# Contemporary Developments in Child Protection

## Volume 1: Policy Changes and Challenges

Edited by

Nigel Parton

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Nigel Parton (Ed.)

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## Volume 1

## Policy Changes and Challenges

MDPI

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# About the Guest Editor

**Nigel Parton** is Professor in Applied Childhood Studies at the University of Huddersfield, England where he has worked for most of the last forty years. A social worker by background he has written and edited over twenty books and a hundred articles and chapters on the broad areas of child protection, child welfare and social work and in recent years has developed a particular interest in studying and comparing child protection policies and systems in different jurisdictions. Recent books include 'Child Protection: International Trends and Orientations' (edited with N Gilbert and M Skivenes. New York: Oxford University Press, 2011) and 'The Politics of Child Protection: Contemporary Developments and Future Directions' (Basingstoke; Palgrave/Macmillan, 2014).

# Preface

## Developments in Child Protection: Foreword(s) for Three Book Volumes

The last forty years has witnessed increasing public, political and media concern about the problem of child maltreatment and what to do about it. This is now evident in most jurisdictions and is receiving serious attention from many international and trans-national organisations. While the '(re)discovery' of the problem in the USA was particularly associated with the 'battered baby syndrome' this has now broadened to include: physical abuse, sexual abuse, neglect, emotional abuse, abuse on the internet, child trafficking, female genital mutilation, sexual exploitation and refers to all children and young people, not just babies. Similarly, the focus of attention has broadened from intra-familial abuse to abuse in a whole variety of settings including schools, day care centres, churches, youth and sports clubs and the wider community more generally. There has also been a broadening of concern from not simply protecting children and young people from serious harm to also attempting to prevent the impairment of their health and development and to ensure that they are able to grow up in circumstances which are consistent with the provision of safe and effective care so that all children can achieve the best outcomes.

In the process, the laws, policies, practices and systems which have been developed to try to identify and prevent child maltreatment have become much more wide-ranging and complex and have themselves been subject to continual criticism and review. A wide range of professionals and members of the community are all seen to have key roles to play in both protecting children and young people and also assessing and monitoring actual and potential perpetrators.

However, while these issues have been subject to often heated and high profile media and political debate, rarely have they received sustained analytic and research attention in the social sciences. It was in this context that the internet journal *Social Sciences,* in 2013, invited papers for publication in a *Special Issue* dedicated to the topic and these were published from July 2014 onwards. In the event thirty papers were accepted for publication—far and away the highest number of papers submitted and accepted previously for a *Special Issue* in the journal. Authors came from a range of countries including: Australia, Belgium, Canada, England, Ethiopia, France, Netherlands, New Zealand, Scotland, South Africa, Spain, and the USA. Sixteen of the thirty papers were based on original research, ten provided a policy analysis, two were based on particular practice developments, one was a literature review, and one provided a more theoretical/conceptual piece. Authors came from a wide range of disciplinary backgrounds including: sociology, history, social policy, sports science, psychology, social work, education, law and various branches of health and medicine. The focus of the papers was diverse, though they did tend to cluster around a number of themes and it is these that have provided the rationale for the organisation of the papers into the three published volumes; however, the process of organising and ordering the papers proved a particular challenge. There are ten papers in each volume.

**Volume 1: Policy Changes and Challenges**

Volume 1 takes as its central theme the ongoing and challenging issues which child protection agencies have to address and the policy and practice initiatives that are developed to try and address these. The volume includes papers on: the relationship between the decline in the rate of ‘unnatural’ deaths and the growth of concern about child abuse in the USA between 1940 and 2005; mandatory reporting; the balance between providing urgent intervention and meeting chronic need; risk and the Public Law Outline in England; the nature and implications of ‘child centred’ policies; the impact of intimate partner and family violence; the intended and unintended consequences of high profile child abuse scandals; developing multi-disciplinary team work in a health setting; and the possibilities of technology-based innovations in prevention programmes.

**Volume 2: Issues in Child Welfare**

Volume 2 is primarily concerned with how best to respond to maltreatment ‘within’ the family and hence has a range of papers which are much more concerned with the area of policy and practice more traditionally framed in terms of ‘child welfare’ and social work with children and families. It also includes a paper on how to respond to child maltreatment and neglect in a large hospital context.

**Volume 3: Broadening Challenges in Child Protection**

Volume 3 takes a somewhat broader brief and reflects many of the changes over the past twenty five years in terms of the broadening of concerns from maltreatment within the family to maltreatment in a variety of extra-familial contexts, including: sport, the internet, various institutional settings and is much more concerned with sexual abuse and the challenges for criminal justice and public protection.

Nigel Parton
*Guest Editor*

# The Relationship between "Protection of" and "Violence Against" Infants and Young Children: The U.S. Experience, 1940–2005

**Jack E. Riggs and Gerald R. Hobbs**

**Abstract:** Between 1940 and 2005, in the United States, the rate of unnatural death declined about 75 percent in infant and young child boys and girls; a remarkable indicator of successful child protection. During this same period, the rate of reported homicide in infant boys increased 64.0 percent, in infant girls increased 43.5 percent, in young child boys increased 333.3 percent, and in young child girls increased 300.0 percent, a dismal and disturbing indicator of failed child protection. Can these simultaneously encouraging and discouraging observations be reconciled? The four categories of unnatural death, homicide, suicide, motor vehicle accident (MVA), and non-MVA, are mutually exclusive classifications. Correlations between the four categories of unnatural death among U.S. men and woman in all age groups for the years 1940 through 2005 were calculated. A negative correlation between homicide and non-MVA death rates was shown for all age groups, encompassing the entire human lifespan, in both genders. This consistently observed negative correlation was only observed between homicide and non-MVA death rates, and was not demonstrated between other causes of unnatural deaths. Moreover, this negative correlation was strongest (less than −0.7) in infants and young children. These observations are consistent with the suggestion that as the rate of unnatural death in infants and young children dramatically declined, society gave greater scrutiny to those fewer occurring unnatural deaths and demonstrated an increasing propensity to assign blame for those fewer deaths.

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## 1. Introduction

Over the past several decades, the problem of infant and child abuse, maltreatment, and neglect has received increased public notice and awareness [1–3]. The magnitude of fatal child abuse has likely been underestimated [4,5]. Infant and child homicide are most frequently the result of abuse by a parent or custodial adult with psychiatric dysfunction [6–8]. In the United States, infant and child homicide became the focus of increased attention in the 1960s [9,10]. Of note, identified risk factors in infant homicide and accidental death are similar [1,11,12]. Moreover, head injury is frequently observed in both intentional and accidental deaths in infants and young children [13,14].

Unnatural deaths may be classified into one of four mutually exclusive categories: homicide, suicide, motor vehicle accident (MVA), and non-MVA. Infants and young children (less than five years old) do not commit suicide. Consequently, there are only three broad classifications of unnatural death in infants and young children.

When classifying two mutually exclusive causes of unnatural death, their relative frequency may be important. For example, if A and B are two mutually exclusive causes of unnatural death and A is much more frequent than B, then those cases in which some ambiguity in the classification exists there may be a tendency to classify the unnatural death as A. However, if A becomes less frequent relative to B and the sensitivity to recognizing B increases, then there may be an increasing tendency to classify ambiguous unnatural deaths as B. Accordingly, when infant and young child reported non-MVA accident mortality rates were both absolutely and relatively high compared to infant and young child homicide rates, underascertainment of homicides was both understandable and predictable. However, as reported infant and young child and infant non-MVA mortality rates absolutely and relatively declined compared to infant and young child homicide rates and societal recognition and sensitivity to infant and young child abuse, maltreatment, and neglect increased, a propensity to assign a homicide classification over a non-MVA death classification as a cause of unnatural death also became conversely understandable and predictable [15–17].

In this analysis, the correlations between the four categories of unnatural death among U.S. men and woman in each age group spanning all ages were examined in order to determine whether further credence and support for the hypothesis that changing propensities to classify infant and young child unnatural deaths as homicides or non-MVA deaths occurred.

## 2. Methods

The data used in this study is publicly accessible from the National Center for Health Statistics [18]. Mortality rates (per 100,000) for unnatural deaths (including homicide, suicide, MVA, and non-MVA) and for all age groups (0 < 1 years, 1 < 5 years, 5 < 15 years, 15 < 25 years, 25 < 35 years, 35 < 45 years, 45 < 55 years, 55 < 65 years, 65 < 75 years, and 75+ years) in the United States for the years 1940 through 2005 in men and women were utilized.

Correlations between annual mortality rates for each of the four categories of unnatural death (homicide, suicide, MVA, and non-MVA) were calculated in each age group spanning all ages and by gender.

## 3. Results

Annual unnatural death rates (per 100,000) for U.S. infant boys and girls are shown in Figures 1 and 2 respectively. Infant boy annual unnatural death rates decreased from 145.9 in 1940 to 35.7 in 2005, a 75.5 percent decline. Infant girl annual unnatural death rates decreased from 122.9 in 1940 to 31.8 in 2005, a 74.1 percent decline. Annual homicide rates (per 100,000) for U.S. infant boys and girls are shown in Figures 3 and 4 respectively. Infant boy annual homicide rates increased from 5.0 in 1940 to 8.2 in 2005, a 64.0 percent increase. Infant girl annual homicide rates increased from 4.6 in 1940 to 6.6 in 2005, a 43.5 percent increase.

**Figure 1.** Annual unnatural death rates (per 100,000) in U.S. boys (infants, aged 0 to less than 1 year) for the years 1940 through 2005.

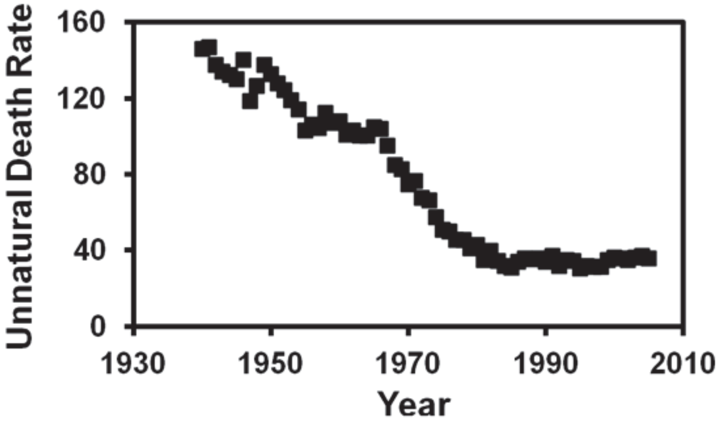


**Figure 2.** Annual unnatural death rates (per 100,000) in U.S. girls (infants, aged 0 to less than 1 year) for the years 1940 through 2005.

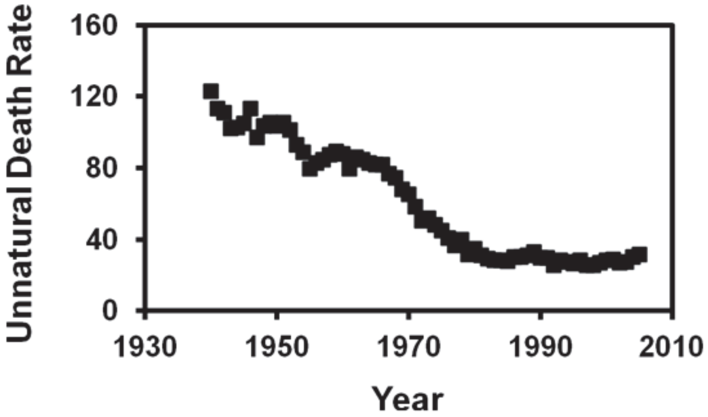


**Figure 3.** Annual homicide rates (per 100,000) in U.S. boys (infants, aged 0 to less than 1 year) for the years 1940 through 2005.

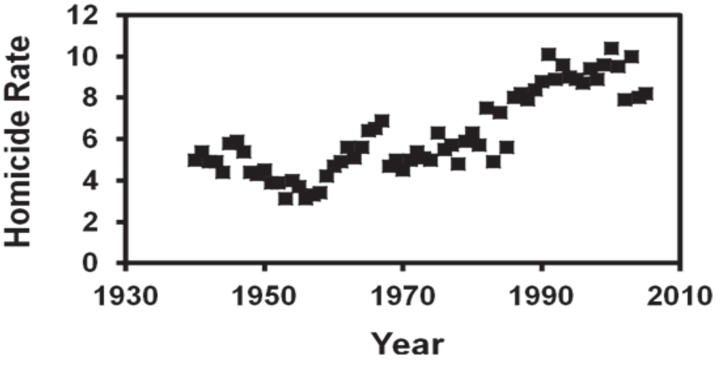
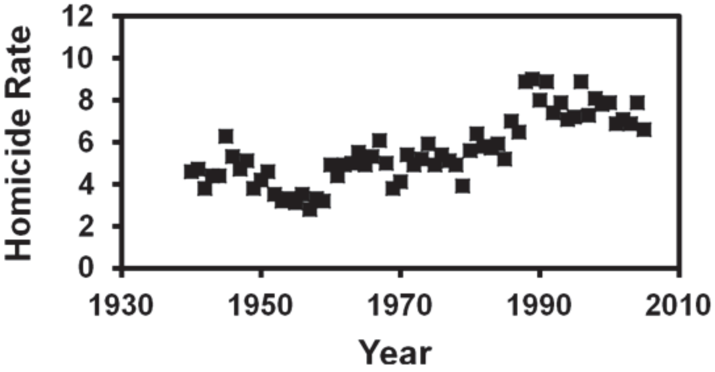


**Figure 4.** Annual homicide rates (per 100,000) in U.S. girls (infants, aged 0 to less than 1 year) for the years 1940 through 2005.



Annual unnatural death rates (per 100,000) for U.S. young child boys and girls are shown in Figures 5 and 6 respectively. Young child boy annual unnatural death rates decreased from 57.5 in 1940 to 15.0 in 2005, a 73.9 percent decline. Young child girl annual unnatural death rates decreased from 38.9 in 1940 to 10.2 in 2005, a 73.8 percent decline. Annual homicide rates (per 100,000) for U.S. young child boys and girls are shown in Figures 7 and 8 respectively. Young child boy annual homicide rates increased from 0.6 in 1940 to 2.6 in 2005, a 333.3 percent increase. Young child girl annual homicide rates increased from 0.5 in 1940 to 2.0 in 2005, a 300.0 percent increase.

The correlations between each of the four categories of unnatural death for every age group for the years 1940 through 2005 are shown in Table 1 for men and in Table 2 for women. The effect size of the 54 correlations listed in each table are large (absolute value greater than 0.5) [19] in 28 instances for men (Table 1) and in 29 instances for women (Table 2). Of the 28 large effect size correlations in men, 11 are negative (Table 1). Of the 29 large effect size correlations in women, 9 are negative (Table 2). Of unique note, the correlations between homicide rates and non-MVA death rates are negative for each and every age group for both genders (Tables 1 and 2).

## 4. Discussion and Conclusions

One measure of how well a society is protecting its youngest citizens is the rate of unnatural death in that group. As shown (Figures 1, 2, 5 and 6), unnatural death rates among U.S. infants and young children of both genders declined approximately 75 percent from 1940 through 2005. One could argue that this decline represents a remarkable achievement and demonstrates sustained commitment to protecting the lives of society's youngest and most innocent citizens through improved accident prevention and trauma management. On the other hand, rates of unnatural death attributed to homicide in infants and young children (Figures 3, 4, 7 and 8) increased dramatically over this same time period in the United States. One could conversely argue that these increases represent an increasing tendency in American society towards violence against our youngest and most innocent citizens. Are these two views of American society compatible? Are we simultaneously protecting and harming infants and young children? More importantly, are the data supporting both of these views interrelated?

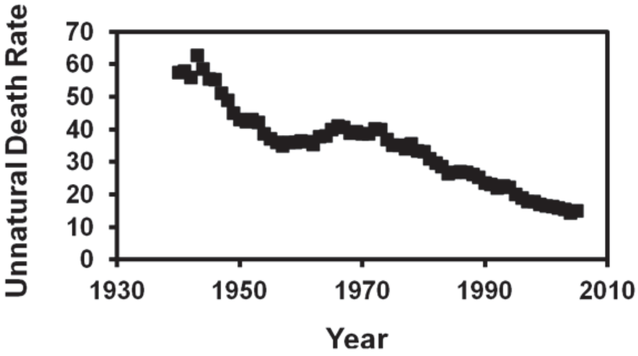
**Table 1.** Correlations between homicide (Hom), non-motor vehicle accident (nMVA) mortality, motor vehicle accident (MVA) mortality, and suicide (Sui) rates in U.S. men within the indicated age groups for the years 1940 through 2005.

| Age Group | 0 < 1 | 1 < 5 | 5 < 15 | 15 < 25 | 25 < 35 | 35 < 45 | 45 < 55 | 55 < 65 | 65 < 75 | 75 + |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Correlation | | | | | |
| Hom-nMVA | −0.7364 | −0.8035 | −0.6720 | −0.6020 | −0.3306 | −0.2043 | −0.1557 | −0.0196 | −0.0308 | −0.2939 |
| Hom-MVA | −0.6712 | −0.7500 | −0.5545 | −0.3858 | 0.1726 | 0.2853 | 0.1109 | −0.0220 | −0.0656 | −0.2404 |
| MVA-nMVA | 0.4554 | 0.8807 | 0.8792 | 0.1199 | 0.3132 | 0.4899 | 0.8117 | 0.9279 | 0.9381 | 0.9029 |
| Sui-nMVA | - | - | −0.8119 | −0.6669 | −0.6248 | −0.2404 | 0.7640 | 0.8629 | 0.8500 | 0.6612 |
| Sui-Hom | - | - | 0.8500 | 0.8936 | 0.7988 | 0.2045 | −0.1108 | −0.0596 | 0.0033 | −0.0793 |
| Sui-MVA | - | - | −0.7819 | −0.2711 | −0.2443 | −0.3341 | 0.8153 | 0.9226 | 0.8819 | 0.6565 |

**Table 2.** Correlations between homicide (Hom), non-motor vehicle accident (nMVA) mortality, motor vehicle accident (MVA) mortality, and suicide (Sui) rates in U.S. women within the indicated age groups for the years 1940 through 2005.

| Age Group | 0 < 1 | 1 < 5 | 5 < 15 | 15 < 25 | 25 < 35 | 35 < 45 | 45 < 55 | 55 < 65 | 65 < 75 | 75 + |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Correlation | | | | | |
| Hom-nMVA | −0.7155 | −0.8465 | −0.6638 | −0.3830 | −0.4288 | −0.3149 | −0.3059 | −0.4132 | −0.6477 | −0.6632 |
| Hom-MVA | −0.5450 | −0.6666 | −0.2849 | 0.5647 | 0.6284 | 0.5232 | 0.1597 | −0.1896 | −0.4314 | −0.4836 |
| MVA-nMVA | 0.3101 | 0.7699 | 0.6228 | −0.3936 | −0.3619 | −0.0400 | 0.3712 | 0.5615 | 0.3898 | 0.5516 |
| Sui-nMVA | - | - | −0.7782 | −0.0806 | 0.3230 | 0.2068 | 0.6250 | 0.8009 | 0.6360 | 0.7586 |
| Sui-Hom | - | - | 0.7696 | 0.8361 | 0.4510 | 0.5446 | 0.2787 | 0.0649 | −0.3107 | −0.3185 |
| Sui-MVA | - | - | −0.6052 | 0.5977 | 0.5474 | 0.5515 | 0.5962 | 0.6961 | 0.7058 | 0.4358 |

**Figure 5.** Annual unnatural death rates (per 100,000) in U.S. boys (young child, aged 1 to less than 5 years) for the years 1940 through 2005.



There are four broad categories of unnatural death; homicide, suicide, MVA, and non-MVA. These four categories are mutually exclusive. Accordingly, an unnatural death can be classified into only one of these four categories. When classifying mutually exclusive events, their frequency may be important [15–17]. For example, if event A is much more frequent than event B, there may be a propensity to bias classification towards event A. However, if event A becomes less frequent and the sensitivity to recognizing event B increases, there may be a tendency to bias classification towards event B. While the classification of an individual mutually exclusive event is inherently competitive [20], there is no reason that the observed rates of such events should be necessarily negatively or positively correlated. However, if a consistently changing propensity to bias classification between two mutually exclusive events is occurring, one might expect to observe a negative correlation between the rates of those two events. Moreover, the larger the negative correlation, the greater the likelihood that such a change in propensity to classify mutually exclusive events one way or the other has occurred.

**Figure 6** Annual unnatural death rates (per 100,000) in U.S. girls (young child, aged 1 to less than 5 years) for the years 1940 through 2005.

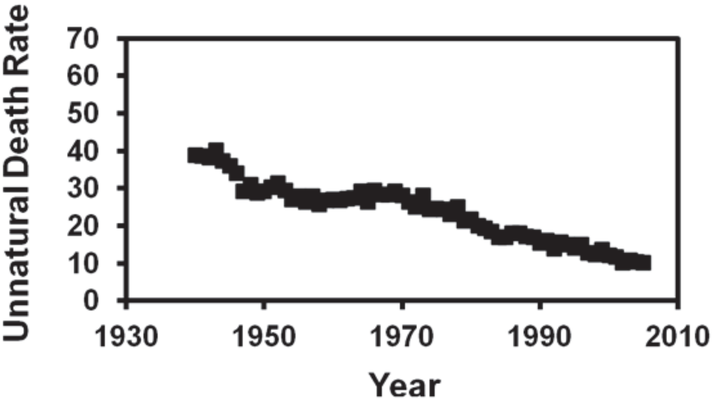


**Figure 7.** Annual homicide rates (per 100,000) in U.S. boys (young child, aged 1 to less than 5 years) for the years 1940 through 2005.

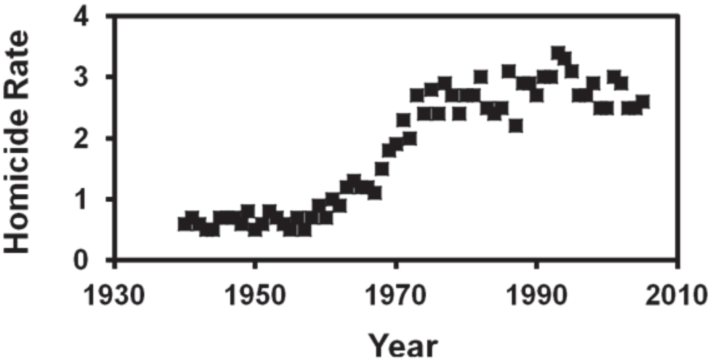
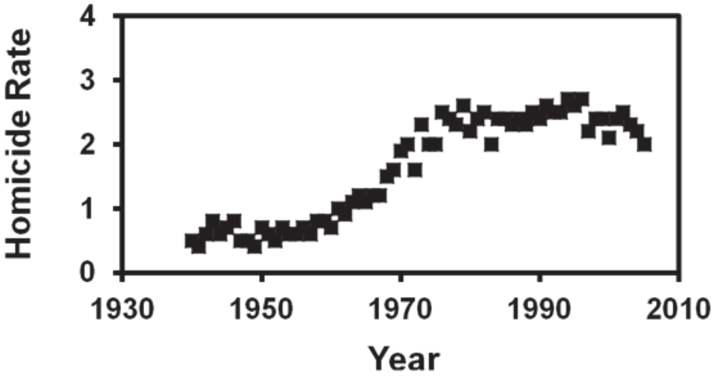


**Figure 8.** Annual homicide rates (per 100,000) in U.S. girls (young child, aged 1 to less than 5 years) for the years 1940 through 2005.



As shown in Tables 1 and 2, a negative correlation for every age group in both genders was shown to only exist between homicide and non-MVA death rates. Moreover, the effect size of this negative correlation was largest in the two youngest age groups, infants and young children.

Can there be some element of uncertainty when trying to classify the death of an infant or young child as a homicide or an accident death? The finding of the triad of subdural hematoma, retinal hemorrhage, and encephalopathy had gained acceptance as being “evidence” indicative of intentional infant injury; commonly referred to as the “shaken baby syndrome” [21]. However, the reliability and validity of using the clinical and pathological triad associated with the shaken baby syndrome to definitively indicate intentional injury has been challenged [22–26]. Consequently, pathological injuries sustained by an infant or young child should not be a sole and sufficient indicator of whether those injuries were intentionally inflicted.

When an infant or young child dies while under the care of an adult, intense scrutiny of the surrounding circumstances may ensue. How does society decide whether to hold a custodial adult criminally responsible for such a death? That dilemma received intense international media attention in the British *au pair* case. Louise Woodward, a 19 year old woman, was working as a nanny for an eight month old boy in February 1997 when the infant became unresponsive and died a few days later. When the infant was found to have injuries consistent with “shaken baby syndrome”, Woodward was charged and convicted of second-degree murder in a Massachusetts court. That conviction was ultimately reduced to involuntary manslaughter by the presiding trial judge [27]. The Woodward case was unusual in the extent of international media attention that it received and served to focus attention on the validity and reliability of “medical evidence” used to distinguish accidental from intentionally inflicted injury. Most such cases and the associated evidence do not receive such media attention [28,29].

When reported infant and young child non-MVA mortality rates were both absolutely and relatively high compared to reported young child and infant homicide rates, underascertainment of homicides was understandable and perhaps predictable. However, when reported infant and young child non-MVA mortality rates absolutely and relatively declined compared to reported infant and young child homicide rates, those changing frequencies, coupled with increased societal sensitivity to the problem of child abuse, understandably and perhaps predictably resulted in an increased propensity to assign a homicide classification over a non-MVA death classification as the cause of an unnatural death in an infant or young child [15–17].

There are many potential problems with utilizing centralized data sets over time. There is not uniformity or quality control of the data as it is collected. In fact, it is that very lack of uniformity and quality control that this manuscript suggests may have been responsible for an evolving pattern of misclassification of infant and young child homicide and non-MVA deaths over time. Moreover, when using macro data sets as was done in this study, the influence of such factors as ethnic origin, income, and urban/rural influences can be readily obscured. Nevertheless, patterns observed at the macro level can help focus attention on subsequent studies or analyses.

While this study focused on rates of unnatural deaths in infants and young children, the absolute numbers in each category can be readily estimated by multiplying the rates by the relevant U.S population for that particular age and gender.

Infant and young child abuse and homicide is a serious societal problem that cannot be tolerated. However, inaccurate classification of an infant or young child unnatural death as a homicide, rather than as an accident, also has unacceptable and intolerable consequences.

## Author Contributions

Jack E. Riggs and Gerald R. Hobbs designed the study. Gerald R. Hobbs was the statistician. Jack E. Riggs wrote the first draft. Jack E. Riggs and Gerald R. Hobbs edited and approved the final version.

## Conflicts of Interest

The authors declare no conflict of interest.

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# Mandatory Reporting Laws and Identification of Child Abuse and Neglect: Consideration of Differential Maltreatment Types, and a Cross-Jurisdictional Analysis of Child Sexual Abuse Reports

**Ben Mathews**

**Abstract:** Mandatory reporting laws have been created in many jurisdictions as a way of identifying cases of severe child maltreatment on the basis that cases will otherwise remain hidden. These laws usually apply to all four maltreatment types. Other jurisdictions have narrower approaches supplemented by differential response systems, and others still have chosen not to enact mandatory reporting laws for any type of maltreatment. In scholarly research and normative debates about mandatory reporting laws and their effects, the four major forms of child maltreatment—physical abuse, sexual abuse, emotional abuse, and neglect—are often grouped together as if they are homogenous in nature, cause, and consequence. Yet, the heterogeneity of maltreatment types, and different reporting practices regarding them, must be acknowledged and explored when considering what legal and policy frameworks are best suited to identify and respond to cases. A related question which is often conjectured upon but seldom empirically explored, is whether reporting laws make a difference in case identification. This article first considers different types of child abuse and neglect, before exploring the nature and operation of mandatory reporting laws in different contexts. It then posits a differentiation thesis, arguing that different patterns of reporting between both reporter groups and maltreatment types must be acknowledged and analysed, and should inform discussions and assessments of optimal approaches in law, policy and practice. Finally, to contribute to the evidence base required to inform discussion, this article conducts an empirical cross-jurisdictional comparison of the reporting and identification of child sexual abuse in jurisdictions with and without mandatory reporting, and concludes that mandatory reporting laws appear to be associated with better case identification.

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## 1. Introduction

Child maltreatment presents challenges for societies in the domains of public health, human rights, criminal justice, social justice, community welfare and economics. Policy discussions and research concerning the identification and response to maltreatment often treat the four classical forms—physical abuse, sexual abuse, emotional abuse, and neglect—together as if they are homogenous. Yet, different forms of maltreatment have different characteristics, contexts and consequences. Sexual abuse, and severe physical battering of an infant, for example, are very different to mild "neglect" of a teenaged child produced only by poverty (such as an inability to provide some kinds of medical treatment), which in many societies would not be classed as neglect. Heterogeneity across and even within types of maltreatment, suggests some legal and policy responses to detect and respond to cases may be especially well suited to some of its forms.

Societies worldwide continue to engage with the question of how best to identify and respond to cases of child maltreatment. There are good reasons to do so, both as a matter of principle and pragmatics. In principle, early case identification and service provision are justified because the majority of child maltreatment is inflicted on helpless infants and very young children who are vulnerable and dependent on their parents and caregivers in multiple ways [1]. As such, maltreatment occurs in a context of extreme power imbalance. Neonates and infants in particular are uniquely vulnerable to violence and neglect, being preverbal, immobile, and completely dependent on the caregiver for all human needs. Other child victims also occupy an unequal position, in physical, cognitive, psychological, emotional, legal and economic terms. While not all maltreated children suffer in the same way, many victims are marginalised and disadvantaged, with maltreatment causing both substantial suffering and health consequences which can endure through the lifespan and compromise functioning in both childhood and adulthood [2,3]. Pragmatically, societies need to be seen as good global citizens. The *United Nations Convention on the Rights of the Child 1989* requires States parties to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of abuse and exploitation while in the care of parents and caregivers (article 19). Moreover, there are self-serving societal interests in developing better child maltreatment detection and response measures, since it offers the prospect of reducing cost to society caused by placing children in out-of-home care, lost productivity resulting from victims' reduced functional capacity, other costs produced by victims' injuries and compromised health, and costs of social welfare [2–4].

Mandatory reporting laws have been created in many jurisdictions in different forms, primarily as a way of identifying existing cases of severe maltreatment which are likely to otherwise remain hidden, so that the child's victimisation can cease, health rehabilitation and other support can be delivered (both to the child and her or his parents and family), the child's safety can be promoted, and, where necessary, perpetrators can be held accountable [5–8]. These laws are always intended to be only one part of a public health response to child maltreatment, primarily forming a tertiary response to supplement secondary and primary prevention [9]. The laws continue to be adopted as a case identification strategy, with recent enactments in jurisdictions as diverse as Saudi Arabia [10] and Ireland (the Children First Bill 2014). This article will first consider some of the key characteristics of different types of child abuse and neglect, and will outline the nature and operation of mandatory reporting laws. It posits a differentiation thesis, arguing that different patterns of reporting between both reporter groups and maltreatment types must be acknowledged and analysed, and should inform discussions and assessments of optimal approaches in law, policy and practice. To add to the evidence base about the effects of mandatory reporting on report numbers and case identification of a specific type of maltreatment, it then conducts an empirical cross-jurisdictional comparison of the reporting and identification of child sexual abuse in jurisdictions with and without mandatory reporting to explore whether mandatory reporting laws appear to be associated with better case identification.

## 2. Child Maltreatment: Different Types and Consequences

### *2.1. Key Characteristics of Different Types of Child Abuse and Neglect*

To clarify the conduct with which this discussion is concerned, it is first necessary to explain the broad conceptual nature of the discrete types of child maltreatment. Adopting the basis of a previous model [11], I will use the following general definitions of each type, which draw on the work of leading scholars, and which are generally consistent with frameworks of mandatory reporting laws as well as rights and obligations in criminal law and civil law:

- *physical abuse* includes acts of physical assault by parents or caregivers which result in death or serious physical harm, or which present an imminent risk of doing so; it excludes lawful corporal punishment [12];
- *sexual abuse* includes acts not only of penetrative abuse, but also acts of masturbation, oral sex, fondling, voyeurism, exposure to sexual acts, exposure to or involvement in pornography and other forms of commercial sexual exploitation, all of which are acts done to sexually gratify the abuser; it is usually inflicted by an adult, but is often and can be inflicted by another, usually older child, where the victim is not developmentally capable of understanding the acts or is not able to provide true consent [13];
- *psychological or emotional abuse* exists when the relationship between the parent or caregiver and the child is characterized by pervasive or persistent acts or omissions which result in serious emotional harm or present an imminent risk of doing so [14,15];
- *neglect* is constituted by omissions by parents or caregivers to provide the basic necessities of life such as food, shelter, clothing, supervision and medical care, which result in serious harm or present an imminent risk of doing so [16].

Importantly, each definition can be seen to include a qualification of severity or "seriousness" of harm caused by or likely to eventuate from the abuse or neglect. Generally, while there are some exceptions, in the context of policy discussions about mandatory reporting laws it must first be recognised that not all manifestations of harm are treated by the laws as "abuse" or "neglect", and nor were they intended to. Sexual abuse is an exception to this, as all sexual abuse is seen as seen as having such seriousness as to merit some kind of response. For the other three maltreatment types, the reporting duties are targeted at instances of abuse or neglect which have already been of sufficient severity to cause serious harm, or to involve acts which have already been committed which may not yet have caused such harm but present an imminent risk or likelihood of causing such harm. They are not targeted at trivial incidents or conditions in children's lives which could simply be seen as less than ideal.

The youngest children are most often victimised, apart from sexual abuse [1]. Based on detailed statistics from industrialised Western nations, and reflecting the increased vulnerability of younger children, those aged under 4 collectively experience one third of all maltreatment, and three quarters of all victims are under 12 [1,7]. There may be patterns of increased incidence of some kinds of maltreatment at transitional ages later in childhood when oppositional behaviour increases. Sexual abuse, which disproportionately affects girls, more often commences around age 9–10 [17,18].

There is heterogeneity across and within types of maltreatment, and in their consequences for individuals. Neglect, for example, has several classes: medical, nutritional, emotional, educational, and supervisory [16]. All of these can have different extents and consequences. Neglect causes more fatalities than any other maltreatment type, followed by physical abuse [19]. Severe neglect in infancy compromises brain growth and development and functioning through the lifespan [20]. Yet, mild or even moderate neglect of a much older child is less likely to produce significant harm. Neonates (those in the first month of life) and infants and very young children are most vulnerable to fatality and very serious physical harm. Emotional abuse also takes many forms [15], and has a range of severity. Physical abuse ranges from acts causing or capable of causing death and permanently compromised functioning, to corporal punishment which moves beyond lawfully permissible discipline. Parents and caregivers inflict the vast majority of physical abuse, emotional abuse and neglect [19,21]. Sexual abuse is less often inflicted by a parent although the NIS-4 still identified biological parents as the perpetrator in 36% of all cases [21], and an Australian study estimated that 1.1% of all children were sexually abused by a parent [22]. Sexual abuse is usually inflicted by a person known to the child, who is often a member of the child's extended family [21–24]. It can range from an isolated incident of external touching, to persistent penetrative abuse taking place regularly for years. Some children can suffer more severe consequences from sexual abuse even though the acts endured are apparently less chronic than those endured by others [25].

### *2.2. Consequences and Costs of Serious Child Abuse and Neglect*

Different kinds of maltreatment are more likely to present different kinds of consequences for the child. Even within types, and even where the acts are of the same kind, duration and chronicity, not all individuals will experience the same type or extent of physical, social and behavioural consequences [2,25]. Yet, overall, in a collective sense the range of severe consequences and the size of the costs of child maltreatment are well established and are vast. The adverse physical and mental health, behavioural, educational, social, and economic consequences of abuse and neglect are often extremely substantial [26,27]. Studies have identified these consequences for distinct maltreatment types: physical abuse [12,28], sexual abuse [25,27,29], emotional abuse [30,31] and neglect [20,32,33]. Maltreatment causes substantial and enduring economic costs to children who experience maltreatment [3], and to communities [4,34]. Maltreatment types often co-exist, and poly-victimisation—where a child suffers several types of victimization—is especially damaging [35]. Some effects are specific to or are more typical for some kinds of maltreatment, such as failure to thrive, impaired brain development, and fatality [20]. However, a range of effects common to multiple kinds of maltreatment include: impaired social, emotional and behavioural development; reduced reading ability and perceptual reasoning; depression; anxiety; post-traumatic stress disorder; low self-image; physical injuries; alcohol and drug use; aggression; delinquency; long-term deficits in educational achievement; and adverse effects on employment and economic status [25–33]. All these consequences also affect the child's dignity and capacity to develop fully as a human being; their core capabilities are compromised [36].

## 3. Nature and Function of Mandatory Reporting Laws

### *3.1. A Response to a Hidden Phenomenon*

Mandatory reporting laws were first created to respond to the problem presented by the fact that severe child maltreatment is a largely hidden phenomenon taking place in the family sphere, which even when it comes to the attention of professionals tends to be ignored. Abuse and neglect is most frequently inflicted on infants who are pre-verbal, and other young children who cannot resist, represent themselves, resolve the situation or disclose the experience [7]. In the groundbreaking article by Kempe *et al.* which exposed child physical abuse and doctors' failure to respond appropriately to it, severe physical abuse (head injuries and fractures) was identified as being mostly inflicted on children aged under three years of age [37]. Sexual abuse is also usually undisclosed by the child and the perpetrator [38,39]. Overall, children rarely disclose their own suffering, and because acts of significant maltreatment often constitute criminal conduct, or may activate child welfare proceedings of some kind, those who inflict abuse or neglect are also unlikely to reveal it to authorities which can help the child [6,7]. The real annual incidence of child abuse and neglect far exceeds the number of cases which are brought to the attention of welfare agencies [21,40].

### *3.2. Nature of the Duty*

A mandatory reporting law is a statutory duty imposed on members of a specified occupational group or groups to report suspected cases of designated types of child maltreatment to child welfare agencies. In some jurisdictions the duty is imposed on all citizens [5]. Where it is placed only on occupational members, the designated occupational groups are those whose members frequently encounter children in the course of their work: common examples are police, teachers, doctors and nurses. The core premise is to oblige designated people who are well-placed to detect cases of severe child abuse and neglect to report known and suspected cases to government welfare agencies. This enables the taking of measures to ensure the child is safe, the maltreatment stops, rehabilitation can be provided, and the needs of the child and the family can be identified and supported. By using the expertise of persons outside the family who encounter the child, the hidden nature of child maltreatment can be overcome. The laws also enable reports to be made by nonmandated reporters (whether family members, friends, neighbours, or nonmandated professionals), and it is important to note that nonmandated reporters in most jurisdictions make almost half of all reports [1].

Mandatory reporting laws can be seen as one part of an overall public health response to child maltreatment which should include some measure of primary prevention at the population level, arguably the highest focus on secondary prevention of high-risk subsets of the population, and a required tertiary response to identify and assist those who have already endured severe maltreatment. Being primarily concerned with identifying cases of maltreatment that have already occurred, reporting laws are an aspect of tertiary response. In their capacity to also identify cases of serious maltreatment before they have occurred, and to prevent escalation of cases, they are also a measure of secondary response.

Because of its hidden nature, the first primary objective of these laws is to identify cases of serious child abuse and neglect. For example, if in the course of their work a doctor, a police officer or a teacher encounters a three year old child who has suffered severe intentional physical injury, or injuries suggesting sexual abuse, or severe neglect, the legal obligation requires the professional to report their knowledge or reasonable suspicion that the child has been abused and has suffered harm to a government child welfare agency so that the agency can assess the child's situation to determine what protective and supportive actions need to be taken. Importantly, and unlike a softer policy-based obligation, the legislation provides the reporter with protections: their identity as the reporter is confidential, and they cannot be liable in any civil, criminal or administrative proceeding for any consequences of the report [5]. Reporters are not expected to always be correct; the indicators of abuse can be mimicked by other health conditions, accidental injuries and childhood adversities [11].

The laws need to be accompanied by sufficient training, as reporters need to know the scope of their duty, the indicators of child abuse and neglect, what they should and should not report, how to make a useful report, and to whom to report. Child welfare agencies are equipped with staff to receive reports and assess them, and where necessary to investigate them and determine the appropriate course of action as set out in child protection legislation. These agencies are not required by statute to investigate every report and data shows that large proportions of reports are screened out at intake [1,7]. Generally, child welfare statutes dictate that the least intrusive course of action is preferred [41]. Consistent with this, methods of differential response are increasingly used, especially for reports of neglect and emotional abuse; this is discussed in more detail below. However, where necessary, cases of severe maltreatment where a child cannot be protected within the home may result in more formal action including court orders which may extend to removal of the child from the family home for the child's protection. Such removal is often only temporary with the child then being returned to the family home, but in some cases it may be necessary to be of a more extended duration, and sometimes may result in permanent placement with other caregivers. The cost component of out-of-home care (foster care, kinship care and other forms e.g., residential care) constitutes by far the greatest economic burden for child protection systems, dwarfing investigation costs [8].

### 3.3. A Spectrum of Approaches

The laws are not uniform across jurisdictions, which means it is neither possible nor correct to make absolute statements about their scope and therefore their consequences. Rather, they can be designed to be broad or narrow. There are two major dimensions of difference (both between countries, and within countries): first, in which types of abuse and neglect must be reported; second, which persons have to report. Accordingly, there is a spectrum of approaches to mandatory reporting laws.

At one end of the spectrum, a law might require reports only of sexual abuse, and limit the reporter groups to teachers, doctors, nurses, midwives and police. This is the position in Western Australia [42]. Or, like the first reporting laws in the USA, it might only require medical practitioners to report serious physical abuse [5,43]. Further along the spectrum, the law might require reports of physical abuse and sexual abuse, as in Victoria and the Australian Capital Territory [5]. At the other end of the spectrum, a jurisdiction might design its law more broadly, requiring reports of all four forms of child abuse and neglect, and perhaps even others such as situations of a child being exposed to domestic violence, where the significant harm dimension is also present; this is the position in several Australian jurisdictions including New South Wales and Tasmania [5]. Regarding the second major dimension of variance, at various points on the spectrum, there may be narrower or broader ranges of reporter groups. Saudi Arabia's legislation, for example, applies only to health practitioners [10]. The Australian jurisdictions of Queensland, Victoria and Western Australia limit the reporting duty to a smaller range of occupations. In contrast, most jurisdictions in the USA, Canada and Australia have an extensive range of reporter groups, and some states apply the duty to all citizens [5].

Many jurisdictions now have relatively broad laws, requiring a range of occupational groups to report a number of types of child maltreatment. However, it is important to recall that these laws are generally not designed to require reports of any and all manifestations of harm or "maltreatment"; rather, for the most part they are directed at serious forms of harm and maltreatment of children [5,7]. Some jurisdictions have a more preventative orientation and so have a lower threshold for the activation of the reporting duty; these jurisdictions would need to devote a higher level of resourcing to receive and respond to the corresponding higher number of reports. Problems can arise where laws are poorly drafted, and reporters are not adequately trained [7].

### *3.4. The Differentiation Thesis*

The *differentiation thesis* proposed here argues that the different patterns of reporting between reporter groups and maltreatment types must be acknowledged and analysed, and careful analysis (including empirical analysis) should inform discussions and assessments of optimal approaches in law, policy and practice. It can readily be perceived that a broader legislative reporting duty will likely lead to differential levels of reporting, and different levels of case identification, than a narrower version. However, reporting practices differ substantially across reporter groups (both mandated and non-mandated), and by maltreatment type, and over time. This differentiation again means that all-encompassing statements about "the effect" of mandatory reporting laws on reporting cannot be made. For example, neglect and emotional abuse, and exposure to domestic violence, are far more frequently reported by mandated reporters and by all reporters than are sexual abuse and physical abuse [7]. Furthermore, the reporting practice of one group of reporters, regarding one kind of maltreatment, can substantially skew total statistics on reporting, and hence can have a disproportionate impact on child protection systems. A good example of this was identified in New South Wales, where reports by police of children's exposure to domestic violence in one year accounted for one quarter of all reports by all mandated reporters of all types of child maltreatment [7]. That single group of reports outnumbered all reports by all mandated reporters combined of physical abuse and sexual abuse combined. For multiple reasons, this particular example of reporting practice has not continued, demonstrating that reporting practices and trends change over time, influenced by changes to the law, reporter training, and other influential variables. Researchers, policy-makers, opinion leaders and practice leaders must remain mindful of the heterogeneity of both maltreatment types, and of reporting practices regarding them, when considering issues concerning mandatory reporting and other methods of case identification, and other child and family welfare responses.

### *3.5. Observations on Mandatory Reporting and Different Forms and Extents of Maltreatment*

It is not the purpose of this article to formulate a systematic proposal for how a child protection system should treat various forms and extents of maltreatment. Such a complex task would require much more detailed treatment and in any event will always be a controversial exercise and one which of necessity also involves political and economic choices. Yet, it is possible to make some observations about current developments in different forms and extents of maltreatment and mandatory reporting laws, and about the motivations behind them.

A range of evidence indicates the reporting laws and associated infrastructure and education will identify more cases, although there can be an added element of systems burden depending on the nature and scope of the laws, differential reporting patterns, and efficacy of implementation [6–8,43,44]. Reports made by mandated professional reporters account for the majority of all substantiated cases ([6,7]; [45], Tables 3–9). Jurisdictions continue to explore the use of mandatory reporting laws to identify cases, overcome the gaze aversion that can otherwise characterise professional practice [10,37], and implement the laws in various forms. Ireland has forthcoming legislation (the Children First Bill 2014) which will apply to sexual abuse, and to physical assault, neglect and other ill-treatment which seriously affects or is likely to seriously affect the child's health, development or welfare. Saudi Arabia recently introduced mandatory reporting laws which apply to health practitioners only [10] with new enactments potentially forthcoming for educational professionals [46]. In 2014, in Australia, Queensland passed legislation which restricts the reporting duty to physical and sexual abuse, placing a new higher emphasis on differential response for other forms of maltreatment.

In every jurisdiction where they have been enacted, except one, mandatory reporting laws apply to both physical and sexual abuse. The exception is Western Australia, where only sexual abuse must be reported. The focus on sexual abuse reflects its serious consequences, its clandestine nature, its criminality, and the well-established difficulty and delay in children's disclosure. The focus on serious physical abuse reflects the genesis of the first reporting laws, the serious nature of physical abuse and its potential consequences especially for neonates, infants and young children, its co-existence with emotional harm, and the likelihood of its continuance. Most reporting laws also require the reporting of serious neglect and emotional abuse, recognizing the serious consequences which can flow from such acts and omissions, and the need to provide appropriate support to the child and family.

However, in several jurisdictions, including some in Australia, mandatory reporting laws do not extend to neglect or emotional abuse, no matter how severe. This indicates that some jurisdictions have concluded for various reasons that this strategy of case identification is not optimal or necessary. This article does not seek to evaluate all aspects of this context, but while it seems reasonable to not require reports of milder forms of neglect (which are not required anywhere in Australia in any event), it is difficult to justify a complete removal of neglect from mandatory reporting laws unless evidence indicates reporting practice is intolerable, irremediable, and on balance unhelpful. Neglect can involve intentional failure to provide medical care, intentional withholding of nutrition, failure by caregivers to engage with assistance and refusal or inability to change. Such cases can result in serious harm and even death; far more children die of neglect than any other kind of maltreatment [19]. Instances of this wilful criminal conduct can result in convictions for manslaughter or murder [47].

Reports of serious neglect can therefore, in theory, save lives. Hence, variance of circumstances and levels of harm within the category of neglect suggests that while some cases may suit a particular strategy, other cases require a different approach.

Similarly, several jurisdictions' mandatory reporting laws do not require reports of emotional abuse; examples include Victoria, the Australian Capital Territory, and Western Australia [5]. Some commentators have suggested that more formal child protection responses may not be appropriate for emotional abuse, due to its particular characteristics which distinguish it from other maltreatment types [48,49]. Glaser has developed a detailed typology of such harmful acts and omissions [15]. Somewhat like neglect, emotional abuse can be of lesser or greater extents, and can cause either low or high degrees of harm. This again may suggest that a range of responses are required depending on the circumstances.

There does appear to be a persuasive argument that at least some instances of some types of maltreatment should not fall within the remit of mandatory reporting laws, although they may well warrant referral to welfare services. For example, where a teenaged child is experiencing non-intentional mild or even moderate neglect (such as inadequate clothing) caused only by poverty, but otherwise displays no indicators of serious harm, and lives in a loving caring family, there seems to be no compelling reason to require any report or formal engagement with child protection agencies. Instead, what is required is an offer of appropriate assistance to the child's family. While such a case would not activate the reporting duty in jurisdictions where the reporting duty is only triggered by suspicion of *significant* harm, in those jurisdictions where the reporting duty is not clearly confined to cases of serious harm it is conceivable that a welfare and service-oriented response is appropriate.

### *3.6. Differential Response*

Differential response is the concept that a different kind of response to formal investigation can more efficiently and justifiably treat some types of situation which do not involve serious harm and which have a different type of needed response [50]. The focus is on situational assessment and provision of services to the child's caregivers and the child. While it varies in implementation, the central premise of such a system is that it can operate in tandem with a more traditional investigative response, so that in cases of only mild or moderate harm or risk of harm, most often characterised by family need, child welfare agencies can respond by the provision of support rather than by investigating the situation to determine formally whether maltreatment has occurred [50]. The idea is that this softer, less confronting approach more flexibly accommodates qualitatively different situations, heightens parental engagement with support services, avoids stigma, and is faster and cheaper [50,51]. Children's situations can be redirected from the differential pathway to the formal investigation path, and vice versa.

Some jurisdictions have legislatively enabled direct referrals of such lesser situations—that is, of need, rather than harm to the child—to be made to community welfare agencies, even where the mandatory reporting duty is only activated by a case of suspected significant harm. Examples of this direct referral by a professional reporter to a differential response strategy in Australia exist in New South Wales, Victoria, and Tasmania. Another way in which lower-level cases can be referred to such agencies for the purpose of assessment of need and delivery of services, rather than for investigation, is by the intake agency forwarding reports by mandated reporters of suspected maltreatment to these agencies. Differential response is also widely used in the USA [51], where, largely for historical reasons related to tied federal grants, some jurisdictions may have traditionally more preventative approaches and so do not as clearly limit the reporting duty to cases of significant harm [5,43].

Differential response has in fact been facilitated by many child protection statutes for years, but may not have been implemented appropriately [7,41]. It is a strategy which is intuitively appealing and appears to offer much practical promise. However, its success is now being vigorously debated [50,52–55]. It has been asserted that such systems must be shown by rigorous evidence to be successful [56] (and not only by measures of parental satisfaction), should not compromise the child's safety, should be supported by a capacity to compel parental compliance where necessary (noting that parental engagement is voluntary), and must not be used by politicians to withdraw net funding from the child protection and child welfare endeavour [53–55]. The release in June 2014 of a recent evaluation of a controlled trial in Illinois found that despite being given a higher level of services and direct financial support, of the group assigned to differential response, less than half of the parents engaged with services to completion, and higher rates of children were involved in subsequent reports of maltreatment [57,58]. Governments seem to find differential response increasingly appealing, but caution should be exercised before concluding that it is a successful option and a rigorous evidence base should be developed to ascertain the extent of its success and the conditions required for it to function. If adopted, it must not result in reduced investment in child and family welfare.

As with all public health measures, it is essential that legal and practical responses to various types and extents of maltreatment be supported by a rigorous evidence base; approaches must be monitored to enable assessment of effectiveness and identify areas where improvement or change is needed [9]. This applies equally to elements of mandatory reporting laws, other approaches to identification of maltreatment, and differential response. Generating such evidence presents logistical, political and methodological challenges, which explains why aspects of this context are generally under-researched. The next section of this article contributes to the evidence base regarding one dimension of a key question in this field.

## 4. A Comparison of Jurisdictions With and Without Legislative Mandatory Reporting of Child Sexual Abuse: Does Mandatory Reporting Appear to Identify More Cases?

Questions arise about the impact of mandatory reporting legislation on the number of reports, and the actual identification of child abuse cases. Some have argued on various grounds, including empirical grounds, that mandatory reporting laws are overall a useful social policy response to child maltreatment, and especially so for certain classes of maltreatment [5,7,8]. Recent government inquiries in Australia, in New South Wales, Victoria and Queensland, have all supported the continuance of mandatory reporting legislation [59–61], and even its expansion [60]. This is not to say that improvements cannot be made; there are specific subsets of reporting which have been found to be problematic, and research should be conducted to identify areas of ineffective reporting so that they may be improved [7].

Others have asserted that mandatory reporting is not an effective measure for case identification [62]. However, when made, this assertion is not founded by a sufficiently detailed analysis of child protection reporting data, either as a whole, or by distinguishing between reports and outcomes of different kinds of abuse and neglect, by different reporter groups. As well, such an assertion is often based on an overall increase in numbers of reports in one jurisdiction without adequate discrimination between different jurisdictions, reporter groups, or maltreatment types. This absence of analysis based on evidence renders the assertion nugatory. Reporting patterns and outcomes differ markedly across different maltreatment types; for example, neglect is generally by far the highest number of reports, followed by emotional abuse (which can include exposure of children to domestic violence). Neglect and emotional abuse combined generally account for around two thirds of all reports [7,40]. In contrast, reports of physical abuse and sexual abuse represent a much smaller proportion of all reports [7]. The assertion also fails to recognise that reports by mandated reporters generally only account for around 50%–60% of all reports, the rest being made by nonmandated reporters such as family members and neighbours [1,5,19]. As well, report patterns over time indicate that report numbers do not constantly rise, and in fact may remain stable over periods of several years, and can even decline substantially [40].

A central question arises, regarding the impact of mandatory reporting within a jurisdiction on numbers of reports and numbers of substantiated, or confirmed, reports (as well as of other reports which may not be confirmed but which are useful). To accommodate the differentiation thesis proposed here, this question must be analysed in a highly nuanced fashion. That is, because maltreatment types are different, and because reporter groups and practices are different, this question needs to be posed for each reporter group, for each maltreatment type. Ideally, this question needs to be the subject of rigorous analysis, as a robust evidence base—both quantitative and qualitative—should inform policy debates about optimal responses to detect cases of child abuse and neglect, and should form the basis of systemic improvements [8]. Quantitatively, for example, the kinds of questions explored by Drake *et al.* [8] should be asked to generate evidence within jurisdictions about whether a mandatory reporting law results in a higher number of reports by mandated reporters, and to what extent. Does a mandatory reporting duty result in a higher number of substantiated or confirmed cases from reports by that reporter group, and to what extent? Do these patterns continue, stabilise, or decline, or does the trend vary? If there is a higher number of reports, do they involve such a higher number of children (at least in unconfirmed cases) and an extra burden on the child protection system, children and families that it is intolerable? As part of a public health approach which requires ongoing monitoring and assessment of systems, all these and other questions should be asked, and investigated, within jurisdictions which have enacted mandatory reporting laws.

A related question often confronts policymakers in a jurisdiction which does not have a mandatory reporting law. Would the introduction of a reporting law for a specific type of maltreatment improve case detection? What other effects, such as an increase in report numbers, might be produced? While no method of measurement in any discipline is perfect, there are several ways in which such questions may be explored to produce useful results. One way of doing so is to empirically compare government data over the same time period on numbers and outcomes of reports for a specific type of child maltreatment in two comparable jurisdictions, only one of which has mandatory reporting legislation. This analysis conducts such a comparison regarding the reporting of child sexual abuse.

### *4.1. A Cross-Jurisdictional Comparison between Ireland and the Australian State of Victoria: Does a Jurisdiction with Mandatory Reporting Detect More Cases of Child Sexual Abuse Than One without It?*

A quantitative comparison across two jurisdictions of numbers of reports of child sexual abuse, and the outcomes of these reports, can add to an understanding of the association of a mandatory reporting duty (and its associated infrastructural measures) on reporting practice and case identification. This analysis compares the jurisdictions of Ireland and the Australian State of Victoria.

These two jurisdictions provide a useful and legitimate comparison for several reasons, with Victoria having several features making it the best Australian comparator jurisdiction[1]. First, based on the best available data, both jurisdictions in the year 2010 had comparable child populations. In the year 2010, child population data was not available for Ireland [63]. However, census data for the Republic of Ireland from the year 2011 was accessed and analysed to reveal a population of children aged 0–17 inclusive of 1,148,687 [64]. This is the same population number cited in the HSE Report [65]. Australian census data from 2011 was accessed and analysed to reveal a population in Victoria of children aged 0–16 inclusive of 1,152,251 ([66], Table 8). A cut-off of 16 years of age in Victoria was used for data analysis purposes because the mandatory reporting duty only applies to children aged under 17, and the data accessed and analysed were restricted to this population group. Hence, these data indicate almost identical populations, and year-on-year birth patterns indicate it is reasonable to assume the populations for the year 2010 were similarly close.

Second, the two jurisdictions are in different countries but have similar demographic characteristics. Ireland is a wealthy industrialised nation classed as very high on the Human Development Index [67], and Victoria is the second largest State in the nation of Australia, which also has a very high HDI [67]. Both jurisdictions have compulsory education systems and well-established health, education and police services. Both jurisdictions also have government child welfare agencies that have existed for decades [41,68]. In addition, both jurisdictions have witnessed numerous government inquiries into child abuse, including child sexual abuse, in recent years and it is not unreasonable to proceed on the basis that at the general societal level there is a similar consciousness of the phenomenon of child sexual abuse. Both Ireland and Victoria are predominantly Anglo-Saxon jurisdictions with cultural characteristics that are not sufficiently dissimilar to suggest there would be distinct differences in the incidence of child sexual abuse or in general public awareness of it; for example, neither is a society in which evidence indicates a lower incidence of child sexual abuse for various cultural and social reasons [69]. There are no other ethnic differences between the two jurisdictions sufficient to warrant a hypothesis that either would have a markedly higher prevalence of child sexual abuse. Some Indigenous communities in Australia have been found to have higher than normal rates of child sexual abuse but these are relatively isolated instances in small communities, are not generalizable,

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[1] Population size, population density, ethnicity, geographical size, duration and consistency of mandatory reporting duty across professions, stability of child welfare approach, and availability of data.

and have occurred in places beyond Victoria. Finally, it is well-established that child sexual abuse affects girls disproportionately, but there are no distinctive gender imbalances at the population level in either jurisdiction such that different incidence and detection patterns could be expected.

Third, population studies indicate that it is plausible to proceed on the basis that the prevalence and incidence of child sexual abuse in Ireland is not substantially different to that in Victoria, or Australia. In Ireland, McGee *et al.* found that one in five women (20%) reported experiencing contact sexual abuse in childhood and a further one in ten (10%) reported non-contact abuse [70]. Penetrative sexual abuse was reported by 5.6% of the female participants. One in six men (16.2%) reported contact sexual abuse in childhood and a further one in fourteen (7.4%) reported non-contact abuse. Penetrative sexual abuse was reported by 2.7% of the male participants. These findings are similar to those produced in Victoria [71], and other Australian studies [18,22,72,73].

Fourth, one key differentiating variable is the presence in one jurisdiction, Victoria, of a legislative duty to report suspected child sexual abuse, imposed on police, teachers, doctors and nurses; together with whatever training about this duty is delivered to these reporters. This duty had existed since 4 November 1993 for doctors, nurses and police [74], and since 18 July 1994 for teachers [75], and it could be expected that over time, a reasonably well-developed awareness of the duty and the nature and consequences of child sexual abuse had crystallised in these professions. The duty in Victoria is actually quite narrow relative to most mandatory reporting duties, since it applies to a small range of reporter groups, and applies only to cases in which not only is the child's sexual abuse suspected, but the reporter must also suspect the child does not have a parent who is able and willing to protect the child [5]. In contrast, Ireland had no legislative reporting duty, although some occupations had policy-based duties to report under the policy framework entitled *Children First: National Guidelines for the Protection and Welfare of Children* [76]. These guidelines were subsequently crystallised in 2011 under the new policy package named *Children First: National Guidance for the Protection and Welfare of Children* [77].

The data presented and analysed are from the calendar year 2010. This year was selected because it is recent, and Ireland stopped collecting and publishing data on confirmed reports after this year [65]. The Victorian data were accessed from the government's child protection department as part of a broader study. The Ireland data are presented in a government publication ([63], p. 39, Table 17; p. 41, Figure 8). Table 1 presents data concerning the number of reports of suspected child sexual abuse, and the number of these reports that were substantiated or confirmed after assessment by government child protection agencies, with breakdowns by mandated/nonmandated reporter groups in Victoria.

These data show several results. First, almost double the number of reports was made in the jurisdiction with legislative mandatory reporting (Victoria) compared with the jurisdiction without it (Ireland). Second, the data show that a substantial proportion of reports in Victoria are made by mandated reporters. They made 3113 reports (53% of all reports of sexual abuse), compared with 2757 made by all other reporters (47%). By comparison, Ireland received 2962 reports from all sources, with a breakdown by profession not able to be made. Third, the higher volume of reports in Victoria resulted in almost five times as many sexually abused children being identified. There were 989 substantiated cases in Victoria compared with 209 in Ireland; a ratio of 4.73 times the amount, and numerically a difference in one year alone of 780. Fourth, a substantial number of confirmed cases are found as a result of reports made by mandated reporters. In Victoria, 536 substantiated cases were identified as a result of a report by a mandated reporter[2].

**Table 1.** Number of reports of suspected child sexual abuse, and number of substantiated reports, in Victoria and Ireland (2010).

| | **Victoria (Children 0–16)** | **Ireland (Children 0–17)** | **Proportional Difference *** |
|---|---|---|---|
| **Number of reports of suspected child sexual abuse** | **5870** | **2962** | **1.98** |
| Number reported by mandated reporters | 3113 | n.a # | n.a |
| Number reported by nonmandated reporters | 2757 | n.a | n.a |
| **Number of reports substantiated or confirmed** | **989** | **209** | **4.73** |
| Number substantiated from mandated reports | 536 | n.a | n.a |
| Number substantiated from nonmandated reports | 453 | n.a | n.a |

* Proportional differences are calculated by dividing the larger total by the smaller total. # n.a. not applicable.

An interpretation of these results supports several important conclusions. First, it can reasonably be concluded that the higher number of reports made is associated with the reporting duty. This has implications for child protection systems because there must be adequately resourced intake and response systems so that the volume of reports and substantiated cases can be dealt with appropriately. However, it should be noted that in Victoria, exactly half of these reports were not investigated at all, and instead were screened out or referred to another service or agency. Accordingly, a substantial proportion of these reports resulted in little strain on the child protection system. It is also prudent to recall that sexual abuse reports are consistently the lowest proportion of any kind of maltreatment in Australia, the USA and Canada [7], although strangely this pattern was not replicated in the Irish data [63]. As well, it must be recalled that many reports that are officially "unsubstantiated" still will involve a level of harm to the child, or some other kind of harm, and require the provision of services to the child and family; there are frequently not substantial differences between substantiated and unsubstantiated decisions [8,78,79]. Nevertheless, any jurisdiction which has mandatory reporting, or which is considering introducing it, must be prepared to invest sufficiently in the necessary infrastructure, personnel, training and service provision required to deal with the expected higher number of reports. This investment is nevertheless worthwhile and should result in long-term returns.

Second, a substantial proportion of reports are made by mandated reporters, accounting for 53% of all reports in Victoria. This indicates that overall there is a substantial amount of compliance with the reporting duty; it is possible that some suspected cases were not reported, but it cannot be

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[2] Of the 3113 reports made by mandated reporters (involving 3039 children), 1838 were investigated and of these, 536 were substantiated.

concluded without further research that there is complete or substantial noncompliance. In comparison, reports made by the rest of the Victorian population accounted for less than half of all reports. In Ireland, without a breakdown of reporting by professional groups, and further research, it is not possible to draw conclusions about different reporting practices of different groups. However, if Irish police, teachers, and medical practitioners made a similar proportion of all reports as were made by their Victorian counterparts, they would have made approximately half the number of reports.

Third, and arguably most significantly, there was a substantially higher number and proportion of sexually abused children identified in the jurisdiction with mandatory reporting. Victoria identified 4.73 times the amount of children than did Ireland in the same year as a result of all reports of suspected cases to child protection agencies. Over 700 more victims of child sexual abuse were identified in the course of a single year. If the primary unit of analysis in this context is the identification of cases of actual child sexual abuse (and in a small minority of cases, imminent risk of sexual abuse), then this outcome suggests the strategy of legislative mandatory reporting, along with its accompanying reporter training, and the cultural, attitudinal and behavioural changes it can help engender, is by far a superior strategy.

Fourth, a substantial number of the confirmed cases were found as a result of reports by mandated reporters. In Victoria, 536 of the 989 substantiated reports were made by mandated reporters (54%). Even in the unlikely event that all of Ireland's 209 confirmed cases were a result of reports by the same professional groups as are mandated in Victoria, the number of detected cases is still exceeded by a factor of 2.5.

### *4.2. A Cross-Jurisdictional Comparison between Ireland and Australia: Does a Jurisdiction with Mandatory Reporting Detect More Cases of Child Sexual Abuse Than One without It?*

It might be surmised that for some unknown reason the Victorian data are a statistical artefact. To address the argument or possibility that an unapparent contextual variable makes the two jurisdictions incomparable, or that for some other reason the Victorian data are an outlier, a further analysis of the broader Australian position may be useful. A scan of the data regarding confirmed cases of child sexual abuse from Ireland compared with the entire nation of Australia may indicate whether the Victorian experience is generally consistent with the Australian statistical picture. The number of reports of suspected child sexual abuse made in each Australian jurisdiction, and the breakdown of these (and their outcomes) by reporter group (including mandated reporters), is not publicly available, although a previous analysis concluded that mandated reporters in Australia accounted for approximately 58% of all substantiated reports of all maltreatment [6]. Accordingly, this additional analysis is simply of the numbers of children in confirmed cases after all reports have been made to child protection agencies, relative to the national child population. Each of Australia's eight States and Territories have legislative mandatory reporting of child sexual abuse (although not of all other forms), and did so for the year 2010 [42,80]. Australian population data accessed from the Australian Bureau of Statistics reveals a child population in June 2011 of 5,074,810 [66]; this compares with the Irish child population of 1,148,687 [64]. The Irish data on confirmed cases are reproduced as above. The Australian data was accessed from the annual national publication of aggregate data by the Australian Institute of Health and Welfare ([40], p. 87). Comparison of the population data from the two countries, and of the numbers of children aged under 18 in confirmed cases of child sexual abuse, is presented in Table 2.

**Table 2.** Number of children aged 0–17 in confirmed cases of child sexual abuse, Australia and Ireland, 2010.

| | Australia | Ireland | Proportional Difference * |
|---|---|---|---|
| Child population June 2011 | 5,074,810 | 1,148,687 | 4.41 |
| Number of children in confirmed cases of child sexual abuse | 4427 | 209 | 21.18 |

* Proportional differences are calculated by dividing larger total by the smaller total.

These data show two results. First, in the year 2010, the difference in the two nations' child populations means Australia had a child population 4.4 times that of Ireland. Second, in this year, there were 4427 children in confirmed cases of sexual abuse in Australia, compared with 209 in Ireland.

An interpretation of these results supports several conclusions. Based on the difference in the child population, and the similar incidence of child sexual abuse in these two countries, it might be expected that under other broadly similar conditions, the number of children determined after investigation by child protection agencies in Australia to have been sexually abused would be 4.4 times higher than that in Ireland. That is, if Australia's performance is used as a minimal baseline, then the number of cases of child sexual abuse identified in Ireland as a result of all reports made child protection agencies would be around 1100. This figure is produced by dividing Australia's number of children in substantiated cases (4427) by the population ratio (4.4). Yet, the data show that in Ireland there were only 209 children in confirmed cases. Accordingly, accounting for population difference, the proportional difference between Australia and Ireland in the detection of child sexual abuse is almost *five times* what could otherwise be expected. This ratio is similar to the 4.73 identified in Victoria, suggesting the Victorian data are not an artefact.

These data show that the core child protection agencies in the two jurisdictions are functioning in significantly different ways. There are incomplete data in some respects; for example, this analysis has not explored the comparative resourcing of child protection departments. It does not require an assertion that Australian child protection agencies are generally functioning in a much more efficient manner than those in Ireland—there are issues of resourcing and implementation in all child protection systems. In sum, in real terms, these data indicate that substantially higher numbers of sexually abused children are having their situations identified in a single year in Australia compared with Ireland. Since Australian jurisdictions have a large range of mandated reporter groups, and as reports from mandated reporters are known to lead to a substantial majority of all identified cases of sexual abuse—as shown by the Victorian finding above of 54%, and by other findings [1,6,7]—it is plausible that the presence of mandatory reporting laws is a significant factor contributing to this difference.

### *4.3. Questions of Systems Burden and Net Widening*

Some have argued against mandatory reporting on the basis of net widening and systems burden [62,81]. Net widening is the claim that an ever increasing number of children are captured by the resulting reports produced by a legislative mandatory reporting obligation. The claim was rejected by the Wood Inquiry in New South Wales after extensive statistical analysis ([61], p. 170). Systems burden refers to the extra time, personnel and financial impositions placed on government child protection agency intake and response services. When made, these assertions do not distinguish between types of maltreatment, are not made with detailed examination of reports by maltreatment type, and do not distinguish between reports by mandated reports as opposed to nonmandated reporters. The claims should be assessed with reference to evidence. The strength or weakness of the assertions require analysis from multiple perspectives, one of which must involve a detailed child population analysis undertaken alongside an analysis of reports by type of maltreatment.

Within the context of child sexual abuse, an analysis of the reporting data in Victoria and Ireland, situated within the context of the child populations in these jurisdictions, generates information which contributes to an assessment of this claim for one maltreatment type. The population data from June 2011 is used for illustrative purposes as Ireland's data from 2010 is not available; this has been calculated to make only marginal difference to the 2010 rates shown below. Table 3 presents data concerning the number of reports, and the number of children involved in these reports, and generates a contextual rate of children involved in reports.

**Table 3.** Rates of children in reports of child sexual abuse, 2010.

| | **Victoria (Children 0–16)** | **Ireland (Children 0–17)** |
|---|---|---|
| Total number of reports by all reporters of suspected child sexual abuse (number of children involved in these reports) | 5870 (5445 children) | 2962 (2962 children) |
| Total number of reports by mandated reporters of suspected child sexual abuse (number of children involved in these reports) | 3113 (3039 children) | n.a |
| Child population | 1,152,251 | 1,148,687 |
| Contextual rate: children in all reports | 1 in 211 children | 1 in 387 children |
| Contextual rate: children in reports by mandated reporters | 1 in 379 children | n.a |

These data show that in Ireland, reports made by all reporters in 2010 involved 2962 children, which equates to one in every 387 children. In Victoria, reports made by all reporters involved 5445 children, equating to one in every 211 children. In Victoria, mandated reporters made 3113 reports in total, involving 3039 distinct children, equating to one in every 379 children. The rate of children involved in reports by mandated reporters in Victoria (1 in 379) is very close to the rate of children in all reports in Ireland (1 in 387). For context, a primary school of 370–400 students would represent a school of reasonable size. On this basis, these data indicate that in each jurisdiction one child in a school of such a size is being reported as the suspected victim of child sexual abuse per annum.

Further, recalling that one half of all reports in Victoria did not result in investigation, it is strongly arguable that, at least for child sexual abuse, the child protection net is neither being cast unreasonably wide, nor is it causing intolerable systems burden.

## 5. Conclusions

Mandatory reporting laws are one component of a society's response to situations of significant child abuse and neglect. The laws can be designed in different forms, thus having broader or narrower potential to identify cases of certain types of maltreatment. As with all aspects of any public health response to a complex problem, a rigorous evidence base must be generated to inform assessments of a particular approach and its consequences, effectiveness, and areas for improvement or change. The different forms and extents of child abuse and neglect present different challenges for child welfare systems, and this heterogeneity suggests a range of responsive measures are required to respond to, and prevent escalation of, different cases. Differential response measures, as a part of an essential secondary prevention dimension in a public health approach to child maltreatment, must also be monitored for effectiveness and outcomes. Their adoption may have promise but should not be unquestioningly accepted.

The differentiation thesis proposed in this article posits that the operation of mandatory reporting laws differs across maltreatment types and reporter groups. This differentiation needs to be recognised and it must inform policy debates about the laws and their effects. Nuanced research including quantitative and qualitative work should explore these different phenomena to understand their operation and outcomes, inform enhancements to practice, and even indicate more substantial reform options. Developments continue worldwide in the adoption and implementation of various kinds of mandatory reporting laws, although the field lacks a detailed evidence base about their consequences. Jurisdictions which introduce the laws should carefully monitor their implementation.

This article conducted empirical analysis of the reporting over a single year of child sexual abuse in two comparable jurisdictions, only one of which had mandatory reporting. It made four significant findings. In the jurisdiction with mandatory reporting, double the number of reports were made (with 53% of these made by mandated reporters); a substantially higher number of sexually abused children were identified (the proportional difference was 4.73; the numerical difference was over 700); 54% of confirmed cases were identified as a result of reports by mandated reporters (2.5 times the entire amount identified by all reporters in the other jurisdiction); and additional substantial systems burden and net widening was not apparent.

Further research into the different reporting outcomes associated with different legal and policy approaches needs to be undertaken, for different kinds of maltreatment. In addition, research should be conducted which compares multiple jurisdictions over longer periods, and studies of the effects of introducing a mandatory reporting duty on reporting practices and outcomes should be done to offer further valuable insights. However, the findings of this study indicate that mandatory reporting of child sexual abuse produces substantial and superior outcomes in identifying children who have been abused, compared with an approach which does not include mandatory reporting.

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## Conflicts of Interest

The author declares no conflict of interest.

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# Urgent Protection *versus* Chronic Need: Clarifying the Dual Mandate of Child Welfare Services across Canada

**Nico Trocmé, Alicia Kyte, Vandna Sinha and Barbara Fallon**

**Abstract:** This study analyzed data from the 1998, 2003 and 2008 Canadian Incidence Study of reported child abuse and neglect (CIS) and compared the profile of children who were reported for an urgent protection investigation *versus* any other investigation or assessment. As a proportion of all investigations, urgent protection cases have dropped from 28% of all investigations in 1998, to 19% in 2003, to 15% in 2008. Results from the CIS-2008 analysis revealed that 7% of cases involved neglect of a child under four, 4% of cases involved sexual abuse, 2% of cases involved physical abuse of a child under four and 1% of cases involved children who had sustained severe enough physical harm that medical treatment was required. The other 85% of cases of investigated maltreatment involved situations where concerns appear to focus less on immediate safety and more on the long-term effects of a range of family related problems. These findings underscore the importance of considering the dual mandate of child welfare mandates across Canada: intervening to assure the urgent protection and safety of the child *versus* intervening to promote the development and well-being of the child.

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## 1. Introduction

Rates of reported child abuse and neglect have been rising across Canada: the number of investigated reports increased from 135,000 in 1998 to over 235,000 in 2008 [1]. In Ontario, the largest Canadian province and the only jurisdiction for which earlier data are available, the number of investigation investigations nearly tripled from just under 47,000 in 1993 to close to 129,000 in 2008 [2,3]. This expansion has been driven by a broadening of child welfare mandates, in particular with respect to the inclusion of: (1) emotional maltreatment [4]; (2) exposure to intimate partner violence [5]; (3) cases where risk of future maltreatment is the primary concern [6]; as well as by (4) professionals becoming more aware of the emotional and cognitive effects of child maltreatment [4,5,7,8].

In response to these changes, concerns are being raised that child welfare practice has shifted in Canada from an approach that had emphasized family support and family preservation towards more intrusive child protection models [9–11]. This shift is attributed in part to the introduction of risk assessment tools [11–13]. Several jurisdictions have sought to re-balance child welfare practice by introducing a range of “differential” or “alternate” response policies, by streaming lower-risk cases to family support services that do not focus as narrowly on protection concerns. Implementing a broader range of child welfare responses has proven to be difficult, especially in a risk adverse environment [14–18]. Part of the difficulty is that the concept of risk in child welfare remains relatively uni-dimensional and does not distinguish clearly enough between different types of risk, in particular, the difference between: (1) situations where the primary concern is to prevent any form of recurrence, such as in cases where escalating physical or sexual abuse poses an acute threat to the safety of a child; compared to (2) situations where the concern is to the risk of the development and well-being of a child exposed to chronic family dysfunction. The purpose of this paper is to explore the difference between the concepts of risk and harm in the context of Canadian child welfare services.

## 2. Disentangling Protection and Well-Being

Expanding conceptualization of what constitutes child maltreatment poses a particular challenge to defining the central concepts that shape child welfare services. While concepts such as "protection", "safety", "harm" and "risk" are relatively clear in the context of specific forms of maltreatment, such as child sexual abuse or severe physical abuse, the meaning of these terms is less clear in reference to an increasingly broad array of forms of maltreatment such as neglect and emotional maltreatment, where the focus of concern shifts from protection from a specific abusive incident to long-term exposure of dysfunctional family interactions that lead to psychological harm [19,20]. A seminal critique of risk assessment in child welfare identified three very different ways that risk assessment was being used in child welfare at the time: as the "likelihood that a given person (usually a parent) will harm a child in the future" ([21], p. 486), as a way of distinguishing between levels of severity of maltreatment and lastly as a need's assessment [21]. Likelihood of recidivism, severity of abusive or neglectful incidents and a child and family's need for supportive services represent, however, three very different assessments. Despite the development of a significant body of empirical research on the predictive validity of risk assessment tools [22,23], the use of the concept of risk in child welfare practice remains as confused as ever [13,24]. This confusion became apparent in a series of validation tests completed at the end of the 2003 cycle of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) which revealed that child welfare workers were force coding "maltreatment investigations", where there was no specific concern about an abusive or neglectful incident having possibly occurred, because of concerns about risk of maltreatment [25]. Following the addition of a "risk investigation only" option in the 2008 cycle of the study, 26% of all investigations were categorized as risk assessments [26].

Confusion about the meaning of risk in child welfare is compounded by a lack of clarity with respect to the notion of harm. Legal definitions often do not specify what is meant by harm, allowing discretion for interpretation by professionals and variability among jurisdictions [27]. Harm is often used as generic concept that combines both physical and emotional harm. For instance, the harm measure used in the U.S. National Incidence Study of Reported Child Abuse and Neglect distinguishes between a "harm standard" and "endangerment standard" that classifies harm to the child as fatal, serious, moderate or inferred, but does not distinguish between physical injuries, other health conditions and emotional harm [28].

In cases of investigated maltreatment, physical harm primarily involves minor injuries and in the most extreme cases severe or fatal injuries [29]. Only 8% of substantiated cases of maltreatment documented in the 2008 cycle of the CIS involved physical harm, and most of these cases involved bruises or other minor injuries that had not required medical attention [26]. Psychological harm, not physical harm, is the primary concern in most situations of child maltreatment. Longitudinal studies consistently demonstrate that for most victims of maltreatment the primary concern is the effect of chronic exposure to maltreatment on their social, emotional and cognitive development [19,30,31]. Even with respect to the neurodevelopmental sequelae of maltreatment, one needs to distinguish between injuries caused by shaking or other forms of physical abuse [32] and damage associated with chronic psychological and emotional dimensions of maltreatment [33].

The key distinction in the context of child welfare interventions is not so much between physical and emotional harm, but between acute harm (or the risk of acute harm) typically associated with severe physical abuse, sexual abuse, and neglect of very young children, and long-term psychological harm associated with chronic exposure to neglect, emotional maltreatment, and less severe forms of physical abuse, as well as with many situations involving acute harm. Most child welfare statutes address this distinction in describing the intent and scope of mandated child welfare services. Canadian Provincial and Territorial child welfare statutes generally make reference to notions of both “protection” and “well-being”, the first referring to concerns about immediate safety from acute maltreating incidents, the second referring to the effects of chronic exposure to maltreatment (Table 1). In British Columbia the legislation states that both “safety and well-being of children are the paramount considerations” [34]. This notion of well-being and safety being equal and central considerations is also articulated in Ontario, Manitoba, and Newfoundland and Labrador [35–37]. Child welfare statutes in Québec, New Brunswick, and Alberta use the terms “security or development” also giving equal importance to both notions [38–40]. Both terms are also used in Saskatchewan, although perhaps in the more limited sense of promoting the well-being of children in need of protection [41], while Nova Scotia, the Yukon and the North West Territories and Nunavut make broader reference to “best interests” [42–44]. Prince Edward Island is the only jurisdiction that does not include well-being, development or best interests in setting forth the purpose of their legislation [45].

## 3. Methods

The Canadian Incidence Study of Reported Child Abuse and Neglect-2008 (CIS-2008) is the third nation-wide study to examine the incidence of reported child maltreatment and the characteristics of the children and families investigated by child welfare authorities [26]. The CIS-2008 tracked 15,980 maltreatment-related investigations conducted in a representative sample of 112 child welfare organizations across Canada in the fall of 2008. Data from the 1998 and 2003 cycles of the study were included as well to examine changes in types of investigations conducted in Canada (Table 2). The 1998 study tracked 7672 child maltreatment investigations conducted in a representative sample of 51 child welfare organizations across Canada and the 2003 study tracked 11,562 investigations in a sample of 55 child welfare organizations in Canada, excluding Quebec where missing data on harm precluded inclusion for the analyses presented in this paper [1,26].

**Table 1.** Purpose or paramount principles guiding child welfare legislation across Canada.

| | |
|---|---|
| **British Columbia** | The safety and well-being of children are the paramount considerations… (BCCFSA[1], 1996, Section 2) |
| **Alberta** | For the purposes of this Act, a child is in need of intervention if there are reasonable and probable grounds to believe that the survival, security or development of the child is endangered… (ACYFEA[2], 2000, Section 2) |
| **Saskatchewan** | The purpose of this act is to promote the well-being of children under 16 who are in need of protection… (SCFSA[3], 1989–1990, Section 3) |
| **Manitoba** | The fundamental principles guiding the provision of services to children and families are: 1) the safety, security and well-being of children and their best interests… (MCFSA[4], 1985, Section 2(1)) |
| **Ontario** | *The paramount purpose of this Act is to promote the best interests, protection and well-being of children… (OCFSA[5], 2002, Section 1(1))* |
| **Quebec** | For the purposes of this Act, the security or development of a child is considered to be in danger….. (QYPA[6], 2007, Section 38) |
| **Newfoundland and Labrador** | The purpose of this Act is to promote the safety and well-being of children and youth who are in need of protective intervention (NLCYFSA[7], 1997, Section 8) |
| **New Brunswick** | The security or development of a child may be in danger when… (NBFSA[8], 1983, Section 31(1)) |
| **Nova Scotia** | The purpose of this Act is to protect children from harm, promote the integrity of the family and assure the best interests of children. (NSCFSA[9], 1990, Section 2(1)) |
| **PEI** | The primary purpose of this Act is to protect children from harm due to abuse and neglect… (PEICPA[10], 1998, Section 2(1)) |
| **NWT and Nunavut** | The paramount objective of this act is to promote the best interests, protection and well-being of children… (NWTCFSA[11], 1997, Section 2(a)) |
| **Yukon** | The best interests of the child shall be given paramount consideration in making decisions or taking any action under this Act; (YCFSA[12], 2008, Section 2(a)) |

Notes: [1] British Columbia Child, Family and Community Service Act; [2] Alberta Child, Youth and Family Enhancement Act; [3] Saskatchewan Child and Family Services Act; [4] Manitoba Child and Family Services Act; [5] Ontario Child and Family Services Act; [6] Quebec Youth Protection Act; [7] Newfoundland and Labrador Child, Youth and Family Services Act; [8] New Brunswick Family Services Act; [9] Nova Scotia Child and Family Services Act; [10] Prince Edward Island Child Protection Act; [11] Northwest Territories Child and Family Services Act; [12] Yukon Child and Family Services Act.

Information was obtained directly from child welfare workers using a three-page data collection form describing child, family and investigation related information that workers routinely gather as part of their investigation. For the 2008 cycle of the study maltreatment investigations were classified under five major categories, with 32 specific forms of maltreatment subsumed under each category. Investigations where no specific incident had been reported and where the concern was risk of future maltreatment were classified as risk-only investigations [6]. For the purposes of this paper, maltreatment categories were classified on the basis of the primary form of maltreatment, the age of the child and the presence of a severe injury, as either urgent protection investigations or other maltreatment related investigations or assessments. Investigations were classified as urgent protection if a child was younger than four and was investigated for neglect or physical abuse, if the primary concern was sexual abuse, or if a child had sustained physical harm requiring medical treatment. Investigations involving severe injuries were classified as potentially requiring an urgent investigation given that such cases can lead to an escalating pattern of maltreatment and the importance of forensic evidence [46]; sexual abuse investigations were included as requiring an urgent investigation because of the importance of forensic evidence and the possibility that the offender might threaten or pressure the child to recant [47]; and abuse and neglect cases involving children under the age of four were included as urgent because of the increased likelihood of severe injury [48,49], their limited verbal skills, and the possibility that harm may escape scrutiny from daycare and school programs.

**Table 2.** Types of child welfare investigations and assessments conducted in Canada, Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) 1998, 2003 and 2008.

| | **1998** | | | **2003** | | **2008** | | |
|---|---|---|---|---|---|---|---|---|
| **Urgent Protection Investigation** | **Count** | **Rate per 1000** | **%** | **Count** | **%** | **Count** | **Rate per 1000** | **%** |
| Severe physical harm | 4193 | 0.67 | 3% | 4565 | 2% | 3486 | 0.58 | 1% |
| Physical abuse <4 | 6595 | 1.05 | 5% | 7586 | 3% | 5523 | 0.92 | 2% |
| Sexual abuse * | 14,240 | 2.26 | 11% | 12,988 | 6% | 9935 | 1.65 | 4% |
| Neglect <4 * | 13,246 | 2.10 | 10% | 18,070 | 8% | 17,355 | 2.88 | 7% |
| *Total urgent protection* | *38,274* | *6.08* | *28%* | *43,209* | *19%* | *36,299* | *6.03* | 15% |
| **Other Investigations and Assessments** | | | | | | | | |
| Physical abuse (≥4) * | 33,006 | 5.24 | 24% | 53,955 | 24% | 38,144 | 6.33 | 16% |
| Neglect (≥4) * | 38,426 | 6.10 | 28% | 55,895 | 25% | 43,440 | 7.21 | 18% |
| Emotional maltreatment * | 25,554 | 4.06 | 19% | 32,871 | 15% | 15,583 | 2.59 | 7% |
| Exposure to intimate partner violence | | | | 38,727 | 17% | 40,975 | 6.80 | 17% |
| Risk assessment | | | | | | 61,430 | 10.20 | 26% |
| *Total other Investigations and Assessments* | *96,986* | *15.39* | *72%* | *181,448* | *81%* | *199,572* | *33.13* | 85% |
| **Total *** | **135,260** | **21.47** | **100%** | **224,657** | **100%** | **235,871** | **39.16** | **100%** |

Notes: The italicized rows represent the totals for cases categorized as either “urgent protection” or “other investigations and assessments”; The last row in bold presents the combined “urgent protection” and “other investigations and assessments” resulting in the annual weighted estimate; The annual weighted estimates are based on samples of 7672 in 1998, 11,562 in 2003 and 15,980 in 2008; investigations from the province of Quebec are not included in the 2003 estimates; * $p < 0.01$, test of significance compares incidence per 1000 children for each type of investigation in 1998 and 2008.

Urgent protection investigations were first compared to other investigations and assessments over the 1998, 2003, and 2008 cycles of the study. Table 2 presents weighted annual estimates of investigations for 1998, 2003 and 2008, as well as rates of investigations per 1000 children for 1998 and 2008; 2003 rates are not presented because of missing harm data in one province. Using data from the 2008 cycle, urgent protection investigations were then compared to other investigations and assessments in terms of harm, selected parent, household and child characteristics and short-term service outcomes.

The harm variables used for the study included (1) whether no harm had occurred, (2) whether harm was in the form of broken bones, a head trauma, bruises/cuts/scrapes, burns and scalds or (3) whether harm was of a mental or emotional nature. There was the possibility of one child sustaining multiple forms of injury. Primary caregiver risk factors included: substance abuse (*i.e.*, alcohol or drug abuse), mental health concerns, cognitive impairment, and lack of social supports. Child functioning concerns which cover a check list of 18 different issues ranging from attachment issues, drug/solvent abuse to academic difficulties were grouped together under a general dichotomous variable of "at least one child functioning concern". For each parent and child functioning variable the four choice ratings of "confirmed", "suspected", "no" or "unknown" were collapsed into dichotomous variables "confirmed or suspected" or "no or unknown". A "housing problems" variable was created based on whether the family had experienced more than two moves in the past year, whether the home was overcrowded or whether there were household hazards present in the home. The two investigation categories were also compared on two additional risk factors: whether the "household regularly runs out of money for basic necessities" and whether the family had previously received child welfare services. Service response documented during the investigation, typically within the first four to six weeks of contact, included whether the case was being transferred for on-going services, whether a referral had been made to specialized services (community based or child welfare agency run service), whether the child had been placed in out-of-home placement (including foster care, kinship care, group home or residential care), whether an application for a child welfare court order had been initiated and whether maltreatment was substantiated. Chi square tests were used to compare differences between the two types of investigations in terms of harm, parent, child or household characteristics and in service responses, whereas independent sample T-tests were used to compare differences in the incidence per 1000 children in 1998 and 2008 for each type of investigation. Both procedures were adjusted to take into consideration the CIS sampling design and the use of weighted data (see [26]).

## 4. Results

The number of child maltreatment investigations conducted in Canada has increased from an estimated 135,260 in 1998 to 235,871 in 2008; during the same period the rate of investigation per capita has increased from 21.47 per 1000 children to 39.16 in 2008 (Table 2). Readers should note that the data for 2003 in Table 2 excludes investigations from Quebec because injury data was not available from Quebec in the 2003 study. Canada-wide investigation estimates published in Table 3-2 of the CIS-2008 Major Findings report [26] show that the increase in investigations occurred entirely between 1998 and 2003, with no significant change in the Canada-wide rate of investigations between 2003 and 2008. Despite the overall increase in investigations, the number of investigations that we classified as urgent has not changed significantly, an estimated 38,274 in 1998, compared to 36,299 in 2008, or 6.08 per 1000 children in 1998 compared to 6.03 per 1000 in 2008. As a proportion of all investigations, however, urgent protection cases have dropped from 28% of all investigations in 1998, to 19% in 2003 to 15% in 2008. The number of cases involving physical injuries and physical abuse cases involving children under 4 has not changed significantly, while the number of sexual abuse investigations has decreased and the number of neglect cases involving children under 4 has increased. As shown in Table 2, the overall increase in investigation is primarily accounted for by exposure to intimate partner violence and risk assessments, which accounted for 42% of all investigations in 2008. Although exposure to intimate partner violence and risk assessments were not explicitly tracked as primary categories of maltreatment in 1998, such investigations would have been included under the neglect or emotional maltreatment categories.

Thirteen percent of investigations categorized as urgent protection involved some type of documented physical harm and four percent of other investigations or assessments involved physical harm not requiring medical attention; keeping in mind that all cases involving harm that was serious enough to require medical attention were re-coded for the present analysis as urgent protection (Table 3). Estimates of fatal harm could not be calculated because the number of fatalities in the study sample was too small to derive estimates. Most investigations where physical harm was noted involved either some other form of a health condition and bruising, cuts or scrape. Ninety percent of the other investigations and assessments that involved a minor bruise, cut or scrape, involved allegations of physical abuse (injury rates by sub-type of investigation not included in Table 4, but is available from the first author). In 16% of urgent investigations and 12% of other investigations and assessments, the investigating worker had documented some type of emotional harm, such as nightmares, withdrawal, or aggression that could be attributed to the alleged maltreatment.

**Table 3.** Urgent protection investigations and other investigations and assessments by harm (CIS-2008).

| | **Urgent Protection** | **Other Investigations and Assessments** |
|---|---|---|
| Total investigations with information about harm * | 36,299/6.03% | 199,573/33.13% |
| No physical harm *** | 87.6% | 96.7% |
| Broken bones *** | 1.7% | 0% |
| Head trauma *** | 1.0% | 0% |
| Bruises/cuts/scrapes *** | 4.4% | 2.7% |
| Burns and scalds | 0.6% | 0.7% |
| Other health condition *** | 5.3% | 0.3% |
| Documented emotional harm *** | 16% | 12% |

*** $p < 0.001$; * $p < 0.05$; rows add up to more than 100% because a child may have sustained several types of injuries.

In comparison to other investigations and assessments, cases reclassified as urgent protection generally involve moderately more parent and household risk factors, including more substance abuse, cognitive impairment, lack of support, and housing and financial problems (Table 4). In contrast, investigations and assessments that did not meet our urgent protection classification involved a significantly larger proportion of children with noted internalizing or externalizing problems.

**Table 4.** Urgent protection investigations and other investigations and assessments by parent, household and child concerns (CIS-2008).

| | **Urgent Protection** | **Other Investigations and Assessments** |
|---|---|---|
| Total investigations | 36,299/6.03‰ | 199,573/33.13‰ |
| Parent substance abuse * | 23% | 21% |
| Parent mental health | 20% | 21% |
| Parent cognitive impairment *** | 7% | 5% |
| Parent lacks support ** | 33% | 30% |
| Housing problem *** | 26% | 18% |
| Family runs out of money *** | 16% | 12% |
| At least 1 child functioning concern *** | 31% | 41% |

*** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$.

Table 5 compares cases classified as urgent protection to other investigations and assessments in terms of investigation outcomes and whether cases had been previously investigated. Rates of opening for on-going services, placement and use of court were higher for cases classified as urgent, while rates of previous child welfare services and rates of substantiation were higher for other investigations and assessments.

**Table 5.** Urgent protection investigations and other investigations and assessments by service response (CIS-2008).

| | **Urgent Protection** | **Other Investigations and Assessments** |
|---|---|---|
| Total investigations | 36,299/6.03‰ | 199,573/33.13‰ |
| Previous child welfare services *** | 55% | 63% |
| Open for ongoing services *** | 31% | 26% |
| Out of home placement *** | 14% | 7% |
| Child welfare court *** | 8% | 5% |
| Substantiation *** | 43% | 55% |
| Substantiated investigations (substantiation x total investigations) | 15,608/2.59‰ | 109,765/18.22‰ |

*** $p < 0.001$.

## 5. Discussion

An estimated 36,299 child maltreatment related investigations completed in Canada in 2008 involved situations where a child: (1) had sustained a severe injury or health condition; or (2) was a possible victim of sexual abuse; or (3) was young enough (under four) to be at high risk of a serious injury as a result of abuse or neglect. From 1998 to 2008 the number of investigations that met one of these three criteria for urgent protective investigation has remained virtually unchanged, at a little over six investigations per 1000 children. In contrast, other maltreatment related investigations have more than doubled, going from a rate of 15.39 investigations per 1000 children in 1998 to

33.13 investigations per 1000 children in 2008, an increase that has been driven by investigations of children exposed to intimate partner violence and risk assessments where there were no specific abuse of neglect allegations [4,5]. As a result, the proportion of investigations that met our urgent protection classification has dropped from 28% in 1998 to 15% in 2008.

Comparison with data from other jurisdictions is limited because few jurisdiction report rates of harm in cases of investigated maltreatment. The Fourth National Incidence Study of Reported Child Abuse and Neglect in the United States, which collected data in 2005 and 2006, reports a rate of 5.5 substantiated Child Protective Service investigations per thousand that met the study's harm standard, and 16.9 Child Protective Service investigations that met the study's broader endangerment standard (derived from Tables 8-1 and 8-8, [28]). While differences in definitions and methodologies limit the comparability of CIS investigation statistics and National Incidence Study (NIS) CPS statistics, it is nevertheless noteworthy that at 2.59 per 1000 children, the CIS rate of substantiated urgent protection cases was lower than the NIS rate of harm standard victims, while the overall rate of substantiated CIS investigations was higher, at 20.81 substantiated investigations per 1000 children (Table 5: 2.59‰ + 18.22‰ = 20.81‰). As a result, a third (33%) of the NIS-4 endangerment Child Protective Service cases met the NIS harm standard, whereas only one in eight (12%) of the CIS-2008 substantiated investigations met our urgent protection rating. The difference between the NIS and CIS can be explained in part by a broader inclusion of risk and exposure to intimate partner violence cases in Canada relative to the U.S. [50], which account for an important part in the overall increase in investigations in Canada [5]. A similar increase in investigations driven by cases of exposure to intimate violence had been documented in Australia [51].

The overall increase in child welfare investigations in Canada is puzzling, not only because investigations involving urgent protection have not been increasing, but also in light of growing evidence from several jurisdictions that rates of child victimization in the population have been declining. Population based victimization studies in the U.S., Australia and the UK point to a decrease in the incidence of physical and sexual abuse [52]. Declines were also observed in the U.S. for victimizations that are serious and indicative of more pathological circumstances like homicide [52]. Rates of child homicide have also been declining in Canada [53]. In contrast, cases of neglect and psychological maltreatment have remained relatively stable over time and in some jurisdictions may even be increasing [54,55]. Explanation for these declines can be attributable to a number of factors with no real consensus as to the driving cause (*i.e.*, reporting practices, definitional standards, increased social intervention). Whereas the stability of neglect trends may be the result of increased education and policy initiatives to include new forms of neglect, which in turn, may be masking a decline of more conventional forms [55].

The comparison between cases classified as urgent protection investigations and the other investigations and assessments show more similarities than differences. The vast majority of both urgent protection (88%) and other investigations (97%) involved situations where no physical harm had been noted, even though all severe harm cases were categorized as urgent protection. Urgent protection investigations involved moderately more situations where parent or household risk factors were present, whereas the other investigations and assessments involved more situations where child functioning concerns had been noted. Emotional harm was documented in more urgent protection cases than in other investigations or assessments, but, as with physical harm, the most noteworthy finding was that in well over 80% of investigations, there no immediate signs of emotional harm had been noted. The fact that relatively few investigations involved situations involving signs of emotional or physical harm is not surprising, given that child welfare statutes include situations where a child has been harmed or is "at risk of harm". For instance, legislation in Alberta makes reference to a child being in need of intervention services "*…if there are reasonable and probable grounds to believe…*" (Alberta Child and Family Enhancement Act, 2000, Section 2) a child has been a victim of maltreatment, and in Quebec for cases of neglect, sexual and physical abuse a "*situation in which there is a serious risk*" of these forms of maltreatment occurring also warrant intervention services (Quebec Youth Protection Act, 2007, Section 38 (b)2, 38 (d)2, 38 (e)2). The focus on risk of harm is certainly consistent with longitudinal studies showing that the effects of maltreatment manifest themselves over time [19,30,31], and is reflected in the general widening of the child welfare mandates to include maltreatment categories that go beyond physical injury and demonstrable harm [54].

Service response patterns vary in an interesting way. Urgent cases were less likely to be substantiated, possibly showing that (1) professionals are more likely to report suspicions when situations involve serious injuries, very young children or possible sexual abuse and (2) that these cases are less likely to be screened out. In contrast, urgent cases were more likely to be open for ongoing service, to lead to and out of home placement and to proceed to court. In other words, the cases that we classified as urgent protection cases appear to be more likely to reported, screened in, open for service, and placed in out of home care. Nevertheless, given that only 15% of cases met our urgent protection classification, the majority of cases open for on-going services—26% of 199,973 other investigations and assessments compared to 31% of 36,299 urgent protection investigations—and the majority of children placed in out of home care—7% of 199,973 other investigations and assessments compared to 14% of 36,299 urgent protection investigations—involved situations where there were no serious injuries, the child was four or older and there were no allegations of sexual abuse. In addition, previous child welfare services were noted in more than half of both types of cases, with previous services being noted most often (63%) in situations involving other investigations and assessments. The vast majority of child maltreatment related reports investigated and eventually opened for ingoing services in Canada involve non-urgent situations where repeated exposure to neglect, emotional maltreatment and family violence jeopardize the well-being of children.

## 6. Limitations

A number of limitations must be taken into consideration in interpreting these findings. The CIS collects information directly from the investigating child welfare workers and the data collected is not independently verified. Child welfare workers are provided with training from the research team to increase consistency in the application of the study definitions. The CIS only examines cases at the point when they completed their initial investigation of a report of possible child abuse or neglect, or risk of future maltreatment. Therefore, the scope of the study is limited to the type of information available at that point, and in particular does not include information about longer-term emotional that may not be manifested at the time of the investigation. The CIS does not include information about unreported maltreatment nor about cases that were investigated only by the police. Comparisons across cycles of the CIS must be made with caution. The forms of maltreatment tracked by each cycle were modified to take into account changes in investigation mandates and practices. Comparisons across cycles must in particular take into consideration the fact that the CIS-2008 was the first to explicitly track risk-only investigations. Finally, it should be noted that the urgent protection and other investigation and assessment categories used in the article analyses are *post-hoc* classifications and do not represent a direct assessment of urgency made by the investigating workers.

## 7. Conclusions

The expansion of child welfare mandates across Canada has resulted in an increase of cases being reported to child welfare authorities where the concerns are long term and are associated with chronic exposure to an increasing range of family problems. While this expansion is consistent with the legislated mandates of child welfare authorities to *promote the protection and well-being of children, there continues to be controversy about the extent to which promoting child well-being is an appropriate function for* child welfare services. It is clear that whenever possible families should be referred to community organizations, however when community services are lacking or families are unwilling to seek services what is the alternative? In the meantime, we know that failure from child welfare agencies to respond to non-urgent cases often results in further deterioration of the family resulting in eventual child welfare response [56,57]. Several Canadian jurisdictions have developed differential response policies in an attempt to address this broader range of maltreatment related problems. The extent to which these policies are being implemented in practice and are truly leading to a better differentiated range of services, remains to be determined.

Hospital emergency rooms depend on clear triage protocols to distinguish between acute and chronic conditions to ensure that the appropriate level of service is provided in a timely fashion. While acute conditions are given priority for urgent care, chronic conditions are not as a result considered to be any less severe. In fact, in many instances the chronic conditions are the ones that in the long term will receive the most intense and extensive services. In response to the dramatic expansion in child welfare mandates across Canada, child welfare service providers and policy makers are looking for protocols and service delivery models that will similarly ensure that the appropriate level of services are provided in a timely fashion. In order to do so effectively, policies and services must be able to disentangle urgent protection from chronic need.

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## Author Contributions

This paper was written by Nico Trocme, Alicia Kyte and Vandna Sinha. Conceptualization and collection of data of the original study was done by Nico Trocme, Barbara Fallon and Vandna Sinha.

The secondary data analyses performed for this paper was completed by Barbara Fallon and Alicia Kyte. All authors read and approved the final manuscript.

## Conflicts of Interest

The authors declare no conflict of interest.

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# Time is of the Essence: Risk and the Public Law Outline, Judicial Discretion and the Determination of a Child's Best Interests

**Penelope Welbourne**

**Abstract:** The Children and Families Act 2014 has introduced a 26-week timeline for Children Act 1989 care and supervision court cases. This article discusses the risks and possible ramifications for children and parents of this measure, which halves the average length of care proceedings. This is to be set against evidence that faster resolution of children's cases is possible without prejudicing the quality of court decision making; however, careful monitoring is indicated to ensure that child welfare is at the forefront in the decision making process and the individual rights of all concerned are protected.

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## 1. Introduction

The following article discusses the problems of delay in children's cases. These are court cases in England and Wales in which the courts decide whether a court order should be made to modify and substitute for the parents' sole right to make decisions about where their child should live and how they should be cared for. Care orders, made under s31 of the Children Act 1989, create a sharing of parental responsibility between a local authority (local government) and the parent/s. They apply only to children who are suffering serious neglect or abuse in the care of their parents and are experiencing or likely to experience significant harm. They are instigated through applications made by local authorities; in all but the most urgent cases, following a period of attempted resolution of the care issues by social workers and other professionals working with the family on a non-mandated basis. Options available to the court under this Act include the making of care orders, supervision orders, under which the local authority is mandated to monitor the progress of the child and support the parent and child, or placement with relatives under a special guardianship order (SGO) or residence order, or making no order at all. The process of seeking a care order starts in most non-urgent cases with a pre-application process, known as the pre-proceedings process, which is considered here together with the care proceedings themselves. Orders made in cases brought by public authorities are known collectively as "public law orders", although the boundary between public and private law is permeable and not always clear-cut. In some cases, such proceedings can lead to the adoption of a child under the Adoption and Children Act 2002. Children's chances of achieving stability and security with a permanent alternative family may decrease if rehabilitation with parents is not possible and care cases [1] take a long time. Prolonged care proceedings place stress on parents and on any children old enough to be aware of their situation. It extends the time children spend living in non-permanent, non-secure situations, with associated risks to placement stability and attachment to carers. Unnecessary delay is to be eliminated under the Public Law Outline (PLO) 2014, updated and implemented on 22 April 2014. Despite the undoubted benefits to children and parents and the cost savings associated with greater speed and efficiency, it is suggested that there may be some risks associated with faster case resolution. These potentially include a threat to the quality of decision making, which may be based on less comprehensive evidence, and a loss of opportunities for parents to demonstrate the capacity to improve their parenting, increasing the chance that children will be placed with alternative carers. These issues may affect only a minority of parents and children involved in the care system, but are nevertheless issues worthy of concern.

This paper examines some of the possible implications of this change, starting from the premise that speeding up the family justice system in public law cases is much to be welcomed, but any change on this scale brings with it some risks. These are considered in the context of evidence from relevant research and commentary.

The question the paper seeks to answer is therefore: what might be the pitfalls in a speedier justice system for children and their parents involved in the new, faster care proceedings? To answer this, a search has been carried out for material relating to child care proceedings and adoption and timeliness; including policy documents, official statistics, law, case law, research and literature from the relevant practitioner community. Similar sources were also searched for material relating to parental rights and parental challenges (such as mental health) and care proceedings and adoption. Analysis focuses on arguments and themes relating to the potential costs and benefits of speedier proceedings, with a view toward reflecting on issues that the courts are likely to have to confront and the possible implications for the probable minority of parents and children for whom speed may not be in the interest of the child nor the parent.

## 2. The Context: The Background to the Current Legal Situation in Children's Care Cases in England and Wales

When the Children Act 1989 was passed, children's public law cases were expected to take about twelve weeks. By the time systematic information became available in the early 1990s, they were taking over 24 weeks. There has been a year-on-year increase most years since then, peaking at 60 weeks. The increase in the number of applications for care orders after the death of Peter Connelly in 2007 defied expectations by turning into an ongoing trend [1]. This, together with lengthening proceedings, made it clear that something needed to change to make care proceedings sustainable in terms of resources and to avoid injustice to parents and children because of unnecessary and

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[1] "Care cases" and "public law children's cases" are terms used to describe cases brought under s31 of the Children Act 1989, when local authorities seek a care order with respect to a child because of concern about actual or likely significant harm to the child.

harmful delay. This came at the culmination of a long period of growing concern about the duration of care proceedings, outlined below.

The 2003 *Public Law Outline* (PLO) [2] set a 40-week target for completion of care cases in England and Wales, to be achieved through elimination of unnecessary delay. The causes of delay were complex, including reliance on expert reports, parents having opportunities to be re-assessed, delay in preparing and filing documents and the absence of a general culture of timeliness or urgency in relation to the resolution of children's care cases [2]. The average length of care proceedings was 42 weeks in 2003: it continued to rise to 52 weeks, and "outlier" cases could take twice that time [3].

The 2005 *Thematic Review* of the issue identified the need for a timetable for each child involved in care proceedings, so that targets would be more than just "lip service" to the best interests of children and to protect statutory duties and human rights expectations better. Judges had discretion to make the timetable fit the individual child, it, "…should exist alongside target times and central Government targets, *i.e.*, not be constrained by them" ([4], pp. 8–9). In 2008, a revised PLO was introduced, adding detail about the timetable for the child[2].

In 2011, the *Family Justice Review Final Report* stated that care proceedings were now running at an average case duration of 60 weeks [5]. Compliance with the PLO timeframes declined as cases progressed, so that only a quarter were still "on track" at 25 weeks [6]. The current "26 week" PLO is a response to this long history of concern about case duration and the failure of previous attempts to control it to have the desired impact. It is designed to be "robust", underpinned by primary legislation.

The aims of the new PLO, piloted in 2013 and in force since April 2014, are to finally reduce "unnecessary" delay, narrow issues for resolution early in the case, reduce the number of hearings, and use experts in a more focused way. Strong judicial case management is presented as the key to success [7,8]. s14 of the Children and Families Act 2014 has enshrined this in primary legislation. The 75% of cases in Brophy's [6] study that were behind schedule at 25 weeks would now be "out of time" altogether by that point, unless there were exceptional reasons for an extension to case duration. The underpinning primary legislation that supports the PLO is summarised below.

Section 14, Children and Families Act 2014: summary of key provisions

The Children Act 1989 is amended as follows:

14 (2) The timetable for dealing with an application for care or supervision orders must be drawn up on the basis of disposing of the application: (i) without delay; and (ii) in any event within twenty-six weeks beginning with the day on which the application was issued.

(3) A court, drawing up a timetable for a s31 case must in particular have regard to: (1) the impact that the timetable would have on the welfare of the child to whom the application relates; and (2) the impact that the timetable would have on the conduct of the proceedings.

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[2] *The Practice Direction Guide to Case Management in Public Law Proceedings* [2008] 2 FLR 668.

(4) A court revising such a timetable or making any decision that may give rise to a need to revise such a timetable must in particular have regard to the impact that any revision would have on the welfare of the child to whom the application relates; and the impact that any revision would have on the duration and conduct of the proceedings.
(5) A court may extend the period that is for the time being allowed for the case, but may do so only if the court considers that the extension is necessary to enable the court to resolve the proceedings justly.
(6) When deciding whether to grant an extension, a court must in particular have regard to the impact that any ensuing timetable revision would have on the welfare of the child to whom the application relates and the impact that any ensuing timetable revision would have on the duration and conduct of the proceedings.
(7) Extensions are not to be granted routinely and are to be seen as requiring specific justification.
(8) Each separate extension is to last no more than eight weeks

Even before implementation of the legal requirement that children's cases complete within 26 weeks, there has been a notable shift in court practice. Initial indications were that courts are, by and large, taking the cultural shift seriously and implementing measures to speed up proceedings, sometimes with dramatic results. In the last quarter of 2013, the average time for the disposal of a care or supervision application had already dropped to 36 weeks, with an 8% decrease in the number of new cases compared with the same period the previous year [9]. February 2013 appears to have been the high-water-mark for care applications [10].

In some Local Family Justice Board (LFJB) areas, the change was dramatic. In the last quarter of 2013, the lowest average completion time was in Truro, at 17 weeks. Other areas showing similarly low completion times in this period include Lincoln (22 weeks), Plymouth (26 weeks), Derby (27 weeks), North Yorkshire (28 weeks) and Worcester (29 weeks) [11]. In areas where case duration is slow to decrease, a backlog of cases that commenced before the introduction of the current PLO may be a factor. Strong judicial leadership appears to be a positive factor in reducing delay [12–14]. We have also seen the first beginning of case law on the subject (*Re S*) [15]; however, these are very early days, and the diversity of families and children's circumstances is likely to require more development in this area.

The next sections of this article look specifically at, firstly, the pre-proceedings stage and then the care proceedings stages of the child and family's journey through the courts, in the context of government measures to ensure faster resolution of public law children's cases.

## 3. The First Stage of the Care Proceedings Journey: The Pre-proceedings Process

The family's journey into and through care proceedings usually starts with a period of engagement with local authority social work services, the pre-proceedings process. Beckett *et al.* describe it thusly:

> "'Pre-proceedings work' can be conceptualised across three phases. The first may be considered preventive work and includes early intervention and 'child in need' work,

> child safeguarding, intensive ‘edge of care’ work, support for kinship care and use of s.20 accommodation. In the substantial majority of cases, this preventive work is successful and the cases do not come to court. It is worth remembering this, in the current climate where there is such an emphasis on speeding cases up towards court, through court proceedings and into adoption. The second stage, which should be used unless it is matter of urgency or likely to increase risk to the child, is the formal “pre-proceedings process”, namely the letter before proceedings and the pre-proceedings meeting, at which the parent(s) can be accompanied by their lawyer(s). The third phase is when the decision has been made to go to court, and all the necessary documents and plans have to be produced.” ([16], p. 35)

During the first stage in protecting children, children identified as being at risk of harm or having suffered harm as a result of parental abuse or neglect are made the subject of a child protection plan, and attempts are made to work in partnership with parents to improve parenting and child wellbeing. Most children who are the subject of court proceedings have been on child protection plans prior to the issue of proceedings, some for several months and occasionally longer. When partnership working fails, for example because of parental non-engagement, and significant harm or risk of harm continues, or if there is an urgent need to protect a child from significant harm, the local authority has recourse to the courts to seek enforceable solutions to the child welfare issue. In all cases except emergency applications, the local authority holds a Legal Planning Meeting to determine whether or not issuing proceedings is the correct and justified course of action, since many cases that are on the edge of care proceedings may be better worked with by some other means where the threshold for care proceedings is not clearly met. The Legal Planning Meeting plans the process of applying to court, where appropriate, and decides on the steps to be taken prior to application. If time permits, *i.e.*, in non-emergency cases, and where the work has a reasonable prospect of engaging parents, the local authority is expected to undertake formally-defined “pre-proceedings” work aimed at helping parents appreciate the seriousness of the situation and to clarify concerns about their parenting. Court intervention is required where the use of compulsion on the parents is necessary to protect the child, especially if the plan for the child is adoption without parental consent. Legal advice is available to parents at this stage at no cost to them, limited (legally aided “Level 2 help”) [17] to assisting them in making an informed decision as to how to respond. This is intended to be a diversionary opportunity, with parents given a last warning and opportunity to respond to concerns: as Beckett *et al.* [16] note, most families that become involved in the child protection process do not progress to the pre-proceedings stage or go to court. The 2005 *Review* called for a “problem solving approach” in the courts and a pre-proceedings process: the pre-proceedings process may be seen as an attempt to divert cases by “problem solving” using legal expertise, among other resources [4,16,18]. The pre-proceedings process is, “…a system through which the relationship between the parents and the local authority is formalised (and possibly renewed) for families at the edge of care” ([18], p. 9).

The time from the decision to issue proceedings to commencement of proceedings decreased slightly under the conditions of a pilot PLO when the pre-proceedings process was employed and stayed the same (at four weeks) when it was not. The authors note that it is difficult to disentangle the effect of the PLO pilot from other contextual changes that accompanied it. A tighter focus on timeliness in court may be leading to increased focus on timeliness at other stages in the process, but the picture is not yet clear enough to draw any strong conclusions.

Parents, but not children, have legal advice and representation at the pre-proceedings stage. In care proceedings, a child has a Cafcass (Children and Family Court Advisory and Support Service) (court appointed) Guardian and a solicitor to represent their best interests. Moving more decisions about assessments forward into the pre-proceedings stage means that many such decisions are now routinely taken without the benefit of separate representation of the child's interests, when previously they were routinely the result of joint instruction by all of the parties. Use of experts instructed during care proceedings seems to be decreasing dramatically, even prior to the introduction of the new PLO, which restricts timescales and therefore provides a strong counter-incentive to making such instruction after proceedings commence [19].

Studies have found differing levels of diversion from care proceedings during the pre-proceedings phase: varying between 25% and 40% [12,18]. A possible explanation for the differing levels of diversion seen is that different thresholds may be applied in different areas for triggering the pre-proceedings protocol and for taking a case to court [18]; some studies have had extremely small numbers of cases, and findings may not be replicated in larger samples. Statistics about diversion need to be understood in the context of the threshold applied for pre-proceedings work and for issuing proceedings. In some areas, the higher levels of diversion may be because more parents enter into voluntary agreements about arrangements for the care of the child, for example, within the extended family network. Parents are a very vulnerable group; for example, Masson [20] found that nearly one third of 381 mothers in a sample involved in care proceedings were experiencing mental health problems. The need to offer robust support to such parents when involved in processes that could lead to the loss of their children seems pressing. The parents' legal representative is seen by some as a defence against unfairness:

> "Negotiated approaches to permanent child placement are then secured legally through private law orders (residence orders, special guardianship). Where the parents' legal representatives and the family court adviser attend the pre-proceedings meeting and plans for permanence within extended family networks are agreed, this provides a level of independent scrutiny in respect of both the rights of parents and children." ([21], p. 1).

The risks associated with negotiated agreements are three-fold: low use of Level 2 help means parents may not have legal advice at this stage and may agree under duress; voluntarily negotiated agreements may never become legally mandated and remain insecure and children may rapidly move out of sight, possibly out the area of the local authority, and be lost to view. The levels of support given to the new carers may be low [21,22]. Masson *et al.* [18] note a national decline in use of Level 2 help for parents and are also sceptical about the capacity of lawyers to "even up" the balance of power between parents and local authorities:

> "The literature on legal representation …illuminates how parents' own lawyers may become part of this… process. They act in their client's interests, but for the main part this is to be achieved by encouraging them to take part in the meeting, and stick to the

> agreement proposed by the local authority. The lawyers are prepared to question the details of the proposed agreement, but any changes tend to be about relatively peripheral matters. The local authority will hold to its core requirements. Parental participation and 'partnership' in the pre-proceedings process is constrained by these limits." ([18], p. 182).

This may be because there is seldom much room for manoeuvring when the safety of children is involved, but the value of the "independent scrutiny" provided by the legal adviser may vary widely. Holt *et al.* [23] found that 16 of their 82 pre-proceedings meetings took place without an advocate present, and when advocates were present, contributions varied from no input to seeking points of clarification; and in only four cases, there was evidence of active "brokering" on behalf of their clients.

The speed of movement through the pre-proceedings process seems to be neither inherently good nor bad: too much time in pre-proceedings may suggest a lack of direction and indecisive assessment; too little or a lack of commitment by the local authority to an authentic attempt to turn things around for the family. Broadhurst *et al.* [12] found that some cases enter pre-proceedings late, already in crisis, progressing rapidly to proceedings. Unnecessary delay may always be prejudicial, but speed is not a proxy for good practice in the pre-proceedings stage any more than in proceedings. Speeding up cases in court does not appear to have led to an immediate increase in time spent in pre-proceedings, but some important decisions that were made in court are now made by local authorities alone (with parental consent and advice, but advice of uneven quality). Most diversions from court are probably the result of good partnership working, but the possibility that parents enter into agreements of which they do not fully understand the legal implications under a feeling of duress is something to be guarded against, especially if parents have special needs that might affect their understanding of the process, as the case of *Re C* [24] illustrates. In this case, the parents, both of whom had substantial difficulties, agreed to the accommodation of their six-day-old child by the local authority "voluntarily", without appropriate support for communication: a failure to respect the public sector equality duty under the Equality Act 2010 that was repeated during the subsequent court proceedings that ensued when the parents withdrew their consent (but which was addressed on appeal; see below). Information about progress through the system of local authority child protection procedures/pre-proceedings processes and court proceedings needs to be analysed in light of information about the reasons individual cases progress fast or slowly and the quality of safeguards available to parents and children at each step of the way.

In summary, early evidence suggests that speeding up care cases is not associated with longer pre-court delay; indeed the opposite may be happening, with pre-proceedings work also becoming more rapid. Good pre-court case preparation may help cases progress once they reach court, but this is not altogether clear from the evidence available at present. It depends on courts accepting pre-proceedings assessments as a solid basis for judicial decision making. Inter-professional trust and respect appear to be important in minimising delay. However, it is clear that parents who are offered fewer opportunities to demonstrate change before proceedings start or who decline to take them up may find that they have little chance to make up this deficit once the court case starts.

The quality of advice given to parents in the pre-proceedings stage appears to be of great potential significance.

## 4. Care Proceedings and the PLO

For parents, involvement in care proceedings combines loss with uncertainty: preconditions for "ambiguous loss" [25–27]. The child is absent, but not yet gone. It is a highly stigmatized loss, with no rituals or conventions for comforting them: disenfranchised grief. It may not end with the end of the court case: if the court makes a care order, there may still be hope that the child may return some day. Cases in which parents have challenged the adoption of their child after a placement order has been made reflect that, for some parents, the end of the court case is not the end of their emotional investment in their child. Yet, however difficult the ending, the strain of proceedings is such that speeding them up may be beneficial to most parents. Freeman and Hunt [28] found that every time parents went to court, they had to "psych" themselves up for an experience they knew would be extremely upsetting. Their level of anxiety did not diminish substantially, and each hearing reactivated their distress. The length of proceedings increasing parents' distress was a common theme in a number of studies [28,29]. Its impact was most marked on parents with mental health problems, possibly impairing their chances of having their child returned to them [28]. Parents were concerned that long proceedings disrupted their relationship with their child, who would be building relationships with other carers, strengthening the local authority's case [30]. The evidence suggests that reducing the duration of care proceedings, consistent with fairness of process and outcome, will be an improvement for parents. Continuity of judge, something parents said they would prefer, is now an expectation in care cases, a subsidiary benefit of the focus on judicial case management and timeliness [29].

It is expected that cases that exceed the 26-week limit will be the exception, even if the term "exceptional" was not included in the wording of the Children and Families Act 2014, which states that, "[e]xtensions are "not to be granted routinely and require specific justification". In a sense, every care case is "exceptional", since they all, or nearly all, concern families in which parents have violated the accepted norms of parental behaviour. However, not all cases lead to orders being made: Beckett *et al.* [13] found no order was made in 5% of cases, and a similar proportion was transferred or withdrawn. Many cases lead to the making of orders other than care orders, such as supervision orders and residence orders, where the child remains with one or both parents or lives with a relative or other commented person. The PLO requires judges making these decisions to differentiate between cases in which judgment can be made within 26 weeks and those for which a longer period is necessary, either in the interests of the child or because "justice requires it". Research shows that expert assessments carried out after the start of proceedings caused delay in many care cases [6]. The child may be in local authority care during the period of the case, since removal from the parents' care should only happen if the child is at imminent danger when with the parents [31]. The level of risk and disruption to the child will vary from case to case, which affects the impact on the child's development. Knowing when there is enough evidence before the court and when more is needed, even at the expense of taking longer, is key.

The timetable for the child must be considered when commissioning expert reports, and the impact of any associated delay must be weighed against the benefits. Evaluating the necessity of an assessment must be linked to an understanding of child development, since the determination that there is, or is not, a gap in knowledge needed to make a disposition in the case has to be made within a conceptual framework, which must be a developmental one, by the nature and purpose of the task. The courts will arguably carry out a three-way weighing exercise: the parent's prospect of success in any treatment being proposed (which may be difficult to quantify), against any harm to the child associated with delay (also hard to quantify, but critical) and the effect on the justice of the proceedings for both parent and child of denying the parent a further opportunity to demonstrate the capacity to change. Research shows that returning from care to live with a parent is the least successful permanence option for maltreated children, with a high risk of re-abuse and return to local authority care. Local authorities vary widely in terms of the resources allocated to support reunification, and the quality of practice is also variable [32]. This may be weighed in the balance when considering agreeing to assessments that may support a return to parents, but it might also be argued that the statistical likelihood of success and the scarcity of local authority and other resources to support parents should not determine case outcomes.

Some flexibility is needed, as has been acknowledged from the outset: "Some planned interventions which are shown to be effective take longer than six months, and it is important that these are not ruled out by this legislation." [6,33]. Parents with fluctuating problems that may improve or stabilize with treatment present another challenge to the 26-week time limit. For some parents, recovery is possible, but may take longer than 26 weeks. The approach of the Family Drug and Alcohol Court (FDAC) has been working with families where child care and drug and alcohol issues are present and has done so by often taking more time to work with parents while they work to address their addiction problems, and cases typically take much longer than 26 weeks to allow for treatment and recovery, as well as evidence of stabilization in recovery [34]. The judge most associated with the project, District Judge Nicholas Crichton, expressed concern that "…process is taking over outcomes… We know parties who have successfully had their children returned home, but who would have had them adopted under the 26-week timetable—it's as tough as that" [35]. The question as to what constitutes an "exception" is likely to be a contested one. However, at present, it appears that a predominant concern is timeliness: assessing and adjudicating on the best interests of each child in time for the individual objectives for the child to be achieved before the child's developmental progress takes them past the age at which they can benefit most from the care to be offered to them. It is not insignificant that the research overview provided to the judiciary is called *Decision Making in a Child's Timeframe* [36].

## 5. Expert and Specialist Assessment

In July 2014, s.38 of the Children Act 1989 Act, as amended by s.31 (11) of the Children and Families Act 2014, came into force. Sections 38(7A) and (7B) state:

(7A) A direction under subsection (6) to the effect that there is to be a medical or psychiatric examination or other assessment of the child may be given only if the court is of the opinion that the examination or other assessment is necessary to assist the court to resolve the proceedings justly.

(7B) When deciding whether to give a direction under subsection (6) to that effect the court is to have regard in particular to (a) any impact which any examination or other assessment would be likely to have on the welfare of the child, and any other impact which giving the direction would be likely to have on the welfare of the child; (b) the issues with which the examination or other assessment would assist the court; (c) the questions which the examination or other assessment would enable the court to answer; (d) the evidence otherwise available; (e) the impact which the direction would be likely to have on the timetable, duration and conduct of the proceedings; (f) the cost of the examination or other assessment, and (g) any matters prescribed by Family Procedure Rules."

Recent case law has added guidance on commissioning expert reports and assessments that will take a case beyond 26 weeks. In *Re S* ([15], para. 38), Sir James Munby said, "Typically three questions will have to be addressed. First, is there some solid, evidence based, reason to believe that the parent is committed to making the necessary changes? If so, secondly, is there some solid, evidence based, reason to believe that the parent will be able to maintain that commitment? If so, thirdly, is there some solid, evidence based, reason to believe that the parent will be able to make the necessary changes within the child's timescale?" Extending assessment in the hope that "something will turn up" ([15], para. 38) is not permissible. In this case, a parent who had previously had three children removed from her care was making progress towards being able to care for the last child, but the local authority and the guardian argued that despite this, she still "had a long way to go" before she could parent this child, and the time involved to make up the remaining distance would be outside the timescale for the child.

Cases have to be assessed individually, but there are some rules to guide courts, as set out by Sir James Munby in *Re S* ([15], para. 34):

> "There will, as it seems to me, be three different forensic contexts in which an extension of the 26 week time limit in accordance with section 32(5) may be "necessary":
>
> (i) The first is where the case can be identified from the outset, or at least very early on, as one which it may not be possible to resolve justly within 26 weeks… Four examples which readily spring to mind (no doubt others will emerge) are (a) very heavy cases involving the most complex medical evidence where a separate fact finding hearing is directed… (b) FDAC type cases… (c) cases with an international element where investigations or assessments have to be carried out abroad and (d) cases where the parent's disabilities require recourse to special assessments or measures...
>
> (ii) The second is where, despite appropriately robust and vigorous judicial case management, something unexpectedly emerges to change the nature of the proceedings too late in the day to enable the case to be concluded justly within 26 weeks. Examples which come to mind are (a) cases proceeding on allegations of neglect or emotional harm where allegations of sexual abuse subsequently surface; (b) cases which are unexpectedly "derailed"

> because of the death, serious illness or imprisonment of the proposed carer; and (c) cases where a realistic alternative family carer emerges late in the day.
>
> (iii) The third is where litigation failure on the part of one or more of the parties makes it impossible to complete the case justly within 26 weeks…"

Courts now have to work in two timescales—that of the court (26 weeks unless there are overriding reasons to go beyond that) and the timescale for the child (based on the child's developmental needs and informed by ideas, such as attachment theory, and recognizing the special characteristics of the child). At the same time, courts must make decisions "justly", which must imply that where there is tension between the rights of parents and the need of the child to have a timely resolution to the case, courts will weigh all relevant considerations. The paragraph from *Re S* above represents a step towards guiding judges on the sort of issues to which they will be called to apply discretion, on a case-by-case basis. The exercise of discretion is made more complex by the very different nature of the elements to be weighed: child welfare considerations, parental rights, administrative imperatives and the broad demands of justice. Predictable practical problems, such as evaluating complex medical evidence and liaising with other jurisdictions; complex parental problems, such as addiction and special communication needs; the unpredictable, such as the appearance of a new player, or the disappearance of a familiar one, or new serious allegations emerging; and failures from within the legal system are all threats to meeting the 26-week deadline that may justify courts exercising their discretion and extending proceedings. However, the four elements noted above have the potential to create a complex four-way pull, as the appearance of new case law on the matter is already fast demonstrating.

In *Re C (A Child)* [24], Lord Justice McFarlane in the Court of Appeal overturned the decision of a lower court and held that the case had to be reheard, with appropriate support for the parents, in the lower court. He held that care proceedings held in the absence of an interpreter able to interpret British Sign Language for a parent and the offer of an "ordinary" parenting assessment as opposed to a specialist parenting assessment that accommodated the special needs of deaf parents was in breach of the parent's rights under the Equality Act 2010 and that the court should have extended assessment beyond 26 weeks in this case:

> "It will be all too easy for courts now to be driven by the 26 week deadline by which care cases should be concluded, but if there are particular aspects of the case that indicate that the timescale for assessment simply cannot provide an effective and meaningful process because of the disabilities of one or more of the individuals involved, that would seem to me to be a reason for extending the timetable for the case by a modest degree, rather than squeezing the assessment in and taking whatever assessment is available within that timescale." (*Re C*, [24], para. 43).

A placement for an adoption order and full care order were set aside, to be replaced by an interim care order pending the outcome of the appropriate assessment. It is also to be noted that this case highlighted several issues about costs and difficulties over costs: the cost of interpreters, especially those with very specialised skills, the cost of specialist assessment and delay in provision of legal aid to the father to enable him to mount his appeal, which led to a 30-week delay after the care and placement (for adoption) order proceedings had concluded. The failure of the lower court to provide appropriate support to parents at the first hearing of the case led to significant delay for the child, since the appeal and consequent re-hearing of the case by the lower court both extended the time it took to conclude the court case and implement the care plan for the child. A further time-related complication is that, at present, many children for whom adoption is the plan have to wait a long time for an adoptive family, and many never achieve this goal [3] [37]. If the plan that is best for the child is adoption and nothing else will do, the court should make an order to that effect, but the decision of whether or not proceedings should be extended to give parents additional time to demonstrate they can parent has to be undertaken in the context of some complex balancing of case-specific and contextual knowledge.

Speeding up proceedings means fewer expert assessments are to be expected, especially ones commissioned after proceedings have begun. The number has already dropped as timescales for proceedings have contracted. There has been no outcry that injustice is the result, although there have been some words of caution [6]. However, it is evident from *Re C* that the pressure on judges to complete cases within 26 weeks has the potential to create some very unjust situations. It is to be hoped that this judgment will be useful in avoiding further instances of such breaches of human rights, including those under the Equality Act 2010.

## 6. Connected Persons Assessments and Special Guardianship

Another challenge to judicial case management within 26 weeks is when a potential carer connected to the child appears during proceedings, and carrying out an adequate assessment of them would take the case over 26 weeks. Parker, J. gave some guidance concerning this matter in the case of *Re K* [38]:

> "Cases where relatives or friends come forward at the last minute are likely to present the greatest challenges to the court in complying with the 26 week limit. The Court has a duty to consider whether there are alternatives to a care order. But in my view the court is entitled to dismiss such an application without detailed assessment and must take into account delay… Orders must record that parents have been advised that failure to identify family members at an early stage is likely to preclude their assessment and that the case will not be adjourned… Any application for further assessment or joinder by a relative or other person must be resolved very swiftly. Such applications will usually be able to be dealt with on paper. Oral evidence, to be adduced only if necessary and proportionate, should be short and focussed." (*Re K*, [38] para, 29–30).

Prior to the 2014 case of *Re C* above, it appeared likely to be that late arrivals for assessment would be turned away, but now, they may still have a chance of being assessed. However, the position appears to be fluid, and it has yet to be made clear how the rules are to be applied, on a "case by case" basis that is as just as possible for all concerned and respectful of individual rights.

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[3] Ofsted found that, on average, it takes two years and seven months for a child to be adopted after entering care [37].

When a Special Guardianship Order (SGO) is being considered, the assessment needs to be of high quality, since the person who acquires an SGO also acquires parental responsibility for the child, indefinitely. Courts faced with this issue might be tempted to conclude cases within 26 weeks by, for example, making a care order to the local authority, which can be done more rapidly, leaving the carer to make a separate "satellite" application for an SGO without the benefit of legal aid or the explanatory context of the care proceedings. SGOs may be attractive to the court, especially when a carers' assessment is in progress or was completed before proceedings started, because parents may be less inclined to oppose such orders than care or placement orders, helping to resolve cases quickly. This could lead courts to favour an SGO over an adoption or a care order. Recent research indicates a small shift towards the making of SGOs may be happening, but until the number of cases completed under the new rules builds up, it may be difficult to identify trends that are statically significant. Different practices in different parts of the jurisdiction could conceal areas in which patterns are changing. Prior to implementation of the new rules, the number of SGOs being made was rising, some with some level of financial support from the local authority attached [39,40]. Scrutiny of the outcomes of proceedings pre- and post-PLO, as Beckett *et al.* [16] have done in three London authority areas [4], would help to illuminate this issue. The numbers of children affected by a change in practice may not be great, and if there is regional variation, as seems likely, any change might not reach statistical significance. However, the impact on individual children could be very substantial if hastily-made SGOs fail or children are placed in care when there are potential related carers who missed the window for assessment.

## 7. Getting the Right Support in Time

Any additional assessments required by the court should be agreed by the first Case Management Hearing. Any special needs on the part of any parent should be considered carefully at this point, this is particularly significant following the judgment in *Re C*, discussed above. Many assessments will have started before proceedings start (see the Ministry of Justice online *PLO Flowchart* [41]). There are potential implications here for parties' rights, in that the instructions will have been issued by one party only (the local authority), although the recommended use of standard forms for instructing experts in the pre-proceedings stage, mirroring those used during proceedings for shared instruction by all parties, may offset this. However, the need for a specific assessment or service not previously provided may become apparent during proceedings. Burman [42] cautions that delays in accessing therapeutic services for parents during the stressful period of the case could also affect its outcome: if by the final hearing, a parent has been unable to access therapy they would benefit from, the local authority will rest its case on a psychologist's report from earlier in the proceedings. The shorter case duration offers both a shorter period of maximum stress for possibly fragile parents and a shorter window within which to demonstrate the ability to cope and improve.

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[4] Beckett *et al.* [16] found no statistically significant change in the pattern of orders made before and during a pilot of the PLO in three London boroughs. However, they did note a rise in the number of SGOs, but not quite large enough to reach significance.

Booth *et al*. [43] describe what they term "temporal discrimination" faced by parents with learning difficulties, because they need more time to acquire parenting skills. The 26-week rule makes it more important than before that parents with learning difficulties have the opportunity to be assessed and address any achievable improvement in parenting in good time, which means starting *Re C*-informed assessments before proceedings, if at all possible. The pre-proceedings stage may be the point at which issues of parental capacity to engage in discussions about their case become significant, as this may be the first point of contact between parents and legal professionals. The Letter before Proceedings sent to parents to formally explain the local authority's concerns and intention to initiate care proceedings if things do not improve rapidly is the trigger for eligibility for legal aid, and the Letter enjoins parents to obtain such assistance. For a minority of parents, this may be the first time the issue of the ability to benefit from legal advice is relevant, and this is a "rights" issue. Parents with a learning disability or communication issue may need more time to understand what is being discussed and to respond to it, which may involve spending more time with them than the current allowance of £364 allows, in which case, the lawyer may make a case for additional funding to be made available. This question of time needed to receive and understand legal advice applies to parents with a range of issues, as well as learning disabilities.

It has already been noted that court proceedings are very stressful for parents, and services may be needed to help improve or prevent deterioration in mental health. There are other possible scenarios in which a parent may require a service that may have relevance to the outcome of the case, and the timeliness of provision is therefore of high importance. If it is delayed, the danger increases that while the parent is "…sorting out her life, her child's life [will have] inevitably moved on in her absence", and the court will find that it is not in the child's interest to "unravel the arrangements made for the child in the interim" (Coleridge, J. in *Re W* [44], para. 30). On the other hand, assessments carried out with undue haste will not find favour: "My enduring anxiety in relation to this case is that in the frenzy of activity which preceded the first hearing in the Family Proceedings court, there was too much local authority emphasis upon securing an expert opinion to support removal from the mother and too little focus upon ensuring a just and fair assessment process. Justice must never be sacrificed upon the altar of speed." (Mrs. Justice Pauffley in *Re NL*, [45], para. 40).

Delay in the provision of support services may have an important effect on outcome in care proceedings, especially where a parent falls short of adequate parenting ability, but may be able to attain it with support [36]. The ability of local authorities to rapidly provide, commission or otherwise secure services for parents is therefore a matter of high importance.

The Court of Appeal case of *Re B-S* [46] concerned a leave to appeal against an adoption order in respect of children removed from their mother's care before she achieved a more stable life. The leave to appeal was granted, but the mother did not win her case on appeal. The judgment covered a range of issues related to the test for making adoption the plan for a child and the quality of evidence and argument required to justify such a plan. It also identified that exploring support for parents before making a decision on whether or not they can parent their children is critical:

> "[B]efore making an adoption order … the court must be satisfied that there is no practical way of the authorities (or others) providing the requisite assistance and

> support …*There needs to be clear evidence that the local authority has considered every possible placement option and the support services that each of these would require*.” (*Re B-S*, [46], para. 28) [Author’s italics]

This must include the option of placement with parents. One might expect the principle relating to “requisite assistance and support” to apply in cases where the issue is the making of a care or other order, as well as adoption. If there were a “practical” way of supporting the parent to care for their child, it would be reasonable to suppose that the local authority ought to provide it. What is “practical” means something that will doubtless have to be negotiated on a case-by-case basis. Further,

> “If, despite all, the court does not have the kind of evidence we have identified, and is therefore not properly equipped to decide these issues, then an adjournment must be directed, even if this takes the case over 26 weeks. Where the proposal before the court is for non-consensual adoption, the issues are too grave, the stakes for all are too high, for the outcome to be determined by rigorous adherence to an inflexible timetable and justice thereby potentially denied.” (*Re B-S*, [46], para 49).

Parents should not, however, expect cases to be extended lightly, even in adoption cases:

> “We do not envisage that proper compliance with what we are demanding, which may well impose a more onerous burden on practitioners and judges, will conflict with the requirement …that care cases are to be concluded within a maximum of 26 weeks.” (*Re B-S*, [46], para. 49).

The issue of what is “practical” does not appear to allow local authorities to rule out provisions on resource grounds, and this clearly applies to care plans other than those for adoption:

> “The local authority cannot press for a more drastic form of order, least of all press for adoption, because it is unable or unwilling to support a less interventionist form of order. Judges must be alert to the point and must be rigorous in exploring and probing local authority thinking in cases where there is any reason to suspect that resource issues may be affecting the local authority’s thinking” *and* “The local authorities must deliver the services that are needed and must secure that other agencies, including the health service, also play their part, and the parents must co-operate fully.” (*Re B-S*, [46], para. 29)[5].

Ryder, LJ in *Re W* [47] advises that local authorities will have to support care plans even when the outcome of the case was not the one they were seeking: a local authority cannot refuse to provide lawful and reasonable services that would be necessary to support the court’s decision because it disagrees with the court’s decision (Ryder LJ in *Re W* [47], para. 83). Ryder LJ also expressed concern that local variation in services could mean that options for parents involved in

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[5] It should be noted that parents cannot be compelled to comply with assessment, but notable that *Re B-S*, *Re C*, *Re S* and *Re W*, all discussed in this article, dealt with the issue of parental entitlement to assessment rather than with non-compliance with assessment, which is often a trigger for care proceedings to be initiated.

care proceedings are pegged according to the resources available in the area that they live in: a variant of the infamous "postcode lottery":

> "To put it in stark terms, it cannot be right that in one local authority a child would be placed with a parent or other kinship carer with significant support to meet the risk whereas in another local authority the same child would be placed with a view to adoption in the implementation of a plan to meet the same risk. The proportionality of placement and order are for the court. The services that are available are for the authority." (*Re W* [47], para. 82).

To take one group of parents at high risk of involvement in care proceedings, there appears to be a wide variability in service provision for parents with learning disabilities across the U.K., and support has been described as reactive and crisis-driven [48,49]. If, after *Re B-S*, "nothing else will do", is the test for making a placement order, how far must local authorities and courts go to ensure that parents have every opportunity to demonstrate the ability to parent, where there is a possibility that they could achieve this with more support? Whether or not "nothing else will do" is, of course, not an exact science. Baroness Hale, dissenting against the majority judgment in the 2013 case of *Re B*, which concerned an appeal against the making of a care order with a view toward the adoption of a child against the parents' wishes [50], said:

> "In the circumstances of this case, it could not be said that 'nothing else will do' when nothing else had been tried. The harm that was feared was subtle and long term. It may never happen." (*Re B*, [50], para. 223).

This highlights the complexity of the decision making process faced by the courts: all decisions are of necessity based on a best estimate of the likely outcomes of various, often very different, options and case-by-case decisions as to whether or not it is reasonable for the local authority to do more to keep parents and children together. A lack of practicable resources must not constrain the local authorities' thinking about options for children; the safest option is not the one the courts should pursue, but the one that is just, and this may require considerable input of time and resources. Both of these are in short supply, and the duty of being final arbiter of how much time and how far local authorities and other service providers should be pressed to provide them falls to the judge or magistrates hearing a case.

## 8. Discussion: Judicial Discretion, Children's Best Interests and Not Sacrificing Justice before the Altar of Speed

Judges are under a new kind of pressure, as are local authorities, Cafcass guardians and others involved in the court process, to complete children's public law cases within 26 weeks. For local authorities, this means being more proactive in identifying necessary assessments, while for parents, it means if the assessments are not the right ones for them at the start of proceedings, they may experience real difficulty getting the situation redressed later. They will have the option of legal advice before proceedings in non-urgent cases, but much depends on the quality of advice available and their ability to use it. Similarly, relatives and other connected persons interested in offering a home to a child who is the subject of proceedings will need to be decisive about coming forward early, which may be difficult for them for personal or practical reasons. *Re C* offers hope that the courts may be more flexible than at first appeared, at least in cases where there are exceptional circumstances.

Judges will have to make decisions about timing and extensions to cases in the context of the four-way pull, described above. They have had their discretion to manage a case according to their own view of the priorities and appropriate timings restricted, in the interests of avoiding the injustice and expense of overlong proceedings. Although, on one level, they have more control [51], they also have tighter expectations placed on them: robust case managers, within parameters that have been tightly drawn. Any exercise of discretion to extend a case for additional assessment is potentially going to be the subject of scrutiny. On the other hand, the situation as it stands appears to offer parties scope for appeal if reasonable requests for additional time are not allowed, especially if they relate to issues that by their nature are not straightforward or easily assessed quickly. The pressure local authorities are under to find resources for assessment or support quickly may impact on the likelihood that a party can appeal on the grounds that the opportunities that they were offered to demonstrate improvement were inadequate.

Managing the timetable for the child and the court timetable is more complex than a two-dimensional managerial balancing act: the “four-way pull” described above, between child welfare considerations, parental rights, administrative imperatives and the broad demands of justice, arguably captures the complexity of the situation more fully. These are ethical judgments, as well as legal ones, in that they reflect an ethically and socially informed view of what children need and what parents should be like. Unlike many other types of case law, child care cases are not about “winners” and “losers” (however parents may feel about them), but the re-ordering of family relationships, which is why they need to be timely, but also why they need to remain focused on identifying the outcome for the child that will offer them the best opportunity to enjoy a secure and nurturing childhood, within the constraints noted above. Decisions about the best outcome for the case are made in the context of hypotheses about the possible outcome of different courses of action, but despite a real and positive move towards basing recommendations and decisions on research evidence, much remains speculative, as Baroness Hale reminds us in Re B. All such decisions involve assessment of relative risk, where clear and unambiguous answers to what is best for children may not be easily found.

For children, ending unnecessary delay is undoubtedly of great benefit, reducing the chance of unplanned moves before the final order is made and increasing the speed with which a plan for their safe and settled care can be implemented. Some children remain with parents during proceedings, either at home with supervision and support or under conditions of parental assessment, but for those that do not, prolonged care proceedings present threats to attachment, so there is much to be gained by careful speed. The early indications here are that, as a group, outcomes may not change much, but stability increases [16]. Any potential negative outcomes may affect only a minority of children for whom 26 weeks is not long enough to make a good enough decision about the key adults in their lives and where pressure to complete the case means a decision is taken that may place the child in a safe place for the immediate future, but is not in the best long-term interests of the child. However, if this were to happen to even a small number of children, this would not be an acceptable situation, affecting as it would children whose life chances were some of the most problematic of any children in the country. For parents, Hoyano is deeply perplexed that the Family Justice Review expresses the view that "…the right of the parents to a fair hearing has come too often to override the paramount welfare of the child…" ([5], para. 57, quoted in [52], p. 598) and argues that both parents and children have a common interest in a fair court process: one that reaches the best solution for the child by just means. It should not be necessary to sacrifice one in the interests of the other, and a system that did so might well prejudice the interests of the child by making plans based on a misapprehension about the parents' capacity, or potential capacity, to parent, or that of another potential carers.

## 9. Conclusions

There has been no evidence to date that faster decision making by the courts in child care cases has led to miscarriages of justice (and arguably when children have waited a year or more for a decision about their future, that could be seen as a miscarriage of justice); however, these are very early days in the life of the new PLO. Recent case law reassures that decision making in children's best interests will not be bound by a 26-week "iron cage". However, the experience of the FDAC, discussed above, suggests that many parents will need longer than 26 weeks to explore the possibilities in terms of their own capacity to change their parenting for the better, and some connected persons' assessments may be problematic, especially when relatives step forward late in proceedings. Excluding late relative applicants to care for children from assessment when they have the potential to provide good care for children risks appeals based on children's right to family life. Balancing the longer term implications for children of courts waiting for more information about the capacity of parents or other relatives to care for the children, against the potential benefits of identifying a clear plan for a child's future at an earlier point in order to assist their progress towards secure and settled care, is very complex. This article has discusses several issues that potentially give rise to difficult decisions for courts about when to give parties time to demonstrate change or secure additional assessments or adhere to predetermined timetables. The concept of "reasonable" delay is highly problematic, despite the very useful clarification in *Re K* [38]. Where parents appear able to care for their children with support, support packages will have to be set up faster, and there will be less time to monitor how that added support affects parenting before the time arrives to make a final decision. Since many children who return home from care do not fare well there and are re-abused [53], it is clear that these are not easy decisions to make, especially under time pressure.

There is a balance to be struck between those risks associated with delay and those associated with speed. Both can have negative consequences, but the natures of those risks are very different, which may make it particularly hard to weigh and balance them. The situation is complicated by the pressure on courts to follow the guidance on timescales for court case completion, and the need to avoid miscarriages of justice, whether or not they give rise to appeals against decisions made by the courts.

The issue on which this article has focused is whether speedier decision making by courts may affect the balance of risks and some of the aspects of the family justice system where such risks may be most likely to occur: some issues that may affect that balance have been explored. Concerns that faster proceedings might lead to "corner cutting" and impair the ability of the courts to ascertain the order, or absence of an order, that are in the best interests of children have not been borne out by the pilot schemes and early feedback [12–15]. However, these are early days, and cases like *Re K* and *Re NL* show that there are no grounds for complacency.

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## Conflicts of Interest

The author declares no conflict of interest.

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# Developing Child-Centered Social Policies: When Professionalism Takes Over

**Nicole Hennum**

**Abstract:** No nation today can be understood as being fully child-centered, but many are pursuing social policies heavily favoring children. The emphasis on individual rights and the growth of scientific knowledge underpinning many of these policies have led to the improvement of the lives of a great many children. Paradoxically, these same knowledge bases informing social policies often produce representations and images of children and their parents that are detrimental for both of these groups. Using Norwegian child welfare policies and practices as examples, I will examine some of the possible pitfalls of child-centered praxis. The key question here is one asking whether the scientific frame central to child welfare professionalism has positioned children and parents as objects rather than subjects in their own lives and, in so doing, required them to live up to standards of life defined for them by experts. A central question will involve exploring the extent to which scientific knowledge has erased political and ethical considerations from the field when assessing social problems.

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## 1. Introduction

The term "child-centered society" is a positively loaded one in the European setting. It refers to societies that not only perceive children as target groups for social measures as citizens of the future, as in social investment states [1,2], but also as social actors in their own right, especially with the right to make their presence known, voice their opinions and judgments and be heard and listened to. In other words, child-centered societies value children's rights, needs and voice *in situ* ([3], p. 15), giving children a claim on the state to protect their interest and to provide them with what is usually named "a good or decent childhood" or "well-being" [4]. Clearly, no nation today qualifies as a fully child-centered society, but many are pursuing social policies highly favorable for children. The emphasis on individual rights and the growth of scientific knowledge underpinning many of these policies undoubtedly have led to the improvement of the lives of a great many children.

However, policies 'putting-children-first' seem paradoxically to give mixed results, even though policy makers operate with the very best intentions in mind towards children [5]. As Gordon has shown, in a country like the United States "where the putting-children-first principle has been particularly strong as a mark of its modernism, driving economy, individualism and relative disrespect of tradition and the elderly", children are "treated worse than other countries of comparable wealth…, with its wretched international records on basic child-welfare indices, such as infant mortality rates, educational attainment, teenage pregnancy incidence and poverty among children" ([5], pp. 332–33). Another country to look at is Norway. In comparative child protection studies, Norwegian society appears extremely child-centered with its generous child welfare system and its prioritization of children's rights when compared to other welfare states [6,7]. Further, Norway internationally scores highest when it comes to child welfare indices. However, in the age group 16–29 years, there has been a tripling of annual new disability cases in the period from 1977 to 2006 [8,9]. An analysis of diagnoses underlining the statistics shows that most of this upsurge is attributable to an increase in the proportion of people with mental disorders. This is in line with recent statistics showing rising levels of young people receiving health-related public benefits with mental disorders as medical grounds [10]. Further, Norwegian statistics show "a high rate of children in care and poor outcomes later in adolescence and adult life" ([5], p. 8), with a relatively high rate of mortality among youth having experiences of been placed in care [11,12]. These two examples raise a key question about why child-centered societies do not deliver as expected. What are the factors at work in child-centered nations accounting for problems of this sort?

In the following, I will examine some of the downsides of child-centered praxis by concentrating attention on Norway as representative of a particularly child-friendly society. In recent decades, the concept of governmentality introduced by Michel Foucault has been much employed in analyses of welfare states to provide insights into how political ideologies and disciplines interplay in the creation of some kinds of subjects [13,14]. The key question addressed here is one examining how the knowledge bases for child-centered policies have created positions for "experts", such as psychiatrics and psychologists, while parents and children are made to fit into these experts' representational and normalizing discourses. These discursive formations reflect ideas about the welfare and best interests of all children and reinforce notions of Eurocentric middle class ideals that, in turn, negatively affect the lives of children and parents who do not fit these ideals. The resulting processes objectifying children and their parents largely explain, I will argue, the statistics about problems that children and young adults in child-centered societies are experiencing.

In so doing, I will first contextualize the emergence of contemporary child centering and its sets of meanings. Secondly, I will describe some features in Norwegian society connected to the perception of Norway as a child-centered society and indicate, at the same time, some of the pitfalls that this kind of child centering entails. Child centering may be understood as an ideal resulting from politicized science, making children and their families responsible for structural and economical inequalities. In concluding this examination, I will ask whether the scientific frame central to the professionalism of adults has positioned children and parents as objects rather than subjects in their own lives and, in so doing, required them to live up to impossible standards of life defined, however, for them as possible by the experts wielding an array of truth claims.

## 2. Child-Centered Societies

The scholarly literature gives a manifold and diverse picture of the emergence of child-centered societies. However, a Foucauldian history of the concept of child-centered societies would show that children as the focus of societies is not a new phenomenon, but that it today takes a special form and content characterized by its intensity and extent. Social policies directed towards children and youth have been part of the development of welfare states since the end of the seventeenth century until today [15–21]. Some laws and measures have been part of the state's family policies, but many specifically targeted children, such as school laws, child protection laws and public health measures. Some laws and measures were aimed to fight the consequences of poverty, such as malnutrition and poor health, but others were to control children and youth as potential offenders. Within child protection legislation, this double aim of help and control has been a guiding principle varying in intensity at different times. The main dilemma was, and still is, to protect children from any kind of harm while also ensuring that society is protected from the harm that children, mostly youth, could cause its members. It could be said, however, that children acquired another political relevance during the nineties, when the concept of child-centered society began to acquire its current meaning. According to Skivenes, a child-centric perspective includes three aspects: (1) children's legal rights and organizational procedures (allowing children to assume their rights); (2) adults' recognition of children as individuals with particular interests and needs in interactions with adults; and (3) the use of an individual child's viewpoint as a way of interpreting what the world means to children ([7], p. 171). Although focusing clearly on children, this definition is open to interpretations and discloses a subtly communicated issue, namely the mediation of the child. This focuses on the questions of how the child should be defined and represented, and by whom. This issue is exacerbated within child-centered societies by many diverse actors raising their voices in the name of the child and competing for positions.

Many factors contributed to the construction of the contemporary meaning of child-centered societies. Firstly, there was a range of new and rewritten child protection laws strengthening children's individual rights, at the international level with the United Nations' Convention on Children Rights in 1989 and on national levels with all manner of newer legislation. These represent today powerful tools in improving children's lives. Secondly, the last two decades of the twentieth century witnessed a massive increase in scientific knowledge about children. Consequently, all academic disciplines currently possess their own specializations focused on children and childhood. They have produced an immense body of knowledge covering a wide variety of areas related to childhood. The vastness of this field makes it impossible to provide an adequate summary, but it is possible to identify some of the central themes in this body of knowledge. On the one hand, there are many studies considering children as universal beings, unaffected by time, place or other categories, and on the other hand, there are studies where children are perceived as situated in time and place—a relativistic perception of youngsters grounded in history and culture. Related to these studies, one also finds gender, age, ethnicity and social class being used as analytical categories influencing perceptions of the category "child" and their activities [22–34]. Connected to politics, these different approaches result in different social policies and measures directed towards children. However, in present-day Europe, one of the central and prevailing representations in child welfare and child protection policies drawing from the literature promotes the universal individualized child combined with individualistic understandings of children's lives. This is a view favored within medical and psychological studies [35–37]. As we shall see, the choices made by policy makers from an array of knowledge-based portrayals of child and childhood available to them have very real consequences for the children and parents whose lives are most likely exposed to governance by child protection policies and practitioners.

When exploring child-centered societies, it is necessary to mention briefly some of the reasons why children have taken on an iconic status in contemporary Western societies ([1], p. 437). The iconization of children is a key component of the complex of meanings defining child-centered societies. Demographically, the number of children has decreased in Western Europe for many decades. This decrease has tended to increase their value and worth [38–40]. Some researchers locate the reasons for child-centered policies in changes in family forms; especially in relation to the instability of today's parental dyads, owing to divorce. In the first place, there is an assumption that children raised in unstable situations require more protection and more following. Moreover, children often assume roles as the most stable partners in relationships with their parents and, therefore, take on additional value [41,42]. Still, other researchers have attributed the reason for child-centeredness to a general state of fear pervading contemporary Western societies, triggering the need to exercise overt control of children symbolizing the future, and in so doing, control the future itself [43–47][1]. Another source of the great value attributed to children in Western societies can be found in the development of the welfare state. A move towards a social investment welfare state favors children as target groups [48]. For the state, it is profitable to invest in and expend resources on children who represent the human capital of the nation's future. Advocates of these kinds of investment strategies frequently emphasize the importance of breaking intergenerational poverty in families, as well as promoting programs for the social inclusion of all members of society, especially those least privileged. Children are cornerstones in these policies, particularly those living in disadvantaged families [1,48–50].

Given these concerns, I will discuss how a well-intentioned child welfare system providing universal services to all children, like the Norwegian one, produces biased results when putting child-centered policies into practice. In examining issues related to the choice and use of knowledge within the field of child protection, a central question will involve exploring the extent to which scientific knowledge has erased political and ethical considerations from the field when assessing social problems. The consequences for children of these policies can be crucial for their lives. Even though I employ here a critical perspective to view child protection services, this does not mean that I am not in favor of a child protection system in society and of state intervention in families. What I question, however, is the belief that child centering implies better child protection and participation. Moreover, I ask if this kind of child-centered focus prevents or greatly limits our reflexivity, producing, as Bourdieu has argued, a failure to systematically explore the un-thought categories of thought that delimit the thinkable and predetermine the thought [51]. This lack of reflexivity, I contend, produces three types of biases that can blur the knowledge base within child protection. These include: (1) the social origins and coordinates of the professionals involved in assessing children and families; (2) the position of professionals in the child protection field in relation to the possible intellectual frames offered to them at any given moment, and beyond, in the field of power; and (3) the intellectual bias that invites a conception of the world as a spectacle, as a set of significations to be interpreted rather than as concrete problems to be solved practically ([52], p. 39).

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[1] The sources of fear are many: the dissolution of the nuclear family ideal, the emphasis put on individual self-realization and attainment of success, high rates of criminality, global financial crises, war and terrorism, environmental pollution, and so on.

In the following, I focus especially on some "side effects" of child centering drawing from psychological and medical knowledge, including practices objectifying children, instrumentalizing parenting and using children in certain ways by professionals.

## 3. The Norwegian Case: Indeed, Nothing New under the Sun

For many reasons, the Norwegian child welfare system is an interesting case when studying child-centered societies. Children have a special value in Norway, as they are a key component in national symbol-building and closely associated with the nation's self-image, with the children's parade in all cities and villages on the national day, 17 May, as the most significant national ritual involving children [53]. Furthermore, the official Norway works to promote the country internationally as a pioneer and champion of children's rights as part of nation branding (Norway Portal). Norwegian childhoods are part of a larger brand presenting Norway as an egalitarian, peaceful and democratic society where children are given priority and space [54]. Behind this representation of Norway as "the children's country" (barnas land) is the belief that it not only is one of the best places in the world to grow up, but also that its lawmakers have pioneered in making the protection of children "the best of what exists in the world" (citation from the ombudsman ([55], p. 4)). There has long existed a series of welfare policies prioritizing children [56,57]. The Norwegian government officially boasts of having been the first nation in the world to have established in 1896 a municipal child protection system with the act on the treatment of neglected children [58]. The Castbergske Children Acts of 1915 upheld both mothers and fathers as responsible for their children's education and their social and moral development. Further, authorities could require contributions from fathers of children born out of wedlock. These children acquired also the possibility to inherit their father and take their father's surname [59]. These laws' clarification of rights and obligations between family members, particularly between fathers and children, were seen as a central part of the state's responsibilities for children and for their status within society [60,61]. Furthermore, the laws set a standard for the further development of the welfare state and contributed early to place Norway as a pioneering country when it comes to children's welfare [62]. A new Children Act was passed in 1953, emphasizing child protection services, preventative duties and supporting measures for families [63]. The latest Children's Act of 1992 strengthens children's rights, highlighting their status as separate individuals (from their parents) and affirming the primacy of the best interests of the child in all decisions, strengthened by the incorporation of the United Nations Convention on the Rights of the Child in 2003 [64,65]. It is, however, not only within child protection legislation that Norway stands as child-friendly and child-centered.

Norway was the first country in the world to have its own ombudsman for children in 1981. The country was among the first to ratify the United Nations Convention on the Rights of the Child in 1991, which was incorporated into Norwegian law in 2003. Being a social democratic welfare state, the Norwegian state provides services to all children through universal access to health care, education and other public services. The levels of these provided services are considered (and evaluated) as good. Healthcare is free for children under seven and school is free for children until eighteen. (There are very few private health clinics and schools, as there is a political will not to develop the private sector within schools and healthcare). Further, paid parental leave is generous compared to many countries. Fathers and mothers both have an equal quota of 14 weeks, and the rest of the time (18 weeks on full salary or 28 weeks on 80 percent salary) can be split by both parents as they choose. By the age of one, most children are secured a place in a kindergarten providing good care for them while facilitating the return to work of both parents. Participation by children and adolescents in a range of activities is also encouraged in many fields, as their participation is viewed as a manifestation of their rights as citizens. The Child Protection Act of 1992 states that children over the age of 12 should be heard in cases affecting them, and since 2003, children under 12 can be heard in special situations. In this context, Norway easily appears internationally as exceptional when it comes to children[2]. As mentioned earlier, in comparative child protection studies, Norway mostly stands as child-centered with its generous child welfare system and its prioritization of children's rights [6,7]. One can summarize the state of affairs by saying that there has been over decades a growing awareness of child exposure and vulnerability, quietly justifying increased control of adults generally. Politically, children's welfare is no longer only a matter of parental duties and responsibilities, but also a common responsibility in society. It is a political wish that any adult responds when children suffer or are subjected to injustice. Moreover, any adult dealing with children has an obligation to report any kind of harm (neglect and/or abuse) to the child protection services. Paradoxically, even though interventions in families are expected to take place and even are desirable, interventions are more or less feared. Citizens want child protection services to interfere when children are abused or neglected, but the threshold to report seems to be high among both lay people and professionals. A probable reason for this is that areas involving children welfare and child protection are heavy with moral and existential issues [35].

The main question to be addressed here focuses on the substantive character of the Norwegian child-centered protection system. Norway ranks among the richest countries in the world, a financial situation giving the country many possibilities to build a child protection system favoring children and promoting their subjectivity rather than reinforcing control and surveillance. Drawing on some studies of the Norwegian child protection system, I will look into the choices made and the paths taken when developing the system. Operating at the interface between government support and government control, the Norwegian child protection system establishes the norms for how society wants the circumstances of children's lives to be ([69], p. 542). As a legal system, it sets the standard for how children and childhood in Norway should be. It is the only state agency that can legally intervene in families without the parents' consent. Not only do these interventions take place when there is no doubt of the legitimacy of the intervention in cases of abuse and neglect, but also in cases where it has been determined that there is a risk for the "wrong" development for the child. Today, this is an increasing reason for interventions in Norway, and it is often stated in terms of the danger of emotionally faulty development. The child protection system "is meant to give children in need equal opportunities compared with other children in Norway" (*cf.* a speech given by the minister of

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[2] The concept of exceptionalism (first used by Tocqueville in 1840, [66]) is used to show how cultural, religious, historical, strategic or social reasons may work for a state or a nation that proves the difference that ultimately helps to create a kind of superiority *vis-à-vis* other states and nations [67,68]. The concept gets its meaning in comparative context and shows how a country initially perceives itself as unique and different in important ways from other countries.

children and equality on 24 April 2009). The statement is based upon the idea that the welfare state should operate to compensate for children's social background and provide all children with equal opportunities to choose a meaningful and healthy life for themselves ([3], p. 8). When the child is meeting the child protection services, the Norwegian welfare state declares that s/he should encounter "a modern child welfare service in which the rights of the child and strictly professional assessments are always given highest priority" ([70], p. 11).

Since the 1990s, Norwegian child protection services have undergone basic changes. There has been a political will to reduce the randomness of decisions and to raise the quality of the provided services. The picture now is one of child protection agencies on their way to be fully qualified as research- and evidence-based organs of the welfare system, with assessments and decisions based on rationality and accountability associated with science. In this respect, science is utilized as a legitimizing justification for the activities of child protection services. It is therefore highly appropriate to raise the question about which knowledge about children is used by the state, represented by the child protection agencies, to legitimize its intervention in families. According to Scott [71], understandings based on local and experience-based knowledge are problematic for modern state's working methods. The state cannot take into account local variations to design a policy in line with its goal, for example to provide every child in the country the best possible upbringing. Thus, it is important for a state to choose knowledge that is legitimizing and that does not hinder it in its duties. Universal and expert-based knowledge fill this role. It is a knowledge that is hard to dispute given the role assigned by welfare states to science in combating superstition, irrationality and ignorance.

Despite "the provision of generous universal and targeted services, together with a strong family preservation ideology and an increasingly strong child-centric orientation", Norwegian statistics show, however (as mentioned in the Introduction), "a high rate of children in care and poor outcomes later in adolescence and adult life" ([3], pp. 8, 11, 12). Further, most studies that examine children's participation when meeting child protection services show that children are little informed, heard or given full part status in cases that concern them [72–74]. Explanations as to why the child protection system does not meet its mandate consisting of better lives for children are many. Pösö, Skivenes and Hestbæk explain these as resulting from: (1) an all-embracing system, leading to in-home services early in children's lives and overshadowing the need of risk assessment; (2) the quality, timing and efficiency of in-home services, assuming that they do not meet children's complex needs; and (3) the quality and nature of out-of-home placement, not meeting the children's needs either, especially when looking at the occurrence of placement breakdowns [3]. They conclude that it is likely that the system is too parent-friendly and family-preserving as it tries keeping the child at home for too long. They conclude that a child-centric orientation will challenge the family preservation principle, meaning among other things that in-home measures must give way to early out-of-placements. Such placements would give children security and continuity, values that are widely shared in the Norwegian cultural context. The conclusion is in line with the 2012 Norwegian Official Report recommending developmental and relational support (psychological parenting) rather than biological relations and early interventions in the form of out-of-home placements rather than in-home measures [75]. These suggestions are justified with references to psychological and medical/neurobiological studies, emphasizing the emotional harm and brain damage some children can be exposed to when living with parents who are not parenting according to normative standards set up by child professionals. Regarding children's right to be heard, Christiansen [74] explains the low participation of children in their cases with references to a number of factors. These include social workers' fear of incurring the child's burdens, social workers' lack of communicative competence with children, the lack of structures facilitating children's participation and the focus on parents' caring capacities within child protection. Others explain this lack of participation by referring to the little faith among social workers that children's participation will help in influencing the decision [76].

What is interesting in these studies and reports is that the knowledge base for the assessment of children's lives stays unquestioned. This applies particularly to the perception and understanding of child and childhood underlying these assessments, as well as the overall roles given to mothers and fathers in children's lives. The knowledge is treated as doxa, *i.e.*, it is obvious and stands uncontested as a premise. When the abovementioned researchers concluded that a child-centric orientation will challenge the family preservation principle, their conclusion relies upon ideas of childhood determinism (the idea that childhood experiences determine the direction of future developments) and parental determinism (the idea that parental behavior decides children's future fate) [77]. According to Furedi [77], these deterministic myths are captivating, as they appeal to a type of common sense or matter-of-factness: no one will deny the significance of parents in their children's lives. Focusing on a parental emotional deficit overlooks the influence of socio-economic and cultural factors on the well-being and life chances of children, covering up societal responsibilities, a lack of collective solutions and political unwillingness to change the structural conditions of childhood. For example, unstable housing is often a companion to low incomes, and this means that the child might have to move and change schools many times during its life. In a country where continuity and stability during childhood are highly valued, parents are required to "anchor" the child in a place. Not being able to do so and moving the child many times during childhood is mainly viewed as detrimental to a child's development. In a typical child protection service's assessment, many residential changes would weigh negatively, independently of the parents' possibilities to fulfill the norm of stable housing. Measures to "anchor" both parents and children over many years would be costly, so would measures aimed to give both parents and children proper housing. Taking the case to the extreme, one can say that it costs less to move the child out of a home than economically supporting a whole family for many years. The social worker will in this case argue for a placement by referring to the child's need of continuity and stability.

Talking about discriminative practices raises the question about which families in society would be affected by a more early intervention in the meaning of risk assessment and the following out-of-home placement. Indeed, several studies show that children in contact with child protection services are mostly children from parents with low incomes and low status in society [78,79]. In this respect, rather than challenging the family principle, the child-centric orientation should challenge the structural and institutional discrimination many families experience and encounter in their everyday lives making parenting difficult, *i.e.*, challenge society's discriminatory mechanisms rather than single mothers or poor parents with their educational tasks and family building projects. In a country where there is resistance to talk about social classes with one's own way of life and where the "sameness" ideology has a strong foothold [80,81], expectations for parenting according to one common standard are strong and stay mostly unquestioned [37]. That these standards reflect norms and ideals of middle class parenting is of little concern when it comes to what is the key ideal of Norwegian child protection services—the best interest of the child, as if the best interest of the child is unproblematic common knowledge. That the family, *i.e.*, the parents, are the ones challenged is in line with a knowledge base giving developmental psychology precedence over other forms of knowledge about children and with individualistic ideologies making parents solely responsible for the life of their children. Moreover, attachment theories have gained a hegemonic place in the Norwegian child protection context, and there are assessment programs based upon these theories under national implementation within every child protection service [82]. These theories on children are more suited to modern management than other approaches that introduce complexity. They fit well with the requirements of effectiveness and results, but it is at best unclear what place the child (or its parents) has as a participant and informant in these assessment templates, *i.e.*, as subjects in their own assessment. Assessments done according to these schemes are easy for social workers to use, and they "scientifically" provide a basis for decisions. Further, they help to point to solutions, as they categorize problems.

According to Cole [83], developmental psychology's search for universal and acontextual theories of child development culminated in a representation of children as human beings with needs. Moreover, the discipline has created "a uniform global child amenable to management and standardization" ([24], p. 80), *i.e.*, a universal child without gender, class or ethnicity [31,84,85]. This representation has tremendous consequences for parenting, transforming parents into adults who have to fill children's needs as defined by psychology and transforming children into objects rather than subjects in their lives. The critique of developmental psychology, particularly of the representation of children as "in need", is a massive one and well-grounded [34,86,87]. Despite these critiques, Norwegian political documents related to childhood promote this representation of children, advancing children's need for care, children's need for security, children's need for belonging, children's need for continuity, and so on [70,75,88–90]. Recently, this knowledge has been supplemented with neurological knowledge intensifying the danger of not fulfilling these needs. This gives priority to psychological parents rather than biological ones if the latter fail to parent according to the scientifically-defined criteria for parenting [75]. Risk assessment in this setting is of importance, employing well-trained psychologists to assess emotional relations between parents and their children, leaving aside the materiality of life. Further, developmental psychology, attachment theories in particular, supports the idea of psychological parenting, an idea advanced more and more within Norwegian child protection. However, advocates of these theories are mostly psychologists and psychiatrists, *i.e.*, professionals who are often in a hegemonic position and who assess children mainly coming from working classes, as shown in one recent study [79]. In so doing, they reproduce over and over again ancient knowledge about lower classes. Their actions ideally intended to help children often result in using these same children as subjects for reaffirming dominant norms and values in society, as well as confirming and reinforcing the existing social order [91].

There are some studies, however, questioning the knowledge base within child protection services [37,79]. One investigation draws from interview data from 715 parent interviews in a cross-sectional study of a project studying child protection's development in the last ten years (The

New Child Protection System (Det Nye Barnevernet, DNBV)). This study also used registry data and focus interviews with child welfare workers. The results show first that there is an overrepresentation of working class families (class as defined by the European Socioeconomic Classification) and families with parents without any tie to the labor market. Statistics from Statistics Norway indicate that many of these families have backgrounds from Asia, Africa or the Middle East. Secondly, the various classes have different paths into child protection, the lower social classes being strongly overrepresented in early childhood. Problem formulation is the third feature differing according to class membership. While problems related to the child are the cause for contact between child protection agencies and families of the higher social classes, characteristics of the parents are the most common cause for contacts with families from the lower classes. Fourth, the choice of measures varies significantly between the classes. Care measures are most common in the lower classes, while voluntary placement outside the home is most common for children in families with high incomes. According to Kojan ([79], p. 71), it is in the assessments that class biases are most clear. She uncovers the middleclass bias within child protection and child welfare generally, especially the moralizing about working class lifestyles and the disfavoring of their parenting styles. Situational factors are underestimated, while personal factors are overestimated in decision making. Problems that are rooted in structural factors, such as unemployment for many adults from ethnic minorities, underpaid work or unusual work hours for many lone mothers, high housing costs, and so on, are understood within categories from what she calls the psychopathological paradigm that is widely shared within Norwegian child protection services, a characteristic already mentioned in the article. She concludes that child protection services are welfare agencies often reproducing oppressive social structures while believing that they are giving children the same opportunities as other children. In 2014, a number of documentaries in the Norwegian media had taken up complaints against child protection services from parents with various non-Western ethnic backgrounds and from young, uneducated mothers with a Norwegian ethnic background. Most of these parents have experienced their child placed out of the home, as they were assessed as emotionally not fit for their child, *i.e.*, being a risk for their child's development by not providing conditions for an "optimal development", as it is often mentioned in documents. Many of them are suing the child protection services in order to get their child back.

Drawing on class studies and postcolonial studies inspired by Foucault, Hennum [37,69,91] discusses the use of children in the control and disciplining of parents when parents are in contact with Norwegian child protection services. She describes how the child protection services emphasize children's legal rights and use scientifically-based knowledge about children to deal with a number of dilemmas created by the dynamics of a pluralistic society. The combination of rights and developmental psychology is a powerful tool, and she concludes that the use of this combination within dialogues is used more to confirm the cultural, moral, political and theoretical viewpoints of the participating professionals rather than to assist the parents in their struggle to create a life of dignity for themselves and their child [69]. The social workers in these dialogical exchanges discipline the parents with a strong moral stance, constantly illustrating what they (and Norwegian society by extension) regard as acceptable parenting by focusing on the child as an emotional individual with rights. She concludes that social workers use children as tools to disallow the recognition of differences; in other words, to prevent too great a pluralization of society. Further, by studying the body of public documents produced in child protection cases, she questions the individuality of the work done, as documents show a remarkable similarity, despite the fact that they dealt with different girls and boys in a diversity of situations. The unique child as a subject of protection seemed to vanish in these documents to be replaced by a kind of familiar and uniform mass-produced object, whose life is structured to fit into standardized stories of deviant childhoods [91].

What is important for the arguments central to this paper? The Norwegian child protection system is on its way to be an all-inclusive child-centric system as part of a developing child-centric society and social investment welfare state. Professionals, such as psychologists, psychiatrists and lawyers, support this move, and politically, it is supported by a will to create space where children and young people can assert their rights as citizens, by a professional improvement of services. What, however, receives little attention is the consequences for children, parents and professionals of the knowledge bases chosen. The knowledge base used by the child protection system leads the professional gaze towards some observations, leaving some others aside. In the Norwegian case, this selective perception focuses attention mainly on attachment and emotional ties and leads to the construction of a hierarchy of knowledge privileging professional knowledge above parental ethno-theories and everyday life struggles. Between parents and professionals stand the children in an uneasy place. Their utterances weigh much in a system based upon the children's rights to utter an opinion or comment on one's own case. However, these utterances have to be constructed and interpreted by professionals, and in this way, the child becomes and remains a mediated child.

Children's statements emerge in a context where professionals control conversations made with children and young people, and in so doing, the child welfare workers control and manage the production of knowledge about the children. Within the child protection services, it is unrealistic to speak of free speech (if it ever exists). Instead, there has emerged a professionalized speech community where adult child protection workers have created a framework for the stories that children and young people are allowed to generate and present in this context [69]. By steering the conversation, these practitioners produce knowledge about children's lives, dovetailing with what is perceived as acceptable in society or with what is appropriate and relevant in child protection cases. In the study of documents in child welfare service mentioned earlier, Hennum found that tales of normality became threatening when decisions about measures had to be taken [91]. Consequently, these tales tended to be omitted in the documents where the implicit rule seemed to be: the less normality in a document, the better. The main emphasis for professionals was with stories of deviance that made decisions possible. In the current societal perception, the talking child is "the right kind of child". An unquestioned assumption is that speaking children also are disclosing children and that there are certain groups of children in society who are asked to be revealing informants. These children often end up having confessional conversations about their parents with welfare professionals. Further, empowering children makes them also assessing subjects and charges them with a normative social responsibility in relation to adults. In conversation with professionals, children increasingly are encouraged to create stories, both about their own and their parents' deviances from normality.

The Norwegian welfare state uses knowledge regimes that are oppressive to some groups in society, since the ideal adult required by these knowledge regimes about children does not conform to the ideals, living conditions and practices for adults of all social groups. The narrow choice of theory within the child protection system creates a hierarchy, positioning some adults over others as addressees for state regulation. Prominent among those at the lower end of this hierarchy are single mothers, families with adults with low education and low income, families with adults with different ethnic backgrounds than the majority; in other words, families with adults who initially are perceived as socially marginalized compared to other adults. It could in fact be argued that there is nothing new under the Sun. As Gordon puts it: “There is a long history of race and class elites feeling entitled to take children away from the poor and those they consider inferior” ([5], p. 335). These groups have been under state control since the beginning of the welfare state. In a society where psychological parenting is on its way toward replacing biological parenting as a principle in child protection, these groups are on their way to experience their children to be placed out-of-home early on the basis of not being able to give them ‘developmental supportive attachment’ as understood by psychologists and psychiatrics, who of course live under other conditions with much greater economic, social and cultural capital. It might be timely to ask about those children in society who can have their parents and those who do not.

Control and management of parents are activities done subtly in various ways as the professionals convey ideas of children and childhood gaining legitimacy by being scientifically based. Individualization of social and ethnic backgrounds allows for the individual accountability of parents rather than encouraging collective change of structural conditions. Professionals are programmed by laws, knowledge and agency norms to support parents by make them understand that it is best for their child to be middle-class children and to realize the government’s desire for them. They get parents to want for their children the same as the state will for them by the power of the dialogue about the child’s best interests. In a classical Marxist perspective, parents are asked to voluntarily participate in their own oppression or, in Foucault's words, in their normalization. In this situation, a key question to be addressed is whether Norwegian society in its child centrism is in the process of developing standardized children and standardized adults on the basis of scientific studies on middle-class children and adults [37]. In so doing, parent-child relationships are being instrumentalized and devoid or emptied of intimacy and ontology [35,37], while outside professionals are empowered both to represent the interests of the child and to give parents the injunction to change. The compensating state might be on its way to be replaced by a more injuncting state.

## 4. Conclusions

This paper opened by asking about possible difficulties or dangers of child-centered societies. In discussing the Norwegian child protection system as a case of a child-centric system, I showed some of the pitfalls, among others: (1) the instrumentalization of parents who are to fulfill their children’s needs and raise them correctly, as defined by instruction given by professionals; (2) the use of children by professionals both in their careers (Norwegian psychologists, for example, have replaced social workers in making many of the assessments of children that social workers once monopolized), as well as producing certain kinds of knowledge of both children’s stories and knowledge about children; (3) the reduction and narrowing of reality when using one knowledge base while excluding others in assessing and understanding children; and (4) the children’s responsibility in their own case as producers of knowledge about themselves and their parents and therefore, having to bear the "moral burden of moral communication" in society ([92], p. 108). These are, as mentioned above, central to many of the critiques raised by researchers studying the development of parenting in European countries [35,93–96].

At the source of these pitfalls, I have identified certain knowledge bases informing child-centered societies' welfare policies. The most powerful impact of these knowledge regimes stems from the images of children they produce. Many of them have been described as "perpetuating the social, legal, and political marginalization of children" [97]. The child in need, the innocent child, the child victim, the vulnerable child and the child at risk are all images having great political and emotional appeal and "are constructed and adopted for particular social, political and psychological purposes" ([97], p. 426). Many of these images have been constructed at the expense of children's parents or their guardians and have involved processes pathologizing adulthood and separating children's interests from the rest of the population [98]. However, as Gordon points out, history has shown that the combination of children's rights and innocent child rhetoric has not historically been constructive; nor have processes enacted for defining children's interest separately from those of their parents ([5], p. 347). There clearly exists a need to critically interrogate prominent images informing social policies for children.

The idea of a child-centric society is a seductive one, maintained and reinforced by some regimes of truth converging towards "creating scientifically optimal children" ([38], p. 162). The idea fits well with fearful societies having heightened risk consciousness related to unwanted or dangerous outcomes and with a dominant ideology defining parenting as the cause of, and solution to, social problems [99]. In this context, it is often difficult to talk about children as subjects. They appear more and more as objects of development for professionals and when assessed as objects of more or less successful parenting. In light of these developments, it seems reasonable to ask if the main danger of child-centric societies might be one involving the formation and acceptance of an authoritarian and moralizing state, even a soft totalitarianism, as suggested by Smeyers [100], all done in the name of children. Our individualized and risk-obsessed societies today seem to foster this development by providing little or no space and time to politicize the moral discourse of the child-centric society often disguised in legal and scientific terms.

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## Conflicts of Interest

The author declares no conflict of interest.

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# The Voice of the Child in Child Protection: Whose Voice?

**Margaret Bruce**

**Abstract:** Article 12 of the United Nations Convention on the Rights of the Child outlines the rights of children to express their views in decisions affecting their lives. There is further evidence to support the positive benefits for children who are afforded this right. However, evidence shows that despite legislative and policy frameworks to support this, repeated messages from inquiry reports highlight failures to do so. This paper draws upon research undertaken in Scotland but the findings of the study are relevant across the UK and beyond. Child protection documentation including reports and case conference minutes were analysed to assess to what extent the child's views were presented to, and considered in, decision making forums. In particular the study considers how the child's views and wishes are represented in writing, and highlights the ways which professionals filtered and interpreted the child's view rather than presented it in its pure form. Messages have emerged identifying a need for workers to be clear about the factors which influence their practice with children. These include the value they place on children's participation, the skills and confidence needed to engage children with complex needs and the impact of competing tensions. One example of such a tension is that between the needs of busy workers, and those of children who are potentially involved in a range of decision making processes.

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## 1. Introduction

This paper considers evidence collected as part of a wider service evaluation in one Scottish locality. This research looked at practices across the area and considered changes before, and after, a service was introduced to support children to participate in, and give their views at child protection case conferences (hereafter "the support service"). In order to establish a baseline of activity in relation to the presence of children's views within their formal child protection meetings, social work case files and case conference minutes of children who had not accessed the support service were examined. The analysis of these documents provides the primary source of evidence for the discussion here. A separate review was undertaken of the support service itself.

This study has been set in the context of wider policy and legislative developments. The United Nations Convention (hereafter UN Convention) Article 12 states that "…parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child" [1]. Since the introduction of the Convention, policy and legislation to reflect this right have been developed across Europe, as countries which have ratified the Convention seek to reflect its intentions. For example, Norwegian child welfare legislation states "Children aged

7 or older and children younger than 7 who are able to form their own opinions always have the right to express their views" [2].

Interestingly there is potential for such statements to be open to interpretation. For example, the determination of an appropriate level of maturity, or whether a child is capable of forming their own opinion opens up the potential for debate and ultimately for these rights to be applied or denied depending on criteria set.

This paper examines practice within a Scottish context where the principles of the UN Convention [1] have been embedded throughout national policy and legislation. This includes the Children's Charter which sets out what children and young people can expect from people involved in their lives and includes the commitment that children will be listened to, involved and taken seriously [3]. Practice in Scotland is supported by a national multi-agency approach known as "Getting It Right for Every Child" (GIRFEC) [4]. This states that anyone providing support to children and their families should put the child at the centre and emphasises that "Children and young people should have their views listened to and they should be involved in decisions that affect them" ([5], p. 8).

In addition to the basic rights afforded to children within legislation, policy and guidance, there is an established body of evidence within the literature that supports children's participation for a range of reasons, including the additional information this can bring to the process, and the benefit for children and young people. A study published by the Children's Commissioner in England encouraged professionals to listen carefully to the child and highlighted that "the child's view of the family situation may provide a professional with different insight into the dynamics within the family" ([6], p. 9).

However, despite the imperatives to involve children, a recurring theme has been the difficulty in achieving a balance between the child's right to have a voice and a duty to protect children and young people. Sanders and Mace raise the issue of inappropriate exposure to information and responsibility [7]. However, they highlight the work of Schofield and Thoburn which suggests that "effective participation in child protection work can be an important part of the healing process" and can help to "counteract some of the powerlessness children may feel from having been abused" ([7], p. 93).

The dangers of not engaging children directly are well established. For example, the findings of the Laming report which considered the circumstances of Victoria Climbié's death determined that "the authorities charged with her care almost without exception failed to talk to Victoria directly but addressed their concerns to those responsible ultimately for killing her" ([8], p. 26). Where Victoria was spoken to it was believed that she had been coached. The study by Sanders and Mace found that parents seemed to be the main source of information about the child's wishes and feelings [7].

Given the range and prevalence of policy and legislation available to support the inclusion of children's views, it would appear on the surface that children's views are of central importance to child protection practice in Scotland. However, the findings of this study show that this is not always the case and indeed there are still lessons to be learned in current practice.

This is echoed across other studies over the last decade [7,9] and, in her review of child protection in England Professor Eileen Munro highlighted "Children and young people are a key source of information about their lives and the impact any problems are having on them in the specific culture and values of their family. It is therefore puzzling that the evidence shows that children are not being adequately included in child protection work" ([10], p. 25).

The debates involving children as active agents or passive recipients are well rehearsed [11,12]. The writer does not intend to repeat these discussions here, rather this paper starts from the position that child protection agencies in the UK have adopted the policy initiatives which afford children the rights outlined in policy and legislation, and examines the reality of this in practice.

While the level and nature of children's participation is still debated and developing, there will continue to be a need for adults and professionals to take a role in presenting the views and wishes of children. This paper in particular examines the use of reports and the presentation of children's views in writing to, and at, child protection case conferences in one locality. It seeks to establish the extent to which there is evidence to support the implementation of these polices and what messages could be drawn from the findings to support the continuing development of practice.

## 2. Method

In Scotland, where concerns exist about significant harm to a child, social work services convene a Child Protection Case Conference (CPCC) [13]. A core component of the Getting it right for every child approach described above is a single Child's Plan used by all agencies involved with the child [4]. Where this plan includes action to address the risk of significant harm, it is known as a Child Protection Plan. A plan of this nature would be considered by a CPCC whose function is to share information to identify risks and consider any actions necessary to reduce these risks [13]. The guidance specifically states that the views of the child, parents and carers should be considered. A key element of this research study was the examination of practice at these meetings.

As part of this process a number of file reviews were undertaken within the wider study, however for the purpose of this paper the writer will focus on file reviews 1 and 2 which examined the experiences of children subject to child protection case conference proceedings and looking in particular at case conference documentation. All file reviews were granted approval from the University Research and Ethics Committee.

File review 1 examined local authority social work files concerning children who were the subject of child protection case conferences prior to the commencement of the support service within the local area. One year later, file review 2 examined a different sample of files. Again, these children had not accessed the support service, but the researcher was looking to establish any change within the overall culture and approach of agencies involved in child protection decision making. These files were sampled over a 4 month period (*i.e.*, 12–16 months after the support service had been introduced in the locality).

The file sample for reviews 1 and 2 were for children within the 7–16 years age range. Although not representative of all children subject to case conference in the time period, this criterion was chosen to broadly reflect the remit of the support service (8–16), and to reflect an age range where, on the whole, children and young people could be presumed to have a view. The selection criterion was given to the Lead Officer for Child Care and Protection in the area who was asked to select a sample from the numbers available. Within these parameters, a spread of age and gender were requested, and opportunities to reflect ethnicity were also created where possible. The sample was not, therefore, representative on any specific variable. See Table 1 for age range across file samples.

**Table 1.** Age range of children and young people considered within the two file reviews.

| File Review 1 | Age | File Review 2 | Age |
|---|---|---|---|
| Child A | 13 | Child P | 12 |
| Child B | 9 | Child Q | 13 |
| Child C | 9 | Child R | 11 |
| Child D | 12 | Child S | 14 |
| Child E | 7 | Child T | 11 |
| Child F | 10 | Child U | 12 |
| Child G | 13 | Child V | 13 |
| Child H | Excluded from data | Child W | 13 |
| Child I | 13 | Child X | 11 |
| Child J | 14 | Child Y | 10 |
| Child K | 10 | Child Z | 10 |

A data extraction tool was developed and used across all file reviews in the study. All available documents for each case conference meeting in the sample were read thoroughly and analysed to establish if, and where, the child's view featured in case conference reports and minutes, who had presented the view, and the quality of the information. See Appendix for outline of headings used within the data extraction tool.

There are acknowledged limitations when undertaking a file review. In some cases it was not possible to identify within the social work files all reports which were made available to the conference. However the researcher reviewed and analysed the full minute of each meeting across both file reviews. Whilst a minute is not always necessarily a full account of proceedings in this case it was agreed that at the time of the research these minutes were designed to be a verbatim account of each meeting.

File review 1 looked at 28 files in respect of 10 children, and file review 2 looked at 15 files in respect of 11 children, both included minutes and reports where available for initial and subsequent review case conferences.

To ensure consistency all file reviews followed the same format and each considered 3 key indicators of children's engagement and participation in the case conference process. These were whether the child or young person was in attendance (or a representative of the child present for the purpose of giving their view), whether the child or young person's report was available to conference (or child's written production, e.g., picture), and whether the child or young person's direct view was evident within the conference (the definition of a direct view is discussed below).

The data extraction tool also allowed for the recording of unanticipated indicators of involvement should they emerge (for example, discussion within the conference regarding barriers to engaging the child); these will be considered in the findings and discussion section.

The gender balance for file review 1 was 40% male and 60% female, and for file review 2 the figures were 64% male and 36% female.

### *Definition of a View*

Early into the research the writer identified that some of the data suggested that the child's view had been present at the conference, however, this was not congruent with what the writer considered to be a robust approach to securing and presenting the child's view. Therefore, in seeking to establish a definition for the research the idea of a "direct view" was utilised. For the purpose of the file reviews a direct view was one that had been prepared specifically by the child or young person for the meeting in question, with the child aware of the forum to which they are contributing and the purpose of their contribution.

A further definition was required in considering the format a child or young person could use to present their views. There was a clear expectation from the documentation that there was scope for the child to complete a report, however from the wider research project it became clear that there were a range of ways the child could present their views. Therefore, a broader definition of child's "report" was adopted to include a report, letter or picture from the child, which could be tabled at the conference or spoken about by the child or their representative.

## 3. Findings and Discussion

The research established that despite frameworks for the inclusion of the child's view there were multiple instances where meetings occurred without the views of the child present. Moreover, on closer examination of the practices where it appeared that the child's view was available, it was evident that there were a range of factors at play which combined to "filter" the view of children. Clear messages from practice can be drawn from these findings and recommendations made for child protection practice which have relevance both locally and internationally.

Differences emerged between the two samples that point to the possibility of an increase in the presence of the child's voice at their case conference meeting. Given the nature of the sample, firm conclusions cannot be drawn at this stage. However, it was interesting to note these and consider some of the possible reasons, but these findings indicate that further study is necessary.

### *3.1. Attendance*

The findings of file review 1 show the percentage of conferences where the child was in full attendance was only 11%, with a further 3% attending for part of the time and a notable 86% of children and young people not at their conference.

The figures for file review 2 represented the picture one year later and these figures remained high with 93% non-attendance by children and young people. However, there were some differences in the data which may represent the beginning of a shift in culture. At one conference the minutes note the child had made the decision not to attend, suggesting that this had been discussed. On another occasion the minutes note that the young person had been offered the support service but declined, showing again that the issue of having their view presented had been discussed and brought to the attention of the conference.

### *3.2. Child's Report*

Figures for file reviews 1 and 2 indicated virtually no change over the year in respect of a report or product (such as a letter or a drawing) specifically prepared by the child for their conference. File review 1 had none in this category. There were two references made to reports prepared by children for a different meeting (in this case a Looked After Child's Review), however, it was not clear if the views contained within these still represented an up to date view from the child. In file review 2 there was no specific report available from the child in all but one example. In the remaining instance a report was prepared specifically for that meeting and shared with the conference.

### *3.3. Child's Views*

Between file review 1 and 2 there was an increase in the presence of the child's view at their conference, where the researcher could identify that the child's view had been present and available for consideration by conference participants.

File review 1 revealed that in 82% of cases there was no evidence of a child's view noted in the minute. Whereas in file review 2 there was evidence of the child's direct view informing the conference in 67% of meetings. This left a much reduced figure of 33% where no view was available compared to file review 1. Overall this represented a notable 49% increase in the availability of the child's view to inform the conference and although clearly still room for improvement, this was sufficient to show a positive trend.

The idea that children's views are only partially represented is not new [14]. The findings of the study indicate that this may still hold true today. Thomas [15] discusses what are described as basic flaws in participatory work with children and young people. Citing the work of Cleaver and Mosse he identifies the "adult reasons" and "adult agendas" involved. He goes on to highlight that participatory work with children tends to include "some kinds of children and exclude others." ([15], p. 203). Where the written word or report is used as a medium for conveying children's views and wishes, the agenda of the adult is potentially powerful. It must be considered that this may lead the adult to "filter" what the child expresses.

In examining the written accounts of discussion and adult views given for the consideration at conference, a number of themes emerged. Interestingly despite the researcher's expectation, there was no indication in any of the minutes that age was a reason for views not being available.

On reviewing reports and verbal accounts within the two file reviews and in particular the report sections entitled "views and wishes of the child", it was not always clear whether what was presented was actually the child's view or not and in fact their view could be filtered in the following ways: interpreted through someone else's viewpoint; what the person thinks the child would say; a view that was previously expressed by the child but may now be out of date, or not completed at all.

While the first three options above can have some validity, the writer would argue that it is not the place of the "views and wishes section" of a worker's report to convey these, furthermore they may not represent an accurate account of what the child may wish to convey to this particular meeting, on this particular day.

A study conducted in Norway by Vis, Holtan and Thomas considered factors which would influence social workers in attempting to give children an effective voice in decision making processes [9]. They examined social workers' inclination to value participation and highlight the possibility that some social workers will see participation as necessary and valuable while another view may be that it is not always in the best interests of the child or necessary. This can be reflected in this study where there were indications that workers may not place a high value on the involvement of the child. For example in one meeting the social work report stated that the child had not been asked for a view but there was no reason noted for this. In another file the social work report stated "it has not been possible to gain an up to date view from the child" although again no reason was given.

One of the key concepts emerging from the analysis, which gave some indication as to what may be determining factors in the presence (or otherwise) of the child's views in the discussion and decision-making, was the idea that it was "difficult". A further theme which emerged and is considered in this paper was the way in which reports were presented and the impact this could have on the presence of the child's voice.

### *3.4. Difficulty with the Process of Engaging with the Child*

Within file review 1, a common theme was that for workers, there was some difficulty involved in the process of engaging with the child. Leeson argues that "we only allow the children we perceive as competent to be rights holders, entitled to have their view" ([16], p. 269). In 3 instances within file review 1 difficulty was associated with 'learning disability' as a factor in the child's circumstances. Sanders and Mace again draw upon the work of Schofield and Thoburn to remind us of the need for the maximisation of understanding through discussion rather than lack understanding used as a justification for exclusion of children and young people from difficult decisions [7]. The file review revealed comments such as "the child is difficult to build a relationship with …[s/he…] has a negative view of self". Communication issues were also cited as contributing to the overall theme, "the child finds it difficult to express emotions". There was, however, evidence within these cases of workers knowing the child and being able to interpret behaviour if the child was stressed or anxious.

It is relevant here to consider the skills involved in undertaking participatory work with children. In 2007, Luckock, Lefevre and Tanner researched teaching and assessment of social work students with regard to their communication skills with children and young people, noting that there is no guarantee that social work students will have been taught about or assessed in communication skills with children and young people [17]. In Scotland similar findings of an audit of qualifying social work programmes led to the development of a set of Key Capabilities in Child Care and Protection, which have effective communication as one of the four overarching areas of the framework [18]. Vis, Holtan and Thomas cite research by Vis who identified a feeling of insecurity in workers about communicating with children [9]. There is a message here for workers to be honest about why they are not perhaps seeking the views of the child. If they are not secure in their own skills and abilities they have a responsibility to raise this in supervision rather than avoid the task or deny the child their rights.

Within the first file review, the issue of difficulty was evident in the meetings of around half the sample. For example, children were described as guarded, wary of professionals, "child does not trust people", and the child described as "closed and difficult to read". However, alongside these are comments about workers offering the opportunity to build relationships, to create opportunities to express views in a safe environment, identifying need for further work in this area and in some cases relationship building with workers is evident.

Within file review 2 however, the emerging picture within these key areas was different. This file review gave some indications of the emergence of the support service which had been offered and declined by one child. Only in one case was learning disability cited as a reason for the child not engaging.

As the earlier discussion describes, there was a much smaller number of conferences in file review 2 where there was no evidence of the child's view at all. Consequently, while there was still a sense in some cases that it was "difficult" to engage the views of the child, this was much reduced in comparison, being discussed on only three occasions. In these examples, children were described as "sensitive and does not share" or withdrawn and reluctant to speak.

### *3.5. Reports*

In attempting to identify the child's view within file review 1, a further issue was noted relating to the reports which are prepared for, and made available to conference participants. In current practice in Scotland, reports can be used for a dual purpose, for example a report prepared for a children's hearing can also be used to inform a case conference. In undertaking file review 1 it was not always possible to identify from the file which report had actually been tabled at the child protection case conference. In some cases reports were clearly identified as dual purpose and in others this was unclear. It is possible that there is an unintended outcome here. Perhaps in an attempt to ease the workload of busy workers and avoid repetition, there has been a situation created where these needs have overtaken the need to be able to identify a direct view from the child.

In another instance, the report had been written in respect of a sibling and the child whose file was being reviewed was identified as part of the household. As such there was limited information about the child himself.

In Scotland there is a system of Children's Hearings which is responsible for deciding if a child is in need of compulsory measures of supervision. The Scottish Children's Reporter's Administration (SCRA) is the body which investigate referrals and decides whether or not a child or young person needs to be referred to a children's hearing [19]. Within the file reviews a question was raised for the researcher when one report talked about the child's awareness of a referral being made to the Children's Reporter but the child protection case conference was not mentioned. This left it unclear if this report was originally prepared for a children's hearing, and raised a question as to whether the views contained were up to date or still relevant.

There was an expectation, on the part of the researcher, that the child's views and wishes would be readily identifiable within the social worker's report, given that there was a section in the agreed pro forma identified specifically for this purpose. The file review showed mixed use of this section. In some cases the section was explicit—for example, one child had clearly been asked and stated a view, in this case that he missed his parents and wanted to return home. In another example, the social worker had noted that the child struggled with articulation of views, and the worker made an observation of the child's behaviour and gave an interpretation of this.

Other examples were less clear; in one instance the section contained a statement about a previously expressed view about unhappiness at home. Another contained observations of the child's apparent feelings and views but was very brief and there was no indication of the child being asked directly. In some instances there were no views contained within this section of the report.

This echoes the earlier findings of Sanders and Mace. Having undertaken analysis of child protection case conference minutes and reports in Wales, they sought to identify how the child or young person's views, wishes and feelings were represented in case conferences [7]. They found a "remarkable lack of clarity as to whether the views, wishes and feelings mentioned were actually those of the child or whether they were an adult's assumption or judgement of what they thought the young person's view was" ([7], p. 101).

They noted a more positive outcome in the examination of social workers reports where they could identify "much more in the way of children's wishes and feelings than conference minutes" ([7], p. 102).

In file review 2 the researcher identified one particularly excellent example of a social worker's report which was based on a pro forma which allowed it to be used for a range of meetings. In this instance it was clearly marked with which meetings it was for and the dates of these. The report was very full and helpful and there was a very clear sense of who the child was. The child had read and signed the report at the end which was unusual. There was a clear sense that in this instance, this meeting had the view that the child had wished to convey to *this* particular meeting, on *this* particular day.

File review 2 contained samples of siblings and the files were read from the perspective of each child. There were two examples of children in the age range where their reports were written from the perspective of an unborn sibling. While there were some observations drawn in respect of both children's presentation, there was no evidence of their view being sought.

Again there was an expectation on the part of the writer that the views and wishes section of the social workers' report would contain these. There are a number of observations to make about this section from file review 2. There were some very good examples of this section of the report where the child's views were discussed and examples were given to support their views. Others, although this section was filled out, were very brief, for example, "child is happy with relative and enjoying contact." There was a repeated issue for siblings where reports relating to different members of the family contained the same information, or in another instance the report for one child contained the views of another child. One had completed this section in respect of the unborn child although the report was for the older child in the family.

File review 2 was able to consider the implementation of new GIRFEC [5] based documentation which includes a section with very specific requirements in relation to the involvement of children and families and in particular the child's views of the plan in place. However on 3 occasions this was not filled out at all; on another occasion, the child's view is noted as "not discussed", and one merely states that "child has been spoken to about the plan and is aware of the concerns", these statements are not in accordance with the spirit of these sections of the report. It should be noted that there were some excellent examples but difficulties also persisted with reports and in the absence of a child at their meeting, or the child's report, worker's reports are key sources of evidence.

## 4. Conclusions and Messages for Practice

For a variety of reasons there will continue to be a need for the written presentation and recording of children's views by others and in the context of child protection, the use of reports to capture and convey children's wishes for inclusion at decision making forums is on-going. This necessitates that for this to be fit for purpose there is a need to ensure all views are represented and information is conveyed accurately. The findings of this research concur with the findings of previous messages which indicate that despite policy frameworks and research to support practice, this is an area which continues to need to be developed and enhanced. While this study has shown only tentative indication of change, it has more importantly provided messages to support the development of engagement with children in their protection processes.

McLeod asked the question in 2010 "are we listening yet?" [20] and according to these findings there is a sense that we are beginning to. However as long as children's voices continue to be conveyed through a third party the potential for filtering will exist and for the meaning to be altered.

There were a number of themes arising from this study which lead to pertinent questions for those practitioners responsible for representing the views of children. We have seen throughout this paper the evidence to suggest that there is a varied approach to participation. Anyone tasked with securing and presenting the views of children should be able to reflect on their own position in relation to children's rights, and in particular the right to have their views heard in decisions making. This opens up the potential for honesty about the value one places on children's participation and identifying potential barriers to presenting the child's views accurately, or at all. Practitioners will encounter challenges, for example where they are perhaps concerned that the view the child is expressing may not be their own, or they do not believe the child. However this offers opportunities to consider why the child may be communicating in this way, which would not exist if the child is not asked. Additionally the child's view is one part of the picture and will be considered alongside the other views within protection meetings.

Children and young people involved in protection processes will have experienced, or be at risk of, significant harm and as such can present a range of often complex needs. This was evidenced in the views expressed that workers found children difficult to engage and communicate with. Here the responsibility lies with professionals to ensure that they are confident in, and have the appropriate skills to respond to the needs of individual children. An acknowledgement that the identified worker may not be the most appropriate person, or have the necessary skills, opens the way for someone who can communicate with the child to be involved. Alternatively for the worker to identify a training need in order to respond effectively.

The systems surrounding the child are also complex and competing factors such as demanding workloads and timescales will have an impact on the process. Adults tasked with making decisions about the safety and protection of children have a duty to consider a number of views, including those of professionals, the child and their family. Alongside this run a number of parallel systems and in Scotland a child can be the subject of child protection case conferences, Children's Hearings and additional meetings if for example they are looked after away from home. Attempts to streamline these and reduce unnecessary work are legitimate, but again there is a message about the potential to lose sight of the voice of the child. When preparing reports and presenting a child's views in written form workers should be sure that they are accurate. For example, that the view is current and from this particular child (rather than a sibling). One suggestion from the professional responsible for leading the support service in the wider study was to specify that at all times the written views of children should be articulated in the first person.

Ultimately, if we are committed to the voice of the child then we need to hold to the view that we can accurately represent "this particular child, on this particular day, for this particular meeting."

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## Abbreviations

UN Convention: United Nations Convention on the Rights of the Child;
GIRFEC: Getting it right for every child;
SCRA: Scottish Children's Reporters Administration;
CPCC: Child protection case conference.

## Appendix

Summary of headings used in data extraction tool:

- Case Information: case code, initial/review CPCC, CPCC recommendation and outcome, age, gender, ethnicity;
- Information about the view: participant expressing view, e.g., child, social worker, which document contained this view, was expressed view written or verbal, brief detail of what was said;
- Outcome: child's views supported (yes/no/partially), reasons for agreeing and/or disagreeing with child, was the child's view debated, balance of child's needs and wants;
- Additional comments and observations.

## Conflicts of Interest

The author declares no conflict of interest.

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# Concerted Practice-Based Actions in Intimate Partner and Family Violence: When the Children's Well-Being Is the Central Concern

**Geneviève Lessard, Marie-Eve Drouin, Anne-Sophie Germain, Pamela Alvarez-Lizotte and Pierre Turcotte**

**Abstract:** In Canada, the exposure of children to intimate partner violence is, along with negligence, one of the most frequent forms of maltreatment. Intimate partner violence raises important issues with regard to child custody and to the exercising of parental roles. The aid provided for children exposed to intimate partner violence covers a range of programs, in particular community services specializing in intimate partner violence, frontline social and health services, and child protection. However, these resource services do not share the same missions, or the same understanding of the problems and possible solutions, since they often operate in parallel networks. The complex situations of families confronted with intimate partner violence present considerable challenges in terms of collaboration between the different organizations. Action research was employed to develop an innovative concertation strategy that fostered collaboration between practitioners from different family resource services. The strategy, which was implemented in the Québec City region between 2011 and 2013, was then evaluated. This article presents the results of this evaluation as well as the positive outcomes that the concertation strategy had for the practitioners' practice and for the improvement of family services.

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## 1. Introduction

Children are often at the heart of family violence situations. In Canada, the exposure of children to intimate partner violence (IPV) is, along with negligence, one of the most frequent forms of maltreatment, representing 34% of the cases taken up by child protection agencies [1]. According to data from the Canadian Centre for Justice Statistics [2], 18,710 children under 17 years old were exposed to intimate partner or family violence in 2010. IPV would seem to be more frequent among couples with children [3]. A study based on a representative population sample of 4549 Americans children under 18 years old [4] showed that one child out of nine (11%) had been exposed to family violence in the last year, and that one out of 15 had been exposed to physical (6.6%) or psychological (5.7%) IPV. If we consider lifetime victimization, 17.9% of young people have been exposed to IPV. The portrait is very similar in the Province of Québec, where a quarter of the children have been exposed to physical, verbal, or psychological IPV [5]. In the last few decades, several studies have shown how IPV exposure can have a deleterious impact on children's development [6–18].

The services provided for children exposed to IPV have evolved considerably since the 1990s [10]. They now include a range of programs, in particular community resources specializing in IPV, frontline social and health services, and child protection services. In the Province of Québec, the Youth Protection Act underwent some changes in 2007, denoting the government's acknowledgement that IPV exposure is a form of psychological maltreatment liable to compromise children's health and safety [19]. The changes made to the law recommend an approach based on a sharing of responsibilities between the different resource services working in maltreatment cases. Nonetheless, the operationalization of this principle is not entirely straightforward, since collaboration between the different services remains awkward. Given that the services for IPV and child maltreatment (CM) have developed in separate networks, the organizations and practitioners do not have the same missions or the same understanding of the problems and possible solutions [20–22]. Action research was recently conducted through a co-construction of knowledge and practices involving researchers and practitioners [23]. This made it possible to identify the main conflicts between the practitioners and to establish a novel concertation [24] strategy for resolving these conflicts. This strategy offers concrete support to practitioners faced with the challenge of collaborating with people from other resource services. The aim is to help practitioners go beyond a simple collective management of risk and broaden their respective views of the needs of children and their families. In so doing, their practice will contribute to a winning partnership that will benefit affected children and families by giving them more continuous, coherent, and integrated support. This strategy, which was implemented in the Québec City region between 2011 and 2013, was evaluated by the participating practitioners. This article presents the results of our testing of this process. The collaborative logic underlying this research project ensues from a professional and organizational desire to be part of a continuum of services that can better meet the overall needs of each and every family member confronted with IPV and CM. The current state of knowledge concerning the consequences of IPV exposure for children will be presented below, as will its impact on parental roles, and the collaboration issues for the different practitioner groups. The concertation strategy will then be described briefly, followed by the methodology used in this study. Finally, the results will be exposed and discussed with the intention of identifying promising avenues for the future development of knowledge and practices in this field.

## 2. Literature Review

### *2.1. Consequences for Children of Being Exposed to Intimate Partner Violence*

When children live in a family environment where there is IPV, they are considered to be exposed to it whether or not they directly witness it happening. These children might see or hear episodes of violence, participate more directly by trying to come between the two parents, or witness injuries and police interventions [10,25].

Living in an IPV environment exposes children to numerous risks. Compared to children from the general population, such children present more risk of developing physical health and emotional problems [11,14,26]. With regards to mental health, these children are more likely to suffer from post-traumatic stress [10,15,27,28]. They may also present different types of difficulties, including adaptation, social functioning, cognitive and academic, and interiorized and exteriorized behavioural problems [5,6,10,11,13,15,18,27]. Furthermore, these children might also reproduce the violence in their own intimate relationships, whether it be in adolescence or adulthood [10,13–15,18].

The presence of IPV in the family increases the risk that children will in turn be the direct victims of maltreatment [29–34]. Several studies have shown that exposure to both IPV and direct CM has an even more deleterious effect on children's adaptation [16,17,35,36].

### *2.2. Direction of Violence and Impact on Parental Roles*

Women make up the large majority of IPV victims: they are twice as likely as men to be at risk [2]. The physical acts of violence of which they are victims are also more frequent, more severe, and more serious in consequence [37,38]. As for men, they make up the large majority of alleged perpetrators of family violence (79%), of IPV [1], and of physical abuse towards children [39]. This is all the more true in cases of severe physical abuse [40,41].

The conjugal context of violence in which some women find themselves increases their risk of developing various physical and mental health problems as well as social functioning and parenting problems [42–45]. Moreover, these women often find themselves isolated or forced to take time off from work due to difficulties at home [44]. IPV also affects the conditions in which parental roles are exercised, in particular by increasing victims' stress [46–50]. While the quality of the relationship between the child and the parent who is an IPV victim constitutes an important protection factor for the former [51–55], studies show that the partner or ex-partner often employs violent behaviour to undermine this relationship [53,56,57]. Negative repercussions on the parenting of these women can be observed [56,58,59]. Despite this, studies have shown that these fathers continue to be present in the lives of their children. Approximately 60% of these children continue to live with their father or to see him regularly after an IPV episode [60]. This is why, for the social practitioners helping these families, IPV is often associated with parental-ability and child-custody related challenges [61,62].

### *2.3. Collaborative Challenges among Psychosocial Practitioners*

Several people from the health and social services network can be called on when IPV and CM situations arise. Certain kinds of organizations are at the heart of the required actions, such as frontline social and health services, child protection agencies, shelters, organizations working with men who conduct IPV, and supervised visitation and custody exchange services [63].

Given the difference in the organizations' mandates, their services, and in the target populations, practitioners working with families can have widely diverging views about the issues at hand [20,64,65]. Consequently, it would seem that each organization's mission, as well as the target population influence the practitioners' viewpoints. Moreover, the simultaneous presence of IPV and CM often point to complex family situations and violence problems. The distinct needs of each family member can make it more complicated to provide support [62]. In these situations, getting the various organizations to collaborate represents a strategy that can provide these families with a more complete and coherent service [66,67].

Challenges in collaboration nonetheless remain, in particular between child protection agencies and shelters for women who are IPV victims [65,66]. It is seemingly just as difficult to get resource services for violent partners and those for IPV victims and exposed children to cooperate [68]. Even though its importance has been pointed out by several authors, collaboration remains difficult in concomitant situations [20–22,65,69–71].

## 3. Concertation Strategy

In order to address collaboration issues between practitioners, a concertation strategy has been developed involving all actors from a participatory action research [23]. This strategy took the form of clinical discussions and it called for two concertation meetings, with a three-month interval, between practitioners working with families concerned by IPV and CM. For each clinical situation, the concertation strategy requires three fields of expertise to be systematically represented: services for child protection, IPV victims, and partners with violent behaviour. If one of these branches is not represented for a clinical situation, a practitioner in this field is invited to the concertation meeting so as to share his/her viewpoint. These "external experts" are selected in collaboration with the Project Coordination Committee, which has representatives from each area of expertise. The concertation strategy provides the animation of each encounter by a neutral actor. In the case of our experiment, it was the project coordinator. During the meetings, the practitioners were first invited to introduce themselves and their organization (*i.e.*, mandate and mode of operation). Then, they shared their respective analysis of the family situation, beginning with the family providers. The meeting ended with the proposal of different possible initiatives for each family practitioner so as to ensure the children's safety. A concertation meeting lasted about an hour and a half and involved between three and six practitioners [72].

The innovative nature of this strategy is based on two main aspects. First, although there are existing concertation structures applicable to various situations, these structures are rarely used in IPV. In one hand, this is due to the obstacles already mentioned in the previous section, while in the other hand it is explained by concertation protocols usually requiring the presence of families, which raises important issues of safety for victims of IPV, who find themselves forced to negotiate solutions with their abuser in a context of unequal power relationships. Thus, there is a risk for the intervention to be used by the abuser as a way to maintain control over the victim before, during or after the concertation meeting, and practitioners least aware of IPV may not be able to detect subtle control strategies. Second, these protocols are generally managed by public services agencies, while IPV expertise lies more in the community services. Therefore, this strategy offers a new approach that allows the recognition of all expertises, thus, helping to equalize the power relationships between practice settings, while providing an answer to security challenges for the concerned family members, who give their consent but do not participate in the meetings [72].

Since the services offered in some organizations are of short duration or have waiting lists for services access, sometimes families do not receive help from two or more practitioners at the same time. Thus, another innovative aspect of this strategy is to provide practitioners with the possibility to consult with practitioners from other fields of expertise in conducting a clinical discussion between him/her and two "external experts". A practice guideline has been produced for practitioners needing more information about the concertation strategy [72].

## 4. Methodology

Since the main objective of this study was to evaluate a concertation strategy for practitioners working in IPV and CM, we opted for a mixed methodology that was both qualitative and quantitative. We will begin by describing the sample and recruitment methods, underlining the ethical concerns, then the data collection tools, and, finally, our analysis methods.

### *4.1. Population, Sample, and Recruitment Methods*

The study population was composed of practitioners from different organizations working with one or more members of families affected by IPV and CM. This research is based on a total of 115 participants (number of questionnaires that were filled out), including 57 different practitioners, taking into account that some practitioners have participated for more than one clinical situation as a provider or as an external expert. Two strategies were used to recruit these practitioners.

The first strategy consisted in making practitioners who were working with families affected by IPV and CM aware of the project. To do so, we organized presentations for each of the work teams of the seven main organizations in the Québec City region, namely: a child protection agency, two organizations offering frontline health and social services, two organizations working with women and children exposed to IPV, an organization working with men who employ violence, and an organization providing supervised visitation and custody exchange services. We met with 474 practitioners and managers working with affected families to explain the concertation strategy. Managers have been informed of the concertation strategy since they have an important influence to encourage practitioner participation in research. As the recruitment stretched over a two-year period, an e-mail newsletter was created to periodically remind the practitioners about the concertation strategy. Moreover, we were also able to count on a snowball effect that enhanced this recruitment strategy: several practitioners who participated in a concertation meeting saw the benefits and in turn referred another clinical situation to our research team. When practitioners indicated that they wished to participate in the project knowing that helped family was concurrently receiving services from another organization, they contacted the project coordinator to obtain the information and documentation needed to present the project to parents and ask for their consent for the practitioners to participate in concertation meetings. The project coordinator then contacted the other concerned practitioners to ascertain their interest, then to schedule the concertation meeting.

The second recruitment strategy consisted in obtaining a list of all the children whose reported cases had been retained by the child protection agency because of their IPV exposure and family conflicts. This list was established by the child protection agency and sent to the project coordinator in a secured document. Only the children's user number appeared on the list so as to protect their identity. This list was systematically checked by the project coordinator and the manager of the team of practitioners working with the children so as to determine whether there were two IPV and/or CM services involved with the same family. When situations were identified, the coordinator then contacted the practitioners in question to invite them to participate in the concertation strategy; if interested, the latter would then communicate with the parents to obtain their consent. Concertation meetings were organized by the project coordinator once everyone concerned had given their consent. The evaluation of the strategy was done at the end of each meeting.

### *4.2. Ethics and Victim Safety*

This project made sure that ethical and safety issues were a priority by ensuring the consent of each party and the anonymity of each family member, and by verifying issues related to the safety of victims of violence through diverse mechanisms, even though it was the practitioners who participated to the concertation strategy.

To begin with, the consent of the parents was obtained and, when present, that of children 14 and over. It is important to note that in Quebec (Canada) the law states that children of 14 and older can provide legal consent. Parents who gave their consent for the participation of their practitioner included both biological parents and, when they lived with the children, the step-parents. The consent of each family member concerned was needed; for example, the consent of only the father or only the mother was not acceptable. It is also worth noting that consent of the two parents was always obtained by the practitioner who was closest to them so as to encourage file confidentiality and victim safety.

With regards to anonymity, the research team never asked for the parents' names if the consent forms were not signed by the latter. When it was necessary to have names, for example, the name list provided by the child protection agency, only the project coordinator had access to the information, which was protected by a password that only she knew. Each member of the research team, like the practitioners in the concertation meetings, had to sign a confidentiality form. It stated the importance of protecting the anonymity of the family members, as well as the confidentiality of those family members with whom they were not working. The names were removed from all the documents and replaced by reference numbers before carrying out the analysis.

The victims' safety was a central concern of the team all throughout the project. To start with, the parents were never invited to participate in the meetings so as not to put the victim in the presence of the partner who employed violence. In certain cases moreover, in particular when the woman was staying in a shelter, the name of the organization was not mentioned on the consent form signed by the partner or ex-partner in order to protect the victim. There were nonetheless a few occasions where we were confronted with complex situations in which the simple fact of talking about the project with a spouse having violent behaviour might have been prejudicial to the victim's safety. The concertation protocol was then abandoned to ensure the victim's safety.

### *4.3. Data Collection Methods*

As it was a question of evaluating the concertation strategy, we used a paper questionnaire that the practitioners had to fill out after each of the two meetings. The questionnaire evaluated: (1) the improvement in their knowledge about the situation and related issues; (2) the consensus and divergent opinions identified by the practitioners during the meeting; (3) the overall appreciation of the concertation meeting; (4) the facilitating elements and obstacles in the meeting; (5) their appreciation of the people who were invited to the meeting; and (6) their other concertation experiences in their field. The practitioners could also write down general comments at the end of the questionnaire.

The questionnaire was primarily composed of short-answer questions that made qualitative analysis possible, but also had Likert-scale questions that allowed certain aspects to be measured with a quantitative approach, in particular the practitioners' satisfaction.

The practitioners answered these questionnaires anonymously, while, nonetheless, indicating the organization for which they worked so that the research team could compare the answers based on the practitioners' expertise.

### *4.4. Analysis Methods*

A theme-based, content analysis method was chosen for the qualitative data [73]. N'Vivo was used to code all of the participants' answers inductively. Two members of the team independently coded all qualitative data using an inductive method involving N'Vivo software. A meeting of the research team then allowed the discussion of the various codes and their definition to agree on a common coding grid, with which the data were recoded by the same two team members, achieving an inter judge agreement score of 99.27%. The analysis was then completed by the team, establishing relationships between the analysis categories.

The aim of the quantitative analyses was essentially to measure the practitioners' satisfaction with the concertation process. The team chose to employ descriptive statistics to do so.

## 5. Results

### *5.1. Participants and Attrition Rate*

In total, the concertation meetings covered 29 different clinical situations. Of these, 27 came from the first recruitment strategy (practitioner reference), whereas the other two came from the second (database of the child protection agency).

In 24 other cases, the references received did not lead to concertation meetings. The main reason for refusing these cases was the length of time it took from the moment when the practitioners referred the clinical situation for the project to the obtaining of the necessary consent to start the process, which took an average of three months. This can be explained in particular by the fact that the actual physical meetings between practitioners and their clients were less frequent or harder to bring about, as well as by the number of consent forms that had to be filled out (generally two, sometimes more). For more than a third of these clinical situations, the cases were closed before obtaining parental consent. For seven other families, their case was not accepted because one of the parents refused that their family situation be discussed in a meeting. For five out of these seven families, the refusal came from the father, whereas, in another two cases, it came from the mother or both parents. Three other family situations were not accepted because: the practitioner refused to take part in the project; the reference came too late for data collection; and the practitioner stated that the safety of the mother and children would be threatened by her participation in the study.

The concertation strategy called for two meetings at a three-month interval. However, for seven of the clinical situations included in the sample, the second concertation meeting could not be held. The reason in these cases was that their file had been closed because the families were no longer meeting a practitioner who could represent them in the concertation meetings.

### *5.2. Practitioners' Satisfaction Regarding the Concertation Approach*

All the practitioners questioned in our study thought that the concertation strategy should be implemented on a larger scale. They greatly appreciated the relevance of this strategy in their work with families with IPV and CM problems, as can be seen by the following quote:

> "It was an excellent approach! It's something that turns out to be very useful in ensuring the children's well-being, since each parent's situation is complex. Hearing about the other practitioners' opinions and approaches is quite enriching. It helps us develop new ways of communicating with each other and being more aware of the issues so that we can ensure the children's well-being" (practitioner working with women).

The results presented in the Table 1 show that a large majority of the practitioners were satisfied or very satisfied with their participation in the concertation meetings, whereas having attended one or two consultation meetings planned in the protocol.

Close to 100% of the practitioners indicated that they were very satisfied or satisfied about five of the measured indicators, namely: the relevance of concertation discussions for their professional practice (99.2%), freedom of expression during the meetings (96.6%), the feeling that their expertise and skills were acknowledged (97.5%), the group's openness to hearing and respecting other people's viewpoints (98.3%), and the facilitator's work in allowing everyone to express themselves freely (99.2%). As for the other two indicators, 100% of the practitioners noted that they were very satisfied or satisfied about other people's professional expertise and skill being recognized, as well as about their own contribution to the discussion.

**Table 1.** Practitioners' Satisfaction with the Participation Meetings for Each of the Following Statements.

| Indicators Mesured | | Very Satisfied | Satisfied | Not very Satisfied | Dissatisfied |
|---|---|---|---|---|---|
| (1) | Relevance of the discussions for my professional practice. | 59.3% | 39.83% | 0.8% | -- |
| (2) | Freedom of expression (I'm comfortable expressing my ideas). | 83.3% | 13.3% | 3.3% | -- |
| (3) | Feeling that my professional expertise and skills are acknowledged. | 74.2% | 23.3% | 2.5% | -- |
| (4) | Other people's professional expertise and skills seem to be acknowledged (no impression that some people are more of an expert than the others). | 81.7% | 18.3% | -- | -- |
| (5) | Openness of the group to hearing and respecting divergent ideas, opinions, and comments. | 85.7% | 12.6% | 1.7% | -- |
| (6) | My own contribution to the discussion. | 68.7% | 31.3% | -- | -- |
| (7) | Facilitator's work in allowing everyone to express themselves sufficiently. | 80.9% | 18.3% | 0.8% | -- |

## *5.3. Support for the Psychosocial Workers' Practice*

### 5.3.1. A Better Understanding of Families and Greater Collaboration between Organizations

The concertation meetings, through the support they provided for the different practitioners who took part in the project, were often beneficial for their practice. Accordingly, the results indicated that the meetings gave the practitioners a better understanding of a large majority of the family situations that were discussed there. These meetings gave them a better overall view of family situations by bringing together diverse viewpoints and complementarity information. Several practitioners pointed out that the meetings also gave them a better understanding of the different organizational fields and fostered collaboration between these organizations for most of the family situations.

> "[Concertation is a strategy we should develop because it] helps us to check our perceptions and analysis. Because we don't see them in a family context, [concertation] helps us to better understand the clients' situation" (practitioner working with men).
>
> "Having a better understanding of the work of [organization name] and [organization name] helps me to better explain to women why other organizations do the things they do" (practitioner working with women).
>
> "We realize that we don't have the choice but to collaborate. Everyone has their approach, but how do you reach a common viewpoint that doesn't suffer from a silo mentality? [We have to] know the issues surrounding children who are under the care of [organization name], develop good relationships by raising awareness, demystify the role of [organization name] and the associated fears, move forward together, hear everyone's opinion, and be more sensitive to other people's experiences" (practitioner working with women).

The quantitative results strengthen the validity of the observations ensuing from qualitative data. The quantitative data indicated that the concertation meetings helped the majority of the practitioners to better understand the mandate of the other organizations involved in IPV situations. Accordingly, 96% of the practitioners improved their knowledge of the other organizations' mandate either a small amount (23%), a moderate amount (38%), or a large amount (35%), whereas only 3% indicated that they had learned nothing about these organizations through the concertation meetings.

### 5.3.2. Consensus and Divergence of Opinion among Practitioners

Several practitioners had similar opinions about the family situations. The consensus among practitioners particularly concerned the importance of protecting the children but also of protecting mothers who were IPV victims, as was pointed out by almost all the practitioners participating in the project:

> "The practitioner's legitimate concern for the victim and children's safety" (practitioner working with men).

> "The notion of the children's safety and well-being [and] the consequences [of IPV]" (practitioner working with women).

Concerning what needed to be done, the practitioners agreed about what should occur in the mid- and short-term. Most of the practitioners pointed to initiatives to put into place for the mothers and their children, whereas some practitioners suggested initiatives for the fathers.

Some divergent viewpoints could be seen among the practitioners. These primarily concerned different readings of the clinical situations, the mandates and roles of each organization, and the initiatives to adopt. The practitioners mentioned that their viewpoints and understanding diverged regarding 12 clinical situations in particular, which mostly involved IPV and its impact on the children:

> "There is no consensus about IPV" (practitioner working with women).
> "Different discourses. IPV or [domestic] conflict?" (practitioner working with women).

Not all the practitioners agreed about each other's respective mandates. Some practitioners mentioned that they found it difficult to understand the reasons underlying the actions of the child protection agency, particularly with regard to the legal framework of their practices. Moreover, some of the participants had the impression that the practitioners from the child protection agency did not know the role of their organization and services very well.

On another note, practitioners who did not have access to the same information about a family situation often had an analysis that was biased by the version of the family member with whom they worked most closely:

> "[The] lack of information depended on our respective mandates. [It was] difficult to know the truth, everyone has limited information" (practitioner working with men).

> "Our understanding of the situation differed. We have a more global view because we have access to all the family members" (practitioner working with children).

The practitioners did not agree about the approach to adopt for seven clinical situations, as can be seen in the following quotes:

> "The work with the father: one practitioner was hoping that the father would get closer to his children, while most of the others [practitioners] suggested working with the children to get them to have more realistic expectations about their father" (practitioner, non-specified client).

> "[The different opinions] especially concerned what our target should be (direct targeting of the father or not) and the strategy for the child" (practitioner, non-specified client).

It is worthwhile noting that, for 80% of the practitioners, the approach employed here helped to reduce divergence in viewpoints either a moderate amount (37%) or a large amount (43%).

### *5.4. Quality of the Client Services*

According to the practitioners, the families also seemed to have benefited from the approach employed in this project because it provided them with better quality services:

> "Some of the discussions allowed us to adjust our practices by taking into account other, complementary viewpoints. This enhanced our practices and improved our work with the service recipients" (practitioner working with men).

The provision of better services might have been related to a greater understanding of the IPV and CM problems that the practitioners said they developed through the concertation meetings. As such, the meetings allowed most of the practitioners to better understand the issues at hand; 93% of the participating practitioners indicated that the meetings helped their understanding a large amount (22%), a moderate amount (45%), or a small amount (26%). According to the practitioners, the majority of their clients have benefited from concerted actions that were better adapted to their situation, in particular for insuring child safety:

> "[During concertation discussions], we develop and become aware of the importance of assessing the victims' degree of safety and of foreseeing ways of ensuring the children's and mother's safety" (practitioner working with children).
>
> "Given everyone's expertise and their involvement in the children's situation, we were able to better determine their situation and make better decisions for them" (practitioner, non-specified client).
>
> "After this meeting, I'm confident that there will be a good 'safety net' for the children and that the actions taken will benefit them" (practitioner working with women).

Another positive outcome was consistent with one of the project goals, which was to improve the protection of IPV and CM victims and maltreatment. When they were asked about this, 92% of the practitioners who took part in the project indicated that the concertation practice resulted in a better response to victim safety issues.

## 6. Discussion

One of the evaluation results that is particularly interesting was the impact of the concertation strategy on the practice of psychosocial workers from different fields working with the affected families. First of all, the results highlight the consensus and difference of opinions concerning the approaches to be taken with these families. Second, they emphasize the concertation structure required to foster collaboration between the different organizations and limit power struggles. Third, they point to different avenues for improving concertation in complex family situations, especially when there is IPV. Finally, they show that concertation can lead practitioners to consider collaborating with their partners in other fields. Thus, this study reveals that, even if collaboration between the concerned fields of practice remains difficult [20–22,65,69–71], it is not an impossible goal to achieve.

### *6.1. Consensus and Divergence*

It would seem worthwhile to take a more general look at the consensus and divergence that were evaluated in the testing of this concertation model. To begin with, the results of this evaluation add support to the findings of a previous study [20], namely that there is consensus among the practitioners about the importance of ensuring the safety of IPV victims, who are often women and children. The triangulation of the qualitative and quantitative data leaves no doubt about this: the practitioners from all the different fields emphasized this point in their comments, and this for more than a third of the concertation meetings.

We believe, furthermore, that an important inverse relation can be established between the practitioners' knowledge of other organizations and their diverging opinions about each other's roles. In some of the meetings, one or more practitioners expressed diverging viewpoints concerning the mandate of other practitioners present. Similarly, a large majority of them (87%) indicated that their knowledge of the other organizations improved moderately or considerably because of the meetings. Everything indicates that a better understanding of the objectives, missions, and issues of the other organizations alongside whom they were working at least partially explained how the concertation meetings contributed to an 80% decrease in disagreements about each person's role. It could be interesting to pursue this point since improving the participants' knowledge of the other organizations in their region working on the same problems is an easy and inexpensive solution. This observation is supported by another finding: the practitioners desired to see other players in the network participate in the concertation meetings, primarily those with expertise in the judicial, mental health, and educational systems, as will be discussed below.

It is likewise relevant to compare the practitioners' reading of the family situations by way of the approach they wish to take in their actions. The practitioners' reading of the family situations was as consensual (13 clinical situations) as it was divergent (12 clinical situations). However, when the practitioners identified the action to be taken, they agreed in a majority of the cases (12 clinical situations) and disagreed in a smaller proportion (five clinical situations). Because the practitioners agreed for the most part about the approach to take, these findings raise the following question: were the practitioners' divergent readings due more to each field's ideologies or to the assisted families' concrete situations? Or did the practitioners relativize these different readings as long as the initiatives involved protected the victims, which was their most common consensus? It would be interesting if future research could examine these questions and concentrate more specifically on these aspects.

### *6.2. Concertation Structure*

Making concertation protocols available to the practitioners is not enough; they must also be structured so as to reduce power struggles. As we mentioned above, one of the common problems is that the existing concertation models are often found in public institutions, whereas expertise in this matter has for the most part been developed by community services. It is thus possible that certain concertation protocols accentuate the power imbalance instead of reducing them. Moreover, several authors have documented collaboration difficulties as well as the importance of improving concertation among different resource services [69,71,74].

That being said, the results of this evaluation indicate that several factors related to the methodology and concertation structure developed in this project made for smoother meetings and reduced the power struggles. The main contributing factor that the practitioners identified was the presence of a neutral facilitator who saw to it that the meeting ran smoothly by ensuring that each organization was present, that the length of the meeting and the time limit for each person to speak was respected, that the context was laid out at the beginning of the meeting, and that discussions were helped along when necessary. The second factor identified by a large number of the practitioners as having contributed to well-run meetings was the positive attitude of the practitioners, as noted by more than half of the project participants (52.4%). Various attitudes, such as respect, listening, and open-mindedness, might have been fostered by the very nature of the concertation strategy, which calls for a neutral person who can explain the strategy's characteristics and encourages all the practitioners to participate in the meeting.

Finally, it is worth noting the usefulness in systematically having people at the concertation meetings with the three main types of expertise: child protection, support for IPV victims, and help for violent partners. Systematically having at the least one practitioner from each of these three fields confirmed the importance of each one and, consequently, reduced the power struggles. Moreover, it is important to remind that this feature contributes to the originality of this strategy compared to other existing concertation models.

### *6.3. Complexity of Family Situations*

In families where there is both IPV and CM, the practitioners are often confronted with other issues, such as poverty, addiction, and mental health problems [75,76]. Several studies have moreover noted the extent to which complex family situations lead practitioners to divergent readings of the issues and needs of these family members [20–22]. It is, thus, interesting to see how the proposed concertation strategy allowed the practitioners to influence each other in their readings of these situations. Accordingly, the results of our evaluation indicate that, after a concertation meeting, the practitioners were more aware of the usefulness of drawing the largest portrait possible of the family situation so as to better outline the issues and more effectively meet the families' needs.

Some of the practitioners nonetheless deplored the fact that practitioners from other fields who had good knowledge of the situation and who provided services to one of the family members did not participate in the concertation meetings. They considered that the concertation discussions could have benefited from these other viewpoints, particularly in those cases where the expertise was not related to IPV. For example, several practitioners mentioned that organizations that provided drug addiction services might have improved the understanding of the family situations through their participation. Other practitioners suggested the presence of practitioners from the judicial, mental health, and education systems.

This avenue could however create an additional ethical challenge, especially if these new actors do not have any responsibilities regarding psychosocial assistance. Indeed, they would have access to confidential clinical information that they do not necessarily need to carry out their work. Further reflection on this subject would be useful to identify the ethical issues related to such a practice and to determine how it might take place.

### *6.4. Participation*

Finally, it is worth noting that several practitioners ($N = 15$) participated in more than one set of concertation meetings in this project, and this, for different clinical situations. In most cases, this was not due to chance: after having participated in one concertation meeting, these practitioners became proactive in recruiting families who met the inclusion criteria. The practitioners saw an opportunity to benefit from the expertise of other practitioners and, thereby, improve their skills.

## 7. Limitations

This study had three main types of limitations, namely those related to the geographical area where it was implemented, to time, and to the nature of the collected data. First of all, the area where the concertation strategy was implemented, that is the Québec City region, is relatively small, having only a few organizations specialized in intimate partner and family violence. This factor greatly facilitated our implementation of the concertation strategy, in particular as concerns the readiness to work with other organizations, the time needed to disseminate the concertation strategy in each organization, and, above all, the possibility for the researchers to make connections with the organizations' management, which facilitated the different organizations adaptation to the strategy. In a larger region or one where many more organizations were present, it would certainly be more difficult to implement such a practice and, consequently, to reproduce the results obtained in this research project.

Second, time is a precious factor when implementing, such a concertation strategy: before being able to organize the first concertation meeting, several stages had to be completed so as to inform practitioners from different fields about this new practice and have them participate. What is more, an evaluation project, such as the one tested here, usually has to be completed in a given length of time due to the availability of funding, which was three years in the present case. Time was also an important limiting factor in the recruitment of practitioners, because in the case of more than a third of the referred cases, we were confronted with a service termination for a family member, thereby rendering the concertation strategy impossible. In most cases where the second concertation meeting could not take place, it was for this same reason. We compensated for this obstacle by asking practitioners who were still working with certain families to fill out an adapted version of the satisfaction questionnaire so as to collect essential data about them. In doing so, we found that it doesn't seem to be any difference between the benefits they obtained from it compared to those who were able to complete the two concertation meetings.

Finally, a few limitations were related to the collected data. To start with, some practitioners participated in concertation meetings for more than one clinical situation. Each situation being unique, these practitioners had to fill out the questionnaire more than once. However, we were not able to isolate these respondents so as to analyze if they were more, less or equally satisfied with the concertation strategy, comparatively with others who participated only once. In fact, the questionnaire did not include the information about the number of different clinical situations in which they took part in the overall project. Despite this, the results would have benefitted to take into account the possible self-selection biases, since practitioners who liked the strategy or found it congruent with their values may be over-represented, thus, inflating the satisfaction rates. This limitation can nonetheless be seen as a strength of the project since, if practitioners took advantage of this concertation strategy more than once, it is likely that this strategy was useful in their practice the first time around. Furthermore, since the answers to the questionnaire were short and sometimes even composed of a single word (e.g., respect, time), they were more difficult to analyze, because the research team had to be sure it understood the meaning of the answer that the practitioner gave. Finally, because it was impossible to ensure that the practitioners would systematically answer questions, we were confronted with missing data in some of the questionnaires.

## 8. Conclusions

The results of this evaluation suggest that greater knowledge of the different organizations that worked with families with IPV and CM problems made for less disagreement about the mandates of the practitioners from these fields and improved cooperation between them. Interestingly, several quite simple and inexpensive solutions can be developed in this regard. For instance, there are already IPV concertation structures in several regions, both in the Province of Québec and elsewhere, which could assist in developing concrete action strategies.

In keeping with this idea, it would be worthwhile to measure how ideologies influence both the different organizations' readings of the family situations and the approaches proposed by the practitioners. Our results seem to show that, while there were different readings of the family situations that were related to the practitioners' "glasses," there was markedly less difference in the approaches they proposed, which aimed primarily at victim protection.

Finally, with the goal of extending concertation to all the social actors working with these families, it would be worthwhile to look at the ethical issues raised by the circulation of information among psychosocial practitioners and other potentially concerned actors, be it in the educational, medical, or judicial systems. While concertation among all these actors could produce more coherent and precise actions, there are numerous issues that need to be considered concerning power struggles, confidentiality, and the misappropriation of information to benefit a given organization.

In conclusion, the aim of this study was to evaluate an innovative concertation strategy developed from 2004 to 2010 and implemented in the Québec City region from 2011 to 2013. The project worked to foster collaboration between practitioners from different resource services who were working with families with both IPV and CM problems. The results of this evaluation show that the practitioners who participated in the concertation meetings were very satisfied, that they gained a better understanding of complex family situations and better collaboration with the other organizations, and that they felt that they were able to provide better services to the families with whom they worked. We identified a few avenues for solutions and further discussion that could foster collaboration among practitioners with different forms of IPV and CM expertise. Nonetheless, there is still a considerable amount of work required to develop and above all support this kind of initiative, since power struggles between institutions and community organizations still occur, and the different types of IPV and CM expertise are often still isolated one from the other.

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## Author Contributions

Geneviève Lessard was the scientific leader of this research project. She designed the aim and the process of the project, constituted the working team and decided about the roles of employees and collaborators. She participated in all steps of the project and furthermore in the writing of this paper. Marie-Eve Drouin (research professional) was the project coordinator. She led every step of the strategy implementation and was the main contact for all concerned actors during the whole process. She led the collection and analysis of data and the redaction of this paper. Anne-Sophie Germain (graduate student) carried out the collection and analysis of data, the literature review, and wrote different sections of this paper. Pamela Alvarez-Lizotte (graduate student) also participated in the collection and analysis of data, and helped for specific requests related to the production of this paper. She read and commented the different versions of this paper, like Pierre Turcotte (co-researcher) also did. All authors approved the final manuscript.

## Abbreviations

IPV: Intimate partner violence; CM: child maltreatment.

## Conflicts of Interest

The authors declare no conflict of interest.

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# Child Protection Victims and the “Evil Institutions”

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**Abstract:** The Dutch child protection system has been the target of harsh criticism in recent decades. The legitimacy of child protection services seems to have eroded. In this article, we analyze this changing legitimacy of child protection against the background of declining parental authority and in relation to the disappearance of positive pedagogical ideologies and the mainly bureaucratic response of child protection agencies. Two recent inquiries in the Netherlands on child sexual abuse within child protection-related services have emphasized the position of children as vulnerable victims of negative pedagogical practices, mirroring a general trend of “victimization”. It is concluded that reinforcement of the professional role of child protection workers may be a start towards building new trust in child protection and establishing a newfound legitimacy.

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## 1. Introduction

Criticism on child protection regimes and practices [1] has increased in many Western societies in recent decades. As so often in the past, the critiques are contradictory, blaming the child protection system for having failed by not intervening (in cases of family casualties) or by intervening too much (as recently, when Dutch parents were accused of affective neglect when they did not prevent their six-year-old daughter from continuing to see a boyfriend of the same age after they played doctors and nurses). What is new in this critique is the intensity and the lack of nuance in the debate. There appears to be no holding back in order to damage the reputation of child protection agencies and their employees, especially in the social media.

Implicit, but underlying this debate, is an ongoing discussion about the relation between the state and the family in terms of preservation of future generations. The debate is characterized by issues such as the primary and final responsibility in raising children or when state-authorized intervention in family affairs is legitimate.

The aim of the present article is to further detail this debate by focusing on the ambiguous relation between child protection services and the family. More specifically, the article will analyze the fading legitimacy of child protection services within the context of growing attention for the victimization of parents and children in care of these services.

## 2. Child Protection Services in the Netherlands

During the last century, the child protection system in the Netherlands has developed into an entanglement of supportive, disciplinary and repressive strategies. Ever since the Dutch Children’s Acts passed into law in 1905, the dominant strategy to protect children and advance their well-being was based upon a state-limited family autonomy, in which parents had regulated freedom [2] in raising their children. Child protection services consisted of a specific pedagogical framework that contained facilities for the support of insecure parents in their pedagogical tasks and aimed at training and educating naive or unwilling parents. Prevention has been an important strategy in preparing parents for parental responsibilities and in avoiding children's potential developmental problems. Only if these "soft-disciplinary" aims failed and parents seemed to be unwilling to normalize did the possibility of state repression enforced by the family court continue to exist.

The child protection system has never been popular with the Dutch population, yet recently, the tone of the debate has become fierce, and the arguments are sometimes presented in an overdramatic manner. In this article, we will show that the fading legitimacy of the child protection system is the result of an imbalance between supportive and coercive measures, as well as of a multitude of social processes: the fading value of the family as an institution, the increasing focus on the victimization of individuals in general and of "side effects" of a lasting confidence in professional social workers and state bureaucracy. As a result, the child protection system is subjected to an ongoing lack of social legitimacy, to which it has to find new answers.

We will first describe the processes of the social legitimacy of the child protection system and of changes in the parental role, which will be briefly illustrated with two relevant cases of inquiries into sexual abuse. In the concluding sections, we will turn our attention to the underlying causes for the changes, the loss of legitimacy and the consequences for child protection services.

## 3. The Changing Legitimacy of Child Protection

Child protection services as a system of rescuing children from their "impotent" parents has its foundations in 19th century charity. Traditionally, philanthropic activities, such as relief for poor and sick people and for orphans and abandoned children, were the domain of the church and of bourgeois committees. In the Netherlands, in addition to municipal and subsequent state services, child protection services have been offered by two strong religious, competing segments: Protestant and Catholic. In the context of their religious pillars, they guaranteed disciplinary and supportive services to people of their denomination only and set aside public surveillance.

Around the turn of the 20th century, and similar to other Western countries, these charity practices became embedded in legislation and administrative measures. At first, the religious institutions offered serious resistance to this transformation, but in the end, they accepted legislation and regulation in these domains. It was not the end of their philanthropic practices and of the benevolence of well-to-do bourgeoisie, but it marked the start of the legal regulation of a general child and family policy for the Dutch population. The basic structure was one of state regulation through laws, guidelines and purchasing combined with the execution and provision of services via private- or religious-based associations [3].

The Children's Acts also brought an end to the unbridled paternal power and introduced the state as a representative of children's interests. The Child Protection Council was founded in 1905 for the assessment of families who were supposed to be at risk of maltreating their children. This Council could also report families to family court, which, in turn, could decide to place families under a supervision order or, if deemed necessary, to place the children out of the care of their parents. Charity initiatives became organized in agencies for guardianship, foster care and residential child care. Residential facilities taking care of these "looked-after children" were mostly non-governmental and were either religious or charity-based. Interestingly, and like in France [4], the child protection system hardly distinguished between children at risk (neglect) and children as risk (delinquency). Both categories of children were placed under the same denominator in a wide network of relief and punishment. It was assumed that negligence and abuse would both result in juvenile delinquency [5]. Hence, in the entanglement of care and coercive practices for children and families at risk, a long enduring collaboration developed between non-governmental and governmental agencies. Already in those days, it was hard to distinguish care and support interventions *versus* repressive practices. Non-governmental religion-based parties claimed to "save" children and families from slipping further into misery by offering care and support on the basis of moral imperatives, meaning disciplining families into what they thought to be appropriate behavior, while government parties were deemed to be in charge of more repressive practices for families that constituted risk for children's well-being and society at large.

In the course of the 20th century, a vast "social" domain developed in which social workers and professionals, like psychologists and pedagogues, prepared children and parents for what, at that time, was understood to be ordinary family life [6]. These social practices were increasingly grouped under the umbrella of the state [7], and their method became ever more professionalized, while preserving strong ideological and religious moral claims of doing well in their professional identity [8]. Within this development, the repressive character of child protection faded into the background. The main aim for child and family policy remained to first prevent serious problems through early interventions. Coercion and repressive measures were seen as a last resort. The general axiom was to better bend than break.

## 4. The Doubts Are Increasing: The Weakening of Child Protection Services

From the beginning, the child protection system was perceived with mixed feelings by the Dutch population: on the one hand, the possibility of safeguarding children against failing parental practices was considered to be a big step forward in promoting children's well-being, healthy development and the protection of society of not well-raised children; on the other hand, child protection workers were labelled as wolves in sheep's clothing who presented themselves as helpers, but in fact, took children away from their parents [9]. Until the 1970s, the child protection regime kept a strong pro-family ideology aimed at supporting parents to bear their parental responsibilities in bringing up their children. The legitimacy of child protection interventions was based on the idea that these interventions helped to restore family life. The two-faced character of the child protection system remained though: on the one hand, the system should guarantee the safety of children, and on the other, it should protect society against children, who were presumably on a path to criminality. Saving children meant the preservation of families. Although child protection was viewed with serious suspicion, because "they" could "just" take your children away, the possibility of intervening in antisocial families was seen as rightful. It was generally accepted that child protection interventions, in families that could not live up to the standards of appropriate parenting, were in the best interest of children, as well as of society.

However, in the second half of the 20th century, criticism on child protection services became stronger, and the core of the critiques was three-fold: (1) the regime was too paternalistic, thereby child protection professionals were overruling parental authority in many respects [7]; (2) the regime was too bureaucratic, costly and inefficient, resulting in waiting lists for those children who urgently needed support [10]; and (3) the regime was morally embedded in a traditional family approach that was no longer accepted as the dominant approach. Together, these critiques resulted in a legitimacy crisis of the system around the 1980s [11].

In reaction to these critiques, the child protection system was gradually submitted to new management styles, which were supposed to pave the way towards more effective care programs that would better fit the needs of citizens [12,13]. In child protection, as in other public services, comments on professional inadequacy caused rationalization of procedures, outcome funding, benchmarking and standardization to make the implementation of child protection quantifiable [14,15]. Confidence in professional protocols and expertise was replaced by legal mandates and inspection procedures in order to prevent potentially fatal consequences [16], implicitly sending the message that child protection professionals were no longer envisioned as reliable and trustworthy agents. Moral- and ideology-based perceptions about “the good family life”, which had been underlying the system since its early days, became disputed as inappropriate and disciplinary moral imperatives and were replaced by outcome measures presented as neutral, such as the number of outplacements, client satisfaction scores and budgetary control. These outcome measures lack reference to intrinsic moral pedagogical goals, which until then, had helped legitimate unpopular family interventions [17,18].

A parallel development that started in the 1990s is the slow shift towards prevention within the wider system of youth care and its services. Although child protective interventions in so-called “antisocial families” were still socially and politically approved of, the aim was geared more strongly towards the empowerment of parents and to prepare parents for their parental role in order to preserve both family life and the well-being of children [19]. The challenge was preventing children from becoming subjected to the child protection system [20]. The shift towards a preventive approach was relatively easily accepted by the Dutch population, as the Netherlands has a long tradition of preventive care for children through extensive municipal public healthcare services that have been offered since the early 20th century [21]. Targeting physical health originally, these services were now expanded to include “light” pedagogical interventions, too. However, although seemingly empowering, the preventive services entail a controlling element, as well: these services developed gradually into a nationwide administrative system in which records and files are kept in order to keep track of the development of children throughout their lives by way of the Electronic Child Dossier [22]. Inevitably, such a system also includes risk assessments and inventories in order to correctly identify families in need of more intensive support and preparation—the “families at risk”. Consequently, the turn towards more preventive services implied a turn in focus from the so-called antisocial families (proven to be “inadequate parents”) to families presumably at risk for experiencing all sorts of problems later in life, thereby subjecting all parents to a form of scrutiny. In a sense, they were, what Furedi would call, “cultivating the vulnerability of people”, as risks may always at any time come to the surface ([23], p. 142). These forms of preventive control and potential intervention were explicitly argued to be in the best interest of the child. In practice, however, they undermine the privacy of the family and the notion of it as a safe institution, thereby undermining parental authority and legitimacy by extension, while its effectiveness in avoiding child development has not yet been proven [19]. This system means that all Dutch parents are now included in the range of risks that can endanger the healthy development of children. Families at risk can quickly turn to families as risk [24,25].

In summing up the tendencies with regard to the Dutch child protection system up to the early 21st century, we state that the system kept its characteristic mixture of governmental and non-governmental interventions, but developed into a bureaucratic system following marketized rules of performance measures. In the process, a morally-inspired debate developed on two related central dilemmas: one dilemma concerns the "best interests of the child" and whether diverse family lifestyles can contribute to this; the second dilemma refers to the privacy of the family and the state's right to intervene. Crucial in these dilemmas is the subsidiarity principle, in which the state should intervene as little as possible in family and community life, but at the same time, should guarantee children's safety. Paradoxically, the state could not guarantee a child protection system that operates in a non-normative and yet effective and accountable way. By implication, professionals of the state working in the child protection system work on a knife-edge; if they intervene too early, they are accused of "state intervention"; if they intervene too late, they are accused of a lack of commitment.

## 5. The Doubts Are Articulated: Conflict and Victimization

In the last decade of the 1990s, attitudes towards the child protection system had changed radically. In addition to the dilemmas mentioned above, parents at stake became more aware of their rights as consumers/clients of bureaucratic agencies. The struggle between the child protection system and parents confronted with out-of-home placements and supervision orders actually was the result of the introduction of the new market logic that turned upside down the previous logics of the system. It transformed professionals from workers who support and advise families into desk-workers and administrators who have to prove their efficiency and have to account for their workload, implying more referrals to the court. It also turned clients into consumers, which inspired parents and their representatives to present themselves as victims of the professional lack of commitment and the bureaucracy of the system [26]. The Dutch government further stimulated the "consumers' road" as antagonism to its own civil servants by offering parents a subsidized platform to express concerns about the child protection system and to articulate demands. By choosing that road, the government gave leeway to pressure groups and fellow victim groups for complaining; they received governmental subsidies, and in child protection agencies clients', councils were installed.

The ambivalence of the Dutch child protection system can be best illustrated by parallel developments in the first decade of the 21st century. Due to the imperious course of action of the child protection services, parents of children placed in care of the Child Protection Council claimed and got a right of inspection into the inquiries about them. It was claimed and accepted that they should not be treated as second-class citizens. At the same time, the number of out-home placed children skyrocketed; probably due to risk-avoiding professional workers and child protection courts. Concurrently, following the ratification of the United Nations Convention on the Rights of the Child (UNCRC) and the critique on the Netherlands for the late implementation of this convention, attention for the legal position of minors (who, until then, enjoyed hardly any legal recognition as a party in child protection cases) was growing [27]. The children's rights movement expanded massively, and the vulnerable position of children became a new guideline in child protection policy, which is, for instance, demonstrated in the introduction of a nationwide network of measures ranging from the prevention of child abuse to therapeutic interventions in overcoming child abuse. This network is compulsorily used by a vast range of professional organizations (childcare centers, schools, general practitioners, hospitals, fire brigades and social work agencies) in order to adequately recognize and trace signs of "possible child abuse".

Contrasting the Dutch way of viewing children as primarily their parents' responsibility, the position of minors has been re-defined as "citizens-in-the-making" [28,29]. As a consequence, the exclusive socializing position of parents has been further eroded: they are not only viewed upon with suspicion regarding their parental capacities, but their rights as parents are now juxtaposed against their children's rights. Family is thus no longer an institution, but an "assemblage" of individuals. This combination of shifting positions has resulted in questioning the legitimacy of the child protection system, which according to current public opinion, makes victims out of children, as well as out of their parents. The victimization of children, and in their slipstream, parents, becomes especially salient in cases of abuse. The long-term effects of sexual abuse are generally severe, and victims with enduring difficulties have limited possibilities to pose questions or to tell their story [30,31]. Two inquiries into cases of sexual abuse have placed the attention on children as victims. The representation of child protection as a victimizing, but ineffective institution adds to previous criticism on the child protection system as ill-defined, too costly and bureaucratic, as well as too uninvolved, with an added focus on the negative effects of such policies. As we shall see in the next paragraphs, child protection agencies are portrayed as perpetrators rather than protectors of children.

## 6. Inquiries into Sexual Abuse and the Blaming of the Child Protection System

In 2012, a report was published of an inquiry into sexual abuse practices by priests and staff members of Catholic boarding schools [32]. The outcomes of this inquiry showed that children who grow up in an institution (of any religious denomination) are twice as likely to become a victim of sexual abuse (22%) compared to the national average. The committee, Deetman, who conducted this inquiry, estimates that in the Netherlands, between 10,000 and 20,000 children have become victims of sexual abuse within residential institutions. The abuse was most frequent between 1950 and 1975, most victims being between six and 14 years of age. There appeared to be serious shortcomings in the way the management of the institutions and the authorities dealt with these cases of abuse.

The second inquiry concerned an "investigation into possible signs of sexual abuse of minors who had been placed in institutions or foster families on the authority of the government during the period between 1945 and 2010" by the Samson Committee [33]. The committee draws a similar picture of the situation in child protection institutions. The outcomes show that children who grew up in residential facilities were victims of sexual abuse more often (143/1000) than the general population of Dutch children (74/1000). Children in residential care also had a greater chance (194/1000) of becoming victims of sexual abuse than children in foster care (55/1000). Girls are twice as likely to become victims of sexual abuse than boys, and children with an intellectual disability are expected to have a three times greater chance of being confronted with sexual abuse.

The first inquiry focused on religious boarding schools, where children were sent by the parents themselves, and the results confirm the international perception of these schools as isolated institutions, characterized by a repressive culture, which has gradually degraded into sadistic and violent practices. Repression was also present in the child protection agencies and residencies, religious based, as well as state based. Abusive practices could continue for years unnoticed; children were not taken seriously in their complaints, and practitioners were backed up by higher-ranked colleagues. A common conclusion was that children under supervision of the child protection system were not safe in residential care. Taken together with recent cases of infanticide for which child protection workers are blamed because they intervened too late, this resulted in a reconsideration of the functioning of the child protection system as such. In their propositions to tackle all forms of child abuse, the Samson Committee emphasized that the monitoring system has failed, and as a consequence, a transformation of child protection practices should not be found in new protocols, as this would only result in a further bureaucratization of child protection.

Both inquiries conclude that it is hard to “measure” the extent of sexual abuse. Yet, the outcomes that many children who were placed in residential settings were vulnerable to sexual abuse, even if the facilities were part of the child protection system, have been accepted in the Netherlands with hardly any hesitation. Both the Dutch Catholic Church and the umbrella organization of Dutch child welfare agencies (Youth Care Netherlands) admitted their wrongdoings and provided for compensation arrangements: the Catholic Church provided a compensation procedure that included mediation and indemnification, and Youth Care Netherlands publicly offered their apologies, as did the Minister of Justice in the House of Parliament. Victims of sexual abuse in child protection would be enabled to make a claim for compensation at a dedicated department of the Damage Foundation for Violent Offenses. After the Samson Committee, Youth Care Netherlands immediately founded a new committee—the Rouvoet Commission [34]. Within a timespan of six months, this new committee advised for a new policy on the prevention of sexual abuse in child protection, which in line with the advice of the Samson Committee, tried to avoid additional bureaucracy.

Parallel to these inquiries and following from the consumers’ orientation in public services, social media offered parents a platform to express their discontent with the child protection interventions. The notion of victimization and the antagonistic relation between parents and the child protection system becomes especially salient in YouTube interviews, where citizens reveal how they were hurt by the child protection system. YouTube has proven to be a new “instrument”, next to earlier established client platforms and pressure groups, through which parents and children can utter their complaints and concerns. Characteristic of all of these digital narratives is the use of criminality, psychopathy and war metaphors to report their experiences with child protection, such as “They robbed me of my childhood”, “Stop the insanity of child protection” and “Arjan’s and Moniek’s battle against child protection”. Dutch-language Internet contains sites and blogs with ominous names as “the anti-child-welfare mafia”. The website, *jeugdzorg darkhorse* [35], offers space to respond to a case of a Russian diplomat who was arrested because he was allegedly a potential threat to his children. The responses include claims like “When your neighbors report to the hotline for child abuse, even diplomatic immunity does not protect you against child protection, which after all is a law unto itself'. The blog, *oudervervreemding* [36], calls on "parents who have suffered from child protection, which is backed by family judges who pass wrongful judgments, to form a front against these crimes". When the chairman of the Amsterdam Child Care Agency, argued that negative press about child protection hinders the work of child protection workers, the spokesman of the *blog senior* [37] said: "Child protection is guilty of small-scale genocide in the Netherlands. We have reported child protection to the police. It is expected that soon criminal proceedings will be instituted against child protection, including G[3], who directs a criminal organization that commits the crime of human trafficking!" The tenor of comments on these kinds of websites is that only few of the children under custody actually are victims of parental maltreatment, but that a mere "worry about their development" is enough to be placed under custody. The war-like metaphors all refer to the position of parents and children as victims. It is noteworthy that parents dominate the conversation and that children's voices are rarely heard, if ever. The blaming campaign on social media is a demonstration of the desperate feelings of parents losing control over their own children and the declined perceived trust in their capabilities as parents. Child protection services are accused of too much interference.

By contrast, the public press focuses on the vulnerable position of children, but thereby equally undermining the legitimacy of the child protection system. They refer to the lacking or inadequate interference of child protective services, who thereby fail to protect children against abusive or neglecting parents. Although they use more subtle terms to express their concerns, the media's instant reaction after cases of infanticide is also to blame the child protection professionals for their wrongdoings. One openly wonders how family tragedies could take place while the child protection system was aware of these problematic families. It also did not help that some cases have been outlined extensively in the media, such as the case of two children who have been outplaced because of being obese and the case of a Turkish boy being outplaced under the supervision of a careful lesbian couple.

Child protection experts also had their say. In 2011, the Investigation Council for Safety concluded on the basis of an analysis of child abuse casualties that child protection was too restrained in its practices. "They often do not dare to intervene because they let parental interests prevail over those of children. They are lacking distinct criteria to assess the risks of unsafety in domestic contexts." A professor in forensic psychology [38] concluded: "Dutch child protection should be overhauled. Too many things go wrong, but nobody really feels responsible. Amateurism is rampant, the organizations are fragmented and introspective, and professionals have no idea of the impact of their work. Parents and children are the victims." In 2013, the Dutch Children Ombudsman concluded that errors in child protection analyses and assessments are frequent. Politicians and experts agree that child protection is dysfunctional, thereby increasingly relying on the vulnerable position of children in their argument.

Taken together, the general response to private family aggression seems to be to blame public agencies. First, in reaction to children's deaths, people blame child protection agencies rather than parents for not having prevented these casualties. They blame these agencies for not realizing their

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[1] The chairman of the Amsterdam Child Care Agency.

aims, even for being a risk for children rather than a rescue. The fact that the child protection system represents the power of the state contributes to feelings of victimization. Child protection agents answer these "attacks" with efforts to purge themselves of these blames and find it hard to explain that it will be impossible to prevent any new tragedies in the future [39]. They defend themselves by pointing to the soundness with which they have followed procedures. As pointed out by Parton, uncertainty and ambiguity are the domain of social work [7]. Moreover, the uncertainty about how much freedom families can be given is at the basis of the child protection system. The idea of regulated parental freedom means that the child protection policy is to honor parental freedom and to only intervene as the last resort. This includes the risk of too late of an intervention.

Second, and with the upmost respect to the seriousness of child abuse, individual misbehavior by child protection professionals in residential settings is translated into the misbehavior of a system. Rather than charging individuals with criminal acts and practices, child protection services as a system came under attack.

In both approaches, the debate has moved away from how to deal with the tension between parental freedom and rights and children's well-being and rights, on the one hand, and state power represented by the child protection workers, on the other hand. The management of the risk of violence against children predominates the agenda, while efforts to come to an understanding of how to achieve committed and supportive professional support for unwilling and violent families is lacking. The implementation of professional accounting systems and outcome evaluations have substituted moral professional criteria regarding children's well-being, and their future development hinders the child protection system from offering any other response.

Recent developments in child protection can be seen in light of parents and children as victims of a not well-functioning child protection system that is unable to do what it is meant for: protecting children against violent parents, but only if it is really needed, in which case, they should be able to safeguard the "looked-after" children. Recently introduced measures are: obligatory professional registration of child protection workers, certification of child protection programs and of child protection agencies, new screening strategies based on scientific knowledge and a database of evidence-based interventions, legal changes to strengthen the position of victims, new screening methods in child protection job interviews and the introduction of new protocols for child protection agencies [34].

The current child protection system had to be evaluated based on its efforts to care for children whose parents were unable to adequately care for them. After these inquiries, the services were also judged on the quality of care they offered and its "iatrogenic" effects. Child protection was not just a bureaucratic system, it also turned out to be a dangerous system for children, in some occasions, even worse than their families. Professional expertise was apparently insufficient to prevent sexual abuse of children consigned to the care of these experts, who were not able to help the victims either. The assumption that governmental or voluntary religious care for children outranked parental care was thus "under attack". As a result, the delicate balance between institutional, voluntary and governmental and parental responsibility for children's well-being became antagonistic rather than cooperative. The veiled conception that child protective services were an aggressor against parents and their children was now stressed, with the notion of victimization and clients' demands at the heart of this debate.

## 7. Victimized Child Protection

In recent decades, the ambiguous opinion towards child protection as a necessary, but sometimes malfunctioning, institution has been transformed into an attitude of child protection as a doubtful system. In public inquiries, in the press, as well as in private blogs of child protection clients, the weak spots of the child protection system are overrepresented as if it is a horrifying, victim-producing machinery. There are several reasons for that change.

Firstly, child protection agents present themselves as the advocates of children's rights and children's interests rather than as guardians of families, like they did in the past. The family is no longer perceived as the uncontested sphere to socialize children [19]; this questions parental legitimacy, which is hard to accept for parents. The social norm of individual responsibility has not only resulted in more attention towards children's rights, but has also changed the relationship between social service providers and their clients. Individualization has put clients' personal choices high on the agenda. Yet, child protection is also a forensic social service representing the power of the state, which may end in coercive intervention. Such interventions are hard to accept now that there is so much emphasis on self-determination, choice and self-responsibility, concepts that have transformed citizens into consumers of public services. The declining legitimacy of parental authority has intensified the rage of parents. More often than before, they carry the matter to an extreme, triggered by the child protection system's predominantly bureaucratic answers to their questions. When family matters get out of hand, parents blame the child protection professional rather than themselves [39]. These blames are mainly founded on a retrospective reconstruction of the fatal course of events, with the child protection worker being accused of not having followed the procedures rightfully. This reinforces the emphasis on procedures in public judgments (see also the third reason below).

Secondly, the attention for the victims of child protection has emphasized the negative effects of child protection interventions without paying much attention to their supportive elements. This attention for victims is part of a more general consideration for victimhood, especially in criminal justice. Boutellier relates this to the fragmentation of great ideological frames (both religious and non-religious worldviews) into private perspectives and lifestyles in the late 20th century. In the disenchanted Western world, there is a negative rather than a positive reference to the content of "the good life", in which morality is defined in terms of what we do not want. Everyone can have his own God, as long as this does not justify or propagate violence against others [40]. The moral claims of the great ideological frames have lost their universal nature, and the only belief that is left is the understanding that we, as human beings, are vulnerable. Morality in that sense is "victimized". The absence of strong and positive ideological frames (which may include ideas like "the family is the socializing unit par excellence" or "the state behaves in the best interest of the child") tips the scale of the legitimacy of child protection interventions to their disadvantage. For want of a positive underpinning of child protection services, negative critiques are decisive.

Lastly, the ongoing bureaucratic and introspective procedures of child protection have reinforced families' experience and public opinion's conviction that the child protection system operates in a Kafkaesque manner: the number of professionals has increased, and professionals can be trained in a wide variety of disciplines (psychology, pedagogy, social work, judicial, healthcare). This has resulted in separated professional responsibilities and a lack of coordination, thereby sending clients from pillar to post. It has become more important to do things well (procedure) than to do the good things (content). This critique is part of a more general attack on public services, which have evolved from supportive services based on social work ideals of solidarity and doing well, into bureaucratic agencies run by managerial principles of regulation, pragmatism and objectivism. In an attempt to organize a child protection system by balanced procedures and rules, things have been overrun by new performance principles. These regulations often break the child protection agents' spirit: they often "serve in an organization without much serving it" [41].

## 8. Conclusions

Child protection has become the object of permanent public criticism. We gave several reasons. First, after secularization, positive, shared pedagogical goals faded. However ambiguously the child protection system may have been received in the past, it was always inspired by a strong moral imperative of doing well for children, while respecting the family as the ultimate unit of socialization, unless the limitations of the family's capacities were proven. That moral imperative has shattered into fragments. Next to that, the child protection system itself failed to guarantee the safety of the children under their surveillance. In reaction, child protection professionals operate according to their private moral perspectives, but even more strongly, according to risk models and calculation schedules, which seems to have adopted a "permanent institutional form" [42]. Second, and as a consequence, child protection professionals increasingly use a defensive policy that is aimed at preventing any accusation of neglect or error. This means that the professionals' decisions are backed up with procedures, such as safety clauses, against blame or even legal action. The result is a continuous effort to come to a clear-cut perspective on the future of clients (children and their families) where there is no place for ambiguity and uncertainty as central characteristics of human life [43]. The goal of child protection services seems to be the prevention of victimhood for both parties involved. Lastly and paradoxically, the cooperative balance between child protection agencies and families has become antagonistic, fuelled by the loss of the legitimacy of both child protection services and parents themselves.

To blame the child protection system for not having been able to protect children against their parents' aggression is too simple a reaction. Fatal family tragedies have a structural component and cannot be reduced to zero, not even in democratic countries that highly value children's rights and have well-developed systems of child protection [10]. The freedom of parents to raise their children according to their own beliefs and insights is considered and has to be considered an essential right. The major role of the youth care system, of which child protection is a major part, is to prepare and help parents to raise their children well. This is both a way to advance the welfare of families and children and a strategy to decrease the risk of casualties. This means that the state should only intervene in worst-case scenarios. When the child protection workers intervene too early, this is immediately considered as a state intervention in the private domain of well-meaning parents [44,45]. Yet, if the state responds too late, it is blamed for malfunctioning. Child protection professionals walk a tightrope: they have to give parents a maximum chance to bring up their children themselves and according to their own perspectives and should thus exercise restraint; yet, if parents are given the benefit of the doubt, this may result in fatal parental behavior. This is an ambiguous assignment without any guarantees that nothing will happen to anybody.

However, not all is lost. The Samson Committee ([33], p. 124) advised changing the child protection system without ending up in a new “tick-off culture” in which protocols have a value of their own. A major recommendation is professionalization: although a vast majority of child protection professionals are employed through child care organizations, only a few are affiliated with a professional association [46]. Hence, they have neither the obligation nor the opportunity to engage in training programs and other means of professionalization. The Dutch child protection system now legally requires professionals to be registered and requires agencies to appoint a behavioral scientist. To keep their registration, professionals are required to take additional training, which might be a strong incentive to increase professional awareness. It may also result in new efforts to look for a more positive interpretation of child protection work, focusing more on possibilities rather than risks, more on changes rather than inabilities and on conversations for taking action rather than placing blame [47]. Recently, strategies of motivational interviewing have been introduced in child protection practices, which encourages professionals to focus on clients’ positive capacities [48].

This reminds us of Durkheim’s analysis of the dual relationship between the state and the individual, the state being both liberator of the individual and a strong force. Intermediary groups, like professional associations, are needed to morally counterbalance the state. They can only do so on the basis of professional ethics that demand strong professional coherence: “professional ethics will be the more developed, and more advanced in their operation, the greater the stability and the better the organization of the professional groups themselves” ([49], p. 8). A professional association according to the great sociologist can and should function as an intermediary between the state and the individual. If so, revitalization of professionalism in child protection may result in new moral foundations for this work.

The usefulness and existence of such a “professionalized morality” also comes forth in Stanford’s analysis of child protection workers’ interpretations of risk [50]. Her study shows that these workers ascribed a moral status to both clients and practitioners who are a risk or are at risk. This is not a necessarily conservative position, because the tensions between the various risk identities enable the practitioners to take a moral stand. As Stanford shows, child protection workers often take a stand for their clients rather than take the “safest” option ([50], p. 215). Risk is shown to be a moral construct. Although it may seem that practitioners start from a personal sense of responsibility and compassion, these perspectives are indeed professionally trained moral anchors that belong to social work.

Child protection laws were introduced and agencies were founded in order to do well for families and children. In public opinion, little seems left of that. The press enlarges the negative practices of child protection. Little attention is paid to how professionals succeed in creating, together with parents and children of different cultural backgrounds and in various relation arrangements, safe and favorable developmental conditions for children. Child protection is chiefly regarded as an evil institution that has become entangled in its own procedures. There is no easy way out, because emotions run high when children and parents are involved. Polarization between the vulnerability of children, on the one hand, and a poorly performing child protection system, on the other, does not do any of the parties involved any good, though. A deep distrust of child protection endangers the legitimacy of child protection agencies, which is a serious threat to what they are supposed to do—to prevent child abuse and other harms on the basis of professional expertise and responsibility and, especially, to support parents and children in living a good life. It will be a future task for child protection agencies to make their positive efforts more visible for the public and to demonstrate how they manage to help parents and children to create socially responsible pedagogical practices, while respecting their "freedom of pedagogical enterprise" [4].

## Author Contributions

The first author provided a first draft of the text, the second and third authors added new parts of the text. The final versions were shared enterprises.

## Conflicts of Interest

The authors declare no conflict of interest.

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# Vulnerable Family Meetings: A Way of Promoting Team Working in GPs' Everyday Responses to Child Maltreatment?

**Jenny Woodman, Ruth Gilbert, Danya Glaser, Janice Allister and Marian Brandon**

**Abstract:** This study uses observations of team meetings and interviews with 17 primary care professionals in four GP practices in England to generate hypotheses about how "vulnerable family" team meetings might support responses by GPs to maltreatment-related concerns and joint working with other professionals. These meetings are also called "safeguarding meetings". The study found that vulnerable family meetings were used as a way of monitoring children or young people and their families and supporting risk assessment by information gathering. Four factors facilitated the meetings: meaningful information flow into the meetings from other agencies, systematic ways of identifying cases for discussion, limiting attendance to core members of the primary care team and locating the meeting as part of routine clinical practice. Our results generate hypotheses about a model of care that can be tested for effectiveness in terms of service measures, child and family outcomes, and as a potential mechanism for other professionals to engage and support GPs in their everyday responses to vulnerable and maltreated children. The potential for adverse as well as beneficial effects should be considered from involving professionals outside the core primary care team (e.g., police, children's social care, education and mental health services).

## 1. Background

It is now widely acknowledged that scarce resources and high demand mean that children's social care in England is functioning as "an emergency service [1]" which prioritises reactive child protection responses over earlier help and prevention, despite policies which have ambitions to the contrary [1–5]. Qualitative studies report that some families and professionals have encountered a lack of early help or child in need services for families who are below the very high thresholds for child protection services [6–11].

In this context, the spotlight has been thrown on the role of other services which have routine contact with all children and families, such as GPs. Researchers have begun to ask how these services might use their everyday contact with families to respond to vulnerable and maltreated children and their families, especially those not meeting thresholds for services from children's social care [12–15].

There is evidence from qualitative studies that some GPs in England are already using their core skills and opportunities as family doctors to identify and respond to maltreatment-related concerns[1], particularly for children with problems related to neglect and emotional abuse [12]. In these studies, GPs were responding directly to families by “keeping a watchful eye” on them, “standing up and shouting” for families (e.g., advocating for better housing), talking to parents to help them realise “that there was actually a problem with the children” or that “stopping drinking was a good thing”, and providing immediate and opportune healthcare for children when parents came to the surgery for other reasons [12,16]. These responses relied on GPs building a therapeutic relationship with parents and/or older children and good links with health visitors [12].

A therapeutic GP-patient relationship might be effective at keeping parents (or other adults important to the child) engaged and motivated to change whilst reducing risk to the child by helping these adults to keep the child “in mind” [17,18]. Without proper team working and professional supervision there is danger that fostering a therapeutic relationship with parents becomes an “accommodative strategy” which affirms patterns of the “bad” behaviour and encourages professionals to focus on parents and overlook the needs of children [19,20]. Good links with health visitors can allow relevant and timely information to flow to the GP to support risk assessment and monitoring of families with preschool aged children [16]. However, with the relocation of health visitors away from GP surgeries, these links may be difficult to maintain and GPs might be working in the context of partial or incomplete information about a child’s situation. Systems which encourage team working, mutual peer supervision, information sharing and inter-professional links appear a common sense way of supporting GPs when they are responding directly to families and of minimizing the risks of isolated working.

Regular primary care team meetings for the specific purpose of discussing vulnerable families (‘vulnerable family meetings’) have the potential to be one such system. Such meetings are recommended as good child safeguarding practice by the Royal College of GPs [21]. However, there is little clarity about the purpose or format of these meetings and we know little about how they work in practice or whether/how they might involve other professionals.

This study used observations and interviews with primary care practitioners to describe the purpose, format and functioning of vulnerable family meetings in four general practices in England. We used the data to generate hypotheses about how these meetings might best work to support GP responses to maltreatment-related concerns and about the role of other professionals in relation to the meeting.

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[1] We use the term “maltreatment-related concern” to capture the full range of professional concern about child maltreatment, including concern about parental risk factors for maltreatment and compromised parenting or parent-child interaction which is judged to have the potential to become harmful, whether or not the problem currently meets children’s social care thresholds for enquiry or action. Therefore, “maltreatment-related concerns” includes children who are judged to be marginally maltreated or at risk of maltreatment as well as cases where practitioners are certain enough to definitively label the child’s experience as “maltreatment”. The term “maltreatment-related concerns” is consistent with a continuum model of child welfare and in keeping with a public health approach which covers prevention and treatment.

## 2. Methods

### 2.1. Recruiting Data Collection Sites and Participants

We purposively selected four "best practice" sites with a geographical spread across England from a convenience sample of 11 GP practices who were participating in an audit of child safeguarding led by the Royal College of GPs. The 11 practices have been described elsewhere [22]. We chose four sites where the GP lead for the audit was a child protection "expert" (held a child protection post, was involved in child protection policy or in delivering child protection training) and held regular team meetings to discuss vulnerable families [21]. These characteristics were ascertained via an online survey which the GP leads completed between April and May 2010. The lead GPs acted as gatekeepers by introducing the study to their colleagues and arranging for the researcher to come to the vulnerable families meetings. Before the vulnerable family meetings started, the researcher (JW) explained the study and collected the emails of GPs, practice nurses and health visitors who were willing to be interviewed. The researcher emailed each of these professionals and where they agreed, arranged to interview them. The four GP leads were also interviewed. A total of 21 professionals expressed interest in the study but four later declined due to lack of time. We conducted a total of 17 interviews.

### 2.2. Interview Participants

The participants tended to be experienced health professionals and to have worked for an extended period with their current team: almost two thirds ($N$ = 11) reported being qualified for 20 years or more (range 1–40 years and 58% ($N$ = 10) had worked in their current team for at least 10 years (range 6 months to 2 years) Eight of the interviewees (47.1%) were "experts", defined as described above). Just over half the respondents were female ($N$ = 10/17; 60%). There were five participants each from Practices 1 and 2, four from Practice 3 and three from Practice 4. The two health visitors worked in different sites from each other, as did the two practice nurses.

### 2.3. Conducting Interviews

One researcher (JW) conducted the interviews with 14 GPs, two practice nurses and two health visitors from the four sites. In the interviews, the researcher elicited narratives by asking the participants to choose two or three "children, young people or families who had prompted maltreatment-related concerns" and describe their concerns and involvement. In keeping with the aim of allowing participants to tell their stories and control the content, the interviews were free ranging with minimal steering from the researcher. Interviews were face to face, conducted between November 2010 and September 2011, lasted an average of 50 min and were audio recorded and later transcribed. In total, we collected 837 min of interview data from 17 participants (602 min from the 14 GP participants).

### 2.4. Observing Team Meetings

The same researcher (JW) observed one vulnerable family meeting at each of the four data collection sites between January and June 2011. During the meetings, the researcher was a complete observer, taking no part in the meeting and sitting apart from the professionals. Thoughts and details were recorded as hand-written structured notes (the researcher noted the apparent purpose of the meetings, the content and the 'tone' of interaction between attendees as well as any additional thoughts).

### 2.5. Analysing Data

We used a thematic approach to analysis as we were interested in identifying recurrent and common themes about responses to maltreatment-related concerns within a defined group (GPs). Our approach was inductive (data driven) and interpretive (rather than simply descriptive) [23]. Although the inferior status of thematic analysis persists, a robust and in-depth thematic analysis can be as insightful and skilful as other "branded" analytical approaches [23]. The analyses generated a detailed description of seven GP responses (monitoring, coaching, advocating, opportune healthcare, recording concerns, referring to other professionals and joint-working with other professionals) as well as theory about the types of families for whom they were used and the contexts which facilitated them. These results are published elsewhere [16].

At the start of the study, we conceived of vulnerable family meetings as one possible 'response' to maltreatment-related concerns in general practice. However, as the analysis progressed, we saw that they were perceived by GPs and other members of the primary healthcare team as a facilitator of other responses (rather than a response in their own right) and were being used in this way. As the analysis continued, we asked detailed questions of the data regarding purpose and form of the meetings and it is these results which are presented here. To generate hypotheses about the most useful form and structure of these meetings, we asked ourselves: 'Are there particular characteristics of meetings that seem to support the stated or implicit purpose of the meetings?' The resulting hypotheses are presented in the discussion of this paper.

Although it would be useful for the reader to know which interview participants came from which practice, we judge such a level of detail to potentially compromise participant anonymity. Unless otherwise stated, we report themes that emerged from at least two of the practices. Where there are multiple quotations to support a single point, they come from participants who worked at different practices.

### 2.6. Ethics and Research Governance

Ethical approval for the interviews and observations was given by Central London 1 NHS Research Ethics Committee on the 8 October 2010 (Reference 10/H0718/6). For each of the four sites, approval was given by the relevant Research and Development Unit of the Primary Care Trust (PCT) who issued a Letter of Access permitting the research to take place.

## 3. Results

### *3.1. Format of Vulnerable Families Meetings*

Table 1 shows that the meetings in each of the four practice were highly variable in their frequency, number and range of attendees, "tone" of interaction between professionals and selection of children and families for discussion.

One practice (practice B; Table 1) allocated an hour every fortnight to discuss problems in adults (e.g., cancer patient or palliative care patients) and, for the second half of the meeting, discussed children and young people:

> It could be anything, from a child that's constipated to a child who's got a serious medical diagnosis to a child who is a cause for concern, and we'll also discuss all the children who have child in need plans or child protection plan (GP, interview data).

In the observed meeting in practice B, just over half of the children and young people were discussed due to maltreatment-related concerns (*N* = 7/13, see Table 1). The other three practices had meetings bimonthly (practices A and D, Table 1) or quarterly (practice C; Table 1) for 45 minutes to an hour, which were specifically dedicated to discussing children and young people who had prompted maltreatment-related concerns and their families. In three practices (practice B-D, Table 1), GPs, health visitors and practice nurses attended the meetings, with general practice (practice D) or health visiting service managers (practice C). In practice A, there were a wider range of professionals from education and health (Table 1).

In two practices, the "tone" of the meeting was relaxed and chatty, seemingly on account of the meetings being well-established and all professionals knowing each other well (practices B and D; Table 1). In one of these practices, there was an air of efficiency with a list of patients to discuss and wider information being readily to hand whilst the other meeting appeared more disorganized. In contrast, the other two meetings were characterized by tentative and guarded interaction between professionals, seemingly on account of the professionals not all knowing each other (practices A and C; Table 1) and the meetings being very newly established (practice A). In one of these practice, a GP subsequently commented that the presence of the researcher had made people more cautious and self-conscious about what they said (practice C). The guarded nature of meetings appeared to be a defense against the uncertainty and "not knowing" inherent within child protection work, which manifested itself as a preoccupation with the thresholds of concern for information sharing (practice A) or a reluctance to admit that the professionals did not know the answers to questions being asked. (practice C).

Only one practice had a clear method of selecting children and young people for discussion (practice B, see Table 1 for reported selection criteria). In this practice, the health visitor also brought children for discussion via a list of children she knew to have a child protection plan and be registered at the practice. In the other practices, selection of children and young people relied on GPs and practice nurses remembering their concerns and bringing them to the meeting.

### *3.2. Purpose of Meetings*

Fourteen (82%) of the interview participants (including both practice nurses and both health visitors) spontaneously mentioned the vulnerable families meetings and did so in the context of them being “good”, “pivotal” and “important” (GP, health visitor, GP participants, respectively).

**Table 1.** Description of vulnerable families meetings (from observations).

| Practice | Frequency, time, length | Purpose * | Attendees ** | N families ‡ | Notes |
|---|---|---|---|---|---|
| A<br>January<br>2011 | Bi-monthly,<br>lunchtime,<br>1 hr | *Stated:* strategic to discuss policy/guidelines/ systems and to monitor specific families via information sharing. Specifically *not* for decision making.<br>*Implicit*: To introduce professionals to one another and establish working relationships. | 2 Healthcare assistants<br>1 CAMHS SW<br>1 Psychiatrist<br>1 Mental health worker<br>4 CP teachers<br>1 SENCO rep<br>1 Practice administrator<br>4 GPs<br>2 Practice nurses<br>NB No health visitor at the observed meeting but she is sometimes present | 1 | • First meeting for many of the attendees. Many attendees did not know one another and the atmosphere was formal.<br>• Safeguarding lead for practice (GP) placed meetings in the context of other lunchtime clinical meetings—“it’s nothing more out of the ordinary than what we would do for children with asthma or those with terminal conditions.”<br>• Most time spent talking about the purpose of the meetings, uncertainties about what attendees were “allowed” to discuss and the way that education/CAMHS/the practice could work together.<br>• ‘Are we allowed?’ summed up the preoccupation of the meeting—great caution about confidentiality and sharing information. Each time a family was mentioned, the discussion quickly became one about confidentiality and processes (hence only one family was discussed).<br>• No obvious selection criteria for families<br>• The SENCO representative, CAMHS social worker and 2 GPs mainly spoke. |
| B<br>January<br>2011 | Fortnightly,<br>lunchtime,<br>30mins | *Stated:* None stated; attendees seems to share an understanding of the purpose of the meeting.<br>*Implicit*: Monitoring and review of families (e.g., what is happening with social care, benefits, medications, children, who is living in the house) and an opportunity for questions. | 2 Practice nurses<br>1 Health visitor<br>5 GPs | 13 | • Participants seemed to know each other very well and were relaxed and chatty.<br>• The meeting was preceded by a 30 minute meeting about adult patients (e.g., new cancer patients, palliative care patients, patients who had died N = 8).<br>• The children discussed were: new births, new antenatal bookings, those on a CP plan, Children in Need, those with a “cause for concern” code in the GP records, children with cancer or children who had died. Children to discuss were identified through a computer search for codes.<br>• 7/13 families discussed were due to maltreatment-related concerns.<br>• The list of children on CP plans was compared with the list that the health visitor had brought to the meeting.<br>• Health visitor was instrumental to the meeting: she provided others with more up-to-date information, including about children’s social care decisions/services. |
| C<br>February<br>2011 | 3 monthly<br>lunchtime,<br>1hr | *Stated:* to discuss and learn from/about principles rather than “get endlessly bogged down” in specific cases.<br>*Implicit*: to enable monitoring and follow-up. | 5 GPs<br>1 GP registrar<br>1 Health visitor<br>1 HV service manager | 3 | • First meeting with “new” health visitor.<br>• Tone of meeting was extremely tentative – lots more questions than answers.<br>• I thought that this was because there was no long standing trust between attendees but afterwards the lead GP told me (unprompted) that her colleagues had been embarrassed to admit that these were cases where ‘the ball had been dropped’ because I had been there.<br>• Implicitly, it seemed as if these children had been brought to the meeting because professionals were concerned but had lost the thread of the story, e.g., there had been a case conference but GP couldn’t go and wanted to know what happened.<br>• Health visitor and her service manager were instrumental to the meeting, providing wider information including updates on children’s social care processes and services. |
| D<br>June<br>2011 | Bi-monthly,<br>breakfast,<br>45mins | *Stated:* none stated.<br>*Implicit:* To monitor families with known concerns by exchanging information. | 3 GPs<br>1 Health visitor<br>1 Practice manager | 10 | • Many of the GPs were away, including the GP who usually led the meeting. The practice could not find his list of vulnerable families and so had to use an “old” one.<br>• Many of the families on the “old” list were not discussed because they had moved practice.<br>• Only 1/10 families was discussed in depth. For the other cases it was a case of attendees saying “no, I don’t have any further information about them”.<br>• Health visitor contributed but brought less information compared to other observed meetings. She did not know many of the children discussed. |

Notes: * *Stated* Purpose reflects that which was explicitly stated by one of the attendees at the beginning of or during the meeting; *Implicit*: purpose interpreted during the course of the observation and during analysis of field notes; ** CAMHS = Child and Adolescent Mental Health Services; SW = Social Worker; CP = child protection; SENCO: Special Educational Needs Coordinator; ‡ Number of vulnerable families discussed at the meeting.

### 3.2.1. Monitoring, Review and Follow-Up

In all four practices, the meetings were seen as important for monitoring children and families. This came across implicitly in the observed meetings (Table 1) and more explicitly in the interviews:

> Well, we would, um, um...I'll probably discuss it at the primary health care team meeting next week […] to those families we...you know...we always talk in our meetings They'll be discussed again, um, so I wouldn't...you know, that's the way we sort of monitor these sorts of families (GP, interview data).
>
> So, yeah, you know, the meetings that we had, we kind of discussed it, that case, and, you know, you obviously hear other information from the other members around the table, "Oh, well, so-and-so and so-and-so..." and they know all about the families and things (GP, interview data).

The meeting allowed GPs to monitor children and their families in three ways. First, the team could act proactively by anticipating important or stressful points in a family's life or changes which could impact on parenting (e.g., the birth of a new baby):

> when we met regularly as a whole team, the whole practice, we were [..] recognising for example that the mother was nearing term [in her pregnancy], that the parents were complying with [methadone] treatment and all was going well (GP, interview data).

Secondly, participants gathered and shared information with other professionals at the meetings, usually the health visitor, who was pivotal for supporting GPs' monitoring and review of vulnerable children and their families:

> Of course [we ask health visitors what they know] at the child protection meetings we have on a regular basis at the practice, you might just say, "Is anyone worried about this family?" (GP, interview data).

In practice C, the cases that were brought for discussion at the meeting seemed to be ones where a professional felt that they had lost sight of the family or not achieved follow-up (Table 1). The professionals turned to the meeting as a way of catching up on what had happened since their initial concern, although as described above this was hindered by a reluctance to admit professional anxiety, uncertainty and incomplete knowledge around the case.

Health visitors were viewed as a conduit of information between children's social care and the police and general practice:

> We found out about this [a very serious domestic violence incident] because the police alerted social services and social services obviously relayed the information to the health visitor. And in such instances where we have reports from social services, they're always brought up in our primary care team meetings so that everybody is aware of what is happening in that family at that particular time (practice nurse, interview data).

Thirdly, concerns by practice nurses and GPs prompted proactive information gathering via the health visitor:

> And I brought her up at the meeting where the health visitors were present as well, […] And, again, the health visitors said they would go out and visit. And, in fact, when they got out to visit, the grandmother was also concerned that the mum, the child's mum, had been going out late at night and not coming back. And, of course, they had years and years of watching their daughter with drug use, and they thought she was using again (practice nurse, interview data).
>
> But [the meeting] makes you think, and... and there have been occasions where people [health visitors] have said well perhaps I'll go around and see them again next week, just to see how they're getting on...(GP, interview data).

### 3.2.2. Risk Assessment

From the GPs' and practice nurses' perspective, the main purpose of monitoring, review and follow-up was to aid risk assessment and make timely decisions about when a concern warranted being shared with children's social care. In this way, information sharing at the meeting was seen to contribute to a "bigger picture" and facilitate more accurate risk assessment:

> *Interviewer:* How did having the vulnerable family meeting influence your view of her and...and the family?
>
> *Respondent:* Um, I suppose it...it concerned me more in that it was, you know, it was part of the bigger picture and... it was more, oh, right, I didn't realize all of those people were kind of in the same household. So it was helpful from a...from a bigger picture, you know, thinking about all of the children rather than just her.

### 3.2.3. Sharing Risk

One participant felt that the vulnerable family meeting allowed her to live with her decision not to refer a family to children's social care after her concern was stepped down following information from a health visitor:

> I can live with it [the risk] and actually it's shared because I have told the health visitor, I have told the other doctor and I will mention it again when I go to the practice meeting and that is as much as we can do at the moment and I don't believe she is in immediate danger (GP, interview data).

### 3.2.4. Encouraging Inter-Professional Trust and Inter-Agency Working

One practice (practice A, Table 1) aimed to build inter-agency trust and joint working between general practice, local schools and mental health care services (CAMHS; Child and Adolescent Mental Health Services). This approach was newly conceived and it was apparent it would take a long time to build these links. The attendance of professionals from outside general practice resulted in a preoccupation with confidentiality and the ethics of information sharing, so that this was the primary topic of discussion and only one family was discussed.

#### 3.2.5. Learning and Peer Supervision

In one meeting, (practice C, Table 1) the stated aim was to learn from general principles rather than support the management of individual cases. However, there was no evidence of this happening in the meeting which was observed. There was no other indication in the observation or interview data that the professionals saw the meetings as a way of learning or accessing peer supervision in this difficult area.

#### 3.2.6. Joint Decision Making

In practice A (Table 1), the GP leading the meeting explicitly stated that the meetings were not a forum for decision making. There was no other mention of joint-decision making as a purpose of the meetings.

## 4. Discussion

### *4.1. Key Findings*

The format of the vulnerable families meeting varied greatly across four "best practice" general practice settings in England. The meetings were primarily used to monitor children, young people and families, aid good risk assessment and support decisions about when to refer to children's social care. These uses of the meetings in this study go beyond those previously described: in feedback about the meetings in one Clinical Commissioning Group area, participants saw their primary purpose as information sharing to support early identification of problems and their secondary purpose as building relationships between professionals [24]. There was no evidence in our study that vulnerable family meetings were used for peer supervision and learning in this difficult area or to support joint decision making about how GPs and the primary care team should manage the family in their everyday contact with them.

Other qualitative studies of multi-disciplinary team meetings to discuss vulnerable families in social work [25] and patients with dementia in primary care [26] have reported that participants saw joint decision making as one purpose of the meetings. Both these studies are set in the US. Effective team meetings in other patient groups in primary care are characterized by clear goals [27] and it is likely that this would also improve the functioning of vulnerable family meetings.

### *4.2. Facilitators of a Fit-for-Purpose Meeting*

From the results, we would suggest four key facilitators of a fit-for purpose vulnerable family meeting (based on the data, a fit-for-purpose meeting is one that promotes monitoring and follow-up of children and their families, good risk assessment, shared risk, joint-working, learning, peer supervision and joint decision making about referral to children's social care and/or continued management within primary care services).

#### 4.2.1. Flow of Meaningful Information into the Meeting

In the meetings we observed, GPs relied on health visitors to act as a conduit for information from children's social care and/or the police and to bring to the meeting detailed information that they had collected during home-visits. There are several challenges to using health visitors to underpin the monitoring, risk assessment and risk sharing functions of the vulnerable family meeting in this way. Health visitors only work with families with preschool-aged children (though they may extend their work to older siblings [28]), their caseloads may not overlap with the geographical area covered by GP practices (*i.e.*, they only work with some of the families registered at the practice); and they may not have time, energy or incentives to attend GPs' vulnerable family meetings. Health visitors may not themselves receive important information from other agencies: in their overview of a series of studies about safeguarding children in the UK, Ward and Davies reported that heath visitors were just as frustrated as GPs at the lack of feedback from children's social care ([9], p. 119). Wider interview data from our study also revealed that health visitors may not pass on all relevant information to the GP even if they are aware of it and even if they attend the vulnerable family meeting [16]. Assuming that health visitors know and share relevant information from other agencies might leave GPs erroneously thinking they have the bigger picture and impede good risk assessment and monitoring. It might also place an unfeasibly large burden on the overstretched health visiting service.

One alternative would be to create a system for regulated information exchange such as automatic notifications of referrals to police or children's social care or an electronic database that could be shared across agencies. However, this type of "techno-rational" solution [29] has been criticized for prioritizing administrative work and formulaic agency responses over thoughtful practice and therapeutic work with children and families [30–33]. As Hall argues in his analysis of inter-professional communication in public enquiries into child death, we should not assume that it is easy or simple to transfer "information" from one professional to another [32]. Professionals from different agencies will draw on the rules, beliefs and habits of their profession to make (different) interpretations of the same piece of "information" [34]. Even when information is shared, the meaning of that information can easily get lost as it changes hands, especially in the context of child protection work which engenders professional anxiety, uncertainty and vulnerability to blame. "Lost" information might be exaggerated with automatic systems, which also threaten to deluge general practice in the sheer volume of information they might receive about their patients, for example domestic violence incidents via the police.

Another alternative would be to resource another professional whose job description included collecting ensuring information flow into the meeting from social care, education and health visitors and feedback to these agencies. This professional could be located either within primary care or within children's social care. A similar role already exists in some hospitals in the UK in the form of liaison health visitors and paediatric liaison nurses. Collecting information prior the meeting might improve its function: a qualitative study of team working for patients in Belgium primary care reported that well-planned meetings worked best [35]. Any member of liaison staff would have to be sufficiently skilled to elicit and transfer the *meaning* of information, which might require interagency training [9] and to ask questions around the information exchange rather than passively accepting what they hear [32]. There are obvious resource implications of using a trained and skilled professional to fulfill this role. One possibility is for the meetings (and staff time) to be funded by the Clinical Commissioning Group as a Local Enhanced Service [24].

#### 4.2.2. Systematic Ways of Identifying Cases for Discussion

In the observed meetings, there was a clear need for systematic ways of selecting children and families for discussion. This might be achieved, for example, by identifying children from codes in their electronic primary care records and cross referencing concerns with children and parents known to be vulnerable by other professionals (as in practice B, Table 1) or by selecting families where parental risk factors are known to the GP practice, such as domestic violence, drug and alcohol abuse and suicide attempts. This latter approach is already used throughout all Dutch ED departments [36–38] and in some English EDs [39] to identify at risk children. Any protocolised selection of children for discussion might also require a filter of professional concern about the child, to make the meeting directly useful to practice [35] and to make numbers manageable.

Having a systematic way of identifying children and families for discussion at the meeting might minimize disruption from the absence of key staff (as seen in practice D, Table 1) and avoid reliance on professionals' memory, confidence and motivation to bring cases to the meeting. Due to disincentives to record maltreatment-related concerns, and particular disincentives to use maltreatment-related codes in the patient's notes, these codes might not identify all concerns known to the practice. However, the Royal College of GPs has recommended a simple intervention to improve coding of maltreatment-related concerns [22], which increased coding by about 30% in 10 practices in England (personal communication). Giving codes a specific and visible purpose (using them to "case-find" for the vulnerable family meetings) might promote their use.

#### 4.2.3. Limiting Attendance to Core Members of the Primary Care Team

There is a high level of anxiety and professional vulnerability in child safeguarding work, which can muddle and overwhelm professionals [30,31,40,41]. Qualitative studies have described how defenses to anxiety and vulnerability creep into team work and joint-working practices [31,41]. The pre-occupation with confidentiality and the reluctance to admit that "the ball had been dropped" that we observed in two meetings might be exactly this type of defense and have been descried as such elsewhere [31,41]. A paralyzing pre-occupation with confidentiality is commonly described in joint child safeguarding work between social works and health professionals [11,25].

Keeping the meetings small (limited to the core primary care team) might help create a "safe space" which allows for the uncertainty and "not knowing" in concerns about child abuse and neglect and has been described as essential for thoughtful practice and peer support in child safeguarding work within children's social care [31]. As opportunities for informal professional reflection, peer review, team building, and moral support are squeezed by a target-based primary care system [42], a formal "safe space" might be increasingly important.

The evidence-base does not clearly tell us whether it is better to have small homogenous groups of primary care professionals in vulnerable family meetings or to have larger interdisciplinary meetings.

A literature review of team work for complex patients in primary care concluded that occupational diversity in a team promoted positive impact on patient care [27]. However, other qualitative studies of interdisciplinary teams for late-stage dementia in primary care [26] and child safeguarding work [25] report that true collaborative discussion and joint-working rarely took place, and could even be absent in the context of co-location of professionals [25]. Co-locating social workers in paediatric primary care settings was one component of a multi-component intervention that improved health outcomes of vulnerable and maltreated children [43,44]. On the other hand, our data suggest that inviting social workers to vulnerable families meetings will only work if there is complete professional trust and ease between the social workers and primary healthcare professionals, taking an unfeasibly long time to build and rebuild each time a social worker changed post.

In an ideal world, professionals from other agencies could come to a vulnerable family meeting and engage in uninhibited and profitable discussion and joint decision making. However, it seems that this is not so easy to achieve in practice. Limiting attendance at the meetings to the core primary healthcare team might be the type of "street level" solution that Hood describes as being a practical solution to the inherent messiness and ambiguity ("the swampy lowlands") of everyday practice [33].

If vulnerable families meetings were limited to the core primary healthcare team, there would be need of structures to challenge assumed and dominant ways of working and to promote inter-agency working outside the meeting. Such structure would guard against meetings which reinforced "routine dysfunction practice" [45] promote inter-agency working to avoid "silo working" [46]. Inter-agency training might be a one way of doing this, although the same review that reported inter-agency training to be a positive and valued way of promoting inter-agency trust also reported that GPs rarely attended [9]. Given the monitoring role of LCSBs and statutory requirement for GP led clinical commissioning groups to sit on these boards, LSCBs might be able to help promote interagency working around children discussed in vulnerable family meetings. However, LSCBs face significant challenges in term of participation, leadership and resources [9].

#### 4.2.4. Locating the Meeting as Part of Routine Clinical Practice

Lastly, locating the vulnerable families meeting as a part of the routine work of general practice might facilitate motivation of the team (by labelling safeguarding as core clinical work) and frequency of meetings. This might be done by including discussion of vulnerable children in regular meetings about all problems in children, which could also be nested within a meeting about problems about adult patients as in practice D. Locating safeguarding work as core 'medical' practice was identified as one of the drivers of GP engagement with safeguarding work in the previous analyses of the data from this study [16].

These suggested facilitators need to be tested in practice.

### *4.3. Strengths and Limitations of Our Study*

This was an in-depth qualitative study that achieved a level of candour from participants, as described in previous publications [16] and used researcher observations as well as professional accounts to generate hypotheses. As an in-depth qualitative study of "best practice" sites, we cannot assume that our results can be generalised to all general practice settings in England. Indeed, we found high variation even between a small number of "best practice" sites. Variation is likely to be greater still over the tens of thousands of GP practices in the UK (there were more than 8000 GP practices in England in 2013) [47]. There are currently no data about the proportion of GP practices in the UK which hold vulnerable family meetings, how frequently they do so or with what perceived purpose.

As described above, other qualitative studies above have generated hypotheses about effective team-working and interagency work about other patients in healthcare settings or about vulnerable children in social work or multiagency teams. Currently, there are no epidemiological data on the effectiveness of vulnerable family meetings on outcomes for children, young people and their families in primary care and this was beyond the scope of this study.

## 5. Conclusions

Vulnerable family meetings were being used for monitoring children, young people and families in some practices in England. We suggest an opportunity was being missed for peer supervision in this difficult area and joint decision making about how to manage everyday contact with specific vulnerable children, young people and their families in primary care. Using the meetings for peer supervision and joint decision making might help GPs manage the "not knowing" inherent in concerns about abuse and neglect and minimize the potential for isolated working.

Our study suggests that there is likely to be some way to go before team meetings in primary care reach their potential for safeguarding children and young people. To maximize the potential of the meetings, practices are likely to need properly resourced and skilled support.

Other professionals should recognize that the meetings are a potential mechanism for engaging and supporting GPs in their everyday responses to vulnerable and maltreated children. The police, children's social care, education and mental health services should feed information into these meetings and provide support when requested, although attendance by outside professionals might cause more problems than it solves.

A large scale survey of a representative sample of GP practices should be undertaken to test the hypotheses generated by our study. We need a study conducting a series of small and linked evaluations to test the most effective way of running a vulnerable family meeting in primary care. These should include epidemiological data from patient records as well as qualitative data and should include a comparison group and, if possible, a randomized design.

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## Author Contributions

J.W. designed the study with R.G. and M.B. J.W. conducted the interviews, analysed and interpreted data. She is the guarantor. R.G. and M.B. designed the study, supervised the analyses and contributed to the writing of the article. D.G. and J.A. contributed to the design of the study, interpretation of findings and contributed to the writing of the article. JW, RG and MB took responsibility for the integrity of the data and the accuracy of the data analysis.

## Conflicts of Interest

RG is supported by awards establishing the Farr Institute of Health Informatics Research at UCLP Partners from the MRC, in partnership with Arthritis Research UK, the British Heart Foundation, Cancer Research UK, the Economic and Social Research Council, the Engineering and Physical Sciences Research Council, the National Institute of Health Research, the National Institute for Social Care and Health Research (Welsh Assembly Government), the Chief Scientist Office (Scottish Government Health Directorates) and the Wellcome Trust (MR/K006584/1).

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# Technology-Based Innovations in Child Maltreatment Prevention Programs: Examples from SafeCare®

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**Abstract:** Each year, hundreds of thousands of children in the U.S. are victims of child maltreatment. Experts recommend behavioral, skill-based parent training programs as a strategy for the prevention of child abuse and neglect. These programs can be enhanced using innovative technology strategies. This paper presents a brief history of the use of technology in SafeCare®, a home visiting program shown to prevent child neglect and physical abuse, and highlights current work that takes a technology-based hybrid approach to SafeCare delivery. With this unique approach, the provider brings a tablet computer to each session, and the parent interacts with the software to receive psychoeducation and modeling of target skills. The provider and parent then work together to practice the targeted skills until mastery is achieved. Initial findings from ongoing research of both of these strategies indicate that they show potential for improving engagement and use of positive parenting skills for parents and ease of implementation for providers. Future directions for technology enhancements in SafeCare are also presented.

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## 1. Introduction

Child maltreatment (CM) is one of the most significant and substantive issues facing the U.S. today with a high incidence and at a staggering cost to the individual and society at large [1–3]. In 2012, an estimated 686,000 children were victims of abuse and neglect, an incidence rate of 9.2 per 1000 children in the population [4]. Over a quarter of these victims were less than three years of age, and approximately 20% were between the ages of 3 and 5. Over four-fifths of abuse and neglect cases (81.5%) were perpetrated by either one or both parents [4]. The incidence rates of CM are widely believed to be underestimates [1,3], and data show that the majority of CM incidents are not investigated by Child Protective Services (CPS) [5]. Although CPS reports indicate that approximately one percent of children in the U.S. are victims of CM each year [4], these data find that the percentage of children who are victims is closer to four percent [5].

Children who experience CM are at increased risk for poor emotional, social, and behavioral consequences [6] as well as increased risk for deleterious long term effects, including poor health and lower achievement, across the lifespan [7–9]. More specifically, adults who were CM victims have higher reports of poor lifestyle factors than adults who were not CM victims, as well as having higher incidences of smoking, severe obesity, mental illness, ischemic heart disease, cancer, chronic lung disease and liver disease [7]. Consequently, the projected lifetime economic burden of new victims of CM in 2008 alone was $124 billion. This figure, while staggering, is based on conservative assumptions, underscoring the importance and cost-effectiveness of CM prevention [2].

### *1.1. CM Prevention: Behavioral Parent Training Programs*

According to data from the National Child Abuse and Neglect Data System (NCANDS), parents are the most common perpetrators of CM [4]. Thus, increased attention has been paid to prevention programs that target parents, especially those at risk. The risk factors believed to underlie CM include parental substance abuse, mental illness, domestic violence in the home (28.5% of victims) [4], child conduct problems, and poverty [1]. Interestingly, the interventions that have been the most successful in reducing CM are not those that address these risk factors but rather those that focus on improving parenting skills [1,10], known as Behavioral Parent Training (BPT) programs. Experts in the field recommend BPT programs as a type of evidence-based model that may benefit families in the child welfare system and serve as a CM prevention strategy [1,11,12].

BPT programs are based on the assumption that parenting skill deficits can be improved by providing parents with a repertoire of skills. They use a specific instructional format that includes: provider instruction and behavioral modeling of targeted skills, parent practice of skills through role plays and live practice with the child, and homework assignments for the parent, for example, to practice targeted interaction skills with the child outside [13]. The rationale for BPT programs in preventing CM is that parents who receive this training acquire and develop positive parenting skills and are less likely to use coercive methods to address challenging child behavior as well as experiencing changes in the attitudes that promote harsh parenting practices [8]. The evidence suggests that helping parents interact with their children and build parenting skills also benefits their mental health [1].

Research on several of these programs has shown that they can reduce the risk of CM perpetration and recidivism in a population of families at increased risk for maltreatment. For example, Chaffin and colleagues [11] conducted a randomized trial of families referred for physically abusive behavior comparing Parent–Child Interaction Therapy (PCIT) to a standard community-based parenting group and to PCIT with enhanced case-management services. Their findings indicate that 19% of PCIT-treated families had a re-report for physical abuse compared to 49% of families treated via the community-based parenting group. Additionally, in one of the few studies to examine the use of a BPT program as a primary prevention program, Prinz and colleagues [14] conducted a large population-level randomized trial of Triple P, another evidence-based BPT program, in South Carolina and results indicate a relative reduction in maltreatment rates for areas in which Triple P was implemented compared to areas where it was not.

More recently, several randomized trials have found the benefits of SafeCare as an effective program for reducing CM recidivism for parents of children 0–5 years. The program consists of three, six-session modules: Parent–Child Interaction (PCI), Child Health, and Home Safety. Each of these modules targets skills that are proximal to CM risk factors. In PCI, parents learn skills to increase positive interaction with their children and reduce challenging child behaviors. The home visitor teaches skills used to structure activities for children including daily routine activities, activities outside of the home, and independent play. Through the child health module, parents are taught how to respond to a variety of health-related situations that may arise. They learn to use health reference materials to help identify illnesses and symptoms and respond accordingly, whether it is by treating at home, making an appointment with the doctor, or going to the emergency room. The home safety module is intended to reduce the risk for unintentional injury by teaching parents to identify hazards in the home, to understand when objects are reachable or accessible by children, and how to remove hazards or make them inaccessible. Parents also learn the importance of appropriate supervision. The first and last sessions in each module are assessment sessions in which the home visitor assesses the parent's skills. In this way, the home visitor can track the parent's skill acquisition. Sessions two through five are training sessions in which the parent learns the material for that session. Each training session is structured around four components: Explain, Model, Practice, and Feedback. As this description implies, the home visitor begins by explaining the skills, then models the skills for the parent, allows the parent to practice the skills, and, finally, the home visitor provides positive and corrective feedback to the parent regarding their use of the skills [15].

SafeCare is a unique BPT program in that it is delivered in the home setting as opposed to a clinic. This delivery strategy provides the benefits of reducing logistical barriers for families, while also offering service providers an increased opportunity to understand factors occurring in the ecological context of the home environment that influence parent decision making and behavior. By delivering the curriculum in this manner, the provider is able to directly observe parent's use of the skills in the home, where they will most often be implemented, and also provide feedback during training in the home environment [16]. Additionally, SafeCare was designed specifically to prevent CM as the primary program objective. The three SafeCare modules address proximal risk factors for both child physical abuse as well as neglect, the most prevalent form of CM [4]. Other BPT programs were developed to target different outcomes and have been applied to CM prevention following positive results for proxy behavioral outcomes.

The largest study to date is a statewide comparative effectiveness trial of SafeCare in the Oklahoma child welfare system. Chaffin and colleagues [17] conducted a six-year longitudinal study comparing rates of recidivism between a group of parents receiving SafeCare services and a control group receiving family preservation services as usual ($n = 2175$). This study found that SafeCare prevented 26% of repeat cases of maltreatment compared to the control group. Participation in SafeCare was also shown to improve parenting behaviors. Separate analyses found that SafeCare was equally effective for a large sample of American Indians who participated in the trial compared to non-minority participants [18]. A second randomized trial by Silovsky and colleagues [19] found differences on a range of outcomes (parent social support, child abuse potential, parent depression) favoring SafeCare as compared to usual services. A third trial also showed results favoring SafeCare participation over services as usual [20]. This study found that SafeCare parents had a higher service retention rate, greater use of non-violent discipline, and fewer child welfare reports related to domestic violence compared to the group of parents receiving services as usual. In addition to these randomized controlled trials, quasi-experimental and single-subject research has been conducted on SafeCare yielding similar results, all supporting the positive effects of SafeCare [21–24].

### *1.2. Using Technology to Enhance BPTs*

The overall public health impact of a program includes the effectiveness of the intervention on targeted outcomes, as well as the reach or the percent and representativeness of individuals willing to participate [25]. While there is increasing evidence for BPT programs to reduce CM risk and incidence for families who complete, there are still significant limitations to the reach of these programs. Family service engagement, defined as parent beliefs about treatment that impact service participation and satisfaction, alliance with interventionist, and, ultimately, service retention [26], is one of the major challenges documented by research [27,28]. Emerging research indicates that, by increasing communication between provider and client and providing information in a unique way, technology-assisted evidence-based BPT programs delivered in clinics [29] and homes [30,31] can improve parent engagement and retention and, consequently, targeted outcomes.

In a special issue of the journal *Child Maltreatment,* Guest Editors Self-Brown and Whitaker [32] called for an increase in the use of technology for intervention delivery to parents to improve reach of evidence-based programs in the CM field. The growing penetration of internet and smartphone usage coupled with the growing resource constraints on state support of families at high risk for CM presents a great opportunity to promote innovative technology strategies. In addition to improving reach, these strategies afford the opportunity to reduce the costs of BPT provision while enhancing home visitor fidelity, or adherence to the intervention protocol [3]. Technology-enhanced BPT programs have the advantage of being adaptable to the individual and overcoming the challenges of implementation fidelity which arise from the incomplete adherence of interventionists to intervention protocols [6]. Delivery of the program through a computer ensures that the information is being delivered as intended in the intervention protocol (*i.e.*, with fidelity). Also, in situations in which providers are delivering an evidence-based practice for the first time and are unaccustomed to following a structured protocol and experiencing increased supervision, the addition of a technology component could alleviate some of the stress related to a new implementation. Numerous research studies have shown that technology can successfully aide in delivery of these programs. What follows is a discussion of how technology has been implemented in SafeCare in the efforts to prevent child abuse and neglect.

## 2. Literature Review of the Use of Technology in a BPT Program: A Look at Previous SafeCare Strategies

The introduction of technology into SafeCare first emerged in the mid-1980s when home visitors successfully utilized an audio slide show to help parents identify safety hazards [33]. Over a decade later, video training was tested in the PCI and home safety modules. In this approach, home visitors brought a ten-minute video, the content of which covered the explaining and modeling portions of that session, to each visit. The video was played on the parent's VCR while the home visitor monitored the child. A single subject study of two parents was conducted for the PCI module and for the home safety module. Results of these studies found that parents' skills improved greatly after the video training was implemented and that parents positively rated the video content and the use of video as an intervention delivery mechanism [21,34].

Since that time technology has improved and expanded greatly, and SafeCare has adapted to incorporate newer technologies. More recent technological augmentation of SafeCare has included use of the iPhone$^{TM}$ in both service delivery and data collection. Jabaley and colleagues [35] utilized a technology-assisted approach to the delivery of the home safety module, such that in addition to the standard home visits, an iPhone was given to parents as a way for parents to capture video of rooms in their home, which they sent to their home visitor in between sessions. The home visitor was then able to remotely assess the room for hazards and provide the parent with praise and feedback. The phone also functioned as a way for the home visitor to communicate with the parent between sessions, providing tips and feedback and reminding the parent of upcoming sessions. In this way, the technology served not only to aide in service delivery and data collection but also as a way to increase engagement. This technology-assisted version of the SafeCare home safety module successfully reduced home hazards across 3 at-risk families and the intervention module was delivered fully in five sessions as opposed to six sessions with the assistance of the technology.

Another way that technology was used to enhance SafeCare is through the use of a digital frame as an enhancement to the Parent–Infant Interaction module. In SafeCare sessions, the home visitor took pictures of the parent as she correctly modeled the skills and uploaded them to the digital frame. The home visitor and mother then reviewed the pictures together to ensure that the mother knew what skills she was using in each picture. The frame was then set up in the home with the pictures shown on a continuous loop. The home visitor helped the mother schedule times when she could practice the skills, using the digital frame as a guide during practice. A single subject study of this approach was conducted with a mother with intellectual disabilities in which the mother increased substantially in her use of both physical (83%) and non-physical (50%–62.5%) parent-infant interaction skills upon completion of training. This increase was sustained at a three-month follow-up [36]. As with the case of the iPhone, technology enhanced the program in this example by providing the parent with a review of the skills between sessions.

Carta and colleagues [30] found success with a technology-enhanced SafeCare adaptation in a randomized controlled trial (n = 371 mother-child dyads). In this study they tested the efficacy of adding a cellular phone component to Planned Activities Training (PAT), a key component of the SafeCare PCI module. The mother-child dyads were randomly assigned to one of three conditions: (1) PAT (the SafeCare PCI module); (2) CPAT (the PCI module plus cell phone assistance); or (3) Waitlist Control. Mothers assigned to the PAT group participated in standard SafeCare PCI in-home sessions with a trained home visitor. The CPAT group received a technologically-augmented intervention that involved simple cell phone text messages and phone calls from the home visitor in addition to the PAT sessions, increasing the contact between home visitors and mothers. Specifically, home visitors would send out texts twice a day. One text was used to remind the mother of a certain PAT skill and one contained a question related to her skills usage or the child's behavior. These messages were tailored to the specific mother's issues that came about during the in-person sessions. Home visitors also called the mothers once a week in order to discuss the content of the text messages as well anything else the mothers felt warranted discussion; these talks were directed by the mothers.

Results showed that both the parents in the PAT and in the CPAT groups utilized significantly more positive parenting skills than the wait-list control group, and children of these mothers had more positive engagement compared to the control group. Furthermore, the CPAT group demonstrated even higher positive parenting strategies in addition to reduced parenting stress and depression and increased child adaptive behaviors compared to the other two groups. Additionally, data suggested that parents in the cell phone group had greater retention in services [31].

These examples highlight ways that technology has been employed to enhance SafeCare in the past. This paper presents two ongoing studies that integrate technology in a hybrid approach to delivering SafeCare. The first will examine family-level data in a technology-enhanced program designed specifically for fathers. The second study will assess outcomes at the provider level in a technology-assisted home visiting program for parents of young children.

## 3. Current Work Examining Technology-Based Enhancements in SafeCare

An innovative approach to technology in parenting programs targeting home visiting is to consider how program providers can utilize technology devices during service delivery to advance client engagement and associated retention. Increasingly, service providers who work with families in the home are provided laptops, smartphones, or tablets by their employers [37], which could simply be utilized in session to offer parents access to web-based information. In recent years, federal grant funding from the National Institutes of Health has allowed for the development of a web-based SafeCare program that can be used during home visiting sessions. The web program was designed using best principles of communication theory, with personally and contextually tailored health information, user-centered design and interactivity, as well as the use of multimodal teaching that can enhance individual engagement, learning, and potential behavior change [38,39]. SafeCare providers take a technology-assisted, computer-mediated approach [40] to session delivery in which the computer is used as a third partner in the relationship between a provider and client. That is, the home visitor connects the parent to the web-based program, and the parent participates in the multimodal learning (e.g., explanation and modeling of skills) of SafeCare target skills. When the parent completes the web-directed portion of the session, the provider takes over and has the parent engage in live practice of the skills discussed in the web program and provides positive and constructive feedback. This approach offers the advantages of computer intervention delivery, without eliminating the provider-client relationship that can be key to child safety when working with at-risk families. Two studies are currently utilizing this technique in SafeCare, Dad2K and SafeCare Takes Care. Both of these SafeCare augmentations are being explored through randomized controlled trials, which have been approved by the Georgia State University Institutional Review Board. These studies and early findings are described below.

### *3.1. Dad2K: Dads to Kids*

*Description of Dad2K.* Dad2K is a technology-assisted delivery approach to SafeCare PCI that has been adapted for fathers. The sessions are action-oriented, and even fathers who have limited visitation with their children will find the interaction skills they learn in this module applicable. In addition to the possibility of fathers having limited visitation with their children, they may also have transient living arrangements, making home visits a challenge. In the SafeCare PCI module, home visitors can conduct the sessions virtually anywhere. For instance, if a father is living with a family member or has visitation in a public setting such as a park, the home visitor can easily conduct the session at those locations. These features make SafeCare PCI especially relevant as the foundation for a program for fathers.

Development of the program was an iterative process, taking place over the course of approximately nine months. Modifications were made to the program to make it more appealing to men. For instance, a sports theme was integrated throughout the program, and the program was named Dad2K, which is a play on the title of a popular sports video game. Also, in PCI, parents complete an "Assessment Form". In Dad2K, the same form is used, but it is referred to as a "Scorecard". Videos in the computer portion of the sessions are hosted by a male "coach", who explains the skills using sports analogies throughout the program; the modeling in the videos is conducted by a father.

Co-parenting is a domain not formally addressed in SafeCare that is dealt with in Dad2K. This component was added to the program due to the possibility that fathers may have custody issues that present unique challenges in co-parenting. At the end of session four, the home visitor asks the father about any conflicts he has with his co-parent related to child rearing. Using this situation or an example of one, the home visitor completes the SafeCare Problem Solving Worksheet with the father, asking him to list all of the possible options to address the problem and the pros and cons of each.

Finally, a technology component was added to the program, creating a hybrid approach to home visiting, as described above. At the beginning of each session, the parent completes the Explain and Model portions of the session via the online computer program. The program is accessed via a tablet and Internet hotspot that the home visitor brings to each session. The home visitor then resumes with the Practice and Feedback portions of the session. The hybrid approach to delivery may be especially relevant to fathers, as previous research has found that fathers do not respond as favorably to the typical structure of parenting programs (*i.e.*, one-on-one discussion with a therapist or home visitor) as mothers do [41]. This dynamic approach to the session structure, beginning with an interactive computer portion and moving to a more traditional method of parent training, may increase their engagement and interest.

*Dad2K Home Visitor Training.* Two female SafeCare Training Specialists and one male PhD student, who has experience delivering father programs, were trained to deliver Dad2K. All three were trained to deliver SafeCare. In addition to SafeCare training, which consists of didactic training as well as field work, the home visitors took part in additional training to familiarize them with the adaptations made to PCI in the Dad2K program, as well as to teach them how to use conduct the computer portion of the session.

*Dad2K Efficacy Trial and Initial Experience.* Funded by the National Institute of Health and Health Disparities, 120 fathers between ages 18–30 with at least one child between the ages of 2–5 years are being recruited from community organizations, local businesses, and neighborhoods in the Atlanta area for the randomized controlled trial to test Dad2K against a control group that receives parenting materials by mail. Thus far, fourteen fathers have enrolled in the study. They are all African American with a mean age of 25.1 years. Fifty-seven percent report an annual income of less than \$15,000, and 43% have a high school diploma or General Educational Development (GED) exam (*i.e.*, high school equivalency) or less.

To date, the rate of program completion for the intervention group has exceeded expectations and typical completion rates found in the literature [27,28]. Of the seven participants in the Dad2K group, four have completed the program and two are actively participating. One participant has been lost to attrition. Participants ($n = 4$) have rated their satisfaction with the program as high. On a satisfaction survey completed at the end of the final Dad2K session, fathers were asked to rate items on a scale from one ("Strongly Agree") to five ("Strongly Disagree"). The mean rating for the item, "Interacting with my child has become easier", was 1.5, with 1, "Strongly Agree", being the most favorable rating. With regard to "I have more ideas about activities I would like to do with my child", and "Routine activities…have become easier", three out of the four participants rated these items a one; the fourth rated it a two. The mean participant rating for the item, "I liked doing part of my session on the computer", was 2.00.

Dad2K home visitors have reported positive feedback from the fathers participating in the intervention. They note that fathers enjoy discussing parenting issues and the sessions sometimes last longer than average SafeCare PCI sessions due to fathers' questions and engaging discussion. Thus far, there have only been two instances of the Dad2K computer portion of the session not being completed due to technical problems. After pilot testing, a protocol was developed whereby home visitors make two attempts at troubleshooting computer problems before they revert to the traditional home visiting method of delivery. If the technical problem is due to Internet connectivity issues, the home visitor can still show the videos to the father, as they are saved directly on the tablet.

The efficacy trial is expected to be completed by August 2016. At that time, the research team will be able to examine how effective Dad2K was in improving maltreatment risk, father–child interaction, father mental health, child behavior, and father involvement.

### *3.2. SafeCare Takes Care Program*

*Description of SafeCare Takes Care (SC-TC).* SC-TC also involves augmentations to SafeCare. However, in this case, the modifications are primarily concerned with the addition of technology to the program rather than use of the program in an atypical group of participants, and the program includes all three modules instead of just PCI. Just as with Dad2K, the home visitor brings a tablet and Internet hotspot, and the session begins with the parent viewing the Explaining and Modeling components through the computer program. The computer portion of SC-TC also involves a combination of video, audio narration, and engaging questions. However, the videos in this program have a talk show theme rather than a sports theme. For each module and session, the host of "SafeCare Takes Care" presents a new topic (*i.e.*, the session content for that day) with video modeling of the skills from "at-home viewers". For example, in PCI, a video begins with the talk show host explaining the skills being covered in the session, then the parent will see video of a parent modeling these skills, and the host may take some questions from studio audience members or from fans on the "street cam". Following completion of the computer portion of the session, the parent practices the skills and receives feedback from the home visitor.

*SC-TC Home Visitor Training.* All home visitors in the SC-TC study receive SafeCare training as usual. This consists of four days of classroom training that involves didactic presentations, modeling of the instruction, and role playing. Home visitors assigned to the SC-TC group receive an additional half day of classroom training in which they go through the computer program on a tablet, learning how to navigate the tablet and the computer program. Following classroom training home visitors in both the SC-TC group and the SafeCare as usual group conduct field work in order to reach certification. After certification, home visitors continue to be fidelity monitored and coached on a monthly basis.

*SC-TC Randomized Trial and Initial Experience.* Funded by the National Institute of Mental Health, the study of SC-TC chiefly examines how well the technology-assisted approach affects implementation outcomes for providers, as well as some basic family-level data. Thirty SafeCare home visitors will be recruited for the study and will either be assigned to standard SafeCare training, or the technology-assisted training (SafeCare Takes Care group). Each provider participant will be asked to recruit two families, resulting in 60 SafeCare families in the sample. This study is in the very early stages of data collection and currently has three home visitor participants enrolled. Two SafeCare parents have been enrolled in the study. One of the home visitors has a graduate degree, and the remaining two have Bachelor degrees. They have all been working in the field for at least six years with two of the participants having ten or more years of experience. Both SafeCare parents are Caucasian females with a mean age of 33. They both report an income of less than $20,000 annually.

Informal, qualitative data obtained from home visitors in the SC-TC group suggest that they find the program feasible and even preferable to standard delivery. Specifically, they have found that the videos and content in the computer portion sparks discussion with the parents, strengthening the session topics. To date, there have been no technological malfunctions precluding session completion in SC-TC. The study will be completed in April 2015, and upon completion the research team will examine whether the technology-assisted providers attain SafeCare certification, maintain fidelity, and sustain delivering SafeCare services at higher rates that providers trained in SafeCare as usual. Family-level outcomes such as maltreatment risk and child behavior will also be explored.

## 4. Conclusions

This paper discussed the use of technology in a CM prevention program and the promise this approach shows in engaging parents, improving the use of positive parenting skills, and easing implementation for providers. Although few conclusions can be drawn at this point in the research process based on the current number of participants enrolled in these studies, the early findings indicate that addition of technology to the program is beneficial to home visitors and parents. In addition to CM prevention, technology enhancement can positively affect outcomes in other programs targeted toward parents. Recent work has illustrated how technology is also being introduced into programs that aim to improve child outcomes by addressing infant social development and child externalizing behaviors. For instance, Baggett and colleagues [6] developed a completely Internet-based adaptation of an evidence-based parenting program that has been found to improve infant developmental outcomes. Their research found that there was a high retention rate, high satisfaction and ease of use, and improved parent and child outcomes compared to a control group. In a study of a program targeting parents of children with disruptive behavior [29], a technology-enhanced version of the program included addition of videos, text message reminders, video recording home practice, and midweek video calls. This study showed that the technology-enhanced group had significant decreases in disruptive behavior, increases in customer satisfaction, and lower implementation costs than the group receiving the standard protocol. It is evident that technology can be used in multiple approaches to enhance, not only CM prevention programs, but programs that address other infant and child outcomes as well.

Technology is rapidly growing and changing, and it is increasingly permeating daily life. Thus, in order for CM prevention programs to stay relevant and engaging to a broad population, technology-based approaches must adapt to these changes. This is especially true in considering work with adolescent parents who are accustomed to both multimodal learning and communication through technology and the Internet, as this has been available for their entire lives.

Also important to consider is access to technology and to the Internet. Internet usage by adults in the U.S. increased overall from 79% in 2010 to 87% in 2014, and smart phone usage has increased from just 35% in 2011 to 58% in 2014 [42]. Despite these increases in overall usage, a digital divide remains. When examining Internet and smart phone use by socioeconomic factors such as education or income, there are significant differences in access. Essentially, there is still a full 20% of Americans who have neither access to a home Internet connection nor to a smartphone [43]. For families without access to technology at home, programs such as Dad2K and SC-TC, in which providers bring the technology to the sessions, will allow them to receive the benefits that technology offers without expecting that the families will supply it. Government leadership has recognized that access to technology is important, and White House initiatives are planned to expand Internet access to at least 98% of Americans [44]. As time goes on and access increases and costs decrease, CM prevention programs should incorporate technology enhancements as part of standard protocol, and future research should examine the feasibility of implementing a technology-enhanced program using parents’ own technology.

With the need to adapt to expanding technology in mind, new approaches to technology-based enhancements in the SafeCare program are under way. One example of a technology enhancement that is already being utilized by SafeCare home visitors and trainers is the SafeCare Portal. This is a secure website to which home visitors upload audio files of their SafeCare sessions for their trainer to listen to for continued fidelity monitoring and where they can track their progress toward certification as a SafeCare home visitor. Before development of the Portal, home visitors uploaded audios to a secure third-party website in a process that could sometimes be confusing for home visitors and for SafeCare trainers. The Portal has made this process simpler, which can ease home visitor job demands, especially for those sites new to implementing an evidence-based practice that requires fidelity monitoring. In addition to the SafeCare Portal, researchers at the National SafeCare Training and Research Center are developing new mobile tools through funding from the Agency for Healthcare Research and Quality. These tools will allow home visitors to collect data on parents’ skill acquisition as they participate in SafeCare, track parent engagement and alert the home visitor if engagement is low, and upload a home visitor’s session audio files directly to the SafeCare Portal. These enhancements have the potential to increase retention, allow home visitors to tailor each parent's sessions based on their needs and level of engagement, and to ease the implementation burden on home visitors. Technology is a significant and innovative approach that can be used to strengthen the public health impact of CM prevention programs by increasing reach, relevance, and engagement for families who are at greatest risk.

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## Author Contributions

Melissa Cowart-Osborne formulated the aims of the paper, prepared the manuscript, and compiled the data. Matthew Jackson and Elizabeth Chege participated in data collection, literature searches, and drafting of the manuscript. Evander Baker participated in data collection and manuscript editing. Daniel Whitaker participated in drafting of the manuscript. Shannon Self-Brown supervised all aspects of the research and prepared the manuscript.

## Conflicts of Interest

The authors declare no conflict of interest.

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