

Report of the Proceedings at the children's Panel National School 2008  
held in Dunblane Hydro Hotel from Friday 14 – Sunday 16 November.

I attended the National School as a representative for the Scottish Association of Children's Panels, and the report is presenting my own impressions and views of the event.

The theme for the weekend was **'ABUSE and BEYOND'** and the conference was chaired by **Barbara Hudson from BAAF** ( Scotland ) {British Association for Adoption and Fostering}. She chaired with skill and humour, despite the theme, pointing out how apposite the theme was , with the three cases currently in the media and courts: Baby 'P' in Haringey; Shannon Matthews; and the report on the Social Work Department in Aberdeen. She said that the most effective child protection system is a responding, caring adult, and if a child does not have one in its life, the caring professions have to pick up the pieces.

First to speak was **Bruce Thomson from the Aberlour Trust, - 'Working with Children and Parental Substance Abuse'**

41,000 – 60,000 children are affected by parental drug use, and even more by parental alcohol abuse, these parental problems causing serious harm to children at every age from conception to adulthood. Effective treatment of parents can have major benefits for a child, and services need to work *jointly* to protect and improve health and well-being of the children affected. Substance abusing parents' behaviour affects their children in various ways - they are not always around; the environment is unsafe; parenting skills are poor; they may be intoxicated; strangers visit the home. Children feel stigmatised by living in such circumstances, and can be challenging to work with - eg they won't keep appointments.

Substance misuse is associated with : poverty and deprivation; poor physical and mental health; poor housing; debt; offending; unemployment – *but*, these things are not always predictable, and the level of impact is variable;

The **very early years**: significant harm can be done, and it is difficult to make up a lot of the ground, eg attachment issues. These children receive poor stimulation and social experiences.

**Older**: lack of consistent care ; stigmatisation; low levels of attachment; feelings of guilt; taking responsibility for siblings.

12 – 16 years: criminality and substance abuse becomes the norm; lack of role models (especially male); unsupported transition from primary to secondary school.

Society is more tolerant of alcohol, but abuse of alcohol has a similar effect and impact. Tolerance affects policy-making, planning, how services approach alcohol, and you get delays in identifying the problems - when should a child be removed from home? Some form of respite might help, or weekend fostering. The effects are cumulative, so that early identification and assessment are needed, and this should be multi-agency and of high quality.

We need to know 1) the nature and level of risk in leaving the child with the parents  
2) the benefits for the child in remaining with the parents

and have to take various factors into account:

- a) the type and level of substance abuse - binge drinking, injecting etc
- b) the history of the parents' engagement with services
- c) the parents' insight into the impact on the child
- d) the safety of the child's environment
- e) the availability and quality of other care options

Protective factors are:

- f) a stable, consistent, caring adult
- g) sufficient income and good physical standards in the home
- h) friends
- i) time away from home
- j) involvement in out-of-school activities
- k) a good degree of self-esteem

Aberlour runs a 'Work Positively' programme –

typical referrals : long-standing parental drug and/or alcohol problems  
usually known to Social Services  
Low socio-economic group  
Commonly opiate users

Due to this programme, improvements can occur:

- risk reduction
- resilience ; ability to thrive within the family and community
- parenting ; consistent, positive parenting
- dependency; parents achieve positive changes in regard to substance use
- life skills ; families participate fully in community life, improve literary skills

The workers try not to focus on the *intent* of the *adult* but always have to be aware of the impact on the child.

Aberlour also does work with the fathers, but it is not a residential service .

There then followed a workshop, looking at the impact on children of various ages of the substance abuse of their parents, before being left to our own devices for the rest of the evening. I was lucky enough to have Professor Marina Barnard in my group for the exercise, having heard her speak at the West of Scotland day at the Beardmore centre in October. No one else in the group seemed to realise that they had one of the next day's speakers in our midst, and she added very knowledgeable input to the discussion.

Saturday morning began with our old friend Boyd McAdam giving an update on 'Abuse, Visibility and Getting It Right for Every Child (GIRFEC).' There are four pathfinders for domestic abuse, and Highland is about to implement the GIRFEC Plan. The Indicator Wheel looks at where a child is, where it should be, and it is then possible to work out if progress is being made. The triangle looks at the child as a whole. The information needs to be plotted against the Resilience Matrix. Each agency will keep its own database, but GIRFEC pulls it all together – if there is progress, the plan is working; if not, it must be renewed, and agencies should be doing this on a day-to-day basis. It is about *individual* children, each with its own map. (This information was illustrated with coloured charts which should appear in the official report of the week-end, so that all is made clear!!)

There are 14 data-sharing agencies across Scotland, and in 2-3 years the model should be technically available. It will then be up to local areas to decide how they use it, and train their staff. How the voluntary sector becomes involved is being looked at. They will be brought in to the information-sharing technology at a low and safe level, with protections.

**Dr Elizabeth Myerscough – consultant paediatrician in Grampian** – then took the floor and gave an absolutely riveting talk; '**Ancient History; Modern Times**'.

The Karen Matthews case – how do we tease out the real woman, and what is happening to her child? **Look at the evidence** – not just factual information, what is in published literature. Some of these processes are not new.

Baby 'P' - Lord Laming pointed out how the art of concealment was employed to prevent the truth being known. We have to be 'streetwise', and sceptical, not taking things at face value. We must not fail to recognise that the *child* is the client.

The Roman Forum in 500BC was a place of factual and logical argument, and this is the root of our word 'forensic'. Hippocrates 450 – 380BC looked for rational explanations rather than superstition, and took the holistic approach, observing symptoms, and using natural healing. He gave the medical model which pertains to this day -

- History
- Examination
- Investigation
- Diagnosis
- Prognosis
- Treatment

Case: 12 month old girl

Social Worker - has heard of several years of chaotic maternal substance misuse. There was SW input during pregnancy, with no obvious change observed. Mum was still producing dirty urines.

Mum - weeps. Maintains she has been to all her appointments. She would never harm her child, etc

Health Visitor- has observed the child is not growing, and has given dietary advice.

Mum - maintains she always feed the child well, but her family are all small

H.V - the child is not using her Left arm. She should be having physiotherapy, but is not improving. The child looks very 'blank'

SW - If the child doesn't seem well, Mum doesn't interact with her. Mum needs help – there is a risk of lack of attachment.  
Family Centre- concern about a bruise – a bite?  
Mum - another child must have done it  
So, over all, we have - Substance misuse  
Poor growth  
Neglect  
Lack of stimulation

Should the child be staying with Mum? -should she be on Supervision?- should she be reviewed?  
.....you have worries! What to do?

Go to the source for information , not the SW, but the Abuse Worker. Will get much better information as to where Mum is at this time, and you find out Mum is doing OK ( although the figures on relapse are high)

Medically there is no threshold for referrals to police for NAI – it has to be 'beyond reasonable doubt' ( in the 90%). The Hearing System works on 'Balance of Probabilities', more 50%

There are two ways to examine children coming into the system:

- 1) All should have a Comprehensive Medical Assessment, done usually by a consultant Paediatrician. This can provide immediate treatment, and identify health needs.
- 2) Forensic Examination is different.  
5% of all children have faltering growth ( of whom 5% are abused or neglected)  
1% of all children are abused or neglected ( of whom 25% have faltering growth)  
*Once a child starts on a growth line it stays on it.*  
The older you get, the slower the child's recovery – do not go round the block again; 'Failure to Thrive' can become permanent

Evidence on bites: There is an overlap between a small adult / child in size of bite. Cannot say by looking whether it was done by an adult or a child, although occasionally a forensic odontologist can be brought in to look. There is no such colour as 'bruise'. Because a bite is undetermined, does **not** mean it is suspicious.

Back to our case history 12 month old –

Mum was working with the substance abuse worker  
Child was growing normally  
Child was not getting better with physio – because the child has a brain lesion  
Child looks 'blank' – child is having absence seizures

So you end up with a totally different perspective – mum needs structured support, and the child has complex long-term needs. There is a significant maternal history.

Healthwise the child will be seen every 3 months to monitor her fits.

You may want statutory measures, but maybe there are enough safeguards in place as long as **someone** ( the right person) is monitoring.

We should expect:

Comprehensive written factual reports  
Expert reports  
Analysis of reports  
Demand a high standard of oral evidence  
Ask for gaps in information to be completed  
Ask for experts to attend  
Read literature

Many agencies are not used to giving oral evidence!

Reports: there is danger in interpreting the information given by other people. It is better to have the 'direct' voice – you can 'phone a consultant, get a letter e-mailed.

( Boyd added that down the GIRFEC line, the original letters should be available electronically. )

### **Professor Marina Barnard then spoke on 'Practitioner Responses to Parental Drug Misuse & Neglect'**

Helpful friend or hostile intruder?

Prof. Barnard's research has been done with 173 family members, and she is amazed that there had been so little formal intervention in regard to parental drug misuse, Why was this? Was it just because it was a small sample, 100 cases in London, covering 4 boroughs. Most referrals had been from SW because of an incident, eg burns, unexplained NAI, but there were some from the public, but these tend to be considered to lack credibility. There were **none** from GPs. One 15-year old 'thought nobody cared', having seen all the agencies coming through the house, but not really *doing* anything for her.

What reasons?

- Because it is a hidden problem
- It is a massive problem - 4 – 6 % of children in Scotland
- The severity of the problem has been unrecognised until recently at policy level.

It is **difficult** work, stigmatising. It is **consequential** – the child could end up in care ( and think ‘care’ is bad for children). It is **intrusive** – we hold on to the notion of ‘family’. It is **conflictual** – likely to ‘kick off’ – SW experience high levels of aggression, therapeutically undermining. It can be very anxiety-provoking work, stressful.

The same issues keep coming up in reference to child protection, because it is intrinsically difficult. A litany :

- poor communication across agencies
- poor assessments
- ineffectual decision-making
- poor information recording
- unwarranted optimism

Lord Laming’s last report involved a lot of procedural changes, but it didn’t affect the work on the ground.

**The decision-making process:** Mum is on methadone. Child of 10 years plus a baby. 10-year old is looking after the baby. People tended not to notice the 10-year old, because the focus was on the baby. They tended to view it as a temporary problem, needing an ‘in house’ solution, and searched for mitigating reasons. The primary focus was on the parent; they tended not to look at patterns of recent history. The 10-year old was ignored.

Suggested actions:

- resolve parental stress - increase the methadone
- get home support
- involve extended family
- wait and see ( tomorrow, next week)
- do nothing - insufficiently serious ( had worse cases, relatively)
- if you have too many cases, it can impede the ability to look critically at the case you are dealing with

“ The least stigmatising interpretation of available data and the least overtly co-ercive possible disposition” *Dingwall*

We all want to think the best of people. We have to work consensually with parents to bring about change. With a good relationship we can:

- get into the house
- achieve co-operation through familiarity and trust
- keep a watching brief on the family

It is a balancing act.

Sometimes SW get to the stage where they think **any** relationship is better than **no** relationship, but in terms of Child Protection, it is not effecting any change at all. The tariff in a neglect case is very high. Who is setting the agenda? Is it the parents? – in their ‘allowing’ entry to the house in the relationship. We have to be **critical**, looking closely at information volunteered by parents. The supervision of the on-the-ground social worker also needs to have this critical approach, in case the SW is not too experienced.

We should be helping people to get stable with drug use.

Preventing girls getting pregnant by default.

A properly trained workforce, properly supported is essential to protect children.

We need to know how many.

We need to have pro-active prevention

We need clear protocols

We need well supported staff.

Do we **see** ‘the child’? The system has to be **right**.

The second workshop considered practice and thinking, looking at a case study on a 6-week old baby with a mother on methadone, and a partner with chaotic substance misuse – the effect on a foetus; the effect on a new baby of parents adjusting to all the new stresses etc. , and whether a Child Protection Order should be continued. One interesting fact emerging was that the mother maintained the opiates showing up in her urine were as a result of eating seeded bread – and we were assured that this could be true. Several of us remained sceptical! The second case study was on a single parent family ( father had died) of 4 young children, and mother was not coping in terms of hygiene, and was neglecting the children. What would be the panel’s approach?

After lunch we had **Gill Levy** from **Barnardo’s** talking on ‘ **Traumatised Systems**’ – the impact of **childhood sexual abuse**.

Gill Levy works with Barnardo's Skylight Project.

- 1) **The extent:**

It is estimated that 20% of females and 5 – 10% of males have experienced child sexual abuse (CSA). Most are abused by people they know, or family members ( 87%)  
The cost of treating survivors is estimated at £80 million.  
Only 1 in 9 cases of CSA is reported, of which 10% go to court, and 5% result in conviction. We now have the Vulnerable Witnesses Act to help support victims in court.
- 2) **Recognising CSA:**
  - This can come from disclosure.
  - From genital injuries; sexually transmitted disease; pregnancy
  - From sexualised play, usually acting out explicit sexual activity; knowledge of sexual activity ; sexual drawings, stories or poems
  - From suicide attempts, self-harming , depression
  - From alcohol and drug abuse
  - From self-mutilation of the breast/ genitalia
  - From being sexually active, involved in prostitution
- 3) **Impact:**
  - post-traumatic stress disorder symptoms - nightmares, flashbacks
  - isolation, withdrawal, depression
  - substance misuse, self-harm
  - inappropriate sexual behaviour in view of the young person's age or development
  - wetting and soiling
  - hyper-vigilant, fearful, anxious
  - development of coping mechanisms – denial, dissociation

Psychological Impact:

  - poor concentration
  - guilt, shame, feeling 'different'
  - low self-esteem, self confidence
  - depression, suicidal feelings
  - anger, hostility
  - anxiety, fear, preoccupation with morbid or frightening things
  - confusion about sexual norms/ identity, sex, love, care-getting

Long-Term Effects

  - physical - pregnancy, STDs
  - affects feelings about themselves
  - affects relationships with intimacy when older
  - can affect concentration and intellectual ability
  - can affect future development
  - difficulty in protecting their own children from abuse
  - mental health difficulties

Factors influencing Trauma experience:

  - parents' reaction of disclosure
  - length of time over which abuse occurred
  - relationship of abuser to child
  - number of abusers
  - nature of abuse
  - level of aggression or threats used
  - compliance / bribes - child's sense of 'participation'
  - coping mechanisms /resources of child's internal and support system
- 4) **Disclosure;**

Why is it hard to disclose?

  - young children see it as 'normal'
  - there is an investment of trust in the friendship – they love the individual, not what they are doing
  - secrets - manipulation of child to keep secrets, joint secrets
  - fear of punishment – use of threats, fear of not being believed
  - corruption of the child
  - child's confusion - shame, guilt, embarrassment

**Retraction:**  
Following disclosure, fears can be founded: abuser denies; mother disbelieves; children are accommodated; child blamed for causing the mess!

Role reversal continues - 'bad' choice is the truth; 'good' choice capitulates and restores a lie for the sake of the family.

Beneath the anger remains an ambivalence of thoughts about the abuser.

4) **Systemic Issues:**

- it is difficult to disclose
- the non-abusing parent
- family impact / community impact
- contact / re-unification
- child's view – put in context why the child wants contact with the abuser

**The Skylight Project** - Edinburgh & the Lothians

Aim is to alleviate the impact of sexual abuse, working with children up to 18

- through individual work and group work
- parent work - working with non-abusing parents
- family work
- training and consultancy

Single parents can be targeted - the abuser offers to baby sit, etc

Therapeutic Work:

- reframe thought distortion – self blame
- understand behaviour / feelings in the here and now and possible links to the abuse
- enable the child to express abuse-related feelings; anger, ambivalence, fear, stigma, powerlessness, revenge
- address fears for the future - sexuality, intimacy, becoming an abuser
- distress-tolerance skills

It is now possible to work with children before a court case, but must ensure that evidence is not contaminated. Counselling can be provided, and will over-ride the court process. There are guidelines, and the Vulnerable Witness Act has helped.

**Peter Yates** from **Barnardo's Lighthouse Project**, based in Edinburgh

This is a small project dealing with 10 –18 year olds who have abused other children, and display harmful sexual behaviour.

Between 1/5 – 1/3 of all sex abuse cases involve young people as perpetrators:

- 'teenager gets 9 years for supermarket rape' - a 15-year old male with a history of sexual dysfunction
- 'kissing game lands boy (11) on sex charge'
- 'sex offender's son (9) charged with rape' ( of 3-year old girl) –referred to the Reporter

Different feelings come up in relation to these three cases. These are *children*, first and foremost. Public protection concerns may supercede child welfare principles, but we need to respond professionally to these children and not go down the road of punishment.

What kind of language can we use to communicate with these children who have displayed harmful sexual behaviour? ( abusive sexual behaviour; inappropriate sexual behaviour; sexual offence; problematic sexual behaviour ) As panel members, we need to prepare well – acknowledge our own feelings and think about the whole child, including the harmful sexual behaviour, but which isn't defined by their harmful sexual behaviour. In general, the more we engage with these things, the more comfortable we are with the topic and better able to find the correct language.

**Recidivism Rate:**

- **18%** re-offend if there is no specialist intervention, but these may be the more serious and persistent offenders.
- around **5%** of young people who have used specialist services go on to re-offend

Different concerning behaviours require different levels of intervention, the base of the triangle being



applied first.

A good assessment should include and cover these four domains:

- the family
- the environment
- the offence
- child development.

It should draw on using a risk-assessment framework using AIM2 or J-SOAP11 ( the kind of tests used for adults are **not** of any use for children)

Questions on assessment should answer:

- why did the child offend? – what was its pathway there? It is less likely to re-offend if we understand and deal with it .
- Pre-pubescent children - chances are they have been sexually abused
- Adolescents – more complex – study shows that only 50% have been sexually abused, but there is a link with witnessing domestic violence.
- How likely are they to offend again?
- Who might they offend against?
- In what circumstances?
- What do we do to manage these risks now?
- What do we need to do to reduce these risks in the future?

**Typical Therapeutic Needs and Characteristics:**

- majority are boys
- age 14+ - although can have raised concerns earlier
- poor sexual knowledge
- poor social skills
- significant childhood trauma ( not necessarily abusive)
- poor impulse control, learning disability ( up to 1/3 of children with sexual behaviour problems show learning disabilities
- lack of daily structure and positive goals
- offend-specific work

We need a coherent, holistic approach.

**Decision-making by Panel Members:**

- The Reporter's decisions before we get involved – on offence grounds? - on welfare grounds? – if the former it will give the young person a conviction on sexual offence grounds.
- do we introduce compulsory measures or not?
- implications for disclosure checks
- conditions of attendance and the 'No Order' principle - the most helpful thing is to undertake therapeutic work ( to decrease risks). Maybe we should make their attendance at a specialist project compulsory – they will not *want* to, therefore *should be compelled*. Denial of their offence is **not** a barrier to being able to work with these young people.
- Condition of residence – what does he have to do to make it OK to have contact with his sister, or move back home? These decisions should be made in a multi-agency context, and panel members can ensure this is done.

Workshop three then ensued, looking at Victim/Perpetrator dilemmas. Reeling slightly from all the excellent information we had been exposed to, we then had a break before the drinks reception hosted by the Scottish Government and Stirling Council, a tasty dinner and a ceilidh and dance. At 1.30am or thereabouts, the fire alarms sounded, and everyone had to leave the hotel, in states of dress varying from party gear, to nighties and pyjamas ( with or without shoes or slippers!) Fire appliances came quickly, fortunately it was not raining ( although cold) and eventually we were allowed back into the hotel.

Sunday morning started with **Helen Hunter** from **Children First** speaking about **Communicating with Children.**

**Why communicate?**

- UNCRC ( United Nations Convention on the Rights of the Child) and Scottish Government policy dictates that the views of the child should be heard.
- children are a competent source of evidence in regard to their own abuse or neglect
- children need the opportunity to make sense of events which may pose a danger to their development.

**The Children's Charter:**

- get to know us
- speak to us
- listen to us
- take us seriously
- involve us
- respect our privacy
- be responsible for us
- help us be safe

The importance of direct communication is significant. Do you see the child's voice coming from the SW report?

We were then shown a clip of children using Childline, which along with Parentline is available to all. Children pick up non-verbal clues.

They say that being hit makes them angry, ashamed, guilty and sore

Most parents believe smacking children is wrong

Many children think that adults never listen. On average abused children have to tell their story **three times** before they are believed.

Understanding child development and how the environment and life experiences influence that are key to helping, but here is no one 'style' or method that works with all children.

**Positive Qualities:**

- listening to and understanding the child
- maintain a non-biased approach
- maintain personal neutrality about any issues raised
- manage personal response to any distressing material the child tells
- adopt perspective that the child is the expert, not the adult
- convey genuine empathetic concern
- use open-ended, non-biased approaches
- if the adult doesn't ask, it is unlikely he/she will be told
- allow children to tell their experiences freely

**Avoid**

- maintaining assumptions and biased views
- employing leading questions
- a pressuring method of enquiry eg "come on, now, you must know what happened"

The Advocacy Service provides a person who builds up a relationship with children in a short space of time, that is age appropriate.

Children First's Directions Project in N. Ayrshire runs parallel parent / child groups

**Responsibility:**

- children have responsibility
- what responsibility do adults have?
- parental responsibility

Life-sized puppets are used to 'act out' scenarios with the children, to help to communicate.

A workshop on 'Communicating with Children' then followed, looking at how, having heard Helen, as panel members we might approach things differently to help children communicate in the hearing situation.

The final speaker was **Dr Emma Hepburn - 'Don't Forget about Emotional Abuse'**

Her aim was to raise the awareness of emotional abuse, to define it, and highlight the impact.

**Emotional Abuse** can be defined as the persistent emotional maltreatment of a child such as to cause severe persistent effects on the child's development.

- OR/
- emotional unavailability - parents unable to respond to a child's needs
  - negative responses - hostility, rejection, child being blamed
  - developmentally inappropriate or inconsistent interactions with the child
  - failure to recognise the child's individuality or psychological boundary – fictitious illnesses, etc
  - failing to promote the child's social adaptation

Lots of situation could *potentially* be emotionally abusive, but to *actually* be, it must:

- must be pervasive and characteristic of the parent/child relationship
- must describe the child/parent relationship, not one event
- except if it is exposure to traumatic events – even on one occasion
- emotional abuse is not one construct

**Emotional Abuse:**

- includes intent/lack of intent and omission/commission
- is a constituent element of all forms of abuse
- overlaps with domestic abuse
- can occur without other forms of abuse
- occurs across all parental backgrounds

According to NSPCC statistics, 1.4 million children in the UK feel unloved!

Emotional Abuse is difficult to identify:

- usually no disclosure
- child is unlikely to report it
- hard to identify as the marks are *inside*
- range of behaviour indicators
- require multi-agency links to identify
- lack of general awareness.

Barbara Hudson then drew the weekend to a close, and off we all went – with a mass of information to digest, all so relevant at this particular time, and becoming more so as the weeks have followed. An excellent week-end, excellent speakers, a good venue, good food, good company – a well worth while exercise.

Joyce H Noble