Addendum – Child and Adult Protection

Recognising Abuse Guidance

The Concept of Significant Harm

The Children Act 1989 introduced the concept of 'Significant Harm' as the threshold that justifies compulsory intervention in family life in the best interests of children and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or is likely to suffer significant harm.

There are no absolute criteria to rely on when judging what constitutes significant harm, however; Under s31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002

'Harm'

Means ill-treatment or the impairment of health or development, including for example, impairment suffered from seeing or hearing the ill-treatment of another;

'Development'

Means physical, intellectual, emotional, social or behavioural development.

'Health'

Means physical or mental health; and

'Ill-treatment'

Includes sexual abuse and forms of ill-treatment which are not physical.

Under s31(10) of the Act:

Where the question of whether harm is suffered by a child is significant turns on the child's health and development, his/her health or development shall be compared with that which could reasonably be expected of a similar child.

Recognising Significant Harm

In making your judgment about whether or not the concerns you have about a child and their family meet the criteria for likely or actual suffering of significant harm, it is more then likely you will have some information but not the whole picture.

This is where an integrated approach and effective joint working between agencies and professionals that have different roles and expertise is essential. Sharing and helping to analyse information so that an assessment can be made using The Assessment Framework is essential, as it provides a way in which all agencies who have involvement with the family can contribute their information and their

understanding to a whole picture of whether the child is in need and/or whether a child is in need of protection.

You may be so concerned about what you see or hear from a child or from an adult about a child that you believe the criteria has been met and action should be taken. However, it maybe that when all aspects of the picture are put together the family is considered to be in need of support rather than compulsory intervention.

Also the piece of information, which you have, may give you cause for some concern but not enough to meet the criteria for significant harm. However, when all the aspects of the picture are put together it may become apparent that this child is suffering or is at risk of suffering significant harm and action does need to be taken.

Your responsibility therefore is not individually to make a judgment about whether or not the threshold of significant harm has been reached; it is to provide the best information possible in order to ensure that this judgment is made on the basis of as full a picture as possible about the family.

To understand and identify significant harm, it is necessary to consider:

- The nature of harm, in terms of maltreatment or failure to provide adequate care;
- The impact on the child's health and development;
- The child's development within the context of their family and wider environment;
- Any special needs, such as a medical condition, communication impairment or disability that may effect the child's development and care within the family;
- The capacity of parents to meet adequately the child's needs; and
- The wider and environmental family context.

Frontline professionals should get to know children as individual people and as a matter of routine consider how their situation feels to them. The child's reactions, his or her perceptions, and wishes and feelings should be ascertained and should be given due consideration, so far as is reasonably practicable and consistent with the child's welfare and having regard to the child's age and understanding (section 53 of the Children Act 2004 amended Sections 17 and 47 of the Children Act 1989).

To do this depends on effectively communicating with children and young people including those who find it difficult to do so because of their age, an impairment or their particular psychological or social situation. This may involve using interpreters, drawing on the expertise of early years workers in communicating with very young children or those working with disabled children.

It is necessary to create the right atmosphere when meeting and communicating with children, to help them feel at ease and reduce any pressure from parents, carers or others. Children will need reassurance that they will not be victimised for sharing information or asking for help or protection; this applies to children living in families as well as those in institutional settings, including custody.

It is essential that any accounts of adverse experiences coming from children are as accurate and complete as possible.

'Accuracy is the key, for without it effective decisions cannot be made and equally, inaccurate accounts can lead to children remaining unsafe, or to the possibility of wrongful actions being taken

that affect children and adults' (Jones DPH (2003) Communicating with vulnerable children: a guide for practitioners).

Child Abuse and Neglect as a form of Significant Harm

Abuse and neglect is not always easy to identify.

The first indications that a child is being abused or neglected may not necessarily be the presence of a severe injury. Indicators can present in numerous ways to the public and professionals alike:

- By remarks made by the child or his/her parents or friends;
- By changes in a child's behaviour or demeanour which may indicate abuse or neglect;
- By indications that the family is under extreme stress;
- By a series of events, which, whilst not necessarily of concern in themselves, are, significant if viewed in their entirety.

Initially, the situation may not seem serious but it should be remembered that prompt help to a family in trouble might prevent minor abuse and neglect escalating into something more serious.

Working Together to Safeguard Children 2015 defines categories of child abuse, which are identified as forms of '**Significant Harm**':

- **Neglect**;
- **Physical Abuse**;
- **Emotional Abuse**;
- **Sexual Abuse**.

Somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm. Children may be abused in a family or in an institution or community setting; by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults or another child or children.

Neglect

Neglect may occur/involve:

- During pregnancy as a result of maternal substance abuse;
- Parent/carer failing to provide adequate food and clothing, shelter including exclusion from home or abandonment;
- Failing to protect a child from physical and emotional harm or danger;
- Failure to ensue adequate supervision including the use of inadequate care-takers;
- Failure to ensure access to appropriate medical care or treatment;
- May also include neglect of, or unresponsiveness to a child's basic emotional needs.

Warning signs include:

- Faltering growth, i.e. where there is poor growth for which no medical cause is found, especially with a dramatic improvement in growth on a nutritious diet away from home;
- A consistently unkempt, dirty appearance;
- Severe and persistent infestations (for example, scabies or head lice) in a child;
- Un-met medical needs, e.g. failure to seek medical advice or attend appointments for illness, severe untreated nappy rash, missed immunisations where they have not been refused on other grounds;
- Developmental delay without any other clear cause;
- Lack of social responsiveness;
- Self-stimulating behaviours such as head banging or rocking (note that some special needs children may exhibit this behaviour due to their disability but this should also be evaluated for context);
- Repeated failure by parents/carers to prevent injury;
- Consistently inappropriately clothed for the weather;
- Hazardous living conditions.

Impact of Neglect on the Child

- Severe neglect young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual development;
- Persistent neglect can lead to serious impairment of health and development and long term difficulties with social functioning, relationships and educational progress;
- Neglected children may experience low self-esteem, feelings of being unloved and isolated;
- Neglect can result in extreme cases in death.

The impact of neglect varies depending on how long the child has been neglected, the child's age and the multiplicity of neglectful behaviours.

(Daniel, Taylor & Scott (2009) 'Noticing and helping the neglected child'.

Physical Abuse

Impact of Physical Abuse on a child:

- Physical abuse can lead directly to neurological damage, physical injuries, disability or, at the extreme, death;
- Harm may be caused to children both by the abuse itself and by the abuse taking place in a wider family or institutional context of conflict and aggression, including inappropriate or inexpert use of physical restraint;
- Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems and educational difficulties;

- Physical abuse of children often coexists with domestic violence.

Physical Features that should prompt you to suspect child maltreatment:

Bruises

- Bruising in the shape of a hand, ligature, stick, teeth mark, grip or an implement;
- Bruising not caused by a medical condition (for example, a coagulation disorder), with an unsuitable explanation, including those:
    - In a child who is not independently mobile;
    - That are multiple or in clusters;
    - Of similar shape and size;
    - On non-bony parts of the face or body, including the eyes, ears and buttocks;
    - On the neck that look like attempted strangulation;
    - On the ankles and wrists that look like ligature marks.

Bites

- Human bite mark thought unlikely to have been caused by a young child.

Lacerations, abrasions or scars

- Lacerations, abrasions or scars on a child that have an unsuitable explanation, including those:
    - On a child who is not independently mobile;
    - That are multiple or have a symmetrical distribution;
    - On areas usually protected by clothing, or the eyes, ears and sides of face;
    - On the neck, ankles and wrists that look like ligature marks.

Burns or Scalds

- Burn or scald injuries on a child:
    - With an absent or unsuitable explanation; **or**
    - Who is not independently mobile; **or**
    - On soft tissue areas not expected to accidentally come into contact with a hot object (for example, backs of hands, soles of feet, buttocks, back); **or**
    - In the shape of an implement (for example, cigarette or iron); **or**
    - That indicate forced immersion (for example, scalds to buttocks, perineum and lower limbs, to limbs in a glove, stocking or symmetrical distribution or with sharply delineated borders).

Fractures

- One or more fractures in a child if there is no medical condition that predisposes to fragile bones or if the explanation is absent or unsuitable, including:
    - Fractures of different ages;
    - X-ray evidence of occult fractures (for example, rib fractures in infants).

Head Injuries

- Intracranial injury in a child if there is no major confirmed accidental trauma or known medical cause in one or more of the following circumstances:
    - There is an absent or unsuitable explanation;
    - The child is aged under 3 years;
    - There are also other inflicted injuries, retinal haemorrhages, or rib or long bone fractures;
    - There are multiple subdural haemorrhages.

Poisoning

- Poisoning in a child in any of the following circumstances:
    - Deliberate administration of inappropriate substances, including prescribed and non-prescribed drugs;
    - Unexpected blood levels of drugs not prescribed for the child;
    - Reported or biochemical evidence of ingestions of one or more toxic substances;
    - The child could not access the substance independently;
    - Repeated presentations of ingestions of substances in the child or other children in the household;
    - There is an absent or unsuitable explanation.

Other Injuries

- Retinal haemorrhages or injury to the eye in a child if there is no major confirmed accidental trauma or medical explanation, including birth-related causes;
- Signs of spinal injury in a child if there is no major confirmed accidental trauma;
- Intra-abdominal or intrathoracic injury in a child if there is no major confirmed accidental trauma, with an absent or unsuitable explanation, or with a delay in presentation. There may be no external bruising or other injury;
- Female genital mutilation, which includes female circumcision, excision and infibulation, is physical abuse and an offence regardless of cultural or other reasons. The only exception is if surgery takes place for medical reasons.

Other Features

- Child has a near-drowning incident with an absent or unsuitable explanation;

- Repeated apparent life-threatening events in a child, if the onset is witnessed only by one parent or carer and a medical explanation has not been identified.

Injuries may also be caused as a result of a parent fabricating or inducing illness in a child.

See **NICE Guidance 'When to suspect child maltreatment'**.

Sexual Abuse

Sexual Abuse is usually kept very secret and are damaging to children, both in the short and in the long term.

Most child victims are sexually abused by someone they know - either a member of their family or someone well known to them or their family. The children are likely to have been put under considerable pressure not to reveal what has been happening. Both boys and girls of all ages are sexually abused and the abuse may carry on for many years before it comes to light.

Sexual abuse often presents itself in a veiled way. Although some child victims have obvious genital and/or anal injuries, a sexually transmitted infection or are pregnant, relatively few show such obvious signs.

Recognition of sexual abuse generally follows either a direct statement from the child (or very occasionally from the abuser), or more often, suspicion based on the child's circumstances, behaviour, or physical symptoms or signs.

The following list of commonly observed indicators is not exhaustive and there may be situations where none of them is present, even though a child is known to have been abused sexually. Equally, even if some are present it may also not be definitive of sexual abuse. These physical signs should alert professionals to the possibility of abuse. Suspicion increases where several features are present together.

Physical indicators

- Sexually transmitted infections (dependent on age, and nature of sexual relationship);
- Pregnancy (dependent on age and nature of sexual relationship);

  See **Sexual Health and Relationships Procedure**;
- Persistent or recurrent genital or anal symptoms (for example, bleeding or discharge) in a girl or boy, without a medical explanation;
- Genital, anal or perianal injury in a girl or boy, with an absent or unsuitable explanation;
- Unusual sexualised behaviours in a prepubertal child (for example, oral-genital contact with another child or doll, requesting to be touched in the genital area, or inserting or attempting to insert an object, finger or penis into another child's vagina or anus).

See **NICE Guidance 'When to suspect child maltreatment'**

Emotional and behavioural indicators

Behaviour with sexual overtones (depending on age and understanding):

- Explicit or frequent sexual preoccupation in talk and play;

- Sexual relationships with adults or other children;
- Hinting at sexual activity or secrets through words, play or drawings.

Children may also behave in the following ways:

- Withdrawn, fearful or aggressive behaviour to peers or adults;
- Running away from home;
- Suicide attempts and self mutilation;
- Child psychiatric problems, including behaviour problems, withdrawal from social contact, onset of wetting or soiling when previously dry and clean, severe sleep disturbances, arson (fire setting);
- Learning problems which do not match intellectual ability, or poor concentration (NB: for some sexually abused children, school may be a haven - they will arrive early, are reluctant to leave and perform well);
- Marked reluctance to participate in physical activity or to change clothes for PE, etc.

Information Communication Technology is an important element in our awareness of sexual abuse and its manifestations. The internet has, in particular, become a significant tool in the distribution of indecent photographs/pseudo photographs of children. Internet chat rooms, discussion forums and bulletin boards are used as a means of contacting children with a view to grooming them for inappropriate or abusive relationships, which may include requests to make and transmit pornographic images of themselves, or to perform sexual acts live in front of a webcam.

There is also growing cause for concern about the exposure of children to inappropriate material via interactive communication technology - for example, adult pornography and/or extreme forms of obscene material. Allowing or encouraging a child to view such material may warrant further enquiry. Children themselves can engage in text bullying and use mobile phone cameras to capture violent and/or assaults of other children for circulation.

Impact of Sexual Abuse

The severity of the impact of sexual abuse on a child is believed to increase the longer the abuse continues, the more extensive the abuse, and the older the child. Also the relationship of the abuser to the child, the extent of premeditation, the degree of threat and coercion, sadism, and bizarre or unusual elements can be important.

A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is strengthened by the support of the non-abusive adult carer who believes the child, helps the child understand the abuse, and is able to offer help and protection.

The reactions of practitioners also have an impact on the child's ability to cope with what has happened, and on his or her feelings of self worth

A proportion of adults and children who sexually abuse children have themselves been sexually abused and / or been experienced other types of abuse but it would be quite wrong to suggest that children who are sexually abused inevitably go on to become abusers themselves

(see **Jones and Ramchandani (1999) Child Sexual Abuse. Informing Practice from Research**)

Emotional Abuse

Emotional Abuse is not usually indicated by a specific incident, but is observed in the interaction with the child. One child may be scapegoated or treated completely differently to their siblings.

Parental behaviours associated with emotional abuse

The following may identify parental behaviours which, if persistent, may be emotionally abusive. What is inappropriate will often depend on the child's developmental stage:

- A persistently negative view of the child, particularly as inherently bad, often combined with "deserved" harsh punishment;
- Inconsistent and unpredictable responses particularly where there is threat to or rejection of the child;
- Expectations which are inappropriate for the developmental stage of the child, either too high or too low, over protective or under protective;
- A lack of emotional availability or responsiveness to the child;
- No respect for personal boundaries of the child; not seeing the child as an individual;
- Promoting mis-socialisation or poor social adaptation;
- Contradictory, confusing or misleading messages in communicating with the child which seriously distort reality for the child or promote confusion;
- Serious physical or psychiatric illness of a parent including periods of hospitalisation;
- Induction of a child into bizarre parental beliefs;
- The child seeing or hearing the ill-treatment of another person, adult or child;
- Breakdown in parental relationship with chronic, bitter conflict over contact or residence (this would also include situations where there is domestic violence);
- Major emotional rejection of the child and parental inability to perceive his/her needs with any objectivity;
- Major and repeated familial change, e.g. separations, reconstitution of families;
- Parental drug and/or alcohol addiction or involvement in seriously deviant lifestyles;
- Entrenched offending behaviour which may be criminal and which might also lead to a term of imprisonment.

Behavioural signs in children

Behaviour in a child, which may indicate emotional abuse, includes:

- Very low self-esteem, often with an inability to accept praise or to trust;
- Lack of any sense of fun, over-serious or apathetic;
- Excessive clingy or attention seeking behaviour;
- Over-anxiety, either watchful and constantly checking or over-anxious to please;

- Developmental delay, especially in speech;
- Substantial failure to reach potential in learning, linked with lack of confidence, poor concentration and lack of pride in achievement;
- Self-harming; compulsive rituals; stereotypic repetitive behaviour;
- Unusual pattern of response to others showing emotions.

Impact of Emotional Abuse

There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse, including the impact of serious bullying.

(see **Barlow & Schrader-MacMillan (2009) Safeguarding Children from Emotional Abuse - What Works?**)

Emotional Abuse has an important impact on a developing child's mental health, behaviour and self esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important if not more so, as other more visible forms of abuse in terms of its impact on the child.

Domestic Violence, adult mental health problems and parental substance misuse may be features in families where children are exposed to emotional abuse. There are separate procedures in Part 4 of this manual which describe these and other areas of concern.

Causes of Abuse and Neglect (Significant Harm)

There is no 'typical' situation or environment in which child abuse or neglect may occur although many children are abused by parents.

Parental responses to allegations of abuse which directly implicate them are very varied. The following do not indicate either that abuse has taken place or that no abuse has taken place, but should raise concern:

- There may be an unequivocal denial of abuse and possibly non-compliance with enquiries or requests, for example, for the child to be medically assessed;
- Sometimes parents may react aggressively to a suggestion that they may be responsible for harm to their child;
- There may be reluctance to give information or explanations may be incompatible with the harm suffered by the child or explanations may be inconsistent over time;
- Parents may display a lack of awareness that the child has suffered harm or that their actions may be harmful;
- Parents may seek to minimise the severity of the abuse or not accept that their actions constitute abuse at all;
- Blame or responsibility for the harm may be projected on to the child (i.e. the victim) or a third party;
- Parents may seek help from any of the statutory or relevant voluntary agencies on matters unrelated to the abuse or its causes. This may be to draw attention to concerns other than those being presented;
- The parents may disappear.

Children may also be abused in an institution or community setting; by those known to them or, more rarely, by a stranger. For example, children may be subject to ill treatment or abuse in the following settings:

- Where they are **Looked After** by the council in local authority or in independent residential or foster homes;
- By teachers in day or residential schools in the public, private voluntary or charitable sector;
- When placed in secure accommodation, prison or custody,
- When participating in clubs or associations;
- At leisure or sporting facilities, events or activities;
- Children may also be coerced into prostitution, sexual exploitation or pornography;
- They may be severely bullied or abused by other children at school, whilst playing, at clubs or in residential or foster care;
- They may be enticed or befriended by 'strangers' whilst away from home, which can include children who have run away or are missing from home or care;
- They can be subject to organised abuse by groups of adults who may be relatives, friends of the family or professionals;
- They may be placed at risk resulting from domestic violence or from parental drug and alcohol use;
- Children may also be subject to risk caused to the mental illness of parents.

Characteristics of parents and children who are more likely to experience severe maltreatment (Significant Harm)

Some children and young people have characteristics which make them ‘hard to engage’ or ‘hard to help/change’ and when combined with one or more of the above parental characteristics are most vulnerable to continuing harm:

- Children born prematurely and/or suffering the effects of drug and/or alcohol misuse, which can make children fretful, hard to feed and unresponsive;
- Children with disabilities and other characteristics which make them hard to parent or ‘unrewarding’ in the eyes of parents who lack self-esteem and confidence;
- Individual members of sibling groups ‘singled out for rejection’ and/or targeted for abuse;
- Children returning home form care, especially if they suffer the loss of an attachment figure;
- Teenagers who engage in risk-taking or anti-social behaviour.

Caring for Children who have been Abused

This is generic guidance and advice for staff caring for children who have been abused, it is not intended as being specific care management guidelines for individual children. If children have been abused or mistreated to the extent that they require specific treatments or counselling, this should be addressed in their Placement Plans, agreed by the Placing Authority/social worker.

In the absence of such a plan, the following may be useful as general guidelines.

Children who have Suffered Sexual Abuse are Survivors

Children who have suffered Sexual Abuse are survivors; not only have they experienced family, society, adult/child relationships being breached, but every taboo this society holds as a basic right to be safe.

Survivors should not be treated as 'victims of Sexual Abuse' but people and children in their own right. It is important to 'look past' any label which might have been placed on them.

That said, Sexual Abuse can be very psychologically damaging, as can any form of child abuse. Child Sexual Abuse is often linked and involved the suffering of Physical, Emotional Abuse and Neglect too.

Behaviours which Might be Associated with Sexual Abuse

There is no definitive list of behaviours that suggest abuse may have taken place, but the following may be indicators (also see guidance above relating to specific forms of abuse e.g. Neglect or Physical Abuse).

a. Mistrust of adults (either gender);
b. Difficulty in establishing close human relationships;
c. Sexually promiscuousness;
d. Sexually precociousness;
e. Withdrawn;
f. Eating disorders;
g. Violence;
h. Offending;
i. Fire lighting (Helen Kenwood made this association);
j. Poor educational performance;
k. Absconding (from care / Home / school etc.);
l. Exhibitionism;
m. Preoccupation with cleanliness;
n. Poor personal hygiene;
o. Disturbed sleep pattern;
p. Rocking (rhythmic swaying either during night or day time);
q. Self-harm;
r. Poor self-image;
s. Low self-esteem;
t. Attention needing behaviour;
u. Delayed speech or poor vocabulary;
v. Destruction of belongings / environment;

w. Hiding clothes especially underwear;

x. Hiding food;

y. Stealing food;

z. Encopresis (incontinence of faeces);

aa. Enuresis (involuntary passing of urine);

bb. Constipation.

Indeed, many more behaviours can also be connected to sexually abused children, some of which involve stimulation of genitalia for self-gratification or solace (often not age appropriate).

‘Day Landmarks’

Areas of the day such as meal times, evenings, bedtimes etc. may be associated with the time abuse was suffered. It is important to be sensitive to this and emphasize that their environment is now safe. Much reassurance might be required.

Health Issues

Children can often be very worried about their physical health, not only in their genital region.

Children who have been sexually abused might suffer from:

a. HIV;

b. Sexually transmitted infections;

c. Urinary tract infections;

d. Damage to genitals;

e. Digestive disorders;

f. Incontinence

g. Thrush;

h. Other genital infections;

i. Hypochondria.

The above might cause the child much distress, anxiety and worry. A medical to prove 'everything's O.K.' is often ignored and should not be assumed happened at investigation or disclosure stage.

Self-Image

Children often suffer from a 'used goods syndrome'. They feel worthless, unwanted, unloved, cheap etc. Staff should praise and help children 'find themselves'.

Relationships

Often the child/adult relationship has been damaged. A feeling of mistrust, in that 'you are only be nice to me so you can abuse me' is evident.

Children may never feel safe in an adult/s company, which can be demonstrated in anti-social behaviours e.g. violence, abusive language, panic etc.

Trust might be very hard to achieve but only time and proof of security will tell. Therefore it is very important that sexually abused children are not 'let down' and promises are kept etc.

What Forms can Child Sexual Abuse take?

a. Inappropriate verbal interaction;

b. Inappropriate non-verbal interaction;

c. Witnessing adults involved in sexual acts (deliberately);

d. Access to pornographic material (magazines, computer disks, videos, audio tapes etc.);

e. 'Hands on abuse' where inappropriate touching occurs e.g. sexual intercourse, fondling etc.);

f. Abusive telephone calls;

g. Witnessing others being abused;

h. Incest;

i. Sibling abuse;

j. Invasion of 'personal space'.

Self-Protection

It is important the child can be encouraged to protect themselves. There is no 'standard format' of attempting this self-protection work but needs to be specific to the particular child, perhaps using examples from their own experiences/behaviour. At some point specialist advice should be sought.

Realisation

Child abuse doesn't go away. The more knowledge a child obtains about sexual relationships and society values in general the more a child realises just what has happened to them. Therefore at some stage in their development it might appear not to be a big issue, whereas later difficulties may again come to the fore. Sensitivity and compassion are needed to cushion these hurtful rationalisations and honesty of reply and interaction are needed. Someone available to listen will be very valuable and specialist help should be sought.

Consistent development monitoring should be an integral part of any treatment programme. Paediatric care, speech therapy, physical and / or occupational therapy, special educational help and various forms of therapy or individual psychotherapy are many of the therapies often indicated for abused children.

Family Ties

When a child discloses it is like a balloon. If the situation is handled carefully the balloon deflates at a steady pace. Sometimes the balloon will burst and bits go everywhere. Disclosure is a traumatic experience. Would you share your most private sexual experience with someone you didn't know very well? in detail? and perhaps on video? No, but this is what children who disclose sometimes have to do.

After disclosure children can be told, often in anger, such things as:

a. "How could you say such a thing about your father";

b. "You're a liar, an evil person";

c. "You've broken your family up now" etc.

Often, therefore, many children who are looked after suffer remorse, guilt etc. Not only because of seeing the traumatic consequences of their disclosure, but also being 'cast out' by their families, the ones who should (and perhaps still do) love them the most. Again, sensitivity and compassion to help bridge building (if possible) into broken relationships might be appropriate at some stage, but only at the child's pace.

Some children recreate the dynamics of their families and invite harm by 'playing the victim' often incurring further abuse from peers or rejecting carers. Where possible therefore, specific provisions for children should be offered in the context of a carefully devised intervention plan for the whole family.

Sexual Abuse Doesn't Stop

Child abuse is very difficult to prove in Court, especially Sexual Abuse. Often before disclosure children are involved in offending, excluded from school and are disruptive at Home. This can be 'set up' by abusers. "Oh this is the next thing s/he's done, look how s/he behaves usually!". Abusers organise a mantle of protection around themselves. They might appear to be very respectable people in their own community e.g. Church attendants, fund raisers, youth club helpers etc. "How could anyone say such a thing about Mr. or Mrs. Bloggs, they're so nice!".

Abusive families and people continue to place responsibility for disclosure on the child. Even when they are in care, in prison or even dead! The 'mantle' of we or I'm a safe person continues to occur and breaking this cycle of 'closed awareness' is often impossible. Staff should always try to actively be aware of this e.g. stopping distressing phone calls etc.

In conclusion, as in many areas of social work there are no 'quick fixes' in this area. The most important factor must always be to support the child, emphasise the positives and keep the child's welfare as paramount.

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