

Chapter 5: Child maltreatment: moving towards a public health approach

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Child abuse casts a shadow the length of a lifetime.

Herbert Ward

Since 1999, when this report was last published, there has been increasing recognition of the role that a public health approach can play in tackling child maltreatment. Calls for a public health approach to child maltreatment – a strategy that aims primarily to reduce risk factors for maltreatment – have been based on four main arguments:¹⁻³ the right of children to be protected from harm in the first place; the frequency of child maltreatment, which, if all occurrences were notified, would overwhelm child protection systems; the inaccuracy of identification systems, which miss the large majority of maltreated children; and fourth, the effectiveness and cost effectiveness of intervening to prevent child maltreatment compared to intervention once child maltreatment has occurred.

In this chapter, we review the evidence to support a public health approach and trace its faltering development in healthcare and children's social care services over the last decade. Education and child care services are also critical to the prevention, as well as recognition of and response to, child maltreatment, but their role is beyond the scope of this chapter.

5.1 Definitions

Public health approach

A public health approach can be defined by a four-step process. Defining the condition in the population, determining the risk factors for the condition, developing interventions to address the risk factors and thereby reduce the frequency of the condition, and lastly implementing and monitoring the effectiveness of the intervention on a population basis.⁴ For child maltreatment, a public health approach means focusing on reducing the risk factors that give rise to maltreatment, rather than on maltreatment once it has occurred. A public health approach, therefore, translates as a preventive approach,

which can act on risk factors at all levels of the ecological model of maltreatment:⁵ whole society, neighbourhood, family, parent and child. Depending on the risk factors being addressed, preventive interventions may be universal (eg legislation), or targeted (eg parent training). A further distinction commonly used in public health is between primary prevention, preventing occurrence of the condition in the first place, and secondary prevention, preventing recurrence once the condition has occurred. This distinction is less useful in the field of child maltreatment. Maltreatment lies on a spectrum of harmful parent-child interaction and is often hidden, making it hard to be certain whether intervention is preventing occurrence or recurrence.

Child maltreatment

Child maltreatment encompasses any acts of commission or omission by a parent or other caregiver that result in harm, potential for harm, or threat of harm to a child, even if harm is not the intended consequence. Four forms of maltreatment are widely recognised – physical abuse, sexual abuse, emotional abuse, and neglect – which frequently coexist (see **Table 5.1**). Increasingly, witnessing intimate partner violence is also regarded as a form of child maltreatment. The impact on children of witnessing domestic abuse is examined in the 2007 BMA report *Domestic abuse*. Neglect and emotional abuse are, by definition, persistent problems, manifest by harmful parent-child interactions, whereas physical and sexual abuse and witnessing intimate partner violence are events, which may be covert.⁶ More than 80 per cent of maltreatment is perpetrated by parents or parent substitutes, apart from sexual abuse, which is most frequently perpetrated by acquaintances or other relatives.⁶

Table 5.1: Definitions of child maltreatment***

	Definition	Comment
Child maltreatment*	Any act of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child. Harm does not need to be intended.	In the USA, 82 per cent of substantiated cases were perpetrated by parents or parent substitutes. ⁷
Physical abuse*	Intentional use of physical force or implements against a child that results in, or has the potential to result in, physical injury.	Hitting, kicking, punching, beating, stabbing, biting, pushing, shoving, throwing, pulling, dragging, shaking, strangling, smothering, burning, scalding, and poisoning. Seventy-seven per cent of perpetrators are parents, according to US figures for substantiated physical abuse. ^{3,7}
Sexual abuse*	Any completed or attempted sexual act, sexual contact with, or non-contact sexual interaction with a child by a caregiver**	<p>Penetration: between the mouth, penis, vulva or anus of the child and another individual.</p> <p>Contact: intentional touching, directly or through clothing, of the genitalia, buttocks or breasts (excluding contact required for normal care).</p> <p>Non-contact: exposure to sexual activity, filming, or prostitution. For substantiated cases in the US in 2006, 26 per cent of perpetrators were parents and 29 per cent a relative other than a parent.⁷ Parents form a smaller percentage (3 to 5%) of perpetrators of self-reported sexual abuse.⁸</p>

Continued overleaf.

	Definition	Comment
Psychological (or emotional) abuse*	Intentional behaviour that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered or valued only in meeting another's needs. In the UK, the definition includes harmful parent-child interactions which are unintentional: 'the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development'. ⁹	Can be continual or episodic, for example triggered by substance misuse. May include blaming, belittling, degrading, intimidating, terrorising, isolating or otherwise behaving in a manner that is harmful, potentially harmful, or insensitive to the child's developmental needs, or can potentially damage the child psychologically or emotionally. In the UK, witnessing intimate partner violence is classified as psychological abuse. ⁹ Eighty-one per cent of substantiated cases in the US were perpetrated by parents. ⁷
Neglect*	Failure to meet a child's basic physical, emotional, medical/dental, or educational needs; failure to provide adequate nutrition, hygiene or shelter; or failure to ensure a child's safety.	Failure to provide adequate food, clothing or accommodation, not seeking medical attention when needed, allowing a child to miss significant amounts of school, failure to protect a child from violence in the home or neighbourhood or from avoidable hazards. Parents make up 87 per cent of perpetrators of substantiated cases in the US. ⁷
Intimate partner violence	Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are, or have been, intimate partners or family members, regardless of sex or sexuality.	Most frequently the perpetrator is the man in heterosexual couples, but there is growing recognition of violence inflicted by females.

*Definitions are based on Centres for Disease Control and Prevention report 2008, with modifications in italics.¹⁰

**Includes substitute caregivers in a temporary custodial role (eg: teachers, coaches, clergy, and relatives).

***US data have been used for this table as the best available data. It is important to note that the detail and extent of routinely collected social care data is poor in England.

5.2 The frequency and nature of maltreatment

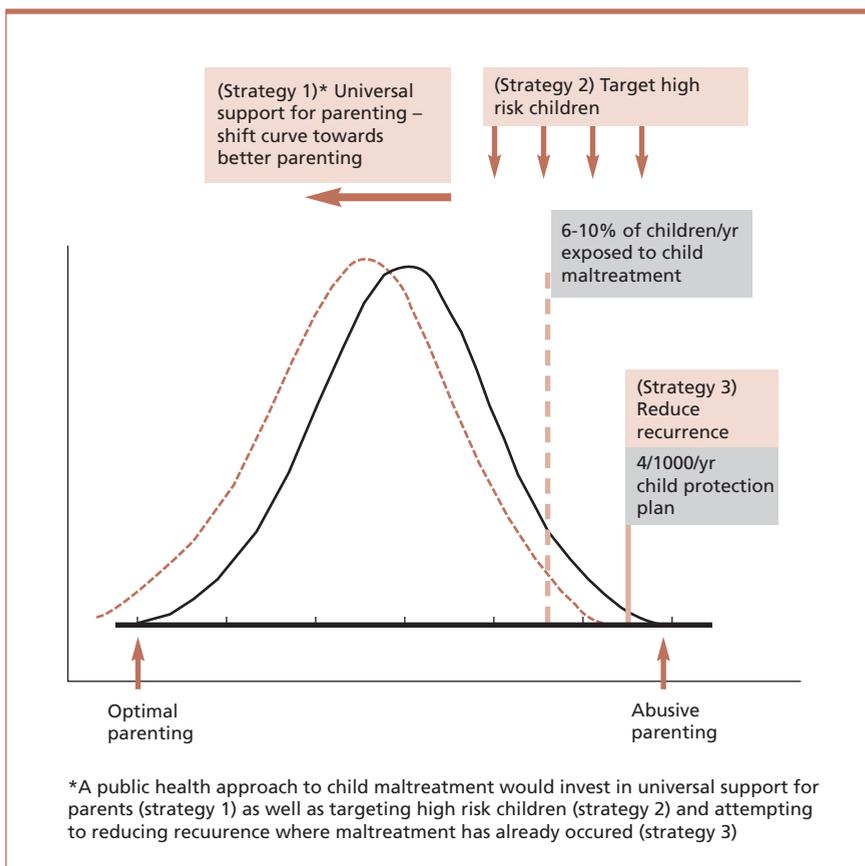
Broad agreement across high and middle income countries on what constitutes child maltreatment has paved the way for improved tools for measuring its occurrence. One new development since the 1990s has been the growing use of validated self-report or parent-report survey tools as an alternative to child protection agency information for measuring child maltreatment.¹¹⁻¹⁷ These surveys have highlighted the fact that child maltreatment is common: between one in 25 to one in 10 children are exposed each year in the UK.^{6,18,19} This is far more than are receiving child protection services at any one time. Approximately 3 per cent of children each year are classified as a child in need and receive social care services, and four per 1000 are on a child protection plan in England – mainly for neglect or emotional abuse.²⁰ Data from child protection agency activity are therefore poor indicators of actual maltreatment. Agency activity is driven more by capacity and policy directives than by actual occurrence of maltreatment.²¹

Self-report and parent-report studies have advanced our understanding of the type of children affected by maltreatment. We now know that, far from being a problem that mainly affects young children, child maltreatment is highly prevalent in adolescents.^{19,22,23} We also know that children exposed to one type of maltreatment are often exposed to other types over time.^{24,25} The same children are frequently exposed to other forms of victimisation – such as violence, bullying or sexual abuse – by peers or strangers, which can be just as harmful.^{26,27} Further advances in our understanding of child maltreatment since the 1990s come from long-term follow-up studies of maltreated children. These have shown that child maltreatment (whether reported to child protection agencies or self-reported) is often a chronic condition with long-term consequences, such as increased risks of poor mental health, obesity or alcohol abuse, and involvement in violence and criminality, which start in childhood and adolescence and persist into middle age.⁶ The impact of childhood and adolescent maltreatment on mental health is also examined in the 2003 BMA report *Adolescent health*.²⁸

Numerous, population-based studies have defined a range of environmental, parent and child risk factors for child maltreatment.⁶ Poverty, unemployment, poor housing and a lack of social support are all related to an increased risk of maltreatment.⁶ Parent risk factors include mental health problems, drug and alcohol misuse, intimate partner violence and parents' own exposure to maltreatment or their lack of experience of positive parenting in childhood; all increase the risk of inadequate or abusive parenting or of harmful parent-child interaction.⁶ Child risk factors include disability, behaviour problems and chronic disease. These risk factors often coexist and interact, adding stresses and demands on parents who may already have limited parenting capacity, family support and financial resources. It is easy to understand how this combination of adversity for the parents and child can lead to some children experiencing episodes of maltreatment or chronic failure of adequate parenting, which manifest as neglect or emotional abuse.

Major consequences flow from these advances in the understanding of child maltreatment. The first is the fact, underpinned by self-report and parent-report studies, that child maltreatment involves a range of severity that reaches far into the 'normal' population. Maltreatment is not inflicted only by unimaginably vicious or neglectful parents but occurs as part of a spectrum of parenting behaviour, ranging from optimal to severely abusive (see **Figure 5.1**).

Figure 5.1: Distribution from optimal to abusive parenting and representation of policy to reduce child maltreatment

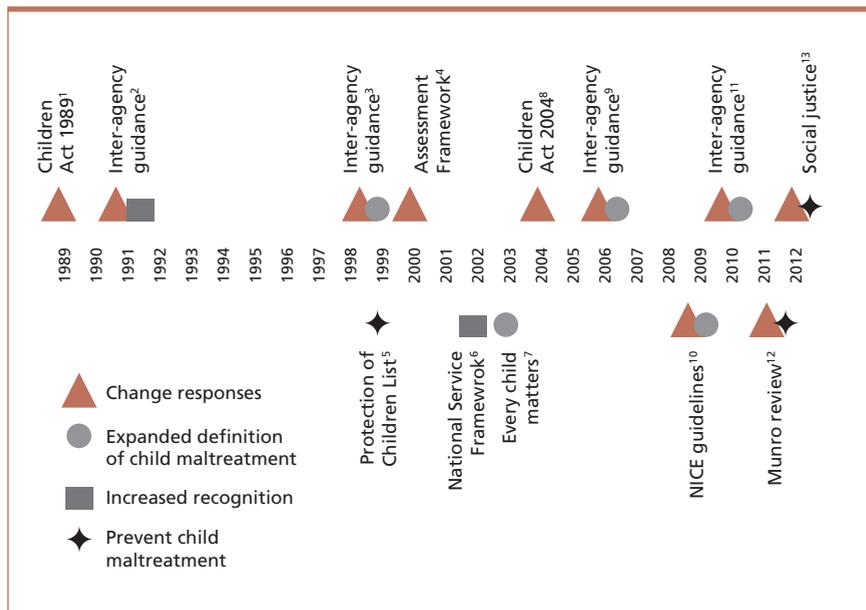


Source: Gilbert R, Woodman J & Logan S (2012) Developing services for a public health approach to child maltreatment. *International Journal of Children's Rights* **20**: 323-42. Reproduced with the permission of the authors.

The second consequence is the realisation that most maltreated children do not come to the attention of child protection agencies most of the time. Numerous studies have shown that professionals (including paediatricians) refer to child protection services only a minority of the children whom they suspect are being maltreated.²¹ Reasons include uncertainty about the diagnosis, lack of confidence that referral will do more good than harm, and concerns about the capacity of services to respond.²¹ Even when children are investigated and followed up by child protection agencies because of child maltreatment, such input is usually short term. The large majority of child protection plans last less than a year and one-fifth last less than three months.²⁰ Most children remain with their family (only 0.2% of the child population became a 'looked after' child in 2010/11),²⁹ and these children's lives do not necessarily improve after social care investigation or intervention.^{21,30} The implication is that even children with confirmed maltreatment spend most of their childhood outside the scrutiny of child protection services. Third, to address the widespread occurrence and serious long-term consequences of maltreatment, strategies need to shift from an emphasis on immediate child safety and forensic assessment to determine culpability, to interventions likely to reap the greatest benefits for children, the adults they will become, their families and wider society. Consideration of the most effective and cost-effective long-term strategies has driven the call for a public health approach focused on reducing risk factors such as early evidence of harmful parenting.

Fourth, along with the focus on a public health, preventative approach, there has been growing use of robust methods, such as randomised controlled trials, to evaluate the effectiveness of interventions for child maltreatment.³¹ These evaluations have found that few in-home interventions are effective for preventing recurrence of maltreatment, especially not for neglect.³¹ The most striking finding, however, is how few randomised controlled trials have been done, despite the harms and costs associated with child maltreatment.^{31,32} There have been no randomised controlled trials, for example, comparing out-of-home with in-home care on the child's safety, health, achievements, and quality of life. More evidence is available for prevention. Targeted interventions to prevent maltreatment appear to be more effective and cost effective than child protection once maltreatment has occurred.^{3,33-35} The need for the shift in emphasis to prevention was advocated in the 1963 Children and Young People Act, reiterated in the Children Act 1989 and in research in the 1990s, and again recently in the Munro report (see **Figure 5.2** and **Table 5.2**).³³ A preventative, public health approach to child maltreatment is slowly gaining momentum, but effective translation into practice has been patchy.

Figure 5.2: Timeline of child protection policy in England



Source: Adapted from Gilbert R, Fluke J, O'Donnell M et al (2012) Child maltreatment: variation in trends and policies in six developed countries. *The Lancet* **379**: 758-72.

Table 5.2: Key to children's social care policy timeline in Figure 5.2

Date	Policy	Significance	
1	1989	Children Act. ³⁶	Emphasised balance between protecting children from abuse and protecting families from unnecessary and unwarranted intrusion by the state. Introduced concept of 'likely' significant harm as threshold for statutory action by local authorities to protect children from abuse (section 47). Set out statutory duty for local authorities to provide services to children 'in need' and their families (section 17). Created statutory responsibility for all professionals to refer concerns about child abuse and neglect to an agency with power to investigate and intervene (social services, police or National Society for the Prevention of Cruelty to Children (NSPCC)).
2	1991	<i>Working Together under the Children Act 1989: A guide to professional arrangements for Interagency Cooperation for the protection of Children from Abuse</i> Guidance on professional roles and responsibilities. ³⁷	Update of 1988 <i>Working Together</i> . Focused on identifying children likely to suffer significant harm and how and when to carry out an investigation (section 47 Children Act). Part eight contained expanded guidance on 'case reviews' (now known as 'serious case reviews'), first introduced in the 1988 <i>Working Together</i> .
3	1999	<i>Working Together to safeguarding children: A guide to Inter-agency Working to safeguarding and Promote the Welfare of Children</i> . ³⁸	Update of 1991 <i>Working Together</i> . Focus broadened from child protection (section 47 Children Act) to also include safeguarding and promoting children's welfare (section 17 Children Act). Published in the context of the 'refocusing debate', which emphasised the importance of family support services for children in need, alongside child protection services for those likely to suffer significant harm.

	Date	Policy	Significance
4	2000	<i>Framework for the Assessment of Children in Need and their Families.</i> ³⁹	Primarily a practice tool for professionals, which was designed to help determine whether a child was in need or likely to suffer significant harm and to determine appropriate family support services.
5	2000	Protection of Children List.	The Protection of Children Act (1999) required recording of individuals disqualified from working with children.
6	2000	NSF. ⁴⁰	Aimed to establish clear standards for promoting the health and wellbeing of children and young people and for providing high-quality services that meet their needs. Set child protection services in the wider context of services to safeguarding children and promote child welfare.
7	2003	<i>Every Child Matters: Change for Children.</i> ⁴¹	The ambitious ECM agenda was framed in terms of supporting all children. It conceptualised children on a spectrum, ranging from those needing only universal services to those needing specialist services, such as child protection. The programme aimed to integrate universal, targeted and specialist services so that child protection and safeguarding were not isolated from services to meet the needs of all families. The guidance aimed to promote prevention while also strengthening protection.
8	2004	Children Act. ⁴²	The updated Children Act placed 'a duty to cooperate' on all services and required all local authorities to replace Area Child Protection Committees with Local Safeguarding Children Boards. It also created a statutory duty for agencies, including health, to make sure they had made arrangements to safeguard and promote the welfare of children.

Date	Policy	Significance
9 2006	<i>Working Together to safeguarding children: A guide to Inter-agency Working to safeguarding and Promote the Welfare of Children.</i> ⁴³	The Working Together guidance was revised in response to the public inquiry report by Lord Laming into the high-profile death of Victoria Climbié as a result of maltreatment from her carers. It offered the first detailed definition of 'safeguarding' and supported the ECM agenda.
10 2009	NICE guidelines: <i>When to Suspect Child Maltreatment.</i> ⁴⁴	Evidence-based guidance for health professionals on recognising and responding to child maltreatment. Guidance was given on the characteristics and features that should prompt professionals to 'suspect' maltreatment and 'consider' maltreatment. 'Suspected' abuse, with high levels of certainty and severity, should be referred to social care. Action following 'considered' maltreatment, where severity or certainty is not high enough to reach thresholds for social care referral but maltreatment cannot be ruled out, was outside the scope of the guidelines. NICE, however, recommends discussion with colleagues, information sharing and further examination.
11 2010	<i>Working Together to safeguarding children: A guide to Inter-agency Working to safeguarding and Promote the Welfare of Children.</i> ⁴⁵	The revised guidance was a response to The Laming Report 2009 <i>The protection of children in England: a progress report</i> ; a report on the implementation of Laming's previous recommendations following high-profile cases of child death from maltreatment, including that of Peter Connolly. Includes further detail on children who may be particularly vulnerable and need safeguarding and incorporates changes to 'Serious case reviews' recommended by Lord Laming (2009). Includes interactive web-based version.

Date	Policy	Significance
12 2011	<i>The Munro review of child protection: final report – a child-centred system.</i> ³³	This Munro review was commissioned by the new Coalition Government in 2010. It calls for greater emphasis on professional judgement and less target-driven, protocolised activity in social care. The report, and particularly the Government's response, acknowledges the role of healthcare professionals in managing children who are below the threshold for referral to social care for child protection, but details are lacking on how this role should be implemented and supported.
13 2012	<i>Social Justice: Transforming Lives.</i> ⁴⁶	The Social Justice Strategy prioritises a preventive approach for Government policies for the family. Under this strategy, there will be resources allocated to universal services to improve parenting and extension of free nursery places for all children, as well as targeted interventions to help families already identified as vulnerable. The main premise of the strategy is that work will improve individual and family health and welfare. This strategy should be seen in the context of other cuts and changes to tax and benefits. Forecasts suggest that there will be net disadvantage to families and child poverty will rise.
14 2012	General Medical Council (GMC) guidance: <i>Protecting Children and Young People: the responsibility of all doctors.</i> ⁴⁷	This guidance emphasised the responsibility of all doctors to bear children or young people in mind, even those professionals who did not routinely come into contact with children or young people. It reassures doctors that they will be able to justify their actions if a complaint is made against them to the GMC, so long as their concerns were honestly held and reasonable. Although the focus is largely on the sharp end of social welfare problems (child protection), nods to a broader approach are seen in the emphasis on understanding and recognition of risk factors for maltreatment

Date	Policy	Significance
		and awareness of supportive community services, such as those run by voluntary groups, to which patients may be referred. Like the 2009 NICE guidance, there is little detail about the types of intervention or approaches that health professionals should use for vulnerable or maltreated children.
15	2012 Health and Social Care Act 2012. ⁴⁸	Under the Health and Social care Act 2012, responsibility for safeguarding was transferred from PCTs to clinical commissioning groups (CCGs) and commissioning boards (CBs). The Care Quality Commission (CQC) will be jointly responsible with The Office for Standards in Education, Children's Services and Skills (Ofsted) for ensuring that safeguarding duties are adequately discharged and will monitor safeguarding provision via biennial inspections. The CQC is currently drawing up an inspection framework for 2013.

Source: Gilbert R, Fluke J, O'Donnell M et al (2012) Child maltreatment: variation in trends and policies in six developed countries. *The Lancet* **379**: 758-72.

5.3 Preventive policies

The curve in Figure 5.1 represents a simplified view of parenting from optimal, which few of us achieve, through to harmful, abusive parenting. Leaving aside arguments about how parenting (on the x axis) could be measured and whether it would be symmetrically distributed, the diagram can help to explain the theoretical impact of a public health approach to improve parenting. The theory states that universal, whole-population strategies for improving levels of parenting would shift the curve to the left.⁴⁹ This could improve parent-child interaction a small amount on average for the whole population, potentially impacting on behaviour, depression, self-esteem, school achievement, obesity and other outcomes related to less than optimal parenting. A small shift for the population overall would, in theory, also shift many of those in tail of the distribution on the right, out of abusive parenting (see Figure 5.1).

Examples of whole-population, universal strategies likely to shift patterns of parenting, include legislation against smacking, reducing child poverty, and improving support for parents. It should be noted that UK law permits parents to smack children as long as it

does not leave a mark, but there is widespread opposition to this policy, with campaign groups demanding that the UK follows the Swedish example and bans all physical chastisement of children. There is general agreement among researchers that babies should not be smacked, and that children who are smacked are more likely to be aggressive and have poor emotional regulation. Smacking is not more effective than non-physical forms of discipline, and it is clearly linked with poorer outcomes. It demonstrates to children that problems can be solved by physical aggression rather than in non-violent ways (see **Chapter 7** for a more detailed discussion).

Empirical evidence of the effectiveness of these approaches is difficult to obtain. The best example comes from Sweden, where repeated self-report and parent-report studies over four decades have shown a decline in the reported prevalence of physical abuse. Pinpointing which interventions caused these changes is very difficult. In practice, multiple factors are likely to have contributed. Much of the decline pre-dated legislation banning smacking (1979), against a background of rising provision of universal pre-school child care, maternal employment, and generous maternity and parental leave.^{6,50} One Swedish author cites the social contagion effects of information about how children should be cared for – disseminated through early daycare settings, and reinforced by other parents – as responsible for the rapid adoption by immigrant families of the Swedish approach to child discipline.⁵¹ Such methods might not work so well in a more class-segregated society, such as the UK.

Government policy initiatives since 1989 are summarised in Table 5.2. From 1997 until the new Coalition Government took over in 2010, the UK Government adopted elements of a public health, risk-reduction approach, improving child wellbeing and reducing maltreatment through investment in universal support for parents. Following Tony Blair's pledge to end child poverty, three strands of policy were developed (for further details on the Labour Government's (1997 to 2010) policies to eradicate child poverty see **Chapters 2 and 3**). Investment in universal child care provision, increased financial support for families, and initiatives to make work pay. As a result, child poverty fell steeply in absolute terms between 1999 and 2010 (with a plateau between 2004/5 and 2008).^{52,53} These policies were coupled with infrastructure targeted at deprived families with young children, with services centred on Sure Start schemes based in Children's Centres.⁵² For school-age children, the children's fund, introduced in 2001, stimulated a variety of local projects that aimed to minimise the negative effects of child poverty and social exclusion (for further details on child poverty and Sure Start schemes see **Chapter 3**).⁵⁴

Establishing whether these initiatives had a direct effect on child maltreatment is hard, as measures of maltreatment experienced by children, as opposed to professional responses to child maltreatment, are not routinely collected in the UK. Better data would be provided by repeated self-report studies of maltreatment in the past year.

Some evidence of a decline is provided by comparing national surveys in the UK done by the NSPCC in 1999⁵⁵ and 2009.⁵⁶ These showed some decline in harsh physical punishment or violence and in verbal aggression but not in neglect.⁵⁶ These data, however, reflect exposure to maltreatment throughout childhood and are strongly affected by recall of recent events by the 18 to 24 year olds surveyed. They are not good measures of change across all age groups. Past-year data were not collected in the earlier study, but the foundation has been laid for future follow-up studies to determine changes, compared with the 2009 survey.

In policy documents, the new Coalition Government has given early intervention and preventive approaches a central role in its *Strategies for reducing family poverty, improving child wellbeing and reducing maltreatment* (see **Figure 5.2; Table 5.2**). With current reforms to tax and personal benefits and cuts to public spending, there is some scepticism about how this approach will work in practice.⁵³

5.4 Preventive healthcare

Primary care services

Public services, particularly in health and education, can play an important role in preventing child maltreatment. Such universal services are able to take a population-wide approach to identifying and targeting high-risk families. Within healthcare services, 90 per cent of contacts take place in primary care.⁵⁷ Primary care is the main universal service for the whole family and virtually all children are registered with a GP. The service is run by skilled family practitioners trained in developing and maintaining therapeutic relationships with patients facing a range of health and psychosocial issues.

Knowledge of the epidemiology of child maltreatment makes clear what a pivotal role GPs could have. First, children in the UK present to primary care frequently. On average, children under five years old consult five times a year with their GP⁵⁸ and about one in 13 children have seen their GP in the last two weeks.⁵⁹ Second, the primary care team has insight into risk and protective factors for child maltreatment and the functioning of the family through caring for the mother and siblings, and often for the father and extended family. They are, therefore, well placed to monitor and respond to domestic violence, depression, drug or alcohol abuse, and signs in family members of stress, trauma or failing parenting. A Danish study found that half the neglected children reported by GPs were first identified through consultations for health problems in the parents.⁶⁰

Third, GPs hold a continuous healthcare record for the child as well as for other family members. Although patients are not always seen by the same GP and may be seen by other members of the primary healthcare team, such as a practice nurse, the record of concerns and past problems is contained in the patient's record. No other services have such longitudinal insights across multiple family members. Fourth, as child maltreatment is often a chronic condition, merging with other forms of victimisation, the primary care

team can play a key role in anticipating stressors for vulnerable families and initiating support or therapeutic services. Fifth, research consistently shows that a substantial proportion of maltreated children (or members of their family) have chronic medical problems or disability.⁶¹ The primary care team can play a critical role in addressing health problems on an ongoing basis. This continuity of care is particularly important for the most vulnerable families, who may spend periods of time being monitored and supported by children's social care services (eg on a child protection plan), but who may nevertheless require ongoing support, possibly throughout childhood, with a focus on health needs.

Although the pivotal role of the GP has been acknowledged by policy makers in practice,^{33,62-66} there is still contention and mismatched expectations about the role and responsibilities of the GP's involvement in child protection.⁶⁷⁻⁷⁰ In addition, GPs' abilities to proactively pursue concerns about child maltreatment have been reduced by relocation of health visitors from GP practices into children's centres, where they work alongside social workers and early years' service providers such as Sure Start.^{21,71} Primary care is not yet maximising its potential for a strong preventive role in child maltreatment.

In contrast to the UK, primary care paediatricians in the US, the equivalent of GPs in the UK with paediatric training, have a more recognised role in responding to child maltreatment and, in some areas, operate a preventive role.^{21,34,62,72} One approach, evaluated in a cluster randomised controlled trial – the Safe Environment for Every Kid (SEEK) study – involved teaching doctors about risk factors for child maltreatment, participation of a social worker in clinics, and use of a parent questionnaire to screen for substance misuse in the family, maternal depression, major stress and intimate partner violence.⁷³ At the two-year follow-up, intervention practices showed modest but significant improvement in their targeting of family problems.

Lessons about a preventive approach to child maltreatment for UK primary care could be taken from the areas of domestic violence and mental health, which are also sensitive and hidden conditions with thresholds for statutory intervention.⁷⁴⁻⁷⁶

Paediatric services

The past decade has been troubled for paediatricians involved in child protection in England, with the result that development of a preventive approach has been limited. Although the GMC reports that complaints against paediatricians which are related to child protection are rare,⁴⁷ surveys of paediatricians suggest that these type of complaints are common.⁷⁷ Against a backdrop of two high profile cases of disciplinary action and prosecutions of paediatricians for their conduct in child protection cases, fear of complaints have risen and interest in specialising in child protection has declined.^{77,78} On a more positive note, coordination of child protection has improved with

establishment of named doctors and nurses for child protection and a local strategic role carried out by the designated doctor for child protection. The evidence base has also improved, particularly on the accuracy of markers of physical or sexual abuse.^{21,79-82} Paradoxically, these developments have reinforced the forensic role of paediatricians and emphasised practices and documentation to support their role in judicial proceedings.⁸³ Much less official attention has been given to their role in a preventive, public health approach to child maltreatment. Prevention of maltreatment, however, is seen as a core activity for UK community paediatricians, who look after children with disability or behaviour problems.⁸⁴

Part of the reason why paediatric services have not focused on a preventive strategy to child maltreatment is the gap between evidence and practice. Emerging evidence on the epidemiology of maltreatment in the community, the chronic nature of neglect and emotional abuse, the inter-relatedness of different types of abuse and victimisation, and their links with chronic illness and disability, parental and environmental risk factors, does not seem to have been translated into services and practice.

Although research tells us that only a small proportion of maltreated children (included physically abused children) sustain a maltreatment-related injury,⁸⁵ most policy and training has been focused on recognition of inflicted injury.⁸³ Even in an acute paediatric unit, the majority of maltreatment concerns arise with medical admissions rather than injury admissions, although these cases are often labelled as psychosocial problems rather than maltreatment.⁸⁶ To respond to these non-injury maltreatment concerns, clinicians need skills in questioning and listening to children and parents. They also need to understand factors affecting parenting capacity and to create opportunities to observe parent-child interaction on repeated occasions.⁴⁴

As with GPs, service configuration limits the paediatrician's preventive role and their ability to respond to risk factors in the family or environment. Action by paediatricians, like other healthcare professionals, is strongly determined by referral pathways and available services laid down by Government or local services. The scope for early intervention is largely limited to referral to children's social services or referral to CAMHS, both with high thresholds for acceptance, or liaison with the GP or with the dwindling workforce of health visitors or school nurses. Barriers to the necessary provision of mental health treatment are examined in the 2006 BMA report *Child and adolescent mental health*. Other options for therapeutic or supportive intervention, such as offering parenting training, support for drug or alcohol abuse in the parents, violence management, or interventions to improve parent-child interaction are not seen as part of the remit of an acute paediatric service. Very often, healthcare professionals simply cannot directly access these services, usually having to go through social services.

For some children, particularly those who are neglected or emotionally abused, maltreatment is a chronic condition. Yet guidance and protocols tend to focus on responding to acute maltreatment events. Less attention is given to long-term management. There is no official framework, for example, for ongoing care or shared care with children's social care services or other providers of interventions.⁸⁷⁻⁸⁹ For clinicians trying to provide ongoing care, lack of feedback from children's social services is a constant complaint.²¹ Anecdotal reports suggest this has not been eased by the development of Common Assessment Framework (CAF) forms, which have proved lengthy and unwieldy for healthcare professionals. Contact with paediatric services initiated by children's social care services, in the form of requests for medicals, tends to be focused on forensic input rather than wider healthcare needs, and applies to relatively few of the children seen by children's social care services.⁸⁴

NICE guidance 2009 and GMC guidance 2012

The 2009 NICE guidance for health professionals has been an important advance in many ways.⁴⁴ It provided official recognition of the uncertainty faced by healthcare professionals and the fact that they frequently see children who raise concerns but do not reach the threshold for referral to children's social care services.⁴⁴ The guidance defined 'alert features' for recognition at two levels: suspect and consider. Suspected maltreatment should lead to referral to children's social care services. 'Consider' reflects a lower level of certainty. The 2009 NICE guidance recommended further action for these children, including discussion with colleagues or follow up with the aim of gathering further information to decide whether to suspect or exclude maltreatment. In practice, a large number of children are likely to remain a concern but below the threshold for referral to social services. A further advance was the emphasis given to non-injury presentations of child maltreatment and the need for skills in assessing parent-child interactions. The scope of the guidance, however, did not include the question of how health professionals should intervene – apart from referral to children's social care services. While a welcome advance, this guidance might have the effect of reinforcing the notion of maltreatment as a problem of 'diagnosis', rather than as one of recognising children who might benefit from intervention.

The recent guidance from the GMC makes a nod towards a preventive approach, by emphasising that all doctors should understand risk factors for child maltreatment and be aware of supportive services to which they can direct families, such as those run by voluntary community groups.⁴⁷ It also places importance on recognising and recording problems which may seem 'minor', as a series of these problems may indicate a more serious problem. Recognising 'minor' concern also allows for early intervention, though this is not explicitly mentioned in the GMC guidance. Despite the mention of risk factors and minor concerns, the focus of this guidance lands squarely on child protection rather than wider child social welfare, and the main role of the health professional is still seen as supporting social care services.

Health and Social Care Act 2012

Under the Health and Social care Act 2012, responsibility for safeguarding was transferred from PCTs to CCGs and CBs. The CQC will be jointly responsible with Ofsted for ensuring that safeguarding duties are adequately discharged and will monitor safeguarding provision via biennial inspections of service providers. The 2012 report by the Children and Young People's Health Forum expressed the concern that the safeguarding responsibilities of CCGs, CBs and service providers was not adequately clear and called for a Quality Standard to be developed.⁹⁰ The Forum also stated that CQC registration alone was no guarantee that safeguarding duties would be properly discharged.⁹⁰ It remains to be seen how the restructuring of the NHS impacts on child safeguarding practice.

5.5 Children's social care services

Today, local authority children's services are responsible for children's social care, which includes both child protection and child welfare. The 1963 Children and Young Persons Act strengthened by the 1989 Children Act, included a broader welfare remit by requiring social services departments to provide services for 'children in need' (see **Figure 5.2** and **Table 5.2**).⁹¹ An initial referral can be made to local social care services for child protection or for welfare needs, such as family dysfunction, parental illness or child disability.

The multiple remits of children's social care services should, in theory, facilitate a preventive approach, with early interventions offered in response to welfare referrals, as well as attending to child protection. And in the last decade some steps towards a more preventive, public health approach are discernible.

Major policy initiatives in the early 2000s, enacted by the 2004 Children Act, explicitly reiterated the earlier preventive focus of Part Three of the Children Act 1989, by requiring local authority social services to work more closely with health services and other local agencies in order to safeguard vulnerable children, meaning intervening to prevent maltreatment or victimisation (see **Figure 5.2** and **Table 5.2**).^{41,43,92,93} Safeguarding includes promoting the welfare of children in need – defined by the 1989 Children Act as those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development or their health or development will be significantly impaired, without the provision of services.^{41,92,93} Safeguarding is a way of targeting the high-risk population, as shown in **Figure 5.1**, who might benefit from targeted interventions.

One source of confusion about safeguarding is the stated aim to prevent maltreatment happening in the first place. This ignores evidence on the chronic nature of child maltreatment and the fact that professionals outside children's social care services are managing, on a daily basis, 'marginally maltreated' children who are already being maltreated, but who do not reach the threshold for referral to social care services.

Because of limited resources, children at risk of significant harm who require formal child protection investigation are prioritised for assessment and services. This system encourages professionals to label children as needing child protection services, which can be intrusive and punitive, less cost effective and less likely to encourage parental engagement, than providing welfare support for a child in need.

A second problem, is the lack of guidance about where the line of intervention should be drawn in the distribution of parenting shown in **Figure 5.1**. The definition of 'child in need' requires an assessment of the child's likelihood of benefiting from intervention. This, in turn, requires information on the risks of failure to develop or thrive in the long term without intervention and the likely effectiveness of the intervention for improving these outcomes. The prognostic and intervention studies required to inform these assessments are not currently available, leaving decisions about who should be targeted to be based on professional judgement and availability of resources, with inevitable variation between local authorities in thresholds for action.

In England, the important ECM policy agenda and associated documents and tools (see **Table 5.2**) effected a shift in rhetoric, broadening language and policy focus from the sharp end of child protection to include children in need of social welfare services and early prevention.⁹⁴ A similar shift in policy was seen in the Scottish policy *Getting it Right for Every Child* (2005). In England, however, this rhetoric was not necessarily accompanied by any significant change in practice. Referrals to children's social care services have not climbed steeply, as happened in New Zealand, where broadening of eligibility for welfare interventions and easier reporting methods led to a four-fold increase in notifications and a doubling in the number of investigations.⁹⁵ In England, referrals increased only slightly from 4.9 per cent of all children each year in 2002 to 5.6 per cent in 2011, and the proportion of children placed on a child protection plan has remained around 0.3 to 0.4 per cent of all children each year.^{96,97} In addition, there has been concern that the conceptual shift needed to successfully implement tools such as the Framework for Common Assessment did not take place.⁹⁸ Services have largely focused in recent years on forensic investigation and interventions to ensure child safety in response to confirmed or likely maltreatment. Part of the reason has been the lack of infrastructure and resources to implement a broader preventive remit.^{94,99} Another is the ongoing tension between a populist, media-driven focus on culpability – bringing people who harm children to justice – and a focus on improving outcomes for children.¹⁷ The sense of moral outrage about child maltreatment can translate into a preoccupation, even among professionals, with detection and punishment rather than with interventions most likely to improve conditions for children. This tension is illustrated by the string of public inquiries into specific child deaths, which have sometimes extended the finger of culpability beyond parents to social workers and occasionally healthcare.^{66,100} Inquiries into individual deaths and national reviews of the 100 or so serious case reviews each year (death or serious injury where maltreatment was a factor) have had an inordinate

impact on policy, while scant attention has been paid to population-based research.¹⁰¹ Of all the reviews into child protection and welfare services conducted by the government, only the most recent (the Munro review, see **Table 5.1**) has not been in response to a child death.⁹⁹

The Coalition Government, which came into power in 2010, commissioned a review into child protection policy and services over the last decade by Professor Munro, with a view to reform.³³ The review reiterated the importance of a preventive, proactive approach, targeted at vulnerable families. The report focused on social care and how the child protection system could be improved through better understanding of the inherent uncertainty and risk in child protection, the need for professional judgement, and the importance of considering the effectiveness of interventions when responding to child maltreatment. The review also recognised the heterogeneity of child maltreatment and the fact that varied responses are needed. One solution proposed, was more scope for localism and innovation, an approach likely to fit well with Government strategy to open up public services to a range of providers. Expanding the research base was mentioned but insufficiently emphasised. Despite the Munro review's focus on prevention and vulnerable families, there has been scepticism that this can be little more than rhetoric in the current climate. Under Coalition policy, there has been a move to focus services (such as Children's Centres and Sure Start) on the sharper end of social welfare need and there have been cuts to resources needed to offer preventive services.⁹⁹ Despite the focus on prevention in the Munro review, the title betrays a focus on 'child protection' and the term 'safeguarding' seems to have been dropped.⁹⁹ Lastly, there was no vision of investment in robust research for children's social care, similar to the National Institute for Health Research (NIHR) investment in applied research for health, and recently for adult social care, to inform practice across the NHS and social care.

The review did recognise the importance of other public services, schools, primary care and adult mental health services specifically to aid social care in their proactive, preventive approach. Details were lacking, however, about how other public services could intervene early in response to concerns about child maltreatment, when the threshold for child protection investigations has not been reached.

5.6 Future directions

The research evidence favours a shift towards a public health, preventive approach to child maltreatment, away from a forensic approach focussed on immediate safety and culpability. Lessons from epidemiology suggest that prevention involving universal support for families has the potential to have the greatest impact, by shifting the curve towards support for effective parenting.¹⁰² There has been some progress towards universal support for families in the last 10 years but the political rhetoric has failed to meet its potential in terms of service change. This seems likely to continue to be the case in the present political and economic climate.^{103,104}

Two areas need urgent development in the future. First, a greater focus on healthcare services for parents as a way of preventing, recognising and responding to child maltreatment. Evidence of such activity is starting to emerge, with official recognition of the potential role of adult mental health services,³³ and trials involving early intervention by clinicians to address parental problems in order to reduce maltreatment.^{73,105} Inclusion of GPs in this vision for early intervention needs to be expanded and evaluated in the UK. Proactive, preventive roles for GPs and paediatricians, particularly where child maltreatment is chronic, will require access to social welfare interventions outside the direction of children's social care services. Given that one role of the Local Children's Safeguarding Board is to map local organisations to facilitate help and support for vulnerable children, perhaps this body could play a part in aiding healthcare to access these types of interventions. The recent Munro review emphasised the importance of Local Children's Safeguarding Boards but it is still unclear whether or how their role in relation to healthcare services will be developed as the NHS continues to be reconfigured.³³

The second area for development is the research agenda. Unless we can provide evidence of effectiveness of preventive interventions on a population basis, the focus is likely to remain on culpability and children's immediate safety where interventions are coercive and sanctioned by law. Early interventions potentially affect many more families, they usually depend on voluntary participation, and they need to be acceptable and helpful. They also need to show benefits outweighing harms, using valid measures of child wellbeing. The same logic needs to be applied to coercive interventions, particularly where early intervention and coercion converge – in the removal of young children from their parents – now more common in England than in most other western high-income countries.^{29,50}

As the research base develops, the heterogeneity of child maltreatment and need for diverse intervention strategies is likely to become more apparent. We need to recognise how thin the evidence base is to support the drastic ways we intervene in children's lives and invest to find out what works, when and for whom.

5.7 Recommendations

Policy and research

- Future policies to tackle child maltreatment should take a public health approach and focus on preventive and family welfare services to improve support for parenting. Research evidence suggests that this approach, rather than a forensic approach of diagnosis and establishing culpability, is likely to make most impact on child maltreatment and child welfare.
- Robust population health research should be used to inform policy, rather than enquiries into individual child deaths.

- In the area of child protection,^a use of routine data and linkage of data from health, social care, the judicial system and education is essential for understanding which professionals are coming into contact with children and patterns of this contact, which children might not have any early or preventive services, where services might be duplicated and which outcomes are linked to input from which services.
- There is an urgent need for randomised controlled trials to evaluate which interventions work and for whom. These studies are needed both for preventive social welfare interventions and for the coercive interventions such as out-of-home care.

Practice

- Healthcare should play a more clearly recognisable role in addressing the health determinants and consequences of child maltreatment.
- Healthcare practitioners should focus on targeting families who stand to benefit from effective interventions to improve parent-child interaction and thereby reduce the risk of child maltreatment and its consequences. Clear guidance is needed on how healthcare professionals can access therapeutic interventions directly, without always going through social care services.
- GPs should be given a more proactive role in the ongoing support, monitoring and management of parents whose health needs increase the risk of harmful parent-child interaction.

^a Please refer to the BMA's toolkit on child protection available via the BMA website.