social or psychological problems there are dangers that the pathological model can obscure implicit aspects of systems of child abuse intervention. Assessing dysfunction in individuals or family systems is necessary but it is also relevant to examine the conditions in which these individuals and families operate. In Western societies parents take the primary responsibility for child rearing with the assumption that they will have the material social and psychological resources to be a parent. These societal level assumptions are becoming increasingly difficult to take for granted with the large scale demographic changes in the nature of families in Britain. Many parents have few material resources and lack the support of friends and relatives. Many parents are single and shoulder the material and emotional burdens of parenting alone. Systems of child protection are based upon intervening when child care is believed to have dropped below a level of minimum parenting, and concepts of what the majority culture defines as such a minimum and its relation to the social context of families so identified become are therefore central to social policy in this area.
CURRENT CIRCUMSTANCES

Material Circumstances and Housing

Case conference minutes only recorded details about income or housing if these were a particular focus of concern and discussion to the case conference or in the submitted professional reports to the case conference.

Few case conference minutes explicitly referred to the type of housing inhabited by the families. The interviews with social workers and the author's observations at case conference indicated that it was assumed that families were living in council accommodation unless otherwise stated. These impressions were confirmed by more detailed data collected for the sub-sample of cases where parents were interviewed in person. For the sub-sample of twenty nine families interviewed for the study twenty six were in state housing. The exceptions were a family who were just managing with a mortgage, a family who were living in a privately rented flat, and a teenage girl placed in a residential home for young single parents. The family with the mortgage were behind with their payments and subsequently had to give up the house. The family in the private rented flat were supported by social security. The young single parent was herself in care of the local authority. Thus, none of the families in this sub-sample were self financing the cost of living in private sector housing. There was nothing in the case conference data or from conversations with social workers to suggest that this was not also true for the total sample.

Parental occupation was only recorded in 17% of case conference minutes and virtually all of these were unskilled manual jobs. The small proportion of cases prevents any proper social class analysis, but more detailed data available for the sub-samples of the series suggest that parental occupation is recorded only when the parent is known to be in work or to have a particular skill or training. It is likely, therefore, that most of the 83% of non coded cases were unemployed and in receipt of Supplementary Benefit (though some of these families may have worked unofficially). Case conference minutes did not specify employment because it was assumed that the families were financially supported by state benefits and living in local authority accommodation unless otherwise stated. In summary the families admitted to the child abuse register were almost all poor, unemployed and supported by Supplementary Benefit. Taitz and his colleagues have reported a similar finding (1987).
There were a few cases of employment in the case series, but these did not significantly affect the families' material circumstances for several reasons. Firstly, all of the known cases of employment involved unskilled and poorly paid manual work. This resulted in working families receiving income that was only slightly higher than the benefits that it replaced. Secondly, it was usually only the men in the sample who were employed and so the extra monies were not directly under the control of the mothers of the children. Any extra monies could therefore easily disappear in the men's consumption of alcohol or tobacco.

The families who were relatively affluent were those who increased their levels of benefit by changing their lifestyle or by defrauding the welfare system. At the time of the study individual adults living alone received more welfare benefits than when living together as couples. It was therefore common for the men to have their own housing accommodation and to just visit their wives or girlfriends. This meant that the men and women had separate incomes and gave the men power over how much, if any, they contributed to the woman and to child care. For the women there were also benefits of having the welfare for themselves and their children paid directly to them rather than through their male partners. There was no extra cost in duplicating the housing accommodation as this was paid for by the State. There were particular economic advantages of separate living when the man was in work as his income would stop the free housing and other benefits that would otherwise be received by the mother and children.

There were few opportunities for claiming welfare benefit whilst engaging in employment. Virtually all the families were living in large housing schemes where there was little casual work and where engaging in work was highly visible. Those who did work and had some special skill (for example, upholsterers or scaffolders) received particularly good incomes as well as receiving welfare benefits including free housing. There was therefore a marked difference between these families and others in the sample in the income coming into the house. The material quality of the subjects' homes were not systematically studied during the research, but there was no obvious difference between homes apparent to the researcher on home visits for the interviewed sub-sample. Nearly all homes had simple and poor quality furniture despite any disparity in income. Fraudulent incomes were particularly common in the small number of comparison families interviewed. In these cases black market employment often included illegal activities such as theft or dubious sales practice. These families were usually very able at working outside the
accepted systems and in vivid contrast to the main research sample did display obvious wealth in sumptuous household furnishings.

Few of the families in the interview sample were able to save as their outgoings equalled or exceeded their income. It was common for families to borrow small amounts of money from their friends and relatives at the end of their payment week. The families were highly dependent on state agencies for finance and housing and so had relatively little real autonomy. They lived within a very fragile family economy where there were no personal reserve resources to fall back on at times of crisis.

The lack of financial resources in the sample of families with registered children therefore had many knock-on effects other than the physical quality of the housing and pressures as to who could reside there. It also determined the area of the housing which had several social effects. First, it influenced social contacts and the people who were likely to be neighbours and friends. Housing allocation was based upon a points system that concentrated those with social problems in similar areas. This might produce empathy and mutual support, but also resulted in concentrations of deprivation. Similarly, these areas tended not to be well served by amenities such as retail outlets or transport. Ironically, therefore, they were not cheap areas in which to live.

Although the families were all from the most economically deprived part of the community they did not all live in the most deprived areas of the city. Figure 7.1 shows the rate of child abuse registrations for each Social Work Department area team against the local authority's index of socio-economic deprivation for the area covered by each team. There is only a slight tendency for the most deprived areas to have higher registration rates. The difficulty is that any association between maltreatment and deprivation may be masked by differing practices of case referral and identification across the Social Work Department area teams. There was anecdotal evidence that a few of the area teams in the more deprived areas had higher criteria for registering cases on the child abuse register.

**Family Structure**

Any attempt to categorise the family structure of abused children runs the risk of being misleading. Relationships were frequently transient with rapidly changing constellations of 'family' members. Also, there was reticence in providing accurate facts, so that information gaps were common. It was therefore difficult for case
FIGURE 7.1

DEPRIVATION FACTORS BY
REGISTRATION RATES
FOR EACH SOCIAL WORK AREA TEAM

PRESCHOOL REG. RATES
PER 1000

PERCENTAGE
VULNERABLE CHILDREN
PER AREA TEAM

STRATHCLYDE REGION
VULNERABILITY FACTORS
REG. = REGISTRATION
conferences to designate the structure and 'system' of a particular child's immediate environment, particularly when the cases first came to conference. With these reservations, families were categorised as follows:–

(a) a nuclear family in which two adults of the opposite sex live in the same place (39% of cases);

(b) parent living with a cohabitant though not necessarily on a permanent full-time basis (24% of cases);

(c) a single parent living with other adults, relatives or others (12% of cases);

(d) a single parent living alone (23% of cases)

More detail was available on the twenty nine families interviewed for the study. Most of the parents in this sub-sample were in their late teens or early 20's. They were younger than the wider research sample with 24 out of the 29 (see Table 7.1) mothers having had their first child by the age of 20 years. The average age for first births is lower for illegitimate than legitimate births, but both are in the early to mid twenties in Glasgow (Registrar General, 1986). The finding of earlier first births for mothers of children thought to have been abused is supported by research by Taitz (Taitz et al, 1987) in Sheffield and by Browne and Saqi (1988) in Surrey.

**TABLE 7.1**

Age of First Live Birth for Mothers in Sub-Sample

<table>
<thead>
<tr>
<th>Age of First Birth</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>
Although two-thirds of the sub-sample were cohabiting (20 of the 29 families of nuclear form, 62%) only a handful of these were in long-term permanent relationships. It was more common for there to have been either major separations and for the mothers to be living in reconstituted families with new partners and with children fathered by different men. Table 7.2 shows that for most of the mothers their current boyfriend cohabitee, or husband, was not their first serious relationship and that only nine of the twenty-nine mothers were in a continuing relationship with the father of all their children. For most of these nine mothers there had been periods of serious separation which could have become permanent.

### TABLE 7.2

Mothers' Report of Relationship and History Fatherhood of Children for Sub-Sample

<table>
<thead>
<tr>
<th>Main Partners</th>
<th>Cases</th>
<th>Current Partner Father of all the children</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2</td>
<td>n.a. 2</td>
</tr>
<tr>
<td>One</td>
<td>6</td>
<td>6 0</td>
</tr>
<tr>
<td>Two plus</td>
<td>19</td>
<td>3 16</td>
</tr>
</tbody>
</table>

(Total: 27 9 18)

(Data not available on 2 cases)

The distinction between single and nuclear families was further blurred by the amount of isolation that the mothers could experience within a relationship. Many cohabiting mothers were experiencing stress from interpersonal conflict and physical abuse. There was overt evidence that eleven of the twenty-nine mothers were victims of physical assault and, for several more, physical violence was part of their relationship with cohabitants and boyfriends.

There are several ways in which a person's social circumstances may not be supporting. Four types of non supporting or negatively supporting contexts relevant to the current data are described in turn.
No positive support

The importance of social support on adult functioning has been demonstrated by many authors (for example, Brown and Harris, 1978). The importance is not only in the lack of received support but in the awareness that supposedly significant others are not providing such support. This includes the lack of 'milieu reliability' (Gottlieb, 1985), the powerful social support received by the belief that significant others will come to one's aid in times of emergency, even if this belief is erroneous. A belief in milieu reliability is difficult to maintain if one's own parents are present but fail to recognise or react to the needs of their young adult children or their pre-school grand children. This may be because the mothers' parents did not have these abilities or because their only motivation for being present was selfish needs such as housing accommodation. It can also be partly because the mother felt unable or ambivalent to request support.

Lack of positive supports can be illustrated by the following examples abridged from case conference minutes:

Subject living in cramped housing without any hot water and attempting to care for her four pre-school children. The cohabitant is temporarily away because of the cramped conditions and because he always leaves when the mother becomes depressed. The mother gets no help from her many sisters and so has to cope on her own. (Case 275)

Husband assaults his wife's father and is jailed for grievous bodily harm. The subject mother stays loyal to her husband but is therefore isolated from her parents and from his parents who blame her for the jailing of their son. She is also isolated from her husband who is in jail. It is in this context that the subject fails to cope with the care of the children. (Case 236)

Isolated physically

There were no real examples of physical social isolation identified in the sample. The single mothers living on their own all had relationships with men even if these were transitory. These were often very recent and displayed the mother's motivation and ability to acquire social relationships often after being transplanted into a new area by the needs for new housing. These relationships did not always
provide the support that the parents said that they sought. This can be illustrated form the following example from a mother interviewed for the study:

Single parent who had a mother and several siblings whom she saw quite often but who offered no real support. She therefore drifted through several boyfriends who were casual sexual and drinking partners but did not offer the continuity and stability of relationship that the subject reported that she desired. Two of her relationships involved men found guilty of physical or sexual assault of children and which triggered the reception of her child into temporary and then permanent alternative care. (Case 133)

Support but with negative costs

There were several cases where there were significant others who provided the mother support, but where other aspects of their lifestyle or personal demands conflicted with the mother's parenting role.

This can be illustrated form the following examples from mothers interviewed for the study:

The husband was in employment that took him away from home for days at a time. When he was away the mother could just about cope but was stressed from the lack of emotional support and role value of a husband in the house. However, when he was present he caused the mother stress by his violence, temper and his demands for perfectly behaved children. (Case 162)

The mother said that she could cope with the child but that she was subject to violence from her ex cohabitee who was on the run from the police. The mother did show her independence by informing the police of the man's whereabouts but also ran off with him several times. The mother reported that she needed the relationship with this man despite the stress he caused from his violence and his continual conflicts with the police and the courts. (Case 180)
Active negative support

The American research literature has discussed the need to consider the negative effects of some social supports and this is confirmed by the wider social support literature. Malevolent intent of the significant others is not necessarily for the support to be negative. All that is important is that it should undermine the mother's ability to support her child (Van Meter, 1985).

This can be illustrated from the following examples from mothers interviewed for the study:

The mother of the child was not in a very satisfactory marriage, had few other supports and had an alcohol problem. Her own mother stayed with her, but does not provide much material or emotional support. The mother reported that she recently discovered that her own mother had been sleeping with the husband (case 242, parental interview). The result was that her roles as wife, daughter and mother (of the abused child) were all undermined. (Case 242, social work interview)

The mother had the tenancy of her own house but her siblings moved in and she and her child had to sleep in the sitting room after they had all finished watching television. The mother was treated as a servant and mocked and liable to violence if she attempted to assert herself. (Case 256, social work interview)

Although the type of difficulty varied between families, all of the mothers in the sample were experiencing major tensions and difficulties in their relationships with their cohabitants and boyfriends and in the ways that these impinged upon their ability to care and protect their children.

Family Activities

It was rare for the families to go on outings even when this involved little expense like trips to a park or to go window shopping. One notable exception was a family that the researcher met by coincidence in the local airport where they had gone to show the children the aeroplanes.
Most entertainment was home based and spare money was often spent on this in the form of televisions, video recorders or music systems. The author saw little evidence during home visits of the mothers or fathers engaging their children in play or joint activities. Children would play on their own or with siblings or friends and would seek parental attention or help. It was extremely unusual for the author to find parents initiating this contact or engaging the children in joint activities such as reading, drawing, or helping with domestic tasks around the house. Neither were there overt expressions of affection such as touching or holding the children. When the researcher asked parents whether they ever played or danced with their children, they reported that they 'felt daft' of conversing in pseudo conversation ('motherese') with a pre-school child and in dancing playfully with their children to music.

The author saw more signs of parent child interaction with the older, mobile, and verbally skilled young children, but these interactions resembled adult to adult interactions. The most obvious difference was the differential power and status with parents being highly directive to their children, though not always successfully. Not surprisingly, many parents had poor child management skills. The directives were concerned with noise, misuse of food, and touching or going near proscribed areas or objects. In other ways the children's lives were similar to their unemployed parents except for the responsibilities for domestic chores. The children usually ate the same food and had similar bed times as their parents.

The lack of an active role beyond the physical care of their children cannot be totally accounted for by a lack of experience in caring for children. Many of the mothers were brought up in large families and had extensive experience of caring for their siblings and baby-sitting for friends and relatives.

Similar lack of skills or motivation was evident in the feeding of the families. In only two families (277, 155) was there evidence of cooking beyond frying and the occasional boiling of potatoes. The main raw foods were beefburgers, sausages, chops, eggs and chips. There was also much use of prepared packaged foods such as pies and baked beans that simply needed re-heating. Green vegetables and fruit were virtually never mentioned by the parents. Much use was made of bread for sandwiches and snacks. Most of the children were also provided with snacks from the mobile shops that regularly stopped in all of the streets. There was regular use of sweets and crisps but the main item was flavoured carbonated water or 'ginger'.


This has a high sugar content and may have provided the largest single source of calories for the children.

The Child in the Family

Mention has already been made of the fact that the majority of families did not contain children with the same biological father. Most of these families were, however, still relatively cohesive in terms of a mother with her children. This contrasted with a few other families where previous children had been passed on to relatives or previous partners (Cases 145, 180) or received into care on a permanent basis (278).

Twelve of the families had only a single child at the time of the incident leading to the child's name being placed on the child abuse register and so the parents had experienced problems at the first attempt at child rearing. This is an underestimate of the real situation as many of the families only experienced problems when the children reached three or four years of age, by which time other children may have been born. In addition, there were two cases where there had been previous children born but all of these had been received into care or been given over to the children's father to care for. In other words, continuing care of all the previously born children had not been achieved.

It is not possible to gauge how planned the pregnancies were. The mother did not usually articulate conscious strategies of planned parenthood, but neither did they report shock or surprise that they had become pregnant. It would therefore not be correct to characterise the children as unwanted even if not coherently planned.

A problem with research on the current sample is that an assessment of the locus of the child within the family is only available historically and bound to be speculative, particularly as it is made after a child injury that the agencies to consider possible or actual abuse. In most cases it did seem as if one child was more likely to be abused than other children in the family but in only two cases was this overt scapegoating where one child received the blame and aggression for all the family ills. Rather it appeared that one child was at a particular developmental stage that the parent found difficulty with or had learnt a particular behavioural repertoire that ensured that any immediate stressors or precipitating events were likely to involve that child.
MAIN CARETAKER BACKGROUND

In addition to the impoverished quality of current relationships the mothers in the sample also came from cultural backgrounds that many would consider to be sub-optimum. Although such judgements are obviously value based they are important for two reasons. Firstly, a background that does not value and make use of formal and informal educational experiences is less likely to result in people fulfilling their potential within society as a whole. Secondly, the quality of the mothers' care of their children will be judged by professionals who do inhabit that culture and may well hold middle class views of child care.

All of the mothers left school as soon as this was possible and without educational qualifications or specific job skills. Two mothers learnt secretarial skills, several went to work as machinists in factories, and one started a course for nursery staff. Only the two secretaries continued to utilise their skills. The others gave up their courses or employment after a few months and joined the rest of their classmates in unemployment. There was little or no suggestion of the need for training and employment despite several women having participated in youth training schemes. An exception was a mother who studied part-time for two 'O' levels during the period of the study.

Unemployment was an accepted view of life from the time they left school. None of the mothers mentioned any hobbies that they had developed. Several discussed subjects that they would like to study and become involved in, but this had not yet been realised. Entertainment centred predominantly around visits to friends and relatives, and television. External entertainments were relatively uncommon and were restricted by finances even when it was of interest. A few went to the bingo and a few to pubs although this was a much more common activity for the men. Several of the women reported that they had enjoyed going to dances in the mid-teens but this had in most cases ceased when they became mothers.

Previous Adult Relationships

Few of the primary caretakers of the registered children (all mothers in the interviewed sub-sample) could be described as having been in stable supportive relationships with members of the opposite sex at the time of case identification. It is therefore useful to examine the mothers' backgrounds to see if there was a history of such a lack of stability in their lives.
Table 7.3 shows that 22 out of the 29 mothers experienced a major loss of one or both of their biological parents in childhood. The table only indicates the overt and continued loss of a parent as there were other cases where the parent was not psychologically available because of their own problems or lifestyle.

### TABLE 7.3

**Loss of Parent in Childhood**

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopted</td>
<td>1</td>
</tr>
<tr>
<td>Put out of house by parents</td>
<td>2</td>
</tr>
<tr>
<td>Death of a parent</td>
<td>5</td>
</tr>
<tr>
<td>Parent leaves family</td>
<td>12</td>
</tr>
<tr>
<td>In care for part of childhood</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

n = 22 cases producing 29 codings

This can be illustrated from the following examples from mothers interviewed for the study:

A subject’s mother being in hospital for extended periods because of 'her nerves' (Case 269)

Did not feel wanted by her parents. Her father was always drunk and her mother was away at bingo or with her boyfriend (Case 146)

A subject frequently moving to stay with her aunt when her mother was drunk and violent. The subject felt that her mother did not like her and at age 14 she moved to stay with her grandmother (Case 162)
After the death of her father, her mother formed a new relationship, had more children and earned money as a prostitute at home. Her mother then had little time or motivation to care for her (Case 180).

There were also many other indicators of problems within the mothers' earlier relationships with their own parents. In particular, the feeling that there was not a reciprocal intimate supportive relationship. This included not speaking to her mother and leaving home as soon as possible (Case 179); her mother not coming to her wedding (Case 189); hearing of father's death by accident (Case 180). There was undoubtedly neglect and physical, sexual, and emotional abuse of these women as children but it was easier to record the lack of warm supportive relationships rather than specific incidents of abuse although a few of these were reported.

The history of early problems in relationships with their parents is important to their own later parenting for at least two reasons. The first is that their understanding of being a parent and appropriate parent-child relations will be coloured by their own experiences of being a child. The second is that there is growing evidence that disrupted parenting can lead to poor social functioning as a young adult and parenting breakdown in the next generation (Rutter, 1989). It is difficult to demonstrate developmental continuities in psycho-social problems but in the study there is some descriptive evidence of the continuing difficulties experienced by the mothers when they were in their teens. Seven of the women reported that they were disruptive or truanted routinely from school and two of them were expelled. One woman ran away from home and overdosed on drugs at the age of 13, one was seriously abusing alcohol from the age of 14, one was caught shop-lifting and two were sent to young offenders' institutions for assault. There were similar reports of problems including truanting, substance abuse and under-age sex amongst their siblings. These findings may, however, simply be a feature of the sub-cultural context from which the families were drawn.

Cultural Relativity

The danger of reporting these aspects of the parents' backgrounds, lifestyle and material conditions is that it can read as a middle class attack on the fundamental culture and lifestyle of parents who are already under criticism for not reaching the standards of child care demanded by the health, welfare and policing agencies. That is not the intention of this thesis. On the other hand, it is dangerous assess the
adequacy of parental responsibility for insufficient child protection and the possibility for supportive intervention without addressing the parents' context and the parenting culture which they operate within. For example, it could be argued that these families are part of a larger group all of whom could be considered to be inadequate parents by the intervention agencies. It may simply be visibility or some specific event that brought the child care to the agencies' attention. The focus on any one family may therefore be largely a factor of chance and this is bound to affect the perspective of the family to the child abuse procedural system. For example, how 'good' does the parenting of the child have to be before child protection services to withdraw, and how do these standards relate to other families living in the same street?

The description of the multiple problems of the families makes it unsurprising that many had received Social Work Department assistance or had been referred to social work as of potential concern. The problem seems to be less in identifying the families with problems as in mobilising sufficient and effective help prior to incidents of abuse. This is partly because there was not a sufficient basis even with some parental co-operation to become involved in any extent in the factors impinging on the parents' lives. The reasons for this could have been available resources, including social work time, the realities of a visiting service being equal to the other forces within people's lives, or due to the implicit ethic of not intervening in a major way without a sufficient basis to justify it.

In several other cases the families were not known to the agencies and the referral and Social Work Department involvement was due solely to the abusive incident. These families had, in the main, presented as adequately functioning families to the health visitors who had been involved. It was common for the health visitors to state their greater concern for other families on their lists than the particular family being discussed at the initial child abuse case conference.

The many problems of impoverished childhoods, current relationships with their children and significant others, their confused and unsatisfactory extended family supports, and poor material circumstances makes child abuse seem almost a random associated event. Systems of child abuse registration selects out certain families as having children at risk, but this is only one of many risks or non optimal outcomes for the families and their individual members. Any social intervention by the state needs to take account of this social context. Firstly, in deciding what intervention is
necessary and for what reason. Secondly, in order to understand and assess the potential for the change that the intervention strives to achieve.

An examination of the social context of the families in the research sample shows that they have experienced a range of difficult life events, a lack of supportive intimate relationships from their partners or their own family, and continuing material stresses of housing and lack of finance. Child abuse can occur in every social class, but many authors now acknowledge that physical abuse is more commonly identified in lower socio-economic groups (Gelles and Cornell, 1990). The more detailed data on the sub-sample confirms the macro result on the total sample that cases of physical abuse identified in Glasgow are virtually all from the most socially, psychologically and economically disadvantaged sections of society.
CHAPTER EIGHT

AGENCY INTERVENTION

This chapter considers the agency intervention that occurred to the study families subsequent to the children being placed upon the child abuse register. The main agency concerned in child protection is the Social Work Department. It is the Social Work Department who manage the initial and subsequent case conferences and it is a social worker who is nearly always the key worker on the case.

The Social Work Department have detailed procedures for working with child abuse cases, but most of these procedural guidelines are concerned with specific procedures or mechanisms such as the composition, content, and conclusion of case conferences. The procedures do not detail the content of case work with families. When mention is made of direct work with families, it is couched in terms too general to inform specific work with individual cases.

A sensible starting point for examining Social Work Department intervention in these cases is to consider the child abuse register system that is used to define whether a case is one requiring the child abuse procedural system for case management. Attendance at case conferences is also examined as it is attendees who assist in making the initial decision about registration, monitor subsequent case management, and decide when de-registration is appropriate. The criteria and process for registration was not a direct focus of the study, but the discussion of registration in the first section of the chapter provides an introduction to the content of agency intervention described in the rest of the chapter.

Case conference decisions on registration raises questions about the nature of the problem of child abuse and the social work task in intervening in child abuse cases. The nature of the problem of child abuse discussed in Chapter Four concluded that the concept of abuse was based upon two underlying concepts of harm to a child and responsibility for that harm. The issue of assessing parents and their responsibility and ability to protect their child is discussed in the second part of the chapter.

Recent central government guidance for England (Department of Health, 1991b) has confirmed that the task in working with registered cases of child abuse is to ensure the future protection of the child. The third part of the chapter provides a brief
introduction to the stances and strategies that the Social Work Department adopted in order to achieve these goals of child protection. This is followed by a longer discussion of the different methods used by workers within their overall stances and strategies. The fifth and final part of the chapter then examines how these stances, strategies and methods were implemented in the twenty nine cases examined in the subsample.

THE CHILD ABUSE REGISTER

The use of the child abuse register was explored by examining some of the factors that may have been relevant to the decision to register or not to register in particular cases; including the decision to remove children's names from the register. The diversity of case presentation and outcome observed in the sample made it difficult to make summary statements about the pathways cases took. However, even individual cases can be useful in pointing towards the implicit policy issues in the management of family support and child protection. Although they might be considered unrepresentative, they at the very minimum indicate the extreme position or the problems that can occur in certain situations within particular policy arrangements.

Registration

In this study information was not available about cases that were considered for registration, but that were not placed upon the register. At the time of the initial registration of the cases in the sample, there was no central recording of case conferences that did not lead to registration, and so it was not even possible to ascertain how many cases were being considered in this way.

Whether registration is appropriate depends upon the purposes that is meant to achieve. The register could be reserved for cases where (according to agreed criteria) is deemed to have occurred; for cases where there is a question of risk to the children in the future; or only for those cases where registration will on balance have advantages for service provision. Recent government guidance in England states that registration should only be for cases where there are unresolved issues of child protection and a child protection plan to address these risks (Department of Health, 1991b). At the time of data collection for this study there was not such specification about the purposes of registration, but even with this greater precision,
there are still many other factors influencing case conferences and individual agencies in their views about registering individual cases. These factors include:

**Potential Advantages of Registration**

- Increase case monitoring, inter agency co-operation, and release resources
- Increases child abuse statistics for local agencies
- Case fits criteria for registration

**Potential Costs of Registration**

- Resources required for case conferences, case monitoring and intervention
- Jeopardise relationship with parents
- Increase tensions in family
- Negatively label a 'good family'
- Need to involve other agencies
- Case not fitting criteria for registration

**Registration Considered Not Necessary**

- Agencies already aware of the situation and co-operating together
- Resources available without registration
- Parents accepting of help offered
- Case not fitting criteria for registration

**Potential Advantages of De-Registration**

- Reduce workload, agency responsibilities
- Removes negative label from family, rewards family, rewards agency
- Case does not meet criteria for registration

**Potential Costs of De-Registration**

- Reduces or ends inter-agency monitoring
- Reduces child abuse statistics
- Case still fits criteria for registration

The study did examine one case where a case conference was convened and registration was not considered appropriate. The family were under pressure from material stresses including severe housing problems. One night, the husband chastised one of the children for misbehaving; causing him to be bruised. The father admitted the over chastisement, and was remorseful and grateful for the offer of social work support. The view of the case conference was that this was probably a one-off incident. The reasons given as to why the circumstances were unlikely to
recur were the father's remorse, and the family's acceptance of a social work service.

In this case the bruising of the child could be defined as abusive, but the case conference argued that there was not sufficient evidence of future risk. There may have been a basis for this optimism; but it is not clear how independent this assessment is from other aspects of the family/agency relationship. The case conference believed that the family were urgently in need of supportive services, and it may have been felt that this could be best achieved without placement on the register - either because it would not achieve extra benefits, or because it would incur disadvantages. Dingwall and colleagues' (1983) analysis of case presentation discussed in the introductory chapters suggests that families presenting in this way would provoke the least coercive forms of intervention. The family admitted that they had a problem and were grateful for the offer of a service. The resulting positive assessment of the family could reduce the case conference assessment of risk, and could also make the professionals less eager to apply potentially negative labels of registration to a family seen as good and caring towards their children.

Two other cases that were placed upon the register reinforce certain of these aspects of registration. The first is the issue of professionals not wishing to take potentially coercive actions because the family are co-operating. In one case the same arguments were explicitly used to justify not referring cases to the Reporter to the Children's Hearing. This may have been the best course of action but there are at least two other arguments in favour of making the referral. Firstly, such justifications can sometimes be applied when professionals are unwilling to be forceful in their intervention - either because it is considered unethical to act in this way or because of the effects it may have on the client-worker relationship, and thus the potential for positive supportive work that the parents will appreciate. The danger of this strategy is that it can divert a worker away from taking necessary legal actions which might be necessary to protect the child; actions that could in practice be adequately and honestly explained to the parents. The second counter argument applicable in this particular case example, is that the appropriateness of calling or not calling a Children's Panel might be better assessed by the Reporter to the Hearings System.

The second case example concerns the belief that an injury to a child is a one-off instance of physical abuse. A child was placed upon the child abuse register following an injury of unknown origin that the parents alleged had been caused by
a third party within the household. Prior to the second case conference the father was observed to over chastise an older sibling, but the case conference believed the father’s actions to be "out of character" and the children were removed from the register. There must, however, have been some continuing concern as there was no request to terminate the home supervision order that was in force.

Data on cases not registered would have been particularly significant for contrasting cases registered where there was an injury to the child, with cases where there was not. Would the problems revealed in the observation of an injury have led to registration, if they had come to light in another context without an injury present? In one case, for example, a case conference was called because of an alleged incident involving physical threats by the cohabitee to an older sibling. The family was well known to the Social Work Department and the case conference decided to place the children on the child abuse register. This was only achieved by forceful views of the most senior social workers present. Other attendees were of the view that the family required intensive support, but felt there was no marked difference or decline in lifestyle or behaviour of the family to justify registration at this point in time rather than at any other time in the past. It may have been the lack of a sufficiently adverse event or injury to the child which made case conference members hesitate from the act of placing the child’s name on the register.

Child injury or other child adversities can provide the starting point for the assessment of parental responsibility, which is central to the interpretation and definition of child abuse (as discussed in Chapter Four). The main forms of parental responsibility considered were inflicting injuries as in physical abuse, not protecting a child from someone who might be a risk to the child, and not caring adequately for the child with the result that the child may suffer from illness or accident.

In many cases the actual circumstances of an injury would remain unknown. It was therefore difficult for the case conference to assign responsibility. This is best illustrated by an exceptional case where a child received serious injuries. The mother maintained that it was an accident and the hospital and community health doctors supported this. The medical data could not determine the exact cause of the injuries, the child could have fallen or have been pushed. The hospital doctors were of the opinion that in the absence of evidence of parental responsibility, the agencies should accept that it was an accident and be supportive and sympathetic to the mother. They felt very unhappy with the social workers wish to investigate possible
child abuse and this difference of view led to a physical confrontation between a
doctor and a social worker in a hospital ward.

The social workers stated (at the case conference and in research interviews) that the
child's injuries might have been due to an accident, but that there were some
worrying features of the case. These included inconsistencies in the explanation of
the injuries, concerns about the care of another child in the family, family's uptake
of health services, mother's nervous medical condition, and the parental attitude to
social work investigation. The Social Work Department therefore concluded that it
was more judicious to register the case in order to monitor the situation and to
provide help if necessary to the family. The health visitor and general practitioner
argued that they had a close working relationship with the family and that they
could adequately monitor the situation without social work intervention. The case
was initially registered but quickly de-registered after considerable pressure from
the parents and the health service personnel.

Before the child abuse investigation the family had recently moved outside the
general practitioner's and health visitor's practice area, but had been kept on the
practice lists because of the mother's difficulties. Research follow up of this case
indicated that there was very little actual contact between the general practitioner or
health visitor and the client despite the description of a close relationship. In the
months following the early de-registration the health visitor accidentally saw the
mother whilst she was collecting a prescription from the doctor's surgery. The only
other contact was by telephone; the health visitor never managed to find the mother
at home at the times that she arranged to visit her.

Even where injuries sustained by a child are accepted by all parties as accidental,
there may be child protection concerns resulting in registration. In several cases,
children presented with a long history of minor accidents. The case conferences that
registered these cases accepted that the injuries were not due to physical abuse, but
were concerned about the general care and protection of the children. It was the
adversity of injury that led to the assessment of adequacy of child care and
protection, whereas other forms of adversity such as failure to thrive rarely precip­
itated such assessments. A finding supported by research reporting that most cases
of failure to thrive are not identified by health and welfare agencies (Skuse, 1987).

Although the various case examples illustrate the importance of injuries to children
in child abuse assessments and registrations it should be noted that, (i), the majority
of children placed upon the register were not injured (see Chapter Six) and, (ii), that injuries at registration were a worse predictor of case outcome than the level of previous agency involvement in the cases (see Chapter Ten). The importance of injuries to this discussion is the way that they reflect the issues affecting the processes of investigation and registration. These are also reflected in the 3 cases which were placed upon the child abuse register without the parents being informed.

Two of these cases of not informing the parents were transfers in from other areas. Both came with histories of concern about the welfare of the children, and a lack of success by the welfare agencies in engaging the family in a meaningful way. In both cases the case conference felt that to inform the family of registration would jeopardise engaging the family and in one case might result in a destructive outburst by the child's father. In the third case there had been a history of minor injuries to the child that produced concerns about the child's welfare, though the situation was complicated by the child having a disease that made him particularly prone to bruising. In this case, the child was removed from the child abuse register after ten months, at the third case conference, without the single parent being informed that registration had occurred.

In most cases of children being placed upon the child abuse register the family will not be happy about the registration, and in many cases there will be problems in the extent of co-operation that is achieved at different times. In the case examples above, the case conference was clearly worried about the effect of registration on this co-operation. Also of interest are cases where there is a very clear lack of co-operation and acceptance of social work services by the parents. In one case this resulted in no key social worker being appointed. The case was held by the Area Officer and monitoring was achieved through the health visitor. After some months passing without further injuries occurring the case was de-registered. In all these examples the case conference felt that there were advantages from registration, even if the parents were not informed or no positive work could be achieved. These examples contrast with the earlier discussion on reasons for not registering cases.

**Attendance at Case Conferences**

Attendance at case conference is important because conferences are a central decision making forum monitoring case management and entry and exit into the child protection case management system. The range of professional attendance at child abuse case conferences in the total research sample are shown in Table 8.1.
### TABLE 8.1

Professional Representation at Case Conferences

<table>
<thead>
<tr>
<th>Profession</th>
<th>% of Case Conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Work</td>
<td>100%</td>
</tr>
<tr>
<td>Community Nursing</td>
<td>75%</td>
</tr>
<tr>
<td>Police</td>
<td>39%</td>
</tr>
<tr>
<td>Education</td>
<td>30%</td>
</tr>
<tr>
<td>Homemaker/Care staff</td>
<td>24%</td>
</tr>
<tr>
<td>Community Doctors</td>
<td>7.9%</td>
</tr>
<tr>
<td>Hospital Doctors</td>
<td>7.6%</td>
</tr>
<tr>
<td>Other</td>
<td>34%</td>
</tr>
</tbody>
</table>

N = 648 case conferences in total sample

### TABLE 8.2

Numbers of Different Staff Attending Case Conferences

<table>
<thead>
<tr>
<th>Profession</th>
<th>All Case Conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.W. Child Care Adviser</td>
<td>14</td>
</tr>
<tr>
<td>S.W. District Officer</td>
<td>55</td>
</tr>
<tr>
<td>S.W. Area Officer</td>
<td>637</td>
</tr>
<tr>
<td>Senior Social Worker</td>
<td>738</td>
</tr>
<tr>
<td>Social Worker</td>
<td>842</td>
</tr>
<tr>
<td>S.W. Out of hours staff</td>
<td>23</td>
</tr>
<tr>
<td>S.W. Homemaker/Carestaff</td>
<td>204</td>
</tr>
<tr>
<td>Nursing Officer</td>
<td>104</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>558</td>
</tr>
<tr>
<td>Hospital Nurse</td>
<td>30</td>
</tr>
<tr>
<td>Hospital Doctor</td>
<td>47</td>
</tr>
<tr>
<td>Clinic Doctor</td>
<td>30</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>24</td>
</tr>
<tr>
<td>Psychiatrist or Psychologist</td>
<td>18</td>
</tr>
<tr>
<td>RSSPCC</td>
<td>79</td>
</tr>
<tr>
<td>Police</td>
<td>313</td>
</tr>
<tr>
<td>Education</td>
<td>255</td>
</tr>
<tr>
<td>Foster Parents*</td>
<td>64</td>
</tr>
<tr>
<td>Original Parents*</td>
<td>240</td>
</tr>
</tbody>
</table>

* (i) refers to sets of parents not individuals; (ii) not always possible to determine if parents present for all or part of conference.
Although there were no health visitors or nursing officers present at a quarter of case conferences, at one fifth of conferences there was more than one health visitor present. Also at one fifth of conferences there was both a health visitor and a nursing officer present. The differences in attendance may partially be a reflection of the different organizational roles. Health visitors, for example, work on the principle of individual professional client relationships, whereas social work is based on the more bureaucratic model of office holder to client, and there is the greater likelihood of senior staff to exercise bureaucratic authority of the decisions of front line workers (Dingwall et al, 1983). The whole process of case conference reviews fits more neatly into the bureaucratic model, as do the statutory responsibilities of the Social Work Departments in these cases. Whether or not these explanations are correct, the differences in levels of attendance may have serious consequences for the level of participation of health visitors within a system largely controlled by a different professional group. This is in addition to the many other factors may limit health visitors participation in case conferences. For example, their potentially ambiguous status as case workers and concerns about the consequences of their revealing confidential material about clients at an interdisciplinary meeting (Hallett and Stevenson, 1980).

Similar considerations are applicable to the low attendance of medical staff at case conferences. The issues involved have also been extensively addressed by Hallett and Stevenson (1980) and some of these were also addressed in Chapter Six when discussing the low rate of referrals from general practitioners. Hospital doctors also mostly attended initial case conferences where the other participants are interested to know the further details of case presentation and the extent of any physical evidence of abuse.

There are many reasons why increased attendance of doctors at case conferences might be preferred by other agencies. General practitioners, for example, may have known the family for some time and be able to provide important health and social data that could help in assessing the risks to the children and the benefits and costs of different strategies. On the other hand the practical and inter agency problems of achieving such participation may not make it a productive suggestion. Attendance of doctors was not increasing at the time of data collection, despite an awareness of the low figures.
Attendance at case conferences should encourage interdisciplinary co-operation, but this may not be achieved. The case conference system can at least achieve the minimal task of keeping the different professionals involved in new events in each other’s work; but it may not achieve interdisciplinary case work. The advantage of the system is that even if certain professionals do not attend the case conferences, they are likely to have the minutes circulated to them so achieving at least a minimum of (one way) communication. For limited two way communication doctors can to submit a short updating report.

TABLE 8.3
Timing of Review Case Conferences

<table>
<thead>
<tr>
<th>Interval in Months</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>88</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>94</td>
<td>18</td>
</tr>
<tr>
<td>3</td>
<td>106</td>
<td>21</td>
</tr>
<tr>
<td>4</td>
<td>57</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>48</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>64</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>12+</td>
<td>2</td>
<td>0.4</td>
</tr>
</tbody>
</table>

(Data available from 509 review case conferences)

The usefulness of case conferences in at least this minimal respect is dependent on their being held on a regular basis. The local child abuse procedures (Strathclyde Regional Council, 1983b, 1989) stated that review case conferences should be held at least every six months - sooner if necessary - and at the request of any agency. Table 8.3 lists the timing interval between Review case conferences and shows that 89% of reviews were held within a six month period. The first case reviews after the Initial case conference were particularly likely to be held within the first month of registration. Fifteen case reviews were held between 9 and 14 months after the previous case conference, and 11 of these reviews decided to de-register the child. It is not clear whether these decisions were simply due to the improvement in the family situation over this time period, or because the child abuse register system
was not being actively involved in the case and was not relevant to the service being provided. In 5 of the cases being de-registered the review was the first after the initial case conference. In other words the cases had been placed upon the child abuse register and were then reviewed approximately ten months later at which point they were de-registered.

**PARENTAL RESPONSIBILITY**

Chapter Four concluded that the concept of abuse was based upon two underlying concepts of harm to a child and responsibility for that harm. In practice, child abuse as defined for child protection intervention by Social Work Departments is limited to intra familial abuse and so the issue of responsibility is normally concerned with parental responsibility for possibly harming a child or not sufficiently protecting a child from harm.

Case conference minutes and social work interviews for the sub-sample of cases where the child had an injury were examined to assess the types of parental responsibility that social workers ascribed to the primary caretaker for the injuries occurring. Five main categories of responsibility were observed and these are listed with cases examples derived from case conference notes and social work interviews:

(i) The caretaker was badly at fault.

Case example: The Social Work Department had made repeated demands for improvements in the care of the child and had suggested specific actions in order to achieve this. These actions were not taken and the child received a series of bruises that were not sufficiently well explained and led to the child being received into care. (Case 247, social work interview).

(ii) the caretaker was to some extent at fault but had difficulty in coping with her situation;

Case example: the children had superficial burns and bruises that could have been accidental, non-accidental or arising from neglect; the caretaker appeared apathetic and dirty and it later emerged that an intermittent cohabitee had been hitting the children; the caretaker's explanations were vague ("he hit his head on the table a few days ago"); in this case, less blame was laid on the caretaker who was seen more as a victim of her circumstances rather than as an actor in committing the abuse. (Case 132, social work interview).

(iii) the caretaker was at fault but that this was a "one-off" incident and the caretaker usually copes;
Case example: the father admitted "losing the place" when chastising the child and explained that the family had substantial material and psycho-social stresses that had caused this lapse in usual standards. The case conference accepted this explanation, thought that the situation would not recur and so did not register the child. (Case 244, case conference minutes).

(iv) the events were beyond the control of the caretaker or that she was unlucky in not being able to control what happened.

Case example: the abuse was committed by the caretaker's brother; the caretaker was a young mother living in her parents' household; the perception of responsibility was supported by the caretaker reporting the incident and having difficulties in her relationships with her mother for doing so; she then refused to have her brother in the same room as the child or herself. (Case 237, social work interview).

(v) the events were sufficiently ambiguous for it not to be possible to assign responsibility.

Case example: a child was found to have a fractured skull when receiving an X-ray for another reason. Medical opinion as to the cause of the fracture was unclear with a conflict of opinion over the degree of concern that was appropriate. In these circumstances, the social workers were uncertain of their own role and at this stage the mother was unaware of the finding; the social workers first task was to visit the mother and to enquire into the possibility of non-accidental injury but with confusion of medical opinion as the background. (Case 157, case conference minutes).

It was rare for mothers to be assigned to the first category of 'the caretaker at fault'. In the few cases where the criminal law was involved it was usually fathers who were prosecuted and mothers who were seen as having found themselves in difficult situations they were unable to control. This perspective meant that the most common view of caretakers was that summarised in the second category of being 'to some extent at fault', when circumstances such as psychological or material stresses were regarded as mitigating factors. Social workers described these parents as being vulnerable in the relationships they formed and were often victims of their own experiences. The social workers' view was that their lack of internal emotional resources, coupled with material deprivations, often led them to be indiscriminate in their own search for affection and thus into inappropriate relationships with cohabiters and others. By the end of the study, three of these mothers had formed new relationships with men who had previously been prosecuted for the abuse of other children.
The third category - the one-off circumstance - was uncommon and in some senses was a 'probationary' category. As knowledge of the family was gained with time, these cases were either re-defined in ways that ascribed some fault to the caretaker or were de-registered. The fourth perspective (circumstances outside the control of the caretaker) was often applied to cases where the cohabitee was believed to be responsible for the abuse and it was believed that the caretaker would cope satisfactorily if this individual was removed from the scene. Again, this was a view that could change with greater knowledge of the family.

The last of the five viewpoints (not possible to assign responsibility) seemed less dependent on the social workers' own interpretations than on conflicts of opinion about what had happened. In cases where there was uncertainty about whether injuries were accidental or not, it was often necessary for social workers to adduce contextual evidence of poor caretaking to support a determination of non-accidental injury. In these cases, the social work view seemed vulnerable to medical opinion even when the latter could contribute little to an understanding of the circumstances in which the event occurred. In these few cases, there were similarities to more recent conflicts concerning the diagnosis of sexual abuse (Cleveland, Secretary of State for Social Services, 1988).

Evaluating the Caretaker

The assessment of responsibility for abuse sketched above cannot be separated from an evaluation of the more general lifestyle of the caretaker, the problems that may exist within it, and their consequences for the well-being of children. Whilst it is possible to describe different elements of this activity in quasi-objective (or "professional") ways, they depend inevitably on the judgements of individual workers and their agency about the acceptability of different parenting and life styles. It is only in a minority of cases when applications are made for legal powers of intervention where such judgements are tested in court or in a Children's Hearing Panel.

There were a number of separate elements in the assessment of the caretakers in social work interviews:

(a) the quality of the parent-child relationship;
(b) the caretaker's motivation to parent;
(c) practical skills in parenting;
(d) the stability of intimate relationships;
(e) the quality of social supports (both quantity and polarity);
(f) the quality and quantity of material supports;
(g) the ability to provide protection from other adults who may be a risk to the children.

Each of these are considered in turn:

**Parent-child relationships**

Interviews with the subsample of families indicated that the parents had considerable problems in controlling their children or in experiencing a warm and mutually rewarding relationship with them. However, the social work interviews suggested that this was not a feature of the cases that ranked very highly in the case-workers' concerns about the families. Little was said about the psychology of relationships with children nor was there much mention of more general aspects of the children's health and development. In describing their cases social workers did make reference to the social and psychological aspects of the children's behaviour, but comments were presented in general terms such as a child being difficult to control or not making sufficient progress. The social workers focused primarily on an update of recent events, an assessment of the present suitability of the child care environment and the implications for the general framework of agency work and intervention. Social workers were not asked directly in the research interviews about their evaluation of parent-child relationships, but there were considerable number of open ended questions about the nature of the case and of case work intervention, including hypothetical questions about what would be the best solution for the children and the parents. The lack of reference to the children or their relationships with their parents was thus unlikely to be a demand effect of the structure of the interviews.

This summary from a social work interview is one of the few examples of direct reference to parent-child relationships:

The mother lived with her alcoholic father with whom she had a violent relationship. She was under emotional pressures and had no one to care for her own emotional needs; she had liked her children when they were babies and would dress them up in order to show them off. When toddlers she continued to want to show them off but was also in competition with them; this meant that she admitted that she had difficulty in tolerating their natural behaviour and in meeting their development needs. (Case 245).
The child abuse literature gives much emphasis to parent-child relationships (Browne and Saqi, 1987) and so the absence of this in social work accounts was unexpected. One reason for this may be that the purpose of the agency intervention was largely focused on reducing the immediate risk of further abuse and bringing about changes in the family that would serve this purpose. Poor parent-child relationships may have been part of the aetiology of the abuse, but at this point of the process the social workers perceived more immediate sources of risk. Improving parent-child relations were part of wider therapeutic objectives that had lower priority. A higher priority was to change the context in which child care was taking place rather than the child care itself. Effort was directed towards the solution of material problems and the quality of inter-adult relationships.

Another reason that social workers may have neglected parent-child relationships is that this is not an area in which they are provided with much training or experience. Much of their work and training is concerned with alleviating material stressors and helping to provide or seek out material and emotional supports. It would not be surprising if social workers employed the methods that they were most familiar and experienced in. This may have been a realistic strategy considering the personal and other resources at the social workers' disposal. The work necessary for improving the quality of parent-child relationships is too detailed and too complex for the level and quantity of interventions that the Social Work Department resources were able to provide. The observation and evaluation of relationships between individuals is a more difficult task than comparable assessments of single individuals (although social workers do tackle problems of this kind in trying, for example, to improve marital relationships). There was also little use of children's' services that were outside the direct control of the Social Work Department which is an additional indication that matters of this kind did not receive high priority in case management.

The Motivation to Parent

The assessments under this heading go beyond the usual meaning of 'motivation'. Collectively, they were an attempt to judge the extent to which a mother was willing to give priority to the care of her children in the present circumstances of her life and the degree to which she might be prepared to change in order to maintain her parental role. The judgement might include arriving at a view of the reasons the mother had a child in the first place and of the 'meaning' of the children within her
present lifestyle. It thus involves further interpretation of the reasons for failing to cope with child care and is central to Social Work Department plans to remove children into care and their later return. This is illustrated by repeating the following case example from social work interviews:

The mother had high standards of child care and it was thought that her skills were acceptable; at the same time, she was subject to considerable stress in her own life and had insufficient social support; her response was to run away from her problems by going dancing, engaging in obsessive behaviour over her housework and attempting to raise her self esteem by dressing up. In these circumstances, it was thought that the mother was unlikely to provide proper care for her children who were received into care. On the other hand, she did not drink excessively nor were there other negative aspects of her lifestyle and so future change might be possible.

The social work assessment illustrated by the example is highly interpretative. Given the larger need to evaluate future risk, it will be evident that such judgements were often finely balanced and provisional. This is important because the only real sanction the social workers had was the serious action of receiving the child into care. Such action might disrupt the process of developing family relationships and interpersonal skills and so work against the central objective of maintaining children within their families. In addition, such action could disrupt the process of assessment of whether the parents had the motivation and ability to care adequately for their child in the long term. Social work assessments could obviously influence later events so it was not possible to assess the validity of these early assessments.

Parenting Skills

The assessment of parenting is a central and continuing component of child protection work (Department of Health, 1988). It is particularly emphasised during the initial investigation and case conference and decision points concerning service provision or interventive action concerning the future care of the child. Two previously cited case examples from case conference minutes help to illustrate the way this topic was open to fairly wide interpretation:

The mother's self-esteem was considered to be poor, she was depressed and reacted to the stresses in her life by withdrawing from them. Her children were undisciplined and her house was in a disorganised state and she responded to the children by shouting at
them in an ineffectual way. Although there was a risk of non-accidental injury, the problem was seen as principally one of neglect; initial management was directed at improving child care skills (case 132).

Since the birth of the children, the mother had not been known to be good at the general care, feeding and hygiene of the child. Rough play was another problem. The children were received into care at a time when the house lacked electricity and gas but were returned when the mother was re-housed. It appeared that the Social Work Department had focused attention on the violence of the grandfather’s home and was giving the mother the benefit of the doubt as far as parenting skills were concerned (case 245).

One limitation of these assessments was the limited time spent with the mothers during home visits. The workers could only collect evidence on the state of the house or of behaviour during the visit. Apart from this, the social workers were largely dependent on reported practices elicited in interviews with their clients. There was no evidence of data of this sort being recorded in the type of systematic way suggested by the central guidance on assessment (Department of Health, 1988). The same situation is probably also true of health visitors. Although health visitors may have a longer-standing relationship with the families similar arguments apply. The health visitors did not report in their interviews any systematic recording of parental behaviour but would record anything that they perceived to be abnormal or worrying in any way. Parental reports matched the findings of McIntosh (1986) that parents were highly sensitised to being judged by health visitors and so would attempt to control what was seen and how they were perceived. Others (such as homemakers) who have goal directed contact with families over longer periods of time are in a much stronger position to judge the quality of parenting. It could be that the absence of more detailed information of this kind is part of the explanation for lack of interest in parent-child relationships referred to earlier.

A feature about which the social workers and health visitors did feel able to comment was on the developmental stage of the child and parents ability to cope with these general stages. Some parents were said to have difficulties in coping at some stages and need support during them but are able to manage their problems more successfully as the child becomes older. Support with problems of this kind was evidenced in the provision of respite care in different ways. For example, voluntary reception into care for fairly short periods or providing a nursery school placement.
Relationships and Social Support

The description of the characteristics of the study population in Chapter Seven drew attention to the proportion of families with unstable (cohabiting) relationships, the number of single parent families and to their material poverty. For more than half the cases, the abusive event was attributed to a cohabitee or to another adult within the nexus of the family.

Even in cases where abuse or risk of abuse was attributed to the main caretaker, the adult relationships of the carer formed a major part of the social workers' assessments of the families both at the time of registration and in terms of their potential for change. A principal question was the carer's personality and the emotional attachments she had or might form - and her reasons for doing so. In parental interviews, the mothers reported many relationships but few positive supporting relationships. The social workers stated their concern in terms of the consequences that these social attachments or the search for new relationships might have on the care of the child. This is illustrated by the following example from a social work interview:

The mother was intelligent and cared for her child but had little emotional strength and few good emotional supports. She would go out to drink and would take up with inappropriate male companions. On these occasions she would take the child with her. Although it was unlikely that she would injure the child herself, there was a danger that the child would be neglected when she was drunk or that he would suffer non accidental injury from another. This behaviour only became apparent to the worker after he had the case for some time. His earlier impression was that although there were problems the abuse might have been a 'one-off' incident. (Case 242).

Similar circumstances might occur in relationships with other members of the extended family. In another case (case 237 cited earlier), the mother had difficulties with her brothers, one of whom injured the child, and with her mother who failed to support her needs. Social workers would often seek to involve grandparents and others in developing improved child care arrangements, but social workers also reported that it was often the poverty of these earlier previous generation parent-child relationships that had led the mothers into largely 'negative' relationships in the first place.
Social workers did not have difficulty in characterising the relationships that existed or for them to propose "ideal" outcomes for the children, but their capacity either to insist on change or to deploy case-work resources to bring it about were limited for a number of reasons. The principal sanction available to them was reception into care and the positive incentives they could offer or negotiate were largely the provision of tangible resources such as a new house. The stance of the system as a whole was that of maintaining the children within the family whenever possible and or providing surveillance directed towards child protection. For all of these reasons, the option of activities directed towards substantial changes in the life style of the mothers fell rather outside the way that the social workers perceived their role.

Another major difficulty in pursuing strategies directed towards changes in lifestyle is that the removal of perceived negative supports make the mother more rather than less vulnerable in regards to emotional needs and stresses at least in the shorter term. The social workers did not have access to preventive schemes such as "Newpin" in south London (Pound, 1987) that provide long-term support by volunteers from the same community in order to re-order emotional and social supports of the pressures and judgements that are an inevitable part of case management once abuse is identified and children are registered.

**Overall Assessment**

Although the social workers' evaluations have been categorised in this discussion the different dimensions of the social workers' evaluations overlap and contribute to a holistic judgement of the caretaker and her circumstances. Nor is this a complete list; the workers would also concern themselves with an appraisal of material circumstances and with aspects of them that might have contributed to the identified problem, such as difficulties with gas and electricity bills or other debts that could lead to stress within the families.

Although there were all these various components to an assessment of the caretakers' care of their children it was the overall adequacy and stability of this care that produced anxiety for most social workers in most cases. This was the situation in sixteen of the twenty nine cases in the subsample. In only six cases was the basic routine child care not under question. In these cases the concerns arose solely from violence from an other adult in the household.
In very general terms, the mix of family circumstances left social workers with three broad choices or judgements. One was to conclude that unsatisfactory relationships were likely to persist and, with them, a continued and unacceptable risk to the child. The end-point of this conclusion was reception into long term care. The second choice was that of somehow removing the caretaker from her existing framework of support relationships and, in effect, trying to persuade her to "start again". Re-housing might be a tangible way of beginning to do so. This strategy included the need to introduce alternative (and seemingly more acceptable) social supports; whilst avoiding a return to the former pattern of "negative" relationships. The third and commonest strategy was the middle course of trying to ensure that risks to the children were minimised within the existing network of social relationships. In these situations, the hope was that options for positive change could be identified and exploited as the management of the case progressed.

All the social work data indicated that the preferred strategy of management was that of maintaining the child within the home so that, even when children were received into care, the strategy was almost always concerned with attempts to return the children at some stage of the management of the case. The strategy might be achieved fairly quickly (in less than six months) but, for some cases, was continuing at the end of the period of data-collection. The assessments were made in the context of this objective and were thus likely to be interpreted in these terms with the social workers tending to give mothers the benefit of the doubt. These were not simply "management" decisions or practices, but reflected the ambiguous position of social workers who had to balance different social attitudes and values in practical ways. These included an interpretation of the rights of parents or families, the rights of children, and the poorly specified concern of society for the welfare of children.

As has already been discussed, cases of child abuse are not susceptible to a simple taxonomy of diagnosis from which to prescribe an appropriate response. The events leading to intervention (or registration) are often indefinite and especially so when the concern is about the risk of abuse. What happens is that concern about the events that led to case referral and registration shifts to a series of other questions that rely principally on the quality of professional judgements and interpretations. These begin with questions about responsibility for the abuse partly in regard to the perpetrator but (more significantly for future action) also concern the child's caretaker and the quality of protection that she is able to provide. It is this last shift
in the area of enquiry - the evaluation of the caretaker - that defines the stance that case-workers adopt and thus the strategies they employ.

PROFESSIONAL STANCES AND STRATEGIES

The previous section considered the responsibility and the parenting of the main caretaker. This section is concerned with the social work strategies for working with the family. The basic task is to ensure the protection of the child, but the family who are a risk to the child are also the people with the closest ties to the child. The alternative is reception into care, but there is considerable evidence that short term care often leads to long term alternative care (Department of Health, 1985). In long term care there may be less physical risks but greater risks of harm to the child's social and psychological development (Quinton and Rutter, 1988).

The basic question for social workers was, firstly, whether the child has a future with his or her parents and, if so, what is necessary in order to enable the parents to care adequately for their child. This strategy may be required even if the worker believes that the child is at high risk and does not or should not have a future with these parents. Decisions about receptions into care and changes in parental rights are not fully at the discretion of workers who can only advise on such courses of action (except for temporary emergency receptions into care). A worker may therefore have to enable a family to care for a child even if the perceived risks to the child are very high.

In practice decisions about parents are not clear cut or made at one point of time, but evolve with work with the family. In the sample, three basic social work stances were observed that related to the degree of perceived risk to the child:

(a) monitoring
(b) task setting
(c) the necessity for change

The first (monitoring) was largely a process of confirming by observation an initial view that the risk of further abuse was small was correct and that the case could be de-registered at an early stage. Sometimes, other justifications for access to the family (such as on-going probation orders) were linked to decisions of this kind.

"Task setting" activities were a more elaborate form of this monitoring activity and often involved setting tests of various kinds that might demonstrate improved or
satisfactory child care practices. Some, such as behaviour in regard to access visits, appeared to be a requirement to conform to rules imposed by the social worker, but others were about more detailed aspects of child care. This is illustrated by the following example from social work interviews:

The child had been in care when the mother's access was controlled; "task setting" was related to the possibility of returning the child to the mother's home (which was actually her father's house) and involved the way that the child was fed; the requirement was that he was provided with hot rather than cold food. The test failed because the electricity was cut off (the fault of the father). The task setting was linked to an attempt to promote parenting skills by attendance at a family centre but the mother did not make much use of this opportunity; her own approach seemed to be one of waiting for the period of controlled access and task-setting to be over (case 247).

The stance requiring change in the social context of child care was more explicitly stated as an objective by social workers in the research interviews although this was not necessarily reflected in their work practice. Necessity for change meant that children could only remain in the family (or could only be returned if already in care) if certain changes were made to the parents attitude or behaviour and lifestyle.

Sometimes changes could be brought about fairly quickly when the strategy would change to one of monitoring the new situation; in others, the differences between social work stances could become much less definite as interpretations changed with time. This is illustrated by the following example derived from social work interviews.

The initial perception of the case was that the mother was a victim of the violence of her cohabitee and was in great fear of him; this was modified to the view that the mother was in some fear of the cohabitee but there were both positive and negative aspects to their relationship - and that the mother's account of it could not be taken at face value. At time she never wanted to see the cohabitee again; at others they were close friends. Change was thought to be desirable, but these changing perceptions and attitudes complicated the main focus of management (case 250).

These different stances would determine the way that the social workers articulated their objectives for particular families but a number of other considerations
influenced the specific content of their management strategies. In the early stages of case management, the most important was establishing a relationship with the families. These relationships had to include the circumstances of the case and the formal actions which had been or may yet be taken, such as reception into care. On the other hand, there was an equal need to establish a relationship that was felt to be constructive and progressive in terms of resolving family problems. Acceptance of the abuse of the child by the client was often regarded in positive ways by the social workers because (in the workers' view) it provided a common ground of the reasons for intervention and acceptance that there was a problem to be solved.

The social workers' responsibility for making sure that the parents understood their rights in these situations could be a less positive feature of these early contacts, however, and was one that could create ambiguity and confusion. Clients reported that their social worker might be able to solve problems but she was also someone who had powers over the disposition of the children, who might influence legal proceedings, and who might disapprove of inter-adult relationships and seek to change them. Social workers reported that they had to pick a careful path in the presentation of themselves and, second, that their relationships were inevitably open to interpretation and manipulation.

These matters found practical expression in various ways. This included the avoidance of conflict as in this example which is a quotation from a social work interview:

"I only see S at the office or when I bump into her in the street; it's dangerous to go to her house because of the aggression of her relatives - my approach is just to chat and to build on S's independence and understanding of the problem. It's difficult to do anything else because the situation is too deep-rooted. There is no best answer." (case 245)

There were also difficulties in making personal contact and building up a sufficient relationship to allow the issues to be address as in the following example from a social work interview:

"At first the husband wouldn't let us across the door but he did after a while and I offered practical help. This was to show that our concern was to help and support them to succeed and not to rap their knuckles." (case 249)
METHODS OF INTERVENTION

The methods social workers undertook in order to implement the broad strategies and stances they adopted varied from case to case and over time. The priority given to particular features depended on the order in which problems were seen to be soluble, their utility in regard to such matters as establishing constructive relationships and the time that may be needed for change to occur. A number of components were identified in the case conference minutes and from the social work interviews:

(a) therapies that might achieve change or mitigate the effects of the abuse either for the caretaker or the child, putatively, mitigating the effects of intervention was a part of this activity;

(b) enabling activities that included the provision of both material or psychological supports;

(c) monitoring assessments which might be broader than simply ensuring that there was no recurrence of the abuse - for example, that new social arrangements were working out;

(d) requirements that made demands of the parents as a part of the "task-setting" stance described above;

(e) monitoring or assessing the parents' motivation for change over time; this activity might also include helping parents to come to decisions about their own potential for change;

(f) ongoing monitoring of the safety (for both children and the caretaker) of the family environment at different times.

These approaches are considered in turn. This is followed by a brief discussion of the use of specialist service centres, styles of work, and case planning. The final section then discusses how these strategies were implemented in the sub sample of 29 families.

Therapy

Mention has already been made of social workers' tendency to adopt a causative model that emphasised change in the family environment rather than direct therapeutic intervention. The child abuse literature suggests the value of different
counselling or psychotherapeutic models as a component of interventions (Gough, 1993b). These might include identification of the need for psychotherapy or family therapy, activities that permitted modelling from peers, and various forms of emotional support. In practice there was little evidence that social workers perceived a need for this in case work and little evidence that it was provided either by the case worker directly or through referral to other services.

An important therapeutic concern is the possible negative effects of child protection interventions themselves. Abuse commonly arose in circumstances where the caretaker was herself under considerable stress and intervention could lead to the further trauma of separation from her children when they were received into care. Whatever the needs of the public interest, social workers reported that child protection work added to the burdens of women whose psychological and emotional strengths were already poor. This applied particularly to single parents whose children sometimes represented all they had achieved in life and for whom (whatever the fault) the abuse and its procedural sequelae constituted a failure of their own lives.

The argument for therapeutic intervention also applied to the children of the families. Apart from the observations of health visitors there was little evidence that the psychological health of the children was considered and thus no formal recognition of the needs they might have had.

The minimal descriptions of the functioning of the children beyond their physical state and developmental progress has already been noted. Similarly, there was not much evidence of services directed at children and their assessment. Some of these were provided routinely by the health services, particularly when a child was suffering from specific disabilities - such as partial sight, or deafness - but there were rarely any details of the routine assessments. In terms of resources directed at children, there was evidence of the children being given priority in the provision of nursery placements, though the extent of this is difficult to estimate.

During the study period there was also a growing use of family centres, which could have a beneficial effect on the children in the development of other significant social experiences and relationships (Lewis and Schaeffer 1981). This was again, however, only described in a very general basis. Also the types of family centre varied considerably (Phelan, 1983). There was little specification of the problems
faced by the children, or the purpose of the services despite the large literature on
the effects of child abuse on victims.

There was little use of psychological and psychiatric services. The case conference
data on the whole sample only documented 15 cases being referred to adult
psychiatry, 2 to child psychiatry and 6 to child psychology. Even on the basis of
measures of psychiatric morbidity in the general population, these numbers imply a
substantial under referral for problems of this kind.

Adult psychiatry was the most common type of referral and consisted of individual
inpatient or more often outpatient work with one parent. Psychiatrists are not
involved in a multi-disciplinary system for child abuse cases. The referrals were
usually made by general practitioners (rather than the child protection services), on
the basis of the functioning of the individual adult. The psychiatrists did not appear
to take a wider role in examining the family or child or child protection issues. The
diagnosis of these cases as recorded in the case conference minutes usually referred
to disabling affective disorders such as anxiety or depression, rather than deep
psychological disturbances - although there are some references to the possibility of
personality disorders in some cases.

The infrequent use of child psychiatry and child psychology services may be due to
their limited availability, and to a relative lack of priority for general child abuse
cases for these services. Child psychiatry exists within the Department of Child and
Family Psychiatry at the local children's hospital, and the long waiting lists are
likely to be a deterrent for social workers requiring more immediate support and
assessment in child abuse cases. Recently, there has been increased awareness about
child sexual abuse with the Department of Child and Family Psychiatry developing
skills and resources to provide consultation and direct work with these cases.

Similar problems of resources apply to child psychology. Clinical psychologists
employed by the National Health Service work within child development clinics or
centres, but a much larger number of psychologists are employed by the Education
Department and work primarily with school age rather than pre-school children.

Enabling

The most common strategy adopted by the social workers was the provision of
either material or psycho-social supports for the mother (or family) in ways that
would enable desired change to take place. The strategy found expression in a variety of ways and often differed in content as the management of the case progressed.

Many of the stresses experienced by the parents can be related to physical resources, such as the general level of finance, specific debts or general housing conditions. Even if the stresses stem more from particular emotional states or psychological relationships, changes to the structural living conditions can be an important method of reducing stress, improving the environment for the parents; and also bringing indirect benefits to the children. In a quarter of the cases in the sample it was a stated strategy to help improve the material environment by advice, direct support, and negotiation with other agencies such as the Department of Housing and the Department of Health and Social Security. This approach is supported by the lack of employed parents in the study sample, and the research evidence on the effects of unemployment and the use of social services (Essen and Wedge 1982, Fagan and Little 1984, MacPherson and Becker 1986).

The tangible aid provided ranged widely and gave the social workers significant instruments in their negotiations with the clients. The fact of controlling or influencing access to grants and loans, to restricted services such as nursery schools or home helps, the provision of respite care and the award of priority in such matters as housing gave the social workers a repertory of resources that could be employed in achieving a variety of objectives. In the early management of cases social workers reported that the purpose was often to stabilise the family's circumstances as a preliminary to focusing on more specific aspects of behaviour and parenting or on a period of monitoring in changed circumstances.

The provision of help that the mother herself could value was often an important way for social workers to establish positive relationships. The social workers also thought that it was the right of the families to have these supports, and so it can be argued also that their provision helped to "normalise" the social workers' own role in their early approaches - they were able to present themselves (in part at least) as solving problems in the way that is expected of social workers.

The provision of tangible help was used to support other objectives. One was related to the local authority's policy of preventing reception into care when nursery school places, family centre provision and homemakers might tip the balance of judgement. Another was a reward or encouragement to mothers who were seen as trying to
conform to the requirements that were imposed. In a cynical interpretation this latter use could sometimes appear to create a distinction between those who "tried" or "didn't try" and it is possible that social workers' personal attitudes to the cases did enter into some of these judgements. On the other hand, the social workers had a relatively weak position in regard to their influence on the social networks and social relationships of their clients. Evidence of their good intent in providing tangible supports allowed the workers to establish their credibility and thus strengthened the other kinds of influence they wished to exert.

Although material supports were important, another dimension of the strategy was simply to provide the time needed for the mother to re-structure her life. The use of social worker time and skills to enable clients to define their wider problems and options open to them are illustrated by the following case example derived from a social work interview:

The standard of child care was not acceptable, the mother had difficulties in her relationships with her father and there were household debts. The enabling strategy was the provision of a new house for the mother, the offer of homemaker services and help in negotiations with DHSS. The intent was to create a new context in which the mother was able to develop her parenting skills but there was an element of "testing" in the strategy because the return of the child from care was conditional on her responding to this opportunity. (case 723)

The emotional support provided by the social workers, health visitors and homemakers and their groups was seen by workers as a major component of their work, but the detail of this work was rarely specified. Any specification was in terms of the particular problems that the parent is facing, rather than in specific strategies that were to be applied. This may not be surprising considering the difficulties in articulating such concepts. It may also not be that important when non specific supportive work including that provided by untrained staff is widely thought to be particularly useful for parents who were finding it difficult to cope (Pound 1987, Van der Eyken 1982). Even within these qualifications it is surprising that there was not more detailing of the approaches of work to be undertaken. When this was mentioned by workers it was rarely in more detail than explaining that the work needs to be developed to increase the mother's skills in handling her baby, or that greater structure or forcefulness needed to be applied to show the concern of the agencies and the importance of there being some evidence of improvement.
The support and counselling the social workers provided for the families was probably important to the families. What is not clear is whether these supports were part of a broad strategy to increase the family's ability to care for their children or whether the enabling strategy is a minimalist position in which "the opportunity for change" and the activities that accompany it are, in reality, simply an extended test of fitness to care for children.

Changing Social Networks

In about half the cases, attribution of responsibility for the abuse was to a cohabitee or another adult; the attribution was uncertain for a further 29%. In the context of later case-management strategies, these attributions meant that the social workers were often concerned with what they regarded as unsatisfactory social relationships and with attempts to construct social supports less hazardous to the children. These activities were problematic for two reasons. The first was that the social workers' position in regard to them was weak; apart from the coercion of removing the children from the mother (or the imposition of conditions for their return) and the "inducements" of the tangible aid, re-structuring the social networks of their clients was highly dependent on their counselling abilities and on the capacity and willingness of the mothers to act on their advice.

The second problem was the mothers' capacity for change. In some cases (such as case 237 where the mother's brother was believed to have committed the abuse), the objective of changing social relationships involved the extended family and, from the client's standpoint, this was a desirable outcome; the abuse had the consequence that the mother was provided with a new house and allowed to set up a home. More commonly, however, the needed break with earlier circumstances was never really achieved and there was a tendency to revert to former patterns as time passed, sometimes with the return of the earlier cohabitee.

Where social workers felt that the child care situation was uncertain, they could present an ultimatum for parents to change their social support network and accept help or to risk the loss of their children into care. There was obviously a third (middle) course which depended on persuading mothers to change and hope that matters might resolve themselves over time. This is illustrated by the following case example derived from a social work interview:
The initial strategy was that of a holding function in which resources were provided to enable the mother to demonstrate her abilities and motivation; there was the option of reversing this plan if this demonstration was not forthcoming but the case-workers were prepared to take several months over this approach before becoming discouraged. The belief was that the mother would respond if and when she was able to confront her problems and begin to deal with them herself. To do this, she needed support and counselling from the social workers and time to work through them. (case 752)

The uncertainty about this third approach is the weakness of the social workers' position as anything other than a support for the client and the inability of the social workers to actively enforce sanctions in practice. The process took time during which the potential to take legal action might fade. Also it might increase the time that the child was subject to unsatisfactory care.

Monitoring

As the word suggests, monitoring as a case work stance was largely a process of continuing assessments of the family's circumstances in order to ensure that the initial view of the problem was the correct one, that there was no deterioration in the situation or that the changes that had been achieved were maintained. It might include some enabling activities when a continuing involvement with the client might partly be about supporting a change of environment and partly about assessing particular aspects of the mother's child care skills after other factors had been removed. A good example is provided by a case in which a mother had, in fact, benefited from the abuse in the sense that its outcome was to resolve longer standing problems with her own family and to improve her personal circumstances. One interesting aspect of the case was that the social worker lent the mother £10 for the purchase of a bottle of whisky with which to establish relationships with her new neighbours. After re-housing (and thus removing the cause of the abuse) it was thought sensible for the case to remain on the register; there was a possibility that the mother would have further difficulties because she was young and isolated; what was really on test was her ability to provide satisfactory child care. The mother was happy with this arrangement, attended case conferences and said that she did not feel that she was on probation.

At a later stage of the same case, the social worker was happy with the mother's new circumstances. She had a new boyfriend; this was seen as a positive
development because his family was providing support and he was kind to her. The question for the social worker was whether or not this was satisfactory in the longer term because the boy friend was only 17 and may not have been motivated to sustain a more permanent relationship. Also, did he just like playing father? If the relationship failed, the social worker questioned whether the mother could cope on her own or might return to her own mother - which is where the problem arose in the first place.

The social worker's view was that monitoring should continue for a few months longer. If no problems arose, then it would be reasonable to de-register the case and maintain contact through the nursery school the child attended. Her cynicism about the boy friend and the couple's planned engagement was because she found it difficult to envisage the boy friend as a future husband.

In other cases, early monitoring revealed more complex circumstances which required more active intervention and then further monitoring, as illustrated by these examples derived from social work interviews:

The initial perception was that the risk of further abuse lay with a violent husband. Increased monitoring resulted from the break up of the marriage when the social worker supported the mother in taking this step while also trying to provide help for the husband. Following the break up of the marriage, the mother's own vulnerability became more evident but this was at a stage when the child was no longer considered to be at risk and with the expectation that matters would improve slowly as the mother grew up and matured and gained in independence. (case 249)

The strategy was to monitor and support the mother who had her own house but whose family circumstances were dominated by other relatives. She was eventually re-housed well away from these relatives but then became nomadic in her life style. Over the period of monitoring, the child had odd injuries and infections although none of great significance. A more intractable problem was that the child was cared for by many different people. This was considered an unsatisfactory situation but there was insufficient risk to the child to merit continued registration and the case was closed. (case 245)
Specialist Centres

A few cases were directed towards specialist services. Some of these were overtly therapeutic in style. For example, the alcohol units run by the Social Work Department in several parts of Glasgow. At least 5 parents in the study were referred to these services. Although alcohol problems were cited as areas of concern in over 30 of the cases in the study (22%). Alcohol problems were also considered as features of family disturbance in a quarter of mothers and a third of fathers in a survey of child abuse cases in Strathclyde in 1980 (Strathclyde Regional Council 1982), but it is also clear that many of the clients were not willing or able to make use of these specialist services.

Two other specialist services undertook a much wider case management role with the families: the RSSPCC Special Unit at the Overnewton Centre, and the Achamore Centre. The Overnewton Centre was a specialist unit with social workers, a health visitor and family centre. The Achamore Centre worked with families where the children were mentally handicapped or were at risk of such handicap, and was able to provide a range of services that would be relevant to a family with a child abuse case that came within its ambit - although the key social worker in any child abuse cases would be from the local social work area team. Both centres had a multi-disciplinary staff and so were able to achieve more cooperative forms of interdisciplinary work and to co-ordinate a wide range of services, continuity and support to their clients. The Overnewton Centre also provided a consultation service for front line professional workers to discuss their cases outside the framework of their day to day work.

All 5 of the cases that were offered a full service by the two specialist centres presented as relatively more difficult cases compared to the total series of cases. Four of the 5 index children were injured at the time of registration; the one non-injured child was a new birth into a family where there had been a previous abuse and the local authority had taken parental rights over other children in the family. All of the families had received previous Social Work Department service, and in 4 of these cases this had been due to concern about the welfare of the children. In 3 of the cases this concern was associated with a history of child abuse within the family.

Four of the 5 children were received into care and, during the study period, 2 of the cases were received into care 3 times. However, only one of the children was in care at de-registration (or at the end of the study period) and this care placement
was at the home of the child's grandparents, with access available to the parents. In the one case where the child was not received into care, she was subject to a home supervision requirement. This child was the new baby, born into the family whose previous children were in long term care following abuse. The parents were being supported and monitored in the care of their new child.

Four out of the 5 cases were subject to supervision requirements from the Children's Hearing System. The one case not subject to an order was received into care 3 times on a voluntary basis even though these were not planned care arrangements. The concern in this case was about the general ability of the parents to provide adequate care and stimulation for the children, and the potentially violent crises that could occur when this care broke down. There were also some possibility of child sexual abuse having occurred within the complicated relationships existing in the extended family, as the family itself was thought to be a product of previous incestuous relationships.

All of the cases referred to these two specialist centres presented as being of more concern, more subject to supervision requirements and receptions into care, and more likely to have repeated crises than was found in the total sample. All of the cases were also continuing to receive intensive social work support at the end of the two year study period. However, none of the cases were moving down a pathway plan towards permanent alternative care arrangements. This may be due to the fact that none of the cases were single parent families and that there was, in the workers' view, more potential for keeping the family together. Another possibility is that the specialist centres worked on a philosophy of long term intensive support that held families together through repeated crises. This is a philosophy less available to local Social Work Department area teams that had less resources to offer individual families.

**Style of Work**

Within the broad stances and strategies of casework and methods of intervention described in this chapter there are a number of other issues to be considered. One is about the style of relationship the social workers adopted with the families. These were diverse and may have influenced the success or otherwise of their strategies in particular cases. Several overlapping dimensions of general aspects of practice were observed in social worker and parent interviews. They included:
(a) the distinction between authoritarian (or controlling) and 'pastoral styles' and the extent that the social worker acts as an advocate for the client;

(b) the visibility and honesty of assessment/monitoring activities and feedback to the client about them;

(c) the distinction between "professional" and "personal" commitments to clients; the ways in which relationships and trust are maintained even when actions against the wishes of the clients (such as removal of the children) are necessary;

(d) the identification or location of the need for change in the client or in the service; in order words, is the service responsible for bringing about change or is it a response required of the client?

(e) as a part of both (c) and (d), the extent to which the worker is motivated to bring about change;

(f) relationships between direct involvement and participation on the part of case-workers and the delegation of some aspects of case monitoring to other workers or agencies - for example, to home-makers.

The potential of service interventions is dependent, not only on the professional skills of the social workers, but on their ability to achieve constructive relationships with a group of clients who are demanding and whose management may provoke anxiety if only because of the hazards of false judgements.

Planning

The emphasis on the content of different professional strategies is principally because of the need to employ them over a fairly long periods with a consequent need to plan the management of cases through various stages of desired change. This 'ideal' view might well be compromised by a lack of the time required for such casework and by the necessity of reacting to circumstances over which the social workers had little effective control. Both might militate against the planning of management strategies.

The case planning reported by social workers and by case conference minutes employed short time scales; progress tended to be measured one step at a time within a general stance or strategy. The interviews with social workers included 'what if ?' hypothetical questions which were regarded as novel and difficult to answer. The author began the examination of the data with the assumption that the case work process might conveniently be divided into activities that related to the
early stages of a case (when matters of immediate priority were being resolved) and later stages when relationships were established and more substantive changes in life style were being pursued. In practice, this distinction did not prove sensible; the cases progressed in time but it is difficult to demonstrate qualitative differences in the content or style or casework in the early or late stages of a case. Instead, the impression was of a much more reactive approach in which problems were to be solved as well as may be along a path to either de-registration or the decision to make alternative arrangements for the children.

One other feature of this seeming lack of planning is that there were occasional examples of cases where a particular broad strategy was adopted but not reviewed or changed.

The following example illustrates the way that the lack of a process of case-planning, or continuity in reviewing objectives, can lead to focusing upon a desired outcome without a continuing appraisal of the chances of achieving it.

An early decision was to rehabilitate the child in the family; this purpose was maintained despite several months without contact with the mother; the child was placed with its grandmother under a supervision order; access visits were arranged for the mother when contact with her was re-established; she then disappeared abruptly. Contact with social workers was renewed when she had a second baby and the process of trying to rehabilitate the family was again put in train. The next event was that the mother reported violence from her cohabitee; shortly afterwards she again disappeared but with the cohabitee and the children and she was eventually found in England. The older child was further abused, was the subject of a place of safety order and was returned to its grandmother under supervision. By this stage the cohabitee had left the family and so the possibility of returning the children to the mother was raised again. Soon afterwards the mother died from an overdose of heroin. (case 250)

A related aspect of the casework process linked to questions of style and to case management was social workers reporting experiencing considerable stress. The media's presentation of child abuse has raised the general level of anxiety about their management and this series of cases included a number where cohabitees in particular could be both violent and highly manipulative. The social workers' concerns were usually with the mothers (and often with attempts to change the make-up of the family) and so difficult competitive situations with husbands or
cohabittees could easily arise. In one or two of these cases it appeared that the personalities of the clients or other adults were simply overwhelming for the social worker concerned. In a rather different example, two children had been badly injured by a cohabitee who was removed from the family; the case then appeared to drift for several months but during this time the cohabitee returned. Although the children were in care, the fact that the future of the children was still unresolved created considerable stress for the social worker in her dealings with her client and her partner. In response to these case work stresses workers reported confiding in same rank colleagues or spouses and partners rather than with supervising Senior Social Workers.

IMPLEMENTING STRATEGIES

The stances and strategies considered in the previous section were often supported by the use of legal powers to protect the child and/or to attempt to enforce required changes on the family. Sometimes children were received into care and then attempts were made (except in the most extreme cases) to enable the families so that conditions would improve sufficiently for the children to return home. In other cases little case work occurred at all. In total six categories of case intervention were noted and these are described for the twenty nine cases in the subsample.

The six categories of cases are not independently existing categories. Rather they are artificial divisions within a dimension of degree of control applied within the social work intervention. The six categories are listed below and the cases that they describe are then discussed in turn.

A. Low key monitoring/support. (n=6)
B. Higher level support. (n=4)
C. Support with controls. (n=7)
D. Control with support. (n=5)
E. Enable returns home. (n=5)
F. No child protection casework. (n=2)

A. Low Key Monitoring Support

There are cases where registration is considered necessary but the actual service provided is not very interventive in terms of either the demands made on the family or of the resources offered to help support the family.
The six cases within this group did not look the least serious in terms of case presentation. There were clear injuries to the children (as in all of the cases in the sub-sample). Three of the cases presented as 'unspecified non accidental injury', two as injuries inflicted by cohabitants (actually the father in these cases), and one was a mother unable to control and cope with her children and with the other stressors in her life. The unspecified non accidental injuries could be worrying because injuries of unknown cause might recur. The risks from the father was reduced in one case because he had left the household, but in the other case the father was still very much part of the family.

In all of the cases the social workers were not terribly anxious about the cases. One case had involved an emergency reception into care Place of Safety Order during the referral process but this was not taken any further by the Reporter. There were no receptions into care or referrals to the Reporter in the early stages of the other cases.

The case work was low key and primarily involved helping families with practical difficulties identified during referral and early intervention. These resources mainly involved negotiating with the Housing Department and providing access to scarce nursery places. The intervention also involved casework visits in the home. These were largely concerned with general conversations about how things were going for the family and dealing with the practical problems that were arising. These conversations allowed the workers to develop a working relationship with the parents and to monitor the situation to ensure that there were not any overt risks to the child. The monitoring functions did not include specific requests to see the child although occasionally this was achieved indirectly. For example, one social worker liked babies and enjoyed the opportunity of helping the mother bath the child whilst it also provided a way of checking on his physical state without a formal request to do so.

Many parents were happy with these casework visits because there was 'care' with little obvious 'control'. The parents benefited from the material resources provided and from the chance to discuss their life with someone who was 'on their side' and who was not part of their social and family circle. Social workers did state that their visits provided opportunities for 'emotional off-loading' and provided the mothers with support and security. For example, in the case where the cohabitant left after assaulting the child the mother needed support at being independent and
the security of the social worker because of the risk that she might be troubled by her husband.

The security and support roles may also have had a child protection role. Simply being involved with the family might have had a holding function that focused the parents on managing their lives in a way that was more protective to their child (similar arguments are made by Corby, 1987). Three of the cases closed quite quickly. In two of the cases the forms for closure was a need to assign a new worker due in one case to a working leaving and in the other due to a geographical move by the family. The third case was closed because no risks were identified although the cause of the injuries was never established. This case was subsequently re-opened initially because the mother requested assistance and then extended because the mother was put on probation for shop lifting.

The three other cases continued to receive a service throughout the two year study. The mother who could not cope continued to have crises and would telephone the social worker for help. At one point the mother requested and was provided with voluntary respite care of the children. The mother was well able to care for the children in most respects, the only danger was from her lack of control of the children under stress and the risk of over chastisement. The approach of the social worker was to be available if necessary rather than to be actively monitoring or controlling the children.

In the two other cases that received a long term service there was an increase in the level of intervention. In one case a new social worker was appointed who felt that the previous worker had acted rather too much as the friend of the family and had not made sufficient demands of the family. The new worker made more specific demands of the mother and directly addressed the problems in the parents' relationship in her casework visits. The social worker felt that the approach of the previous worker made it difficult for her now to apply a more focused approach and the case was closed.

In the other case where there was a change in approach it also coincided with a change in worker, which occurred due to a geographical move by the mother following a crisis in the family. This crisis provided a focus for a more interventive approach, but it was a change that the new worker would have desired anyway. She was highly critical of the previous area team:
"I do not care for that team's philosophy". "It is always doing the minimal". "If they went in a bit more decisively they could maybe go in and get the whole thing over and done with and come out again, rather than all this procrastination". "(I know children) who have been roaming the streets like wild dogs ...... not going to school, being looked after or cared for or fed and it is almost like just shut your eyes long enough and they will be sixteen eventually". (Case 385).

The social worker obviously favoured a more interventive approach. She achieved this by a directive yet positive approach underpinned by a referral to the Reporter and a home supervision order. In the family’s crisis the parents had separated with a child each. The social worker put controls and demands on the family whilst developing the independence and confidence of the mother. The social worker said that her strategy was to be clear and direct in her concerns and yet positive in her help and support. For example, when the oldest child was about to start school a small grant was given to ensure that the child had nice new clothes for his first day. School entry was therefore able to be a positive and rewarding family experience although the family were disappointed with the attitude of the school (the social worker was damning about the negative attitude of the school to the first day of their new entrants and the way that it jeopardised her efforts to help the family be positive and instrumental with the services available to them).

Most of the day to day work with the family was accomplished by the homemaker. The social worker only saw the family at major decision points or if there were problems in the family that required her direct presence and authority. She did not attempt to be the family's friend. Instead she was the professional in charge of both trying to help the family and making demands and putting controls on the family. There were some set-backs but the worker reported that the family became a much more cohesive and functioning unit and were responsive and appreciative to the social worker's intervention.

**B. Higher Level Support**

This category was distinguished by receiving a higher level of supportive intervention than in 'A' but still without any real level of control or demands made upon the family.
The four families presented in very different ways but all of them had serious problems. Two of the mothers were living as single parents. One provided a high level of care for her children but had over chastised a child whilst under high levels of housing stress and a lack of support. The other mother also experienced stress and a lack of support and was considered to be in danger of both over chastisement and not sufficient care and protection. In the third case it was a cohabitant (now departed) who had over chastised the child, but the now single mother was, like the other three mothers, not coping and was in danger of over chastising the child. The fourth family had severe multiple problems and few skills or social supports.

Although there were considerable risks to the children in these families, the mothers were well aware of their problems and actively welcomed the social work support. The intervention provided gave significant emotional and material support but there was not seen to be a need to take a surveillance or controlling approach. In one of the cases there was a routine referral to the Reporter, but no action was taken. In the other three cases voluntary reception into care was used at times of risk or other crises and as a respite to the parents.

Other resources used were nurseries or family centres and the normal forms of assistance with material problems including negotiation with agencies such as Housing and the Department of Health and Social Security.

All of the cases were continuing to receive a service after two years of being followed by the research study. There continued to be difficulties and crises requiring assistance and in two of the four cases there was an acceptance of the need for long term or even permanent support. This went against the typical social work approach to cases in the subsample which was that intervention was to help families to be self supporting rather than to provide long term additional external support.

In one case where a mother was contriving to scapegoat one of her four children at times of stress the Social Work Department provided weekend respite care as well as a homemaker, a single women’s group, and day care. In the other case (the family with multiple problems), there was full time day care for all four children, speech therapy, a homemaker, a family holiday, and the services of the Achamore Centre (a multi-disciplinary resource for families with children with learning difficulties). In this case not everyone agreed with the high level of support being provided. The view of some other workers associated with the case was that attempting to fulfil all the children’s needs outside the home was not allowing the
family to learn to cope. Also, the children would (or should) end up in a new permanent family and therefore this would be better achieved sooner rather than later. However, the main case worker felt that the family trying very hard to succeed and that the professional staff were prepared to strive hard to help them achieve this.

There were no major changes in the management of these cases over the two years of the study. In one case there was a slight increase in the interventive stance when the case was transferred to a new social worker. The mother asked him for respite care at a time of crisis and he refused as he felt this was not a solution to the mother’s lack of support. Instead he took a more proactive approach by providing a homemaker, helping to re-schedule the mother’s debts, reducing the nursery place from full time to a more realistic part time and negotiating with the boyfriend to be more consistent in his limited support.

C. Support with Controls

This category involved seven cases provided with high levels of support but where there was a more overt use of controls of child protection intervention.

The least interventive case involved a husband pretending to injure a child and then accidentally doing so. It was clearly an accident that should not have happened and although the social workers did not refer the case to the Reporter, they were forceful in reminding the husband of his responsibilities and insisting that there were problems that needed to be dealt with. The major approach within this case was to enable the mother to be more independent so that she could properly choose what she wanted to do. In the end she separated from the husband who was becoming more difficult including locking his wife out of the house and physically assaulting his father in law. The separation changed the social work tactic of developing independence in the family to providing support to the mother by way of a homemaker, by negotiating with the Housing Department, and providing advice concerning her application for a divorce.

In four of the cases Place of Safety Orders were taken right at the start of the case and were followed quickly by home supervision orders. One of these cases was a relatively stable and capable family where the mother had been scapegoating one particular child. The family went through several stages of instability and the social worker used the supervision order as a controlling back drop to these changes. In
the end the social workers felt that most of the work had been done by the family and that social work had merely cajoled them to achieve this.

In the second home supervision case the mother had been found drunk in charge of her child. The Social Work Department helped with housing and a place at an alcohol project. The mother had a relationship with a 'binge drinker', who she said was not staying in the house and who was not a focus of the social work intervention. No attempt was made to encourage a division between them. The case was transferred to another social worker who felt that he was able to develop a more open and trusting relationship as the more formal aspects of child protection intervention had been in the past. Supervision was ended and the case was removed from the register because of a perceived decrease in the mother's drinking. Case work continued because the mother had been put on probation for a Breach of the Peace for which she had many convictions. The probation is of interest because it was seen as less interventive and controlling than child protection and because it allowed casework to have a purpose and to continue after de-registration. It may therefore have made de-registration occur earlier than otherwise.

The third case of home suspension concerned physical abuse of the child by the father who was convicted for the assault. The social worker helped the mother with practical problems, was able to give some emotional support, and made demands on the mother in respect of her care of the children. For example, the mother was given a stern warning about a burn to the child that had not been well cared for and had become septic. Control was also applied by stipulating that the father could not stay. There was no legal force behind this except that the Social Work Department could have requested a Children's Hearing with the threat that the children would be removed. The family managed this by slowly stretching the Social Work Department stipulations in terms of the amount of contact the father had with the family. The social worker did not feel that this was done sufficiently dramatically for her to be able to prevent it, although it caused her anxieties in terms of not being in control of what was occurring and because of possible risks to the children. In the end the mother was able to sufficiently clear her debts to move away to set up house again with her husband and the case was transferred to a new team that took a more historic view of the problem and a low key monitoring role.

The fourth case of home supervision was referred after a young infant was found with bruises and in the care of a friend of the family incapacitated from alcohol. The mother was of low intelligence and came from a very difficult and non
supportive background. She was cohabiting with an older man who had a Social Work Department service because of the learning difficulties of several of his much older children. The Social Work Department offered the normal range of services as well as a place at a family centre to increase the mother's skills and confidence and also to provide some more stimulation for the child. The social worker did not feel that the cohabitant was particularly appropriate and allied herself with the mother in a way that rather excluded the cohabitant. When the family moved house, a new worker was assigned who was less controlling and increased the resources for the family. The parents saw the social worker as a friend and ally to them both and were more open to the resources offered that included a home visiting teacher, a psychological assessment of the child's speech, and adult literacy classes for the mother. This change of tactics by the new worker was helped by serious illness in the child. The work became seen as supportive of the whole family rather than of a vulnerable mother against a more powerful and instrumental male partner.

All of these four cases differed in their specifics but were similar in that the caseworkers did not become particularly close with the parents. The workers were attempting to engage the families and provide support and access to resources but within the context of demands of minimal parenting being set.

There was a further case in the group that had similar characteristics but differed in that there was a pattern of repeat injuries, repeat receptions into care, and returns home to the parents starting afresh. The parents were personable and articulate. The mother had lost two previous children into permanent care and this new child had been received into care at birth. This seemed a highly interventive approach, but this contrasts with the subsequent willingness to keep returning the child home despite her being repeatedly bruised. Two factors that might have encouraged this approach may have been. Firstly, at the time of the crises resulting in reception into care the parents tended to say 'well maybe this is it, we have failed and maybe we should not have the care of this child'. Secondly, the new homes set up each time by the family were in different locations and therefore involved new workers who re-assessed the situation. The workers would ask if the parents were really sure about taking such a major step and then the parents became enthusiastic about making a new start. In the last three months of the study period the child had received five sets of unexplained bruising in the last three months of the study follow up.
Finally there was a case that initially had a panel order requiring minimal standards but the child was then received into care on a Place of Safety because the mother moved into a house where a Schedule 1 Offender was also living. The child was not immediately returned home and so it became a case of attempting to enable the child to return. This case is discussed under category 'E' because it has more similarity with the cases in that category.

D. Control with Supports

This category covers five cases where the controlling function was more prominent than in category 'C'. All of the focus children were received into care at some point, but unlike the cases in 'C' the children were not immediately returned home. They were kept in care for some time and were returned in a slow planned way. In most cases there were Children's hearing supervision orders stipulating residence at a foster home, but in one case the placement was voluntary although there was subsequently a home suspension order issued.

All of the children were received into care at times of crisis and Place of Safety Orders were common. These however were different from emergency receptions into care that occurred at the beginning of cases because the situation was unknown. The situation was known in these cases and the emergency admissions were usually after there had been some casework with the family. It was either that the stresses around at registration had increased of their own accord or that the actual controlling function of the intervention had forced issues to come to a head and lead to crises.

The caseworkers offered the normal range of practical support with the families, but the distinguishing feature was the attempts to directly engage the family in a very overt way. The aim was to work in partnership with the families to achieve the necessary change, but it was clear that a close working relationship was being demanded and so it is unsurprising that underlying tensions in the families often became apparent early in casework.

Two of the cases were managed by the Overnewton Centre, the RSSPCC Special Unit, who provide an intensive multi-professional service demanding a high level of engagement in their direct work with families (RSSPCC, 1989). A third case involved worrying injuries to the child followed weeks later to injuries to a second child and a similar level of engagement was required by the social worker.
The fourth and fifth cases were a bit different in that the workers attempted high level engagement but the families attempted to avoid this. In one of these cases constructive work was only reported to be possible after the crisis leading to reception into care. The social worker and the mother then worked together to help the family reform and so the case management became less controlling.

In the other case the worker continued to have a problem in engaging the family. This was very difficult for the worker because the lack of trust meant that she had to continually check up on the mother in a destructive 'chasing' manner. She was trying to support the family but felt continually manipulated and lied to and felt she had no option but to increase the controls. Although the family moved house, the moves were so frequent that the case was not transferred to a new team. The case was only transferred to a new worker when this was requested by the mother. The senior social worker did not seem aware of these problems from the case supervision and the keyworker did not seem able to bring it to his attention. The social worker felt that the family were particularly manipulative in their use of services and that a personally much easier route would have been the reception of the child into care on a permanent basis.

In all of the cases in this section the workers were very controlling and demanding but offered other intensive services that provided a softer and more emotionally supportive service. For example, the cases at the Overnewton Centre would attend the family centre for individual sessions with a family centre worker and also sessions where other parents were present. This not only allowed role modelling or positive reinforcement of child care skills, but also provided positive social and emotional relationships that might be missing from the parents lives. The workers reported that parents developed ambivalent feelings towards the workers. They were largely dependent on the help they were receiving yet also found it difficult to change from the patterns of behaviour that they had learnt over many years.

E. Enable Returns Home

In five cases there was a very early reception into care from which a return home was not achieved. In a further sixth case, already mentioned in section C, the reception into care came after a few months of casework.
For one of the cases the reception into care was a placement with the child's paternal grandmother and the parents had open access to the child. This is different to all the other cases where the children were placed in foster care. The case was managed by the Overnewton Centre and involved intensive casework typical of the cases described in section D.

The other five cases all involved basically single mothers although they were at times cohabiting. The social work plan in all cases was that the children could not immediately return home, but that the plan would be to attempt this having first ensured that this is what the mother wished and that the mother was able to provide a suitable home for the child. Four of the five mothers only had one child and both of the two children of the fifth mother were in care.

In carrying out the casework plan the social workers attempted to enable the families to make decisions about the future of their children. In being without their children the parents had more free time but this tended to be spent in activities such as drinking or forming a series of new relationships that the social workers did not think displayed sufficient motivation or ability to care for their children. Motivation and ability were also assessed at access visits. Social workers sometimes made negative statements about the behaviour of mothers at access visits, but the most important criteria seemed to be actual attendance. The difficulty for workers was in deciding whether the social drifting and poor attendance at access was a display of a lack of motivation to parent or a reaction to the stresses and difficulties of the crises that resulted in the child being removed and the continuing stress of that removal. In some cases there were particular demands made of the mothers. For example, one mother was allowed one access visit per week at home with the precondition that she gave the child a hot lunch of not pre-prepared foods although many parents only eat re-heated foods such as pies and beans and lunch usually consisted of a filled bread roll.

The social workers attempted to engage the single mothers in the task of returning the children home, but with only limited success and none of the children were returned to their care. Help with practical problems provided one focus for social work assistance, but there was little else to focus on apart from the access arrangements. This casework had a very different flavour to casework visits where the children were at home, from visits when some of the children were still at home, or even from visits where there were two parents attempting to get their children returned. Again it is difficult to say whether this is a function of who the
single parents in this group were or because of the attitudes of workers to these single parents. On the one hand these parents were not showing a willingness to fulfil the minimal tasks being required of them, on the other hand children in other cases discussed in previous sections were being returned to nuclear families providing very poor living conditions or were being subject to repeated sequences of bruising.

One of the mothers agreed relatively early on in casework that it would be in the best interests of both her and her child for the child to be permanently placed elsewhere. She gave birth to another child from a new relationship and the Social Work Department continued to support her in this new task with a type 'B' level of service. The case was also continued because the mother was on probation for an unrelated offence. The mother was a highly personable teenager and the case had to be transferred because the male worker was becoming too personally involved in the client's welfare. The new worker was female but she also felt very positively towards the client and went around to have supper with her and seemed reluctant to transfer the case on to the area team for the place that the mother had moved to.

Three of the other mothers were not happy with the move towards permanency that slowly occurred as a return home was not being achieved in practice. They were not aggressive or difficult but extremely passive in their dealings with the workers. They did not request or receive much of a direct social work service for themselves when it became clear that the children would not be going home. In the fourth case the lack of progress with the mother led to the Social Work Department exploring a return of the children to their father from whom the mother was separated. He was displaying much greater ability and motivation with fulfilling the access arrangements and so the children were returned to him. At the end of the period of the study the mother was re-establishing her relationship with her husband and she was planning to be reunited with him which would result in her being reunited also with the children.

**F. No Child Protection Service**

The final two cases were not provided with a child protection service for more than a very short time despite the children's names being placed on the child abuse register.
One case arose from an allegation by the mother that her child had been assaulted by her cohabitant. The Social Work Department invoked the child abuse procedures, but it later transpired that the woman was receiving a service from a psychiatric social worker and was well known to create dramas. The mother decided to let the child live with his father some way away, and so the case was not taken further. There was another child still in the care of the mother. The psychiatric social worker and the worker therefore kept the case open and were prepared to see the mother at any time in order to help diffuse any crises or dramas that were building up. The worker felt that the mother was able to give adequate care to the children as infants but not as toddlers and also had concerns that the mother's psychological problems might result in her going 'over the edge' without much warning.

CONCLUSIONS

This chapter has examined the nature of case assessments in terms of parenting, the stances of Social Work Department intervention, the methods of intervention, and described the implementation of these strategies on the subsample of twenty nine cases.

The degree of intervention seemed to hinge on the perceived stability and quality of parenting, but this was only assessed in the broadest of terms. The system was operating on the basis of ensuring that a basic minimum of care was being provided, rather than some detailed analysis of the adults motivations and abilities at parenting. The assessments of such a minimum of parenting was not formalised or set out in the ways suggested by the recent publication from the Department of Health on assessment (Department of Health, 1988). Furthermore the assessments rested mostly on an understanding of the possibility of the parents providing a sufficiently caring context than an assessment of the children. Even in the few cases where the children were being more formally assessed the identification of any deficiencies in their development were used to inform the provision of extra resources in the home rather than being a factor in deciding on whether or not to remove the children from the home.

There was a range of levels of intervention observed rather than simply a particularly liberal (Dingwall et al, 1983) or a particularly interventive approach (Dale et al, 1986) being adopted by the Social Work Department. There was an
acceptance by workers that there were limits to what could be changed within families and their social contexts. One social worker commented on her case that:

"It is probably true that ---- (the mother) has not basically changed ... but there are some cycles that you can not change ... so its natural that these things will recur".
CHAPTER NINE

CARETAKER PERCEPTIONS OF SERVICES

The data reported in Chapter Eight showed that the ultimate focus and client of child protection services was the child, but that attempts to fulfil the needs of these clients were primarily through the secondary clients of the child's caretakers. The focus of child protection services was directed primarily at the main caretaker of the child (usually the mother) in order to assess the quality of care and to provide assistance to enable that care to be improved. In addition, the child's main caretaker was sometimes considered a client of social services in his or her own right, although concerns about child protection probably increased the likelihood of such services being available.

If the only concern is child protection, then parental satisfaction with services might not be considered important. An extreme hard line policy could consist of ultimatums to parents about standards of child care without any offer of services to help the parents achieve such standards. However, where it is believed that in usual circumstances the best place for children is in their original homes and where there is commitment to assist parents over crises that threaten this, then how the parents relate to that service may be crucial to the actual outcome for the children and families. This is particularly clear when immediate risks result in children being taken into care on a temporary basis, where a productive working relationship between parents and professionals may be necessary for a successful return home of the children. Furthermore, even when children are removed into alternative care on a permanent basis the parents may be helped to adjust to their loss. Such supportive services may also effect child protection for other or future children in the household. It may effect the parents' desire to have more children, their attitude to those children, and their willingness to be able to approach services for assistance in any future difficulties they encounter.

POSITIVE REPORTS

Ten parents reported very positive feelings towards their social workers with seven mothers experiencing particularly strong relationships with their workers. Such positive perceptions of the social worker even existed when the parents' care of their children had been called into question resulting in their children being received
into care. Seven of the ten overtly positive relationships involved at least temporary receptions into care. The impression is that these parents were having the most difficulty in coping with the care of their children and other relationships in their lives and genuinely appreciated the care and support of their social worker. In an eighth case there was a strong relationship with the worker existing before registration but this did not survive the child protection intervention and the reception of the children into care. The mother was angry that the worker did not believe that the child's injuries were due to an accident, but the social worker reported that his concerns were more about the general standards of care rather than non-accidental injury (Case 305).

Care Versus Control

It is not surprising that parents had ambivalent feelings towards the Social Work Departments who were offering both supports and controls. These ambivalent feelings may have been ameliorated by the different positions being taken by different members of the Social Work Department. In a few cases the parents made overt distinctions between good and bad professionals that seemed to be based on who was most explicitly taking the authority role and demanding change in the family. This is illustrated by the following case example derived from both the social work and parental interviews:

Towards the end of the investigation the senior social worker visited the family with the keyworker and gave the parents a severe lecture about minimal standards of care and actual changes that were being required from the family. In contrast, the keyworker used the strategy of not making overt demands but of asking how things were going and how she could help and also gave some small possessions of her own to the parents (case 336, social work interview).

The parents said that they liked the keyworker, but not the senior social worker who was trying to tell them how to live their lives and care for their children. (Case 336, parental interview)
The division of care and control roles between individual professionals was not always so clear cut. It was more apparent in cases where quite a hard line was being taken by the Social Work Department rather than simply low-key monitoring. In these more interventive cases it was also more likely that other staff would be involved in providing a social work service. One mother, for example, reported that the only professional she could trust and confide in was the homemaker. Similarly, the specialist child protection agency of the RSSPCC, the Overnewton Centre, offered intensive long-term support to families and the parents developed different kinds of relationships with the range of workers involved. The relationships seemed to be largely determined by both the particular role the worker was undertaking in their work and the response of the parents. Although different professionals had different jobs and responsibilities, the system was sufficiently flexible to allow parents to choose a different emphasis in their relationships with different staff in the centre within the limits of the case work plan.

In nineteen of the cases the complexities of the care and control relationship meant that the relationship could not be described as overtly positive, but this did not mean that the relationship was all or even predominantly negative. The clients' behaviour showed that they were prepared to make positive use of the services. This can be illustrated by the following examples derived from parental interviews:

The mother said that she did find the services of the Overnewton Centre useful and had recently used the emergency telephone service to ask for help when she was getting fraught when her child was not settling at night. However, she objected to all the questions that were asked, the questioning about her life, and the attempts to catch her out by testing for consistency in her accounts of events, particularly in relation to child care or child accidents. (Case 382)

The mother, separated from her very dominating cohabitant, had increased her independence and relief from the children by getting a job and support to care for the children whilst she worked. At Christmas the mother gave up her job and the cohabitant returned for a short time. The mother went into a crisis, returned to drinking, and was unable to cope with the children. Social work had virtually ended by this point and the mother re-initiated contact to request the children's temporary reception into care so that she could recover her equilibrium. (Case 338)
A less overt way in which parents were able to use workers effectively was as allies and sources of strength in their personal relationships. There were five cases where this was particularly obvious and all concerned the women's relationships with their cohabitants or boyfriends. The social workers could give direct assistance to women to carry out courses of action that they had decided upon. They could negotiate to try and arrange some compromise agreement, or they could be indirectly used to affect the power balance in relationships as illustrated by the following case example derived from a social work interview:

The mother had decided that she did not want to continue the relationship with the cohabitant. She had made demands for assistance in the running of the household and the care of the children but any effort on his part was very short-lived. She was extremely anxious about asking him to move out and so asked the social worker to visit at just after the time that she planned to insist that the cohabitant leave. This strategy worked, but the cohabitant continued to harass the mother and so the social worker helped to negotiate with the police to ensure that this did not continue. (Case 344)

In other cases the social worker made direct demands of the men or made negotiations with them on the women's behalf as in this case example (from parental interview):

The mother was continuing to find it difficult to cope with the control of her three children. Most of the time she would ignore their wild, aggressive behaviour by sitting passively and then she would suddenly lash out physically or verbally to no effect. She was also distressed by the lack of commitment from her boyfriend, who was the father of the children, who lived with his parents and visited when he wished to. The social worker negotiated directly with the boyfriend that he would, as a basic minimum, visit on two particular evenings each week so that the mother knew that he would at least be there on those evenings. (Case 323)

Social Worker as Ally

Another way in which the mother were able to use social work as an ally was as an indirect force in the power balance in the relationship. In two cases the men were
aware that co-operation with the Social Work Department was necessary in order to safeguard their relationship with the mother; there was always the possibility that the children would be removed resulting in the break-up of the family and less need for the women to rely on them or to continue the relationship. This is illustrated by the following case example from the social work interview:

The mother went to see the social worker in tears because the husband had not been coming home, or had been bringing all his friends around every night, had been spending a lot of their meagre state benefit payments and had been saying that he could do as he liked now that the homemaker was no longer visiting. The social worker gave the mother some money and made a home visit. Her approach was to reinforce his protective role to the family with statements like "you must not let people act like that in front of your wife and children, in front of your family". (Case 334)

The supportive role as ally in the parent's relationship could also be used in a more worrying way that could encourage maltreatment of the children. The following case example is the researcher's observation arising from a parental interview:

The parents together make out that everything is fine in their relationship but when the children's father is out of the room, the mother explains that he has been going out drinking and not coming back. Virtually the only sanction that the woman has in their relationship is the threat of the children being taken away and his losing the family life. Over chastisement of the children and requests by the mother for voluntary receptions into care occur at times of crisis in the marital relationship. (Case 357)

Workers found less difficulty in being appreciated by parents towards the end of involvement with the families where there was less likely to be high level concerns about the welfare of the children or a need for intensive intervention. Social workers who took over cases at this stage reported that they had a minimal monitoring role and were not attempting to contain risks or require some change in the child's environment. The social workers could afford to be relaxed, friendly, and unthreatening to the families. In the cases where the children were heading for long term permanent alternative care there was often more tension and animosity, but an individual social work service was not provided for the adults themselves if they did not want it. Any contact (above the minimum required for the legal
processes in separating the child from the parents) only occurred if the parents found it helpful.

A difficult challenge for workers was to be seen in a positive light early on in cases where the care/control dilemma is more acute. Control is required to ensure the present and future safety of the child yet this is to be attempted by working in partnership with the family who may resent the intrusion in their lives and the questioning of one of their few areas for positive reinforcement in their lives (see Chapter Two). Integrating the care and control aspects of their role in child protection must be a considerable challenge for the workers and so it is useful to briefly examine some of the actions of social workers that were most appreciated by the parents.

**Material Assistance and Respect for the Client**

The provision of assistance with material problems such as housing or debt was nearly always highly appreciated. This was well understood by social workers who reported that it was a commonly used strategy to engage a family by showing them firstly that you have the skills and resources to be useful and, secondly, that you are sufficiently interested in their welfare to undertake these actions on their behalf. Most of these actions involved negotiating with other organisations such as housing, social security, electricity and gas boards, or debt agencies. It could also include the provision of small loans and grants from the Social Work Department. Occasionally it also included workers giving small possessions of their own.

Nearly all the other instances of particular appreciation concerned actions that showed interest in the clients and that took them and their future plans seriously. For example:

The social worker had to complete a report for the mother’s appearance in court for an offence. The worker argued strongly for a non-custodial sentence. This was appreciated by the mother as for a previous offence another social worker had recommended that a custodial sentence was the most appropriate. (from social work interview, Case 335)

The mother reported that the new social worker takes her long-term plans of staying with her cohabitant seriously as she
involves him in the discussions about the future care of their child.
(from parental interview, Case 319)

A good example of a worker winning the co-operation of the family by her respect for them as individuals concerned a case where the family's self esteem was particularly low because of their higher than usual social ambitions. The following is derived from a parental interview:

The father's business had failed, there were large debts that could not be paid as they were on social security yet prevented any immediate gain from getting a job, they had to move to a council flat in one of the worse streets in Glasgow, the father had assaulted the children who were now in care, and the family were required to attend a family centre as less than equals with parents whom the father considered to be virtual 'scum'. The social worker (1) arranged for the father (who still had a car) to be the official transporter of the children from foster care to the family centre, which not only gave him responsibility and payment of expenses, but obscured the fact that the children were in care to the other parents at the family centre; (2) supported the father's decision to remove the children straight back to the foster parents against the protests of the family centre staff when he heard that there was infection amongst other children; (3) took the parents for a light meal at a fashionable Glasgow cafe after a Children's Hearing Panel. The appreciation of the parents was in being treated as an equal rather than the financial cost involved. (Case 287)

Families subject to a child abuse investigation may not know whether they should be trusting and open with the social workers involved. They may not know whether the worker really is concerned for them and wanting to help them or whether their co-operation and openness will be used against them with the danger that they would feel doubly violated by the system. Secondly, they may not know whether to accept the worker's judgements as to what is the best strategy for them to take in their lives and that if they take certain actions they can expect certain outcomes. Some of the appreciation reported by parents was on the basis that what had been advised had been proved in practice to be successful. For example:

When the husband was released from prison he planned to go and live with his wife and then apply for their children to be returned. The social worker advised that because of all the events
that had taken place, issues that still had to be resolved, and the husband’s violence on his last meeting with his wife, that it would be preferable for them to live separately and to slowly plan for setting up a new home for their family in a new house and only then return the children. The success of this strategy (which the parents had to be persuaded of), and that its aim was the positive outcome of the return of the children, helped to change the attitude of the parents to the social worker. (case 300, summary from parental interview)

"Obviously she (the social worker) had seen the same situation before and, well, she did not know we had problems but she had a good idea that there could be so she thought it would be as well to leave the kids out of it which was probably a good idea". (Case 300, quotation from parental interview)

Workers success at developing a good relationship with parents always carries the danger that the relationship will become too close and result in the workers becoming over involved and cloud their professional judgement as to what would be the best strategy or advice for the parent. More dangerously, it could result in the worker not giving sufficient attention to the protection of the child whose needs might conflict with that of the parents. Social workers and their seniors seemed well aware of these problems as new workers were assigned in three cases because too close a relationship had developed. In two of these cases the children were in care and the male social workers were concerned about the dependent emotional relationships that were developing with their female clients. These clients (as with the wider group who had developed close relationships with their workers) reported to the author that they missed their previous workers who had been so kind and helpful to them.

Parents varied in the distance that they kept from their social workers. Some parents maintained a distance whilst others were particularly responsive to committed and supportive relationships offered by a several workers. At the extreme, there were one or two families who were grateful for any attention or social contact. The second factor in the relationships was the particular stance and strategies being undertaken by the workers and how the care and control roles were being implemented, but this was mitigated by the third factor of the age and personality of the worker. Some parents complained that their workers were too young and inexperienced. Others preferred workers of similar age. For example, in one case a middle-aged homemaker was replaced for a few weeks by a recently trained worker. The mother got on extremely well with the replacement homemaker and saw her as
half-way between a 'pal' and an older sister - a relationship that she really appreciated (Case 334).

Outcome of Intervention

It was not possible to determine how much impact the social work intervention had upon the changes in the family. Even the moves towards permanency could have been the mechanical application of a criteria of minimal parenting to the actual or potential caretaking situations presented. The situation was probably considerably more complex with the context of the single parents' lives determining their ability to change or accept help and the type of assistance offered and of assessment of future risk perceived by the workers involved. Parents varied in whether they felt that the intervention from social work had been effective or relevant. The majority of parents responded to this question by referring to material help and negotiation with other agencies. It is not clear how relevant consumer views are to the actual causes of change (Sainsbury et al, 1982), but two brief examples of parents who had addressed this problem are given below.

Case examples:

Mother believes that the intervention was both necessary and useful. She was not coping and although Sharon (the child) was being extremely difficult she was scapegoating her and she could have ended up killing the child. (Case 146)

The mother feels that, however well intentioned, the agencies could not help her. She had to deal with it herself. The only real possibility of help was the couple up the stairs who she could talk to and who tried to introduce her to a social club for support, but she never carried this through. She says that she does not like to admit to herself that she has any problems and does not prepare herself for them. (Case 236)

In two cases there were dramatic improvements in the lives of the mothers from relatively straightforward forms of assistance; both of which were very appreciated by the mothers. One case was simply negotiating new accommodation for a mother under intense housing stress who had felt unable to come forward for help. In this way the non-accidental injury she inflicted on one of the children had a positive effect in summoning help. In the other case, the mother had a severe hearing
problem and was also unable to read or write (case example from social work and parental interview):

The mother was virtually unable to communicate to anyone and used to smile and nod as if she was understanding. She was very low in self-esteem and very dependent on her husband who was very dominant and was having an affair with another woman. All the agencies (including the general practitioner) assumed that the hearing problem had been investigated, but this was only done after the case was transferred to a new social worker who investigated the problem. The mother received the simple hospital treatment necessary and recovered her hearing. She became very much more confident and able to assert herself. She also got on better with her neighbours as she did not need to play her records at full volume. (384, social work interview)

The mother admitted to the researcher that she had never known what the social worker, the health visitor, or the Children's Hearings had been actually saying to her. (Case 384, parental interview). The mother was very appreciative of the change in her life, but the social worker was very critical that no one had dealt with the problem before:

"A member of the public might think she was daft as opposed to deaf but any doctor who has got any qualification ought to know better than that....She has a way of speaking that is about being deaf" (quote from interview with interview with social worker)

NEGATIVE REPORTS

It would be unsurprising if the parents in the sample were not at the very least ambivalent about child protection services however much those services might be wanting or even succeeding in providing them with help and support. Ultimately, there is the threat of the children being removed from the parents and this can result in their agreeing to things that they might not normally be prepared to accept such as questioning of their child care, questioning of their social life and intimate relationships, and the imposition of a probably different value system into their lives. The level of positive partnership described in the first section of the chapter is therefore encouraging. This section looks at the difficulties that did occur in engagement and co-operation in the other cases.
Levels of Co-operation

Four different levels of problems in engagement and co-operation that were evident in the sample.

(a) passive co-operation  
(b) pseudo co-operation  
(c) little co-operation or engagement  
(d) total rejection of service

Passive Co-operation

Parent(s) co-operated in the sense that they did not actively fight the intervention but they were not actively engaged or involved in a partnership with the social worker. The parental attitude seems to be one of resignation and powerless.

Case example from parental interview:

Mother feels that the social workers are interested primarily in the child and that they have not given much help to her except to try and get a house allocated to her. She says that the decisions are up to the Social Work Department, that she has little control and she doubts whether they will allow her to have her child back from care.  
(Case 324)

Pseudo Co-operation

These were cases where parents agreed to demands for change made by social workers suggested but in practice did not follow these through and tried to hide this from the workers. Parents sometimes joked with the researcher about how they had managed to avoid the social worker demands or deceive the social worker. Some parents described social work intervention as it were some sort of life hazard. It could occur to people like them, and if it did, they had to at least marginally cooperate with the agencies until they had 'done their time'. This 'pseudo co-operation' occurred in low level monitoring cases, where the agencies were not fully sure as to what led to the child being bruised, but did not have high levels of concern. The families in these cases co-operated but only within the narrow and implicitly agreed limits of co-operation, which has some correspondence with
McIntosh's (1986) finding that parents feel checked up on by health visitors even though they will cooperate with them and use their services. However, more overt pseudo co-operation also occurred to varying degrees in cases with more intensive intervention.

The parents said that it was not possible to tell the social worker to "bugger off" as there was the danger that they might be able to take the children away. The husband, who had assaulted the child, therefore did not stay overnight on his visits to the family home. However, the parents did in practice slowly stretch the social workers 'rules' so that the husband did return to the household, but they did this in a way that the social worker found hard to resist or to take any action against. (Case 189, from parental interview)

Case (described earlier in chapter) where the mother avoided the social worker because (1) she found her difficult to relate to, (2) communication was negative rather than positive, (3) it was painful to admit that she was not caring sufficiently for her child and therefore not, in hers and others eyes, a good enough mother, (4) the possible consequences such as the children being removed. The mother said, "I try to avoid her as much as possible and then she tells me to come down to the office and stuff, I do not go". Later, the mother was hit by a car and admitted to hospital for two and a half days. She was returned home with both legs in plaster which she immediately removed as they constrained her ability to do things including care for her children. She also reported to the researcher that had not been to her doctor to check on the cause of a lump in her breast. (Case 300, parental interview)

**Little Engagement**

Most families co-operated to some extent with the agencies even if this varied considerably during the course of the intervention and even if the families felt that they had no choice but to comply with the worker's wishes. At the very start of the case there might be considerable resistance to the investigation and any suggestion of a need for services, but this usually mellowed into at least a moderate level of real or pseudo co-operation.

The continuing lack of engagement was most clearly seen in families who varied between total co-operation and total avoidance of the service. This occurred in one case in the sub-sample and in one other case in the main study sample. They both
concerned mothers who were seemingly totally co-operative with the worker and blamed many of the problems on their boyfriends who were now away. The workers would then put their effort into setting the mother up in a new house as an independent single mother, but during this process the boyfriend would reappear and there would be a renewed crisis or complete disappearance of the family, who would eventually be traced, resulting in a repeat of the process with or without the boyfriend being part of the worker’s attempts to develop some stability.

**Total Rejection of Services**

The total rejection of the social work service was rare because families often did have problems needing assistance, because the agencies could apply for legal powers to remove children, and because families were not always aware of the limits of social work powers or felt unable to block their requests. For example, social workers did not go out of their way to inform parents that they did not have to admit workers to their house even if the children's names were on the child abuse register. To the knowledge of the study, only one parent on one occasion refused to admit a worker to their house. Parents were more likely to pretend to be out when a worker called if they were unwilling to meet them.

In two cases in the sub-sample, the parents totally rejected the need for a social work service from the area team and in both cases the Social Work Department acceded to these demands. In the first case the area team had investigated the case and registered the child but it then transpired that the mother was already receiving a service from a hospital-based psychiatric social worker who questioned whether the non-accidental injury alleged by the mother had taken place or whether the mother was manipulating the services for her own needs. In the face of the mother's lack of acceptance of a service the team allocated the case to the psychiatric social worker. Subsequently the mother handed the toddler child to her ex-husband, as she had previously done when her older child had reached this age, and concentrated her efforts on her infant baby (Case 145).

In the second case, the child has a serious injury that was compatible with the parent explanation but other factors raised social work anxieties and led to an investigation strongly resisted by the hospital medical staff. In the face of total opposition from the parents and from the hospital and community based health services the Social Work Department withdrew (Case 190).
A strategy of rejecting services could be an effective way of limiting agency intervention, but only if it were totally successful. If the agencies still felt a need to intervene and had the legal basis to insist on this, then the lack of parental cooperation might be interpreted as further evidence of their incorrigibility (Dingwall et al, 1983).

Control Versus Care

It is to be expected that parents would be more favourably disposed towards material resources and emotional support provided by social work and less in favour of the child protection role even if they might ultimately agree that the child protection was useful and/or necessary.

Child protection intervention cannot just involve support and care (Dingwall, Eekelaar and Murray, 1985; Corby, 1987). It also involves control even if this is only the assessment of parents' relationships and the protective care of the children. Also, new injuries to a child, although they may well be accidental, are likely to require investigation. Some of these tasks arising out of the controlling aspect of child protection are bound to be difficult and painful for parents. They are also difficult for social workers. They may have to face confronting the parents and jeopardise their working relationship. In some instances, social workers coped with this by simply avoiding the issues. The majority did confront the issues and with varying degrees of success. This is unlikely to be due just to the skill of the worker or to the level or type of abuse. It is also likely to be affected by the way that the parents involved reacted to the child protection investigation. Parental methods of coping with crises could be to avoid the issues that the social worker was trying to work through in casework. For example (from parental interview):

"So I kind of avoid her (social worker) as much as possible. You know, just keep out of the way. Specially just now I am trying to keep everything quiet; keep away from them and things like that, so there is nothing they can bring up, you know, when there is this appeal and stuff. They just upset me every time they come near and they have got something to tell you that's bad. It's nothing good. I know I have got to (find a way), to just stick it. I mean he (the child) has caused me that much heartbreak I can't really control him ... but I would not go to the social workers to discuss it with them. I could not see myself sitting down and going 'I've got a son I cannot control'. What am I going to do, because first thing they are going
to say is fostering and they have already said that so I would not go near them." (Case 300)

Months later the mother said:

"(I needed) help rather than people walking over the top of you. I just realised they kind of things just now .. just now realised thinking back what an idiot I was, know what I mean, all the carry on" "...but at that time ... could not talk ... did not want to talk. I could not be annoyed". (Case 300)

The child protection role or style most criticised by parents was bossing and nagging the parents. For example:

Mother said that she did not feel that the social worker was on her side. The social worker just tells her what to do and not only does she dislike this but believes that it will be ineffective. She has complained about the social worker and in consequence the case is about to be transferred. (case 180) (case previously discussed where worker had difficulty in engaging the family and seemed to be chasing after them to try and apply some controls to their behaviour. The worker made it clear that she found the case very difficult and did not know how to resolve these problems).

Mother with a child in care said she preferred access visits at the normal nursery rather than the family centre because the homemaker did not attend the nursery and therefore could not nag her: "She is no there to nag you". "Do not get on with her at all." "Just every time she asks me something I just let it go in one ear and out the other. I cannot be annoyed answering." (Case 305)

Mother complained that she tried to object to the social worker's view and suggested plans of action but the social worker would always try to talk her around to her way of thinking and that is how the casework interviews were always concluded. The husband had had enough of this particularly those discussions concerning the possibility of his returning to the household. There was no legal barrier to his return, but the social worker was not happy about it and there was always the threat of removal into care (although legal back-up of such action might well not have been forthcoming). The mother said, "I mean, sometimes I am really sorry that I got in with social workers. I mean, she has been good for me ... but when you
think that it's my house and it's my man and it's my kids and I cannot decide who stays in my house". (Case 189)

There was also a feeling amongst some parents that they were not trusted by social workers questioning of bruises or burns to children during the case. Questioning about such matters at the beginning of a case was not welcome and often caused much distress but it seemed to lead to less resentment than investigations after there had been on-going direct work with the family. Parents were very aware of being asked trick questions to check the consistency of their stories and explanations and that social workers were themselves sometimes liberal with the truth. For example, in stating that a child taken to casualty needed to then stay in hospital for tests whilst the social worker reported to the researcher that it was really a social admission to ensure that the child did not go straight home. (Case 350).

There were also feelings that the social workers were being unfair. Three parents explicitly stated that social workers should be spending their time protecting children who really were getting battered rather than troubling their family. Some parents also felt that Social Work Departments were not logical in their arguments or in their demands. For example (from parental interview):

Parents had housing debts and debts to a mail order catalogue. The parents wanted to pay money towards both debts but to put the greatest effort into the housing debt as this was a barrier to their being provided with better accommodation. The social worker was advising that the catalogue debt was more pressing. This seemed illogical to the parents who felt it was a strategy by the social worker to stop them moving house. (Case 347)

Most of the parents with children who were in care but not being returned felt that there was no consistency in what was being demanded of them. The plan was for the children to be returned if the parents co-operated. They felt that they had co-operated. For example:

"(They say that) I am no working well with him. Well, I think I am working well with him. I do everything I can for him, but they turned around and said to me on Friday there that they don't think that I should get him back, but you have got to make up your mind what you want to do." "They said to me (before that) as long as you have got a man behind your back you will get him back but now I
have got the guy that I am going to marry and the guy that I want they (turn) round and said he is no use. There is no use in you getting married". (Case 247)

The feeling of this mother (as with the one complaining that the social workers were not logical in their arguments) seemed to be that the social workers have their own idea of what should happen and that will prevail. It is as if the workers are employing a 'good citizen' model where attempts are being made to reform the parent rather than to apply external criteria of minimal parenting. The mother in case 247 was maybe correct in believing that the social workers were not happy with the official plan of reuniting the child with his mother. In the social work interview the case worker reported her doubts about whether the mother could really care for her son. The social worker felt that it would be best for the mother to come to understand that it would be better for her and her son for them both to fully start new separate lives. The mother did not agree:

"Well, I want him back. I definitely want him back but I think that every time that I say that to them they expect me to give in and say 'Well, I'm not capable with him, just take him away'. Because every time that I tell them I want him back they turn around and say that I am not co-operating." "But if I had him home and I do want him home, I want to prove that I can look after him, but they are not having it." (Case 247)

Other mothers also felt that the criteria of what was required of them for the return of their child was changed over time (Case 180), and that the social workers were trying to persuade the mother to agree to adoption when she wanted the child home (Case 133). From the social workers' point of view they needed to be satisfied that they were returning the child to a caring, protective and stable home. However, the parents felt that they were being required to show a higher level of standards than exhibited by their neighbours and peers. In addition, they were not being able to demonstrate their abilities in direct care of their child at home but by through different criteria such as setting up a home for the child to return to, by attendance and behaviour at access visits, and by general co-operation with the agencies involved. Co-operation was seen by the agencies as evidence that the parents accepted that there was a problem, a willingness to accept help, and a motivation to get their child back and so conflicted with the parents' views of why they should
have their children returned. For example (from parental and social work interviews):

The child was placed on the child abuse register after an insufficiently explained bruise. The child was received into care when the mother moved into a house where a Schedule I offender (sexual offence against a child) was also living. The child was received into care under a Place of Safety Order and the mother, who drifted in both her accommodation and adult relationships, was not able to convince the social worker and the Children's Hearing Panels that she had set up an appropriate home for her child. (case 133, social work interview)

The mother felt that up to the reception into care (which had been on the basis of the presence of a third party) she had cared adequately for her child for 13 months. (Case 133, parental interview)

Decisions about case management may be made in a variety of different ways but their formal expression is at Children's Hearing Panels and interdisciplinary case conferences. There were examples of parents feeling that the case conferences were difficult but such complaints were not made about the supposedly more powerful panels. For example:

Parents were disappointed that the case was not de-registered at the last case conference. They find the case conferences difficult because so many people attend and spend the time criticising their care of their children. (Case 161)

In response to the researcher's questions about why the mother was saying that she did not participate in the case conferences: "No wonder, there was police and everything there and I was over there sitting with the foster mother and Paul (the child) he was away". "There was too many people to talk to, they were all going yap, yap, yap." The researcher asked if she was asked questions. "Aye, but you didn't know even who was talking because there was that many people talking." (Case 247)

Children's Hearing Panels on the other hand contained fewer people and, apart from the social worker, they were unknown to the parents. In some cases they were seen
as independent tribunals and families did occasionally request and achieve the return of their children from the Hearings (for example, Case 278). In other cases the Hearings were seen as bureaucratic procedures to carry out what the Social Work Department had decided as illustrated by this case example from a parental interview:

"There was a thing we went to ... well, it was not that you had to go to it. It was a kind of board ... where there was some people sitting at the table and that, but no I was kind of vague about the whole thing, you know that. The Social Work Department were behind (it) and I was just there because ... (the social worker) asked me to go you know. I mean I just seen it clear cut the whole load you know. I just, as far as I can see it was just a case of doing the place up and getting them back. Oh obviously there was paper work and things had to be done you know. There was a procedure." (Case 236)

Quality of Service

In addition to the problems of engaging the family in the context of child protection and care and control issues there were also complaints by parents about the quality and quantity of the services offered.

Sometimes these complaints concerned the appropriateness of the particular resource offered; for example, one parent did not wish to go to the mother and toddler group because she felt that there would be a lot of gossiping amongst the parents. She preferred the idea of being offered a normal nursery place (Case 168). Mostly, however, the complaints were directed at the individual social workers. Three parents complained that social workers attempted to persuade them to have abortions when they became pregnant. One parent complained that the social worker was "lackadaisical" about getting material resources and negotiating with other agencies and that the Area Officer was much more competent (Case 168). Three parents complained that the social worker did not visit often or regularly or not, though one of these families was wanting social work to cease. Their view was that if they had to have social work they should at least get a full and proper service (Case 189).

More fundamental criticisms were made by two other parents. One said that after registration all these people came to her door, but none of them actually offered any solutions to her problem in dealing with her previously scapegoated and now
The other parent complained that both parents had been attending the family centre and now that they had split up she had ceased going whilst he continued to do so in order to see his children and because he had become highly involved in the centre. The problem was that the centre had become allied with the husband and took his side in their acrimonious relationship. This went as far as the family centre initiating a child abuse referral for bruises already known and accounted for. The social worker agreed that the family centre had become a bit 'trigger happy' about identifying non-accidental injury to this child (Case 275).

Other complaints often referred to the actual abilities of social workers; that they did not know about children, that they were too young and that they were not married. For example:

"I don't think that social workers are great with wains as they are made out to be. They do not know much about them." (Case 172)

Mother would prefer a worker who was "older, very much mature, knew what she was doing or talking about", and that she could have a laugh with. The worker assigned did not fit this model: "I don't know. I just. I know she is only about the same age as me - maybe that's got something to do with it. I know she's single and things. I don't know, funny." (Case 236)

"She does not understand because she is not married. Wrong to put single people into deal with break-ups in marriage." (Case 189)

Parents prefer new social worker as he is 'straight' with them, he prefers not to break up families, acts more like a friend, does try to help, has kids of his own and 'knows the score'. Previous social worker was thought to have none of these attributes. (Case 277)

**Permanency**

The different ways in which parents reacted to social workers when it was clear that their children were unlikely to be returned home have already been discussed in
previous sections. Some parents accepted that it was the most realistic plan. Others felt that they had been treated unfairly and not given a chance to care for their children. Mothers did talk about fighting in the courts for the return of their children but this did not occur in practice and it is not clear whether this was because in their hearts they agreed with the plan, because they did not have the emotional strength for a battle that they felt was already lost, or because they were advised by lawyers that they had little chance of success. The parents were surprisingly unaggressive in their expressed feelings towards social work. The expressed emotion was one of resignation.

CONCLUSIONS

The descriptive data presented in this chapter showed that many parents developed positive constructive relationships with their social workers although there were difficulties in integrating the role of care for the parents with the more control based roles necessary to ensure the protection of children in some cases. In cases where there was only low key monitoring then there was less potential for problems from the controlling roles; however, there were still all the negative aspects of registration and also less scope for an intense caring role. There was, therefore, just as much possibility for the family to maintain a low key or pseudo co-operative stance with the workers.

The positive aspects of the interventions enjoyed by parents were material resources including negotiating with third parties, emotional support and even friendship to the most socially isolated, and relief that someone had intervened in what was an unsatisfactory situation. There were some difficulties experienced in terms of specific actions or advice by workers, or their age and marital status, but the main problems seemed to arise around the issues of control inherent to child protection. The task of engaging families was made more or less difficult by the degree of controlling intervention being attempted, the part of the sequence of the case in which they were involved, the attitude of the parents and the personality match between worker and client.

Despite the intrinsic difficulty in engaging a family in these circumstances and taking account of the variation between the cases that occurred, the author was still left with the impression that some workers were more successful than others in tackling these problems. In the sample there were cases which to the outside observer seemed difficult on nearly all these counts and yet the families were
successfully engaged in working to the common goal of allowing the children to remain or be returned home. The difficulty is in establishing what those specific differences were.

The study was not experimentally based and therefore it is not possible to distinguish which were the relevant factors. The author's impression, however, is that the workers who were least successful were those who (a) skirted the issues and applied 'care' but little 'control' to ensure the child's safety or to indicate to the family that change was required; (b) those who were on the families' side but seemed to be chasing the families in unsuccessful attempts to pin the family down; (c) those who applied both care and control but who did not seem to invest much of themselves in the future of the families. The workers who seemed from the outside to achieve their goals in a partnership, if not total agreement, with parents were both confident and direct and honest in their use of authority and yet also were personally committed to helping them to stay as a family or to take a different route if they so wished. Parents know that there is a control element to the social work role and seemed to appreciate this being openly acknowledged as long as it was in the context of respect and commitment to them as people. Both factors seem to be necessary for successful engagement in the more difficult cases.

The most difficult question raised about parental views was the fairness of taking children away on a permanent basis. This is obviously the crucial value question within this type of work. How minimal is the minimal level of parenting allowed, how should this be assessed, how much effort and time should be invested in trying to raise the standards to a minimal level before permanent alternatives are sought? In this sample, permanent alternatives were only decided upon after a long period of intervention, but the views of several of the mothers was that neither the type of help they were given nor the criteria used to assess whether they should parent were appropriate. Obviously, these mothers are not likely to be happy about permanency, but there is a need for these issues to be addressed in more detail and for them to constantly be the focus of assessments of social policy in this area.
CHAPTER TEN

LEGAL INTERVENTION AND CASE OUTCOME

Chapter Seven described the background of the families in the case series. Chapter Eight then described the casework intervention that was involved and Chapter Nine described parental reactions to these interventions. This chapter is concerned with the resultant outcome for the children and families.

The families whose children were placed on the child abuse register were particularly disadvantaged on almost all criteria and these type of families are the most prone to experiencing negative life events. It would not, therefore, be surprising if they experienced major change and trauma in their lives over the two years of the study. These would be expected even if the children had not been injured, been placed on the child abuse register or been in receipt of social work intervention. This makes it extremely difficult to assess the impact of the intervention on families. Also, this was a descriptive study rather than an experimentally controlled intervention trial. It is, however, possible to describe some of the major changes that took place and examines any obvious ways in which the child protection intervention could have been relevant.

Outcome for the families was affected by their presenting circumstances, the social work intervention, and the families' response to that intervention. One important aspect of the intervention that has a powerful effect on outcome is the powers of legal intervention issued by the civil legal system. Legally based interventions were part of the case discussions in Chapter Eight, but this chapter starts with an overall description of the degree of legal involvement in the families. The second section of the chapter then describes both short and long term changes in family membership.

The third section of the chapter provides a broader classification of the outcome of the families in respect of registration and legal involvement. The fourth section then contrasts these categories of outcome with the presentation of the cases at the time of registration.

LEGAL INTERVENTION

Placement of a child on a child abuse register invokes the local child abuse procedures for case management and constitutes the main agency system of child
protection. This system, however, works alongside the system of civil child care law which forms the basis of more interventive action concerning a family's care of their child.

In Scotland this child care law based system of child protection is provided by the Children's Hearing system. This system was developed primarily as a sensitive and more child centred method of disposal for cases of children committing offences. Cases are managed though this system by an officer called the Reporter to the Children's Hearings. The Reporter accepts the referrals to the Hearings system and, if appropriate, orders an investigation. If there seems to be a need for 'compulsory measures of care', the Reporter calls a Hearing. This initial hearing will discuss the case with the parents and child and, if there is agreement about the facts, make an appropriate disposal. If, however, the parents or child do not accept the facts, or, if the child is believed to be too young, or otherwise incapable of understanding the facts, the case must be put to a Sheriff's Court which decides on these facts. If the facts are not proven the case is dismissed. If the Sheriff's Court decides that the facts of the case have been proven, then a further Children's Hearing is called to decide upon disposal.

A Children's Hearing Panel is a lay panel consisting of three local volunteers trained to be panel members. The panel has the responsibility to decide on the preferred disposal of cases. The options available to the panel - apart from dismissing the case - are to make time limited orders placing the child in the care of the local authority at various possible types of location or on a supervision order at the home of the child's parents or relatives. A more permanent change in parenting rights is achieved through separate systems that include adoption, custody and the assumption of parental rights. These are not included here as none of these long term processes were achieved in the current sample within the study period.

Of the 147 families in the study many of the index children were referred to Reporters to the Children's Hearings, but not all of these proceeded fully through the system. There are many points at which the case may not be continued and, to illustrate this, the main decision points in the pathway are listed below.

1. Formal referral is made to the Reporter to the Children's Hearings. (This is automatic if an emergency Place of Safety Order has been implemented to remove a child from very immediate danger).
2. Investigation ordered by the Reporter who decided whether or not to call a Hearing.

3. Hearing is arranged by the Reporter. The Hearing decides whether to deal with the case or to refer the facts or Grounds of Referral to the Sheriff's Court for Proof.

4. The Grounds of Referral to the Children's Hearing are heard in Court. The Grounds of Referral are found to be either proven or not proven. If not proven the case does not proceed through the Hearing's system.

5. If the Grounds of Referral are found to be proven, the Reporter calls another Children's Hearing to decide on the disposal of the case. Disposals are restricted to time limited supervision requirements determining amongst other specific items - where and with whom the children will reside. (For the purposes of this thesis, the term 'in care' is restricted to supervision requirements away from the child's normal home or voluntary admissions to local authority care and does not refer to supervision orders in the original family).

6. Review Hearings at intervals of a maximum of one year or earlier if requested by any party in the case. The Hearings can terminate or alter supervision orders. If new grounds of referral are presented and proved at court, then these need to be considered by the panel.

For the 147 index children in the study, 58 (39%) were subject to legal powers of supervision. Thirty (52%) of these cases with legal powers of intervention involved the children being removed from the family into care at some point during registration. Fourteen of these cases who were placed in care (10% of whole sample) were still in care at the end of the study (at de-registration or at two years post registration). The remainder were at home on home supervision orders.

Twenty eight (48%) of the cases with legal powers of intervention were not removed into care, but were only subject to home supervision orders. Twenty three (82%) of these home supervision orders were still in force at the end of the study, and the remainder had been terminated.

Eighty nine of the cases (61%) were not subject to legal powers of intervention but in 14 cases (10% of whole sample) the children spent some time in care on a voluntary basis, though all were back at home by the end of the study period. The remaining 75 children (51% of whole sample) not subject to legal powers were not received into voluntary care. In four cases, however, a referral had been made to the Children's Hearing system but no legal powers were obtained. In a further three cases, new attempts to obtain legal powers of intervention were being attempted by
the Social Work Department at the end of the study period resulting in two of these children being in care.

The description of legal intervention provided up to this point may give the impression that the different routes of legal intervention taken by case were relatively simple and clear cut. The legal pathways taken by the cases presented in the Appendix shows this not to be the case. Many cases had multiple receptions into care on emergency or longer term legal orders. The pathway maps also indicate what were the starting points for referral into the system. Twenty eight cases were initially referred to the Reporter, though 13 of these cases did not result in legal powers being obtained. Forty one cases were initially referred through an emergency Place of Safety Order, but 11 of these cases did not result in legal powers of supervision. Five cases were referred into the system following voluntary receptions into care and 3 of these resulted in legal powers being granted. Four cases were already subject to legal powers of intervention at the point of registration.

A summary of the different types of reception into care is provided by Table 10.1.

**TABLE 10.1**

Frequency and Legal Status of Receptions into Care

<table>
<thead>
<tr>
<th>Frequency</th>
<th>P.S. Only</th>
<th>Vol. Only</th>
<th>Supervision Order *</th>
<th>Mix Types</th>
<th>Total RICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1X</td>
<td>18</td>
<td>10</td>
<td>14</td>
<td>3</td>
<td>45</td>
</tr>
<tr>
<td>2X</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>34</td>
</tr>
<tr>
<td>3X</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>4X</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Totals: 22  13  17  14  92

* or Warrant

(P of S = Place of Safety Order; Vol. = Voluntary Section 15 reception into care; Mix = more than one type of reception into care used)
There were a total of 92 receptions into care from 66 cases. A third of these 66 children were only received into care on Place of Safety Orders which then lapsed. Apart from Place of Safety Orders, 22 children were received into care once only, and eleven of these children were still in care at the end of the study period. Thirteen children were received into care twice and four of these children were still in care at the end of the study period. Three children were received into care three times and none of these were still in care at the end of the study. Four children were received into care four times and only one was still in care at the end of the study.

Sixteen children were in care at the end of the study period. In one of these cases there was a plan to return the child to her father. In a further two cases it was unclear whether the children would return home. In the remaining thirteen cases, the case conference minutes did not mention any likely possibility of the children being returned home, but most did mention plans for the long term alternative care of the children. In no cases had these plans yet been achieved.

Ten of the cases moving towards permanent alternative care had never been returned home since their initial reception into care. In four of these cases attempts at returns home were made but the parents' life styles were such that social workers were never sufficiently confident that the parents had the motivation or ability to adequately care for their children. The three other cases had returned home at least once, but new crises had occurred resulting in the children being removed again.

In eleven of the cases where the children moving towards permanent alternative care there had been Social Work Department involvement prior to registration. Nine of the thirteen cases had been registered following an injury to a child. Two of the uninjured children had been newborn babies, the mother of the third had psychiatric problems, and the fourth had been left unattended by her mother.

**FAMILY MEMBERSHIP**

**Short Term Change**

The process of case investigation and registration do not typically occur during periods of calm in the life of parents or children. There is usually some incident which either results in some overt harm to a child, or which is of sufficient magnitude to raise the concerns of health and welfare professionals. Even if there is no overt crisis precipitating referral, the investigation and case conference system
are likely to produce anxiety; and consequent changes and reactions in the family. Any such reactions may be a direct result of the immediately preceding events or may be more of a culmination of difficulties that have been existing for some time.

The changes in the families do not seem to be a direct result of crises within families. The impression from the data is that crises precipitate agency intervention which then leads on to changes in the household. In practice the agency intervention is negotiated with the family and this is particularly clear in the Section 15 admissions to care. Also, many of the hospitalisations of children result from referrals that were initiated by the caretakers themselves. In other cases Place of Safety Orders were considered necessary, or it was made clear that these would be requested if any attempt was made to remove the child from hospital. No statistical relationship was found between legal status during the investigation and prior Social Work Department contact.

Changes that occur in the households around the time of registration are likely to have an effect on the process of investigation - whether they are due to changes within the families, or due to the agencies' concern to provide respite care or protection for the children. This adds to the complexity of the investigation task. Furthermore, workers often have to achieve sufficient protection for the children, and offer assessment reports for initial case conferences in the absence of baseline information about the family. This may, however, be available from some other sources; particularly from health visitors who were involved in the case conference system - rather than general practitioners who were not (see Chapter Eight). Although many of the clients will be already known to the Social Work Department, that knowledge may have been gained by a different group of workers and at some time in the past. The typology of the different manner in which cases were presented to initial case conferences in the current case series emphasises the way in which the agencies were attempting to provide a service in the context of partial information. It seems that they were attempting to decide which procedural responses would best achieve the preferred outcomes, when these outcomes themselves were not clearly known or stated.

The initial assessment of the family and the caretaking environment for the child occur in atypical situations. On the other hand the changes instigated by the child protection investigation may have positive effects. The removal of a child to care may provide a breathing space for parents in which there is some respite from daily pressures and, potentially, room to consider and tackle any decisions that might be
necessary. The open and direct consideration of any problems that the family has been experiencing may come as a relief to family members who have been attempting to cope by suppressing aspects of these problems. A time of crisis may also be a time at which clients are more open to approaches and suggestions by professional workers - a time when changes can be achieved.

**Longer Term Change**

For ninety three families (63%) there was no difference between family membership at registration and at the end of the study period. There may, however, have been some changes that were later reversed. Also, the full sample includes some cases de-registered after only a few months. Thus, the finding that 36% of families changed in membership is relatively high.

The changes in household type between registration and the end of the study are presented in Table 10.2. There was not much variation in the extent that purely single or nuclear households changed with over a third to a half of each type undergoing change. The most change was in single or nuclear families with friends or relatives in the household.

**TABLE 10.2**

Change in Household Structure over Study Period

<table>
<thead>
<tr>
<th>At Registration</th>
<th>Single</th>
<th>Single + Others</th>
<th>Nuclear</th>
<th>Nuclear + Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>35</td>
<td>5</td>
<td>16</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>Single + Others</td>
<td>7</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Nuclear</td>
<td>12</td>
<td>5</td>
<td>49</td>
<td>1</td>
<td>67</td>
</tr>
<tr>
<td>Nuclear + Others</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>56</td>
<td>19</td>
<td>70</td>
<td>2</td>
<td>147</td>
</tr>
</tbody>
</table>
There was a significant difference in the extent that children were received into care from different types of families. Table 10.3 shows that at the end of the study twenty of the index children were not being cared for by the person who was their principal caretaker at registration. Fifteen of the children were in foster care and five were being cared for by relatives away from the main caretaker. Eighty percent of the children in new families were from families that were originally single in structure. This result is consistent with other research indicating that single parents have the highest risk of losing their children into care (Millham et al, 1986; Quinton and Rutter, 1988).

A similar picture is presented by the 29 families in the research sub-sample. Two thirds of the single parents remained single and two thirds of the nuclear families became single and two thirds of the nuclear families remained nuclear. Four of the six families who lost their children into care were single parent families. Furthermore, the two nuclear families who lost their children into care were the two cases that were placed with close relatives. The numbers of cases considered are small but the results are consistent and provide greater detail to the findings on the main sample that single parents represent under half of the families yet account for most of the permanent removals of children. Furthermore, this removal is not so dramatic and separate in the nuclear families where close relatives were used for the child placements. In the sub-sample four out of six of the single parents lost their children to separate permanent alternative care whereas this did not occur for any of the twenty-three nuclear families.

<table>
<thead>
<tr>
<th>TABLE 10.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Placement over the Study Period (Percentages)</td>
</tr>
<tr>
<td>At Registration</td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Nuclear</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Chi Square for single plus nuclear family structure at registration versus new carer or not at end of study = 8.1. p<0.05, DF=1.
The two single parents who did not lose their children into care were both living alone but did get visits from their boyfriends who were also the fathers of their children. The support offered by these men was not high or particularly consistent and in one case produced high levels of stress. Both of the single mothers had virtually no control over their children. It was only necessary to visit either household for a few minutes to see that the parents were unable to control their children and then threats of punishment were inconsistent and ineffective. In the author's view there was serious risk of over chastisement of the children. The mothers were aware of their problem and were co-operative and grateful for social work intervention throughout the study period. This contrasts with the four parents who lost their children who were constantly on the move into new homes and into new relationships.

CLASSIFICATION OF LONGER TERM OUTCOME

At the end of the study period the majority (135 of 147) of the children were no longer on the register two years after registration. The formal reason for removal from the register is that there are no longer the concerns about the child's welfare to require the child protection work of the child abuse register procedural system. An examination of the case conference minutes, however, showed that there were a variety of circumstances in which the decision to de-register was made. In addition, there were some cases still on the register at the end of the study period. This section provides a broadly based classification of the different contexts of de-registration reported in the case conference minutes. The next section then contrasts these outcome categories with the initial presentation of cases at registration. The case outcome categories are considered in turn.

A. Improved home situation.
B. No particular improvement, but no evidence of continued risk.
C. Child in care and therefore not at risk.
D. Family or child outside of Glasgow and of scope of register.
E. Registration continues.

A. Improved Home Situation (n = 78)

The most common reason given for de-registration in the case conference minutes was that there had been an improvement in the home situation. The assumption was
that these improvements would result in better care of the children, though this was not always specifically stated.

The improvements were of a variety of types. These included general improvements in the coping of parents which might coincide with changed housing or other material conditions, an increase in social supports, or the removal of specific stresses. In at least 13% of these cases this increased stability was only achieved after several periods of improvement and deterioration and so it is not certain whether the stability continued after de-registration. This is illustrated by the fact that five cases were de-registered and re-registered at least once during the study period. Three of these cases were in the present category as being de-registered due to increased stability and lower risk at the end of the study period.

In a quarter of the cases de-registered due to an improved situation, there was a clear change in circumstances marked by the absence of a specific person who had directly or indirectly been a risk to the child. In many of the cases there were still concerns about problems within the family but registration was not considered to be necessary either because (i) the risk was not very high (ii) it was considered inappropriate to continue registration that was initiated by the presence of a particular person who was now absent, or (iii) there were other benefits to be achieved by de-registration.

The issue of stability in improvements can be illustrated by the following case examples. The first was a case de-registered due to an improved home situation. The second case was still registered at the end of the study.

Case examples:

At referral the mother was staying with friends no. 1. Crisis and child received into care (RIC), mother and cohabitant to private hotel (bill not paid)
Moved to council house no. 1. Crises but child returned
House vandalised and moved to two homeless persons hotels (HPU)
Parents disappear to seaside resort
Move to a 3rd HPU hotel
Move to council house no 2 but argue and mother leaves after 4 days
Move to three 4th, 5, and 6th HPU hotels
Child abuse investigation. Children RIC in Place of Safety and then return home
Change in social worker at mother’s request
Move to council house no 3. Children RIC, then return home
Crisis, move to 7th HPU, to friends no 2, then to council house no. 4
Family disappears and return to friends no. 1
Family to England, then back to council house no. 3
Children RIC for 3 weeks due to lack of stability
Children return and removed from register
(Case 180)

Child born and received into care due to previous history
Child returned home
Bruises on child, admitted to hospital, registered and returned home
Mother cannot cope so voluntary RIC
Child returns home and de-registered (new social worker)
Injury from over chastisement, RIC on Place of Safety Order
Child returned home, placed on register (new social worker)
Injury to child and RIC
Child returned home (new social worker)
Five incidents of bruising in three months since return home
(Case 287)

Improvements in the home situation may result in reduced risks for the children,
and so it is unsurprising that this should be associated with the decision to remove
children's names from the child abuse register. However, this decision to de-register
is likely to be influenced by other factors that might make de-registration occur
earlier or later than it would otherwise. No independent data is available to estimate
the level of concern or risk at which de-registration was occurring, nor to provide
detailed information on the variations in the manner in which this decision was
made.

The data did show that de-registration did occur whilst there was still concern about
the children's welfare. This is indicated in various ways such as the continued
involvement of support services after de-registration, which occurred in nearly
every case that was de-registered whilst the child was at home. This is a positive
indication of the social services wider role in supportive work, beyond the narrow
confines of protection for children at risk. However, in 39 cases, the children were
de-registered whilst on continuing orders of home supervision from Children's
Hearings, and in only 8 of these cases were there explicit plans to apply for a
termination of the orders. It is not clear whether the continued orders reflected
continued concern, or were fulfilling some other function for the workers involved.

Normally it would be expected that supervision requirements from Children's
Hearings would represent higher levels of concern in child protection than
placement on the child abuse register. It may have been that the workers required
the supervision requirements for reasons other than child protection. Unless these non-child abuse related concerns were included in the original proven Grounds of Referral to the Children's Hearing, then they should have been referred to the Reporter to decide whether to call a Children's Hearing to apply for new Grounds of Referral to be tested in court before a second Children's Hearing could decide if a Supervision requirement for these new grounds was appropriate.

It has already been noted (in Chapter Eight) that there are many possible reasons why de-registration might occur earlier than expected. It was, for example, not uncommon for case conference minutes to refer to the positive effects that de-registration would have on the parents and on their relationship with the agencies involved. In one case conference minute there was a clear statement that de-registration would have a positive effect in marking for the parent the effort that had been made and the changes in the home situation that had been achieved. This could also function as a reward and positive feedback for the agencies, in having helped the parent make these changes. A third effect would be the way in which de-registration would present the agencies in a positive supportive light, rather than in a negative authoritarian role that was attempting to find evidence of the parents' inability to adequately care for their children. The aim would be to encourage further engagement of the family with the continued support that was always offered - and was often necessary because of continued concerns for the children.

That social workers are very aware of the negative connotations of registration was shown in the earlier discussion of arguments against registering cases, and of not informing parents of such registration. This may be made more acute by the practice of inviting parents to the review case conferences. In over 40% of the case conferences held whilst the child was still at home, the parents attended at least part of the conference. These may be difficult situations to manage, and a positive line might be considered the most constructive. The issue of whether to continue registration may be drawn into this atmosphere and result in de-registration. This would have the effect of ending the review system of case conferences.

De-registration also occurred when the positive change in the family reported by case conference minutes was the movement away of a person who had been the major source of concern at the time of registration. In the earlier discussion of these cases it was noted that there were often wider residual concerns that had become evident in the continuing assessment of the family after the initial registration. These concerns may or may not have justified continued registration, but it is of
interest that the argument was often made that de-registration should occur because the original concerns were no longer present. Registration did continue in most cases where there were very strong concerns, but data from social work interviews on the sub-sample indicated that many social workers were aware that parents, once in the system, might not being able to extricate themselves without showing higher than average standards of child care.

De-registration also had workload benefits for the workers involved who were required to deliver a level of service to those families specified by the local child abuse procedures (Strathclyde, 1983). Families had to be visited at frequent intervals, casework notes had to be typewritten, and verbal and written accounts of casework and case progress required at regular intervals by senior staff and inter-agency case conferences.

B. No particular improvement, but no evidence of continued risk (n=35)

This category is made up of cases where continued registration was not considered appropriate even though the records did not make statements about improvements in the child care environments.

Some of these cases presented as unspecified non-accidental injuries. The parental explanations were not considered adequate, but after monitoring the home situation for several months with no evidence of serious further risk to the child de-registration took place. In at least 6 cases de-registration occurred despite continuing concerns about the children's welfare. For example in one case a child was registered after being injured by a cohabitee who then left. The review case conference minutes at de-registration questioned the stability of the present arrangements whether there was really any difference in the situation. They also noted that the mother was very depressed and suggested that similar problems would recur. The child's name was removed from the child abuse register but powers of home supervision were retained.

Another reason for de-registration in the presence of continuing child welfare concerns is that without much engagement of the family or focus for social work support, then there was little opportunity for positive planning of future work. Since these cases were studied central government has produced guidance stating that child protection registers should only include details of children for whom a plan of
action and review has been recommended by a case conference (Department of

It may be that case conferences are only happy to take on a solely monitoring role
for a certain length of time. In several cases in the sample, statements were made
that continued registration was inappropriate whilst there was no prospect of a
positive role and input from the appointed keyworker. These considerations usually
occurred in those cases where concern was not particularly great, but it is possible
that registration would have continued if a social work role had been possible. This
may partially reflect the dominance of the register system by the Social Work
Department. They are the holders of the register, they have the statutory
responsibility to investigate and protect children in these cases, and they
significantly outnumber the other professionals attending case conferences (see
Chapter Eight). It would not be surprising if social workers were not enthusiastic
about maintaining a child on the register in cases where there is little potential for
active social work involvement, and where monitoring is achieved by workers from
other agencies - particularly when the cases are defined as child abuse, with all the
responsibilities that this involves.

On the other hand continued registration would offer the co-ordination and service
delivery that might be useful in such cases. In four cases in the whole sample there
were explicit concerns about the ability to provide a supportive service when the
intervention itself was perceived as being highly stressful for the family. In 28 cases
there were overt statements about the levels of co-operation from parents and a third
of these statements occurred in cases de-registered with no major change in
caretaking situation.

There were also 2 cases de-registered despite continuing concerns about the
children's welfare where it was explicitly stated that continued registration would be
counter productive. For many parents in the sample, the Children's Hearing system
or the general aspects of social work involvement, may have held greater
significance than the child abuse register but for these two sets of parents the
registration was a particular source of distress. In one case, the parental objections
to continued registration was the main focus of the review case conference. The
case conference members felt that nothing positive would be achieved by resisting
the mothers' wishes, even if it brought forward the timing of de-registration.
C. Child in Care and therefore not at risk (n-16)

All but one of the children in care were no longer on the child abuse register at the end of the two year study period. The children may have been kept on the register when first received into care, but once they had been in care for some time then their names would be removed. In some cases the children's' names were removed from the register when in care and re-registered when the children returned home within the study period (up to 2 years).

The majority of children in care at de-registration had not been returned home since they were taken into care, but there was a much larger number of children who were taken into care at some point, but who were not removed from the register until they had been returned home for some time. The Appendix maps the individual 'care' and legal pathways taken by some cases and shows that some children were taken into care and returned home several times. De-registration whilst in care typically occurred where there were no current plans to return a child home, and so there was no immediate likelihood of the child being at risk of the home situation which led to the initial registration.

In 7 cases the likelihood that the child would not be returning home in the near future was a primary stated reason for de-registration.

In some cases children were removed from the register whilst in care and then re-registered on a later return home. This was not always the situation and in at least one case a child who was in care had his name removed from the register although a planned return home was already in process. In another case a child was de-registered although the child had just been made subject of a Place of Safety Order with placement at the house of a relative. This variation in practice sometimes reflected the difficulty in assessing whether children would or would not be returned home at some point. At other times it reflected a different policy as to the use of the register for children in care.

This different policy is best illustrated by the cases removed into care at the time of the initial referral. Most of these cases were still placed upon the register, even though they had been removed from the immediate source of risk. In other cases the children were only placed upon the register on their return home.
In one case the child was twice not registered on reception to care and subsequently returned home not on the register. The child was then injured and re-received into care but again not registered because the child was no longer at risk, being in care. This child was later returned home and placed upon the register and remained there beyond the end of the study period when the child was in care for the third time with a planned return home underway.

D. Family or Child outside of Area and Scope of Register

When a child moves out of the area covered by the register the case is transferred out to the holders of the register covering the new address. The register system in the new area will then decide whether to place the child's name upon the child abuse register and what services and or legal steps to take. No research data is available on the subsequent management of these cases at this level of analysis. There was some suggestion, but little clear evidence that some cases that were thought to be about to move out of the area were de-registered prior to the move. This could give the parents a 'new start' at their new home, but equally might jeopardise the ability of the relevant agencies to become aware of any deterioration in the child's circumstances.

In two of the cases the families moved virtually immediately after initial registration. In one of these two cases the family moved out of the area on the actual day of registration. In the second case the children had moved temporarily to stay with a relative in Glasgow and then they moved back to their father's home. In most of the cases the moves may well have occurred anyway and so were not necessarily a consequence of agency involvement. In several cases the family situation had been improving and the family were moving on to a new house or to work in another area. In one of the families there had been no real improvement and there were continuing concerns about the family but the child was sent by the mother to live with relatives abroad. In another case the child most at risk in the family (of school age) was placed in a residential school outside of the register area and the removal of this child was considered to have reduced many of the tensions and the risks to the other children in the family.

E. Registration continues at Two Years (n = 10)

The ten cases still on the register at the end of the study period were not considered to have shown sufficient improvement or reduction of risks to the children for de-
registration to occur by the end of the study period. On the other hand, the cases were not so serious that the children were in long term care and so not at risk and so removed from the register.

The cases continuing long term on the register did not appear from the case conference minute descriptions to be very different from those in which not much change had been achieved but that had been de-registered (group B). In three cases there were worries about the co-operation of the parents with social workers. All three of these cases initially presented with concerns about the adequacy of parenting (categories 1 and 2 of case presentation in Chapter Eight).

In the past there has been concern that cases could be forgotten on the register and remain on it for years without proper review. This was not true for this group of cases, which were regularly reviewed by the professionals involved, and which continued to generate concern. It was not possible to undertake an independent assessment about the advantages of continued registration, but the earlier discussions have indicated a tendency of case conferences to remove cases from the register rather than to keep them on at all costs. It is more likely that the continued registrations reflected a wish to try and work with difficult cases over a long period of time. If the strategy had been to attempt permanent alternative parents at an early stage with these cases, then they would have been removed from the register by this time. Such policies are of course dependent upon the various legal forums that support such care planning decisions, but the variation found in care planning (DHSS, 1985) and strategies in child abuse work (see, for example, Dale et al, 1986) suggest that the agencies can be influential in these legal decision-making forums. Another possible explanation for the continued registration of these cases is that it was due to a lack of overt co-operation from the parents with the welfare agencies, which would serve to raise the level of professional anxiety about the parents' ability to ask, for help in the future, and the professionals' views of the parents attitudes and responsibility as defined by the agencies.

Removing children's names from the child abuse register and, in effect, put them outside the child abuse monitoring system but decision to register or de-register are not made purely on the basis of the need for child protection monitoring. There is also the cost benefit assessment of the value of continued registration achieved by registration once registration has been achieved. One example of this is the value of registration in communicating the level of agency concern to the parents. Once the registration has occurred, the agency may feel that the parents have been made
aware of the level of seriousness, and understand that the agencies are prepared to take such steps and would be prepared to do so again in the future. Such an analysis would fit well with a view of de-registration as a way of rewarding parents who had been defined as imperfect parents.

Another example of benefits that may be achieved simply by the act of registration, is its monitoring and co-ordinating function. It could be argued that once registration and the initial inter agency case conference has taken place, then all the agencies will be aware of the situation and so registration is no longer necessary. This may seem a rather optimistic analysis, particularly when considering the low level of interdisciplinary work achieved with cases even whilst they were on the register. The purpose of registration is to ensure that a basic rule of monitoring and interdisciplinary co-operation will occur rather than simply assuming that it will.

Examining the breadth of cases in the sample has suggested many factors that might influence the decision-making processes of both registration and de-registration. None of these factors is likely to work in an individual powerful way, but each of them is likely to subtly influence the assessment of the appropriateness of registration.

CASE PRESENTATION AND CASE OUTCOME

It has already been noted that children from single parent families were more likely to be removed to new families either to foster parents or to the care of the parents' relatives. This section considers whether there is any evidence for case outcome to be related to the nature of case presentation when the children were initially placed upon the child abuse register. Is there, for example, any relationship between initial child protection concerns and case outcome at the end of the study period?

The relationship between child injury at registration and case outcome is presented in Table 10.4. The cell sizes in Table 10.4 are too small to draw firm conclusions, but slightly more children injured at registration were in care at the end of the study period. On the other hand, other injured children seem to have been more likely to have been de-registered as 'no major change, but no evidence of continued risks'. In these cases an injury occurred that resulted in registration. Often the circumstances in which the injury were caused were never established, but there was sufficient concern for the child to be placed on the register. After some months of no further incident, the case conference minutes stated that there was no strong reason to
continue registration. Cases of child injury, therefore could be associated with a case monitoring or with highly interventive action by the Social Work Department.

**TABLE 10.4**

**Case Outcome by Child Injury**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Initially Injured</th>
<th>Initially Not Injured</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Improved Home Situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) General</td>
<td>18</td>
<td>30</td>
<td>48</td>
</tr>
<tr>
<td>(ii) After some deterioration</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>(iii) Absence of -ve person</td>
<td>9</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>B. No Major Change</td>
<td>21</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>C. Child In Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) No return achieved</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>(ii) Return unsuccessful</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>(iii) Only Recently to Care</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>D. Move Away from Area</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>E. Registration Continues</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>71</strong></td>
<td><strong>76</strong></td>
<td><strong>147</strong></td>
</tr>
</tbody>
</table>

For cases where there was no child injury general home improvement was a common reason for de-registration. This may because in some of these cases there was no specific incident like a child receiving an injury that prompted registration. If registration was due to more general concerns about the adequacy of parenting, then such criteria might also be applied in considering de-registration.

The importance of assessment of general parenting is also indicated by Table 10.5 that contrasts the classification of broad case type (from Chapter Eight) with category of case outcome. Nearly a third of the index children initially thought to be receiving inadequate care were either still on the register or were placed in care or where registration continued at the end of the study period. Under 9% of the
### Table 10.5
Case Outcome by Presentation

<table>
<thead>
<tr>
<th>Situation at Deregistration</th>
<th>Adequacy of care</th>
<th>Adequacy and injury</th>
<th>Violent Cohabitee</th>
<th>Abuse by Friend on Sibling</th>
<th>Unspecified NAI</th>
<th>Excuse Accepted</th>
<th>Abuse by Parents in past</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Improved Home Situation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) general improvement</td>
<td>0</td>
<td>12</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td>8</td>
<td>10</td>
<td>48</td>
</tr>
<tr>
<td>ii) after some deterioration</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>iii) absence of -ve person</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td><strong>B. No Major Change</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>but ? cont’d risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. Child in Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) no returns home</td>
<td>3</td>
<td>2</td>
<td>1*</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>ii) returns home unsuccessful</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>iii) Only recent RIC</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>D. Child/family moved from Glasgow</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td><strong>E. Registration Continues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>10 + 1*</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>15</td>
<td>25</td>
<td>19</td>
<td>13</td>
<td>35</td>
<td>21</td>
<td>19</td>
<td>147</td>
</tr>
</tbody>
</table>
remaining cases were still receiving such child protection interventions at the end of the study period.

The families thought to be providing inadequate care at registration consisted of both nuclear and single carer families. However, all of the 'inadequate care' cases where the children were in care at the end of the study were from single carer families. All those still on the register at the end of the study period were from nuclear families. It therefore seems that the conclusion made earlier that single carers are more likely to lose their children into care is also true when only the more serious cases are considered. A confounding variable may be previous social work involvement or concerns about child care. Children received into care and never returned home were more likely to have had such involvement. The children received into care late in the study period came form families previously unknown to the Social Work Department.

Other cases previously known to social work agencies included thirteen of the cases in the sample that were initially registered after being transferred in from other geographical areas. Ten of these cases were cases of suspected previous abuse and three cases concerned adequacy of care. Two of these cases were de-registered after moving again out of the Glasgow area, one case was de-registered after no observed change, the remainder were de-registered after some observed improvement.

Another sub-group of cases were the ten children registered at about the time of their birth. The reasons for registration given in the case conference notes concerned parental ability to care for these new babies, but in five of the cases there had been previous incidents of suspected abuse within the family. Two of the ten cases had no legal involvement and were de-registered after no specified change in the home situation. The seven other cases were all referred in some way to the Reporter. Five were received into care on emergency Place of Safety Orders shortly after they were born. Two of these children were in care at the end of the study period.

The three other cases registered at birth were referred to the Reporter for consideration of compulsory measures of care. Two children were made subject to home supervision orders and de-registered after small changes in the home. One was taken into care and was not returned home within the study period.
CHAPTER ELEVEN

CONCLUSIONS

After a brief review of the background of child abuse work, this thesis provided a review of approaches to child abuse research, the limitations of mainstream research, and an examination of the sub-components of the concept of child abuse. It was argued that placement of a child’s name on a child abuse register was a central operational definition of child abuse. Registration defined a case as one of child abuse and invoked the local child abuse procedures for case management by the Social Work Department. The subsequent chapters then described an exploratory study to describe whom was included within this operational definition, how those cases presented to the Social Work Department, what services these cases then received, the main carers of the children’s views of these services, and the case outcomes at the end of the study period up to two years post registration.

This chapter reviews the findings and arguments of previous chapters to draw conclusions under the headings of research, practice, and policy.

Research

Chapter Two argued that mainstream child abuse research adopts a medical model in its aims and methodology. This is not a new conclusion (Parton, 1985). Many current researchers are aware of the medical analogy to child abuse research and might not accept that their work could be characterised in this way. They might argue that they take a broader approach and consider broad causative factors including social factors. In essence, however, most research continues to focus on what distinguishes child abusing individuals or families from other families, whether this be in terms of case identification, cause, outcome, or efficacy of interventions.

The other main methods or approaches to child abuse research could be characterised as being concerned with (i) broader social causes of child maltreatment, (ii) sociological analysis of how child abuse is defined as a social problem, and (iii) management information on how child protection is undertaken in practice. One reason for the preponderance of pathology model research may be researchers perceiving it to have advantages over the other three main approaches or a failure to distinguish it from the other three models of research.
Firstly, some researchers may simply prefer individual or family analyses over community, societal, or other social factor explanations of child maltreatment. The researchers may believe that these individuals and families are markedly different from others in the population. The purpose of research is thus to identify the nature of these differences. The researchers might accept that certain social factors are correlated with child maltreatment, but would still be interested in why certain individuals sharing similar social backgrounds are involved in child maltreatment, whilst others from the same backgrounds are not.

Secondly, some researchers may be sceptical of sociological analyses of the concept of abuse. For example, at a national conference on child abuse in Leicester in 1987 a leading individual/family type researcher responded to a paper on the sociology of abuse by stating that he was one of the people that believed that child abuse cases did actually exist. This statement might have been a deliberate over simplification of the sociological approach of examining how child abuse is defined in practice, but the statement aptly conveyed the suspicion felt about the sociological model.

Thirdly, even if researchers and practitioners are sensitive and sympathetic to social causes of maltreatment, the researchers and practitioners possess the skills and are employed in contexts relevant to the individual and family type of analysis. They may feel unable to confront these in their daily work. They may be sympathetic to developmental models of welfare that aim to change the social circumstances in society rather than ameliorating or treating casualties in society, but in practice people do what they can to help cases or increase understanding within the limits of their skills and the context of their daily work. The predominance of these skills and employment opportunities is, of course, itself a reflection of social factors in society.

The fourth reason for an emphasis upon individual family explanations is the failure to distinguish the psychopathology model from the practice of child protection. Most research uses child protection definitions of maltreatment rather than adopting independent definitions of child maltreatment or individual or family behaviour such as violence or family scapegoating. Child protection services are applied when a child is considered at risk of maltreatment or insufficient care. The social and psychological reasons for these problems to have arisen may be diverse, but the concept of these risks has been reified into a syndrome of child maltreatment. This confusion is best illustrated by the use of child protection statistics to indicate the
incidence of child maltreatment in the population rather than the different (though maybe related) variable of child protection activity (discussed in Chapter Three).

Studies of child protection register statistics in Scotland undertaken by the author (Gough, 1987, 1988, 1992) specifically examined data available of cases through different parts of the register system from referral, to case conferencing, to registration, to de-registration. The studies also collected data according to the child protection register categories actually being used by the register systems in use rather than according to the categories listed by government guidance. The aim of this research was to create child protection management information rather than child abuse statistics. This same approach has now been adopted by the new system of annual statistical returns for child abuse registers in Scotland by the Social Work Services Group of the Scottish Office (Social Work Services Group, 1992).

Not all pathology type research makes the error of confusing psycho or socio-pathology with child protection. Research on the efficacy of behavioural treatments in cases of child maltreatment, for example, typically adopts independent definitions for research samples based upon an analysis of the behavioural contingencies that are thought to require intervention (see Gough, 1993b).

The argument is not that the pathology model is an unimportant method of research inquiry in child abuse. Both individual/family pathology and child protection system issues will be relevant to individual cases of child maltreatment within the child protection system. Research on both types of issue are important (Graham et al, 1985), can co-exist and are highly interwoven with each other. Research, however, needs to make a fundamental conceptual distinction between the attempts to isolate individual or family pathology and research on the systems and processes of child protection. Most research undertaken to date has used an individual/family pathology model with a few studies examining broader social factors, sociological analyses of child abuse, or study of the processes of child protection work. The research described in Chapters Five to Ten was an attempt to add to the body of research on actual child protection practice.

Practice

The study reported in this thesis described the nature of the families who were subject to their children being placed on the child abuse register (Chapter Seven). The families were poor, living in areas of concentrated deprivation, with parental
histories of unstable and unsupportive relationships in both childhood and adulthood. Almost half of the families were reported to have had contact with the Social Work Department prior to the child abuse investigation and subsequent registration.

The characteristics of these children and families are important for a number of reasons. Firstly, they may provide some insights into the nature and cause of child abuse, though, for reasons already discussed, it is dangerous to believe that more than insights can be provided. The representativeness of these sample are severely limited by being the heterogeneous mixture of families determined to require registration. The sample does not consist of cases rated as meeting pre-specified research criteria for different types of maltreatment.

The second reason that the nature of the families is important is that they may reveal aspects of the way that cases are identified, referred, and then described as child abuse cases. The registered cases are the outcomes of such processes and so are evidence of the workings of those processes. This not only indicates how cases are identified, but also how different values and cultural assumptions are applied in practice to these cases.

The nature of the families is also important in providing the context for any interventive services or case work with the families. Whether these characteristics are or are not related to the cause of the abuse, they are likely to be important factors in any attempts to assess, monitor, or intervene in the families lives.

The cases of child protection were only able to become such cases because they were identified and made known in some way to the Social Work Department who then in conjunction with colleagues at multi-disciplinary case conferences placed the children's names on the child abuse register. Chapter Six showed that there were various routes by which this was achieved and that many of the cases were initially referred by members of the family or other members of the community. They were not the result therefore of direct policing of the community by the Social Work Department. However, nearly half of the families had prior contact with the Social Work Department and these cases were less likely to have involved an injury to the child.

This prior Social Work Department involvement with the family was another important context of families receiving a child protection service. There are many
reasons why registration may have perceived to have been necessary despite an absence of child injuries. The prior knowledge of the families may have resulted in a greater awareness of the risks to the child and a higher rate of monitoring the family in the community. Alternatively, it may have been a technique to release extra resources to the family. Resources are always subject to restriction but the priority given to child abuse cases can make resource provision more likely. Alternatively, registration may have been an increase in pressure on the family to change its behaviour according to social workers' wishes. This is in line with Farmer and Owen's (1991) argument that registration is but one of many responses in a range of tariffs of child protection intervention in families.

Few cases were referred by general medical practitioners which is surprising considering the close roles some practitioners have with families. A similar finding was reported by the authors survey of cases of suspected sexual abuse seen at the local children's hospital in 1989 (Gough, 1990). The explanation may be that there is not such a close contact between general practitioners and families in deprived urban areas. Also general practitioners may not be that familiar with child protection issues as hospital medical staff and may be less likely to consider maltreatment as an explanation of any child adversity. Alternatively, they may consider the possibility of maltreatment but for a variety of reasons prefer others to raise this issue with the families.

A finding of both the study reported in Chapters Five to Ten and in the study of sexual abuse investigations at the children's hospital was that different types of case were more likely to be identified by different sources and to travel down different referral routes. In the present study, referrals from parents, others in the community, and education were more likely to involve an actual injury to the child. In the sexual abuse survey, disclosures of abuse by the child were more likely to be referred to the police, whereas concerns about abuse arising from symptoms in the child were more likely to be referred to health services.

These may seem like obvious observations, but they have important consequences. The cases referred down different pathways have different characteristics, the cases are then processed by different agencies with different roles and responsibilities, and who respond differently to child protection concerns. This would have some impact even if all cases were eventually referred to the Social Work Department, because the manner of their referral and the work done prior to the referral being received by the Social Work Department will have effected the nature of the case.
In practice, however, many cases may not reach the Social Work Department. In the current study cases were defined as having been placed on the child abuse register, so the Social Work Department was necessarily involved in all of these cases. The survey at the children's hospital, however, revealed that many cases were subject to full formal medical examinations for physical signs of sexual contact without any involvement of social workers, who would only be involved if hospital staff concluded that sexual abuse had occurred or had a high risk of occurring. The different referral routes, and possible referral outcomes (in terms of both destination and intervention during the referral process) are also another example of the importance of research sample recruitment in child abuse research. For studies of individual or family pathology different sources will identify different types of case and hence different types of pathology. For studies of child protection, referral source is a central variable in examining the child protection system. In the current study only cases placed on the register were included and there is little reason to believe that the operational criteria for registration were applied consistently across cases (see Chapters Three and Eight; Bacon and Farquar, 1993; Dingwall et al, 1983).

An important finding in the present study was the lack of information provided at all stages of the child protection intervention (in registration documents and social work interviews) on the development and general well being of the children. At the time of the study the only two categories of registration were injury and at risk of abuse, so it is not surprising that the statements that did exist about the children were predominantly concerned with the presence and likely cause of any injuries. There was little other data on the children or the parents' relationship with them.

The services that were provided to the families subsequent to registration were also not child focused but were aimed at the parents who in British society have the main responsibility for the care and protection of their children. The aim of the child protection service seemed to be to be in evaluating and if necessary supporting the parents in undertaking this responsibility. The casework was therefore concerned with assessing parental responsibility for any risks to the child including actual maltreatment or failure to protect from maltreatment, but not so concerned with actual level of skill in carrying out the caretaking tasks, the parental relationship with the child (except for motivation to parent), or the child's developmental status.
Subsequent to the initial assessment, the main stances taken by the Social Work Department were of monitoring (or a form of low level continuing assessment), task setting in which parents could demonstrate their motivation and responsibility in undertaking their child care role, or necessity for change where the Social Work Department demanded that there should be some change in the parental behaviour or living conditions.

The main methods used to achieve these strategies were monitoring with material and social support to enable the parents to maintain a stable equilibrium in which they could be responsible parents. This support sometimes included material supports or counselling, emotional support, time, and freedom from emotional stressors to enable parents to make their own choices about their future with or without their child. There was little use of resources that were not in the direct control of the Social Work Department and so little use of more specialist assessment or treatment services. The most commonly used specialist services were a child abuse unit and a local community resource for parents of limited intellectual ability. The way in which the strategies and resources were implemented in practice were characterised by the level of support offered and the extent that controls were applied to try and enforce change or to protect the child from risks in the family. This often included temporary removal of the children into care, though most of these children were subsequently returned home. The child protection service was in practice a time limited service with most cases removed from the formal system within one year of registration. It was only in a small group of cases that there were continuing serious concerns about the children's welfare resulting in long term registration or continued placement of the children in care away from their families.

Parental responses were generally favourable to practical support offered by the Social Work Department and social workers admitted that this was a conscious strategy in attempting to obtain a constructive relationship with parents. Material supports could demonstrate that the social workers were wanting to assist and understood the stresses the parents were experiencing. Social workers requiring information on the parents' lifestyle, challenging their competence or motivation in carrying out their child care responsibilities, requiring change in their lifestyle, or threatening or actually obtaining legal methods of control including removal of the children into care were less well received by parents. Social workers who were explicit and consistent in their use of authority whilst also showing respect, concern, and motivation towards assisting the parents were most appreciated by parents. Social workers had particular difficulty in cases where parents refused to fully
participate in the social workers plans. This refusal could be demonstrated by passive co-operation, pseudo co-operation, little practical co-operation, or direct rejection of services. These issues of care and control were only apparent in the cases perceived by workers as more serious. Cases of low key monitoring were less problematic.

Despite service provision being concerned with child protection, no data was available on the outcome of the service for the children. One child died in an accident not directly linked to child protection though probably attributable to the living conditions and lifestyle of the family. The same was true for the two parents who died of a drug overdose and tuberculosis respectively. Although no data on the children was available in the study it is likely that these background factors of socio-economic deprivation and lifestyle would mitigate against optimum developmental outcomes. Recent ten year outcome research on cases placed on NSPCC child abuse registers demonstrated poor developmental outcomes compared to comparison families from the same communities (Gibbons, Gallagher, and Bell, 1992).

Most of the outcome data available on the families with children placed on the register concerned the parents. This showed that in the short term during and following the process of investigation and registration there were many crises and changes in family membership. This may not be unexpected but has practical consequences for child protection investigations which are attempting to assess the parental ability and motivation to care for their children at a may be non typical time in the family's history. Families differ in their ability to adapt to new circumstances so that parents who might be assessed as perfectly capable at times of quietness and stability might be assessed as incapable if assessed during times of stress and turmoil. Some families lacking in adaptability may never be subject to such stresses and so never be judged unfavourably in terms of their coping abilities or execution of their parental responsibilities.

The main long term outcome data also concerned stability of family membership. There were high rates of change in family membership. This may have partly been due to the problems of child protection and of child protection service intervention, but were also probably part of the context (previously referred to) of the unstable nature of the lives of families recruited into the child protection system.
The most obvious direct influence of the child protection intervention was the long term removal of children into care. This was much more frequent in single parent than nuclear families (see Chapter Ten). Nuclear type families where there were long term concerns about child protection were likely to be subject to long term placement of the child on the register but with the child remaining at home. This may be because the single parent families were a higher risk to the children or showed less long term potential for adequate care of their children. However, it is also possible that a higher criteria of care being required of single parents. In single parent families the assessment of responsibility of care is focused upon one person, whilst it is more spread and diffuse with the two parents in a nuclear family.

Even if single parents did present more serious concerns about long term parenting, the extent that this required long term alternative placement of the children would depend upon the type of service support offered. This is illustrated by the cases referred to the two specialist intervention services observed in the study. Cases referred to the special units were of particularly high concern to the professional staff but resulted in long term attempts to maintain the children in the home rather than to seek alternative long term homes for the children. In this way, decisions about long term risks and the need for alternative placements for the children can not be separated from the nature and intensity of attempts to support the children in the home.

Another important finding was the apparent inconsistency in the criteria for removing children from the child abuse register protection system. Some children were removed because there were no longer concerns about the level of child protection. Others were removed following objections from the parents or where continued registration was considered unproductive despite continued concerns about the children's welfare. Continued concerns were most strongly demonstrated by the continuation or renewal of legal powers of home supervision after the child's name had been removed from the register.

Research and Policy

The purpose of the work reported in this thesis has been to raise both research and policy issues in regard to child protection services. The study has been an attempt to address the common limitations of much child abuse research, and to begin to describe the process of child protection services. It is only through initial description and analysis that vocabularies can be developed to better characterise the
processes of child protection and lead to more objective research outcome studies of different child protection policies and methods. This would include routine management information services so that policy makers and managers could identify how policies are actually implemented in practice.

In this final section of the thesis a few of the research and policy issues raised by the current study are discussed. These discussions are limited by the exploratory nature of the present study. As other studies appear the vocabulary and analysis of these child protection policies can be further developed.

Families have the responsibility to care for their children, but the state supports, monitors, and controls this care in many ways. The state provides financial support, medical and welfare services, and requires that all children receive education. The child protection system of registration and child protection casework plans under central and local procedural guidance is one of the more overtly interventive aspects of state involvement in family life and parental care of their children.

An important finding in the study relevant to this issue was the complexity of different routes into the registration system and evidence from this and another study by the author that different types of case are referred down different referral pathways with unknown consequences on later decision making by agencies and cases conferences. The child protection register system is only one small part of the extensive health, welfare, education and police enforcement systems and there is very little data on the inter relationship between them.

The system of child protection raises the issue of how broad the system should be. The system is narrower in size than the supportive health and welfare services made available to all families and yet broader than legal interventions of home supervision or removal into alternative care. The findings of the current study showed that the service was concerned with future risk even if the possibility of such risk had been drawn to the agencies' attention by an injury or an abusive incident. The child protection practice was thus in line with the later central guidance emphasising the importance of future risk. However, the risks of concern at the time of the current study mostly related to the two categories of registration operable at the time of injury and at risk of abuse.

One way of examining the breadth of the register system is by examining the proportion of the local child population placed on the register. Chapter Two showed
the variation in these statistics. Much of this variation is probably due to different operational criteria being applied with some areas having broader definitions (or wider child protection systems) with others having narrower definitions (or smaller child protection systems). Anecdotal evidence of the extremes of this was provided by one local Area Team Manager stating that he tried to ensure that he had no cases placed on the register in his team. It is difficult, however, to be sure how much of the variation between registration rates is due to actual variations in incidence rather than definitional criteria.

Another insight into concepts of the breadth of the register was provided by the one case of over chastisement not placed on the register. There were concerns about negatively labelling a family for a 'one off' incident. The trouble is that the case conference could not be sure that it was a one off incident. A possible strategy would have been to register the child to monitor the situation for a while to ensure that the child really was not at risk. The case conference decided that the advantages of such a strategy were outweighed by the disadvantages of negatively labelling the family. However, that decision has the effect of implicitly increasing the negative labelling of all the other families whose children were placed on the register.

The register has no legal consequences and could be seen as a purely bureaucratic tool for ensuring inter agency co-operation and planning for cases that are causing concern to agencies. This was the approach of the Social Work Department in the case of a child receiving serious injuries that the mother said were accidental, but the social workers were anxious about unknown aspects of the case and wanted to monitor and offer supportive services to the mother. In this case the health services felt that the family was being unfairly labelled and requested an early review case conference for de-registration. The thinking is that the register is only for those parents who require the negative label of registration.

Another aspect of breadth of the register system was suggested by the categories under which children could be placed on the register. The study found that there was a pre-occupation with injury at entry to the system even if later work deciding upon long term placement and de-registration also involved more general concerns about parental lifestyle and ability and motivation to care for their children. The limiting effect of the child abuse register categories was also observed by the author in respect of sexual abuse cases before the category of sexual abuse was fully introduced. The first category concerning sexual abuse in Strathclyde Region was sexual abuse injury. This category was for known cases of sexual abuse. The Social
Work Department Child Care Adviser stated that there were difficulties in registering cases at risk of sexual abuse because there was not a category for such cases. Recently there has been a broadening of categories to include sexual abuse, neglect, and emotional abuse so that virtually any type of intra familial abuse could be included if the criteria for such abuse was reached. Also cases are registered because of a need for a child protection plan with rather less stress being placed on the register categories. The logical consequence of this is that child protection system is concerned with all aspects of the child’s welfare and not simply the risks of a limited number of pre-specified types of maltreatment. The previously narrow focus on physical injury is broadening to a concern with the optimum development of all aspects of a child’s functioning. This would require a much broader evaluation of the child’s social, intellectual, and physical development than was observed in the study which found little data being provided on the children’s development. It would also suggest that the interventive services should be more concerned in providing direct support for the child in these areas rather than only concentrating on direct services for the parents.

The broadening of register categories has not been followed by an increased sophistication in the way in which the categories are used. The categories used to confound the three variables of area of concern (the potential type of maltreatment), the state of the child (such as injured, failing to thrive, etc) and level of concern or knowledge (at risk/grave concern versus abused). The level of concern or knowledge has now been dropped with all cases being registered because of a need for a child protection plan (Department of Health, 1991; Social Work Services Group, 1992), but there is still confusion between area of concern and state of child. A child may have an injury but the professional concern may be about neglect or physical injury. With the specification that registration is for all children in need of a child protection plan there may be less need to have such rigid categories of registration. Computerised child protection registers could include separate variables for area of concern and state of child. Also, type of knowledge or nature of concern could be re-introduced. Not as a risk category but as a description of the basis of concern. This may, for example, be because a child has been abused, a sibling of the child has been maltreated, or a person known to abuse children has recently joined the household. Routine collection of such data (as currently planned by the Scottish Office) could provide much better indicators of differential practice concerning registration and de-registration within and between different social work departments.
A related issue is the process of placing a child’s name rather than a parent’s or a family's name on the register. The child protection practice observed by the study was focused almost entirely on the parents yet it was the child who was at the centre of the bureaucratic process of the register system. This sometimes created difficulty when someone known to be a risk to children moved from family to family or when a new child was born into a family with a history of child maltreatment. There may be ethical or legal problems in creating a register of perpetrators of child abuse, but a register of parents currently having difficulty with the care of their children would not be that different ethically from the current situation of registering children as at risk. It would fit better with the practice observed of focusing services on the parents. On the other hand, maybe the services should not be so focused on the parents. Also, children found to be at risk or victims in one environment may continue to be at risk even if moved to a new environment, so a focus on risks to the child may be better able to track and monitor this. In practice, however, most children in the current study were removed from the register in under a year or even quicker if they were moved to a new caretaking environment. The system was not used as a long term method of monitoring children's welfare.

This leads on to another issue of breadth of the register which is the quick turn over of cases. Registration was in practice a short term measure of under a year in duration. It was only a long term method of casework management for a small number of cases considered to be particularly intractable. Even in these difficult cases there was a tendency to de-register on the basis that although there were still risks, the family was well known to all the agencies, a number of supportive and monitoring services were being provided and inter agency co-operation was good. This does not however fit with a philosophy of the register system of ensuring that a basic level of service quality and quantity is being carried out. That an appropriate service is being delivered is not a basis for removal from the safety net that the register system provides.

Another set of issues raised by the findings of the study is the methods used by the child protection system to assess the adequacy of parenting and whether it was appropriate for the child to stay with its family. At what point should efforts to help a parent look after their child be abandoned and plans for long term alternative placements be made? The study found that no long term plans had been formalised for any children although about a tenth of the index children were in care at the end of the study period with little likelihood of being returned home. The time taken to achieve permanent alternative arrangements for children in care is well known
(Department of Health, 1985) and raises questions about the amount of time and level of support parents should be given before alternative plans are taken. Some authors argue for intensive controlling interventions requiring a necessity of change in parents within six months (Dale et al, 1986). Although such policies are appealing, they may not have fitted the cases in the present study which were mostly single women doing little to actively harm their child but also not perceived by the Social Work Department at being sufficiently protective of their child. The crises and risks to the child did not occur with sufficient intensity or frequency to allow early decisions to be easily made. On the other hand may be the parents could have coped independently with more intensive support or more long term low level support. As previously noted, nuclear families or families attending a specialist unit were more likely to be allowed to keep their children with low level long term support.

The study also revealed the complexity of the legal pathways taken by the nearly 40% of cases that proceeded through the Children's Hearing system. There is very little research data available in the literature on the complexity of these pathways or the effect that they might have on case management and case outcome. Would case management, for example, have been equally served by the use of voluntary measures or was it necessary to take enforceable measures to protect the child from short term risks? Alternatively, were more powerful legal sanctions necessary in case a child at a later stage was considered to not have a future with their original family? In the present study about a quarter of the cases where legal measures were taken were heading towards long term alternative care at the end of the study period. Also, in several cases legal measures were obtained for the first time at the end of the study period. If there are serious concerns about the child's welfare after considerable period of voluntary case management, it may still be possible to obtain legal powers. It may be more difficult to prove appropriate grounds of referral at this stage than at the crisis that initiated original. On the other hand, if there are no current provable grounds of referral then may be legal powers are not appropriate.

The whole of this thesis has indicated the large number of policy issues that are raised by an examination of the child abuse register system. Some of these policy issues have been addressed by developments in central government policy in regard to registration and the responsibilities of different government services. Many of the issues raised, however, continue to be unresolved despite the length of time since the study started and the publicity surrounding child abuse and the many inquiries into specific child abuse cases.
One reason that many policy continue to be unresolved is that the procedural guidance issued both centrally and locally provides guidance on what physical action to be taken in specific circumstances. The difficulty is that these circumstances are usually only specified using undefined terminology such as abuse or risk. This may have an advantage for professional workers because it allows professional judgement about the interpretation of the needs of individual cases. It is also can be dangerous for workers because their actions can be determined to have been faulty in hindsight if there is an unfortunate outcome such as a child dies at the hands of their parents. If local or central government are more specific about the actual policies concerning what is abuse, how interventive child protection services should be, and over what time period then these agencies are making themselves vulnerable to criticism when children die or are considered to have been removed inappropriately from their parents. The agencies are vulnerable in so far as they have to publicly defend their policies.

One difficulty is the lack of information on practice. One aim of the current study was to make a contribution to this knowledge. A second and related aim was to assist further studies of practice by classifying case practice and outcome to aid the development of a vocabulary for describing this work. The development of an appropriate taxonomy can then be used for further studies to specify practice and case outcome in more detail. This process can be illustrated with the example of child abuse categories. These first reflected a taxonomy of child abuse as a syndrome with cases of actual cases of this abuse or risk of this abuse. The descriptive studies by the author of cases registered by Scottish Departments of Social Work (Gough, 1987, 1988, 1992) revealed great variations in practice in the use of register categories. This variation was not only in the area of concern (type of abuse) but also in the types of concern with different practices concerning registration of siblings, unborn children, children in the household of a known perpetrator of abuse. These descriptive surveys then informed the development of a comprehensive management information system for registration by a government working party (Social Work Services Group, 1992).

With the development of computerisation there is scope for routine management information systems to examine the implementation of child protection policies and to allow policy makers to make informed decisions about the further development of such policies and methods of child protection intervention. This practice has been
started in Scotland with the development of a management information system for child protection registers.

The classifications of case presentation, child protection interventions, and outcomes in the study reported here could be developed to produce similar information systems for on-going child protection work. Policy and practice in child protection will be able to progress with the greater clarity available from the description and classification of practice. The current study is one small step towards this process.
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APPENDIX
APPENDIX : PATHWAYS THROUGH LEGAL CARE SYSTEM

The following conventions are used:

PS  Place of Safety Order
S15 Voluntary Reception into Care
Reporter Referral to the Reporter to the Children's Hearing System
Panel Children's Hearing Panel
Sheriff Sitting of the Sheriff Court to assess proof of grounds of Referral to the Children's Hearing
44h Supervision order made by a Children's Hearing with placement with the child's parents
44rel Supervision order with placement at a non-parent relative
44fp Supervision order with placement at foster parents
44ch Supervision order with placement at a children's home

The above sometimes occur together in the following pathways and the addition of 'end' to any of them indicates that that particular feature has been terminated.

The pathways only illustrate the legal interventions applied to index cases. The pathways are more complex if siblings are included.
PATHWAYS DOWN CARE SYSTEM FROM REFERRALS TO THE REPORTER

Reporter end (n = 7)

Reporter ----> Reporter end (n = 1)

S15 ----> S15 end (n = 1)

Panel (n = 1)

Panel end (n = 1)

44h (n = 7)*

S15 ----> S15 end (n = 1)

44h + PS (n = 1)

44h ----> 44h + S15 (n = 1)

44fp ----> 44h ----> 44h + S15 ----> 44h (n = 1)

44 fp (n = 2)

44 rel (n = 1)

44 fp (n = 1)

(*includes one case registered at birth)
PATHWAYS DOWN CARE SYSTEM FROM PLACE OF SAFETY ORDER (PS)

PS end (n = 4)

- panel (n = 1)
- sheriff --> panel end (n = 1)
- 44h (n = 8)*
- PS --> PS end --> 44h (n = 2)

S15 --> 44fp (n = 1)

- S15 end --> 44h --> S15 --> S15 end --> 44h
  --> 44h + PS --> 44fp (n = 1)

S15 --> S15 end --> panel --> sheriff (n = 1)

- panel --> sheriff --> sheriff end (n = 1)

- sheriff (n = 1)
- 44h (n = 3)
- 44ch --> 44h --> 44 end (n = 1)
- 44h + PS --> 44h (n = 1)
- 44fp --> 44h (n = 1)
  --> 44h + S15 --> 44h (r: 44 rel)

- 44 rel --> 44h --> 44h + PS --> 44 rel --> 44h (n = 1)

- 44fp (n = 5)*
  - 44h (n = 5)*
  - 44h + S15 --> 44fp (n = 1)
  - 44h + PS --> 44fp (n = 1)

(*includes one case registered at birth)
PATHWAYS DOWN CARE SYSTEM FROM VOLUNTARY RECEPTION INTO CARE (S15)

\[ \rightarrow S15 \text{ end} \quad (n = 7) \]
\[ \rightarrow S15 \rightarrow S15 \text{ end} \quad (n = 1) \]
\[ \rightarrow S15 \rightarrow S15 \text{ end} \quad (n = 1) \]
\[ \rightarrow \text{panel} \rightarrow \text{sheriff} \rightarrow \text{sheriff end} \quad (n = 1) \]
\[ \rightarrow 44h \rightarrow 44h + \text{PS} \rightarrow 44fp \rightarrow 44h \]
\[ \rightarrow \text{PS} \rightarrow \text{PS end} + S15 \rightarrow S15 \text{ end} \quad (n = 1) \]
\[ \rightarrow 44fp \quad (n = 1) \]
\[ \rightarrow 44fp \rightarrow 44h \quad (n = 1) \]

PATHWAYS DOWN CARE SYSTEM FOR CASES ALREADY IN SYSTEM AT INITIAL REGISTRATION

\begin{align*}
\text{Registration} \\
44h & \rightarrow 44h \quad (n = 1) \\
44 \text{rel} & \rightarrow 44h \rightarrow 44h \quad (n = 1) \\
\text{PS} & \rightarrow 44h \rightarrow 44h \rightarrow 44ch \rightarrow 44h \quad (n = 1) \\
44fp & \rightarrow 44h \rightarrow 44h \rightarrow 44fp \quad (n = 1)
\end{align*}
SUBSEQUENT PATHWAYS DOWN CARE SYSTEM FOR RE-REGISTERED CASES

At end of Initial Registration

No panel involvement

Re-registration

Reporter end (n = 1)

44h

44h + PS

44fp

Sheriff + warrant (n = 1)

(*This case was re-registered three times and continued to be on 44h order)

Not on Register

44h*

Reporter

44h (n = 1)

44h + PS

44fp

44h (n = 1)

44h + PS