A COMMUNITY HEALTH APPROACH TO THE ASSESSMENT OF INFANTS AND THEIR PARENTS

The CARE Programme

Kevin Browne
Jo Douglas
Catherine Hamilton-Giachritsis
Jean Hegarty

John Wiley & Sons, Ltd

A COMMUNITY HEALTH APPROACH TO THE ASSESSMENT OF INFANTS AND THEIR PARENTS

A COMMUNITY HEALTH APPROACH TO THE ASSESSMENT OF INFANTS AND THEIR PARENTS

The CARE Programme

Kevin Browne
Jo Douglas
Catherine Hamilton-Giachritsis
Jean Hegarty

John Wiley & Sons, Ltd

Telephone (+44) 1243 779777

Email (for orders and customer service enquiries): cs-books@wiley.co.uk
Visit our Home Page on www.wiley.com

Other Wiley Editorial Offices

John Wiley & Sons Inc., 111 River Street, Hoboken, NJ 07030, USA
Jossey-Bass, 989 Market Street, San Francisco, CA 94103-1741, USA
Wiley-VCH Verlag GmbH, Boschstr. 12, D-69469 Weinheim, Germany
John Wiley & Sons Australia Ltd, 42 McDougall Street, Milton, Queensland 4064, Australia
John Wiley & Sons (Asia) Pte Ltd, 2 Clementi Loop #02-01, Jin Xing Distripark, Singapore 129809
John Wiley & Sons Canada Ltd, 22 Worcester Road, Etobicoke, Ontario, Canada M9W 1L1

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Library of Congress Cataloging-in-Publication Data

A community health approach to the assessment of infants and their parents: the care programme / Kevin Browne . . . [et al.].
p. cm.
Includes bibliographical references and index.
ISBN-13: 978-0-470-09251-4 (cloth: alk. paper)
ISBN-10: 0-470-09251-3 (cloth: alk. paper)
ISBN-13: 978-0-470-09252-1 (pbk.: alk. paper)
ISBN-10: 0-470-09252-1 (pbk.: alk. paper)
1. Community mental health services. 2. Infant health services. 3. Maternal health services. 4. Child development. I. Browne, Kevin.
RA790.5.C662 2006
362.198´92–dc22 2006011226

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

ISBN-13 978-0-470-09251-4 (hbk) 978-0-470-09252-1 (pbk)
ISBN-10 0-470-09251-3 (hbk) 0-470-09252-1 (pbk)

Typeset in 10/12 pt Palatino by SNP Best-set Typesetter Ltd., Hong Kong
Printed and bound in Great Britain by TJ International Ltd, Padstow, Cornwall
This book is printed on acid-free paper responsibly manufactured from sustainable forestry in which at least two trees are planted for each one used for paper production.

CONTENTS

ABOUT THE AUTHORS

Professor Kevin Browne is a Chartered Psychologist and a Chartered Biologist and is employed by the School of Psychology, at the University of Birmingham, as Director of the Centre for Forensic and Family Psychology. He has been researching family violence and child maltreatment for over 25 years and has published extensively on these subjects, acting as co-editor (with Margaret Lynch) of *Child Abuse Review* from 1992 to 1999. His most recent co-edited book is *Early Prediction and Prevention of Child Abuse: A Handbook* (Wiley, 2002). After 12 years as an Executive Councillor of the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), he is currently Consultant to the European Commission, World Bank and the WHO on child protection strategies and to the WHO and UNICEF on training in the public health approach to the prevention of child abuse and neglect. He has worked and presented in over 47 countries worldwide, having spent two and a half years as Chief Executive of the High Level Group for Romanian Children. In support of international work, his book entitled *Preventing Family Violence* (co-authored with Martin Herbert, Wiley, 1997) has been translated into Chinese, Japanese and Polish and his papers on the topic into Greek, Turkish, Romanian, Russian, Slovak, French, Italian and Spanish. His current research interests are the influence of media violence on children and teenagers, the concept of victim to offender and the effects of early institutional care on child development and adult behaviour.

Jo Douglas is a Consultant Clinical Psychologist who has specialised in working with children and families over the past 30 years. She was Head of the Psychology Service at Great Ormond Street Hospital in London and Honorary Senior Lecturer at the Institute of Child Health (University of London). She has worked extensively with a wide range of childhood emotional and behavioural problems and has written books and articles for both parents and professionals. She is well known for her work with managing sleeping and eating problems in young children and has lectured and trained primary and secondary health care staff across the country in these skills. She is now an independent psychologist.

Dr Catherine Hamilton-Giachritsis is a Chartered Forensic Psychologist and Senior Lecturer in Forensic Psychology at the University of Birmingham. Previously she worked in Birmingham Social Services Psychology Department, undertaking assessments of families where there was considered to be a risk to children, or assessing the needs of children and adolescents in such families. She is co-author of the Wiley volume '*Early Prediction and Prevention of Child Abuse: A Handbook*' (2002). In addition, Catherine has published widely on child maltreatment, family violence, the institutionalisation of infants and young children, and the links between media violence and crime. Catherine is chair of the West Midlands branch of the British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN West Midlands) and is currently engaged in further training in clinical psychology.

Jean Hegarty has had a long career working with children and their families. Her experience has encompassed midwifery practice and nursing sick children. For the past 23 years, Jean has worked in the community specialising in preventative approaches to health care for children and their families. She practiced as a Health visitor prior to becoming the Designated nurse for Child protection in Southend-on-Sea from 1988–1998. Jean's last appointment prior to leaving the N.H.S was as a Sure Start programme manager in Southend. During Jean's time in the South East of Essex she successfully worked with her Health visiting colleagues providing training and support. Jean has shared this practice with colleagues throughout the country over the past 13 years. She has spoken at National Nursing conferences and Child protection forums including the International congress on child protection. She currently undertakes Supervision and Consultancy work as an Independent practitioner. Jean would like to convey her high regard for the Health visitors in Southend who worked with her during the development of the programme. This regard is extended to the Social workers, Midwives and Essex Police who were also superb in 'working together' to achieve best practice. Jean remains aware that the fieldwork practitioners gave their commitment to the development of quality services. It is to the practitioners then, that Jean conveys her highest regard for their achievements and for the constant support, gratitude and interest they gave her.

PREFACE

Following the Kennedy (2001) and Laming (2003) reports, which were critical of services for child health in England, the National Service Framework for Children, Young People and Maternity Services (Dept of Health, 2004) outlines a ten year programme to improve services for children and their families. The national standards set within the framework advocate a fundamental change in the design and delivery of children's services across health, social care and education. 'Services are child-centred and look at the whole child – not just the illness or the problem' (Dept of Health, 2004, p. 2). The NSF for children also emphasises the needs of vulnerable children in society and refers to high profile cases of fatal child abuse (e.g., Laming, 2003). Consequently, it advocates early assessment and intervention that are both comprehensive and timely, to improve access to services for children and families according to their needs.

The book describes, in detail, a method of assessment and intervention for young children and their families entitled the Child Assessment Rating and Evaluation (CARE) programme. Characteristics of the infant, the parents, the family and the environment in which they live are used to identify need and guide further interventions by a variety of professionals. The focus of the model is the early prediction and prevention of problems for child health, development and protection. The emphasis is upon the principle of partnership with parents.

The CARE programme developed as a pragmatic attempt to deal with limited resources in community services and how best to apply those limited resources to maximum effect. Consequently, a 'risk approach' emerged, where all families are briefly assessed by community nurses visiting the home (midwives and health visitors), who identify those families in need of further support and help. These families are recognised as those of highest priority for services to meet the needs of the child and ameliorate any family difficulties in meeting those needs.

The model is best applied within a universal community service offered by trained health/social service professionals, such as midwives and health visitors, as a part of their normal primary care services and incurring no

further costs. Using a universal service of home visits to families with newborns as a foundation, families with factors associated with increased 'need' can be recognised. Targeted services can then be offered in addition to the standard, universal service already received by all families. On occasion, the need of the child and their family will be so urgent and/or extensive that specialist services will be required. These specialist services aim to respond to any current or underlying situation that has the potential to significantly harm the child. Specialist services are offered in conjunction with targeted and universal services already received.

The majority of the work on methods for 'targeting' families with maximum sensitivity and specificity was carried out by staff at the Centre for Forensic and Family Psychology, University of Birmingham. However, this book represents the culmination of more than a decade of work developing a health practice-based approach to assessing the needs of children and their families in the community, and intervening in the community to support and prevent undesirable outcomes for children. It owes a lot to the imagination and foresight of Jean Hegarty, who placed this work within health visiting practices. Under her supervision, many of the ideas derived from academic research have been successfully translated into practice in Essex (1995–2005), mainly within the Southend-on-Sea health care setting and the Sure Start programme.

The aim of this book is to make these ideas available to a wider audience in order to inform policy and practice. We also felt it was important to demonstrate the research and thought behind the model so that professionals can have an understanding of how the programme was developed based on evidence. For grammatical simplicity, we have referred to midwives and health visitors as female throughout the book, reflecting the fact that the majority of health professionals are female. However, we readily acknowledge that the community nurse's role does not relate to gender and the reader should equally apply our comments to both male and female community nurses.

Kevin Browne, Jo Douglas, Catherine Hamilton-Giachritsis
and Jean Hegarty
January 2005

The forms and booklets in Appendices 1–5 are also available online, free to purchasers of the book. Visit www.wiley.com/go/care to access and download these materials.

ACKNOWLEDGEMENTS

In 2003, Jean Hegarty (nee Ware), the Programme Manager for Sure Start in Southend invited Jo Douglas to look at the work she had been involved with as a health visitor and a designated nurse for child protection over many years. Jo initially became involved with the CARE programme in her role as Consultant Child Clinical Psychologist. Jean was keen and had the strategic foresight to recognise how incredibly important the Child Assessment Rating and Evaluation programme (CARE; Browne, Hamilton & Ware, 1995) is and wanted a book written in order to disseminate the ideas that had developed in the CARE approach to community nursing and primary care and to promote good practice.

Jean was the instigator and had the drive to conceive this book and Jo was invited to write it in collaboration with Kevin Browne and Catherine Hamilton-Giachritsis. Kevin, Catherine and Jean had developed and researched methods of assessing risk factors for child protection referrals in infants and their families in Essex using risk factors in combination with observations of parenting and indicators of attachment. This was a significant advance on the purely risk factor approach that was first developed by Kevin in the Surrey area (Browne & Saqi, 1988a).

It was agreed that all four of us would pool our resources to create a book that would provide useful clinical, evidence-based practice guidelines for community nurses. However, we are indebted to Jean for the confidence and support she has shown throughout the ten years of CARE development and implementation. We are also indebted to Jo for kick-starting the process of writing this book by pulling together all the materials that had been developed over ten years into a coherent structure.

In addition, we must mention Carol Steff, Senior Health Visitor and Team Leader for Sure Start in Southend, for her invaluable help in discussing cases and supporting us in understanding the impact of the programme on the clinical practice in Essex. Also, thanks to Terry Fultan, midwife, who has used this programme very successfully in her practice and has shared some of her findings about the process. Jo has also received invaluable clinical information from the team of health visitors and Sure Start workers at

Southend during their fascinating and illuminating supervision sessions. Jo is extremely grateful and feels privileged to have been able to join with them in thinking about many of the tremendously difficult and distressing clinical issues they have to cope with on a daily basis.

The book has now finally arrived after a long gestation. We only hope that this new arrival will continue to flourish and influence clinical practice in the forthcoming years and go forth and multiply!

Kevin Browne, Jo Douglas, Catherine Hamilton-Giachritsis
and Jean Hegarty

1

INTRODUCTION: CHILDCARE AND PROTECTION – A PUBLIC HEALTH APPROACH

Most countries offer at least some services to children and their families, especially around the time of birth. In those countries with more developed health care systems, this usually includes community support and home visits by health professionals. These health professionals are at the front-line in promoting the rights of children as they enter the world. Following the United Nations Convention on the Rights of the Child (UNCRC, 1989), one of the most important aspects of community support is helping the parent(s) to recognise the importance of registering the child as a legal entity in the local community and, indeed, the national population. A child's identity (usually secured by a certificate of registration at birth) opens the opportunity to health and education provision, at the same time as protecting the child against abduction and trafficking.

Having established a child's identity, the right to survival and development is further enhanced by the child and family's registration with primary health care services, usually through a general practitioner or family doctor. The child's right to health care up to the age of 18 years is then usually secured, although in some countries this is means tested with free services only available to children of parents on low income.

Health and social services for parents are also associated with the rights of the child, as the UNCRC (1989) clearly states that the child has the right to grow up in his or her own biological family. In addition, services should be made available to families in order to ensure their capacity to meet the child's social, emotional and developmental needs (Article 19, UNCRC, 1989). Only as a last resort when, despite services offered, parents fail to meet their child's needs and the child is at risk of significant harm, is it recommended

that the child should be removed from the family and placed in alternative family care (on a temporary or permanent basis). Adoption is only recommended when it is in the long-term best interests of the child.

In the UK, the Children Act (1989, 2004) closely follows the principles of the UNCRC (1989) and many of the above rights and services offered are taken for granted by the population because free health and social care is available. The government has highlighted the role of professional responsibility and inter-agency communication when 'Working to Safeguard Children' (Dept of Health, Home Office, Dept for Education and Employment, 1999). This concept has recently been emphasised and reinforced in the publication 'Keeping Children Safe' (Dept of Health et al., 2003), which represents the government's response to the inquiry into the death of Victoria Climbié due to horrendous abuse and neglect (Laming, 2003). This inquiry had a major impact on the recent 'Every Child Matters' initiative (Dept for Education and Skills, 2004a).

It remains the Local Authority's responsibility to safeguard and promote the welfare of children who are 'in need' and to support parents to care for their children within a family environment. Therefore, health professionals should work closely with the Local Authority and social services to provide a range of interventions related to family crisis and support, positive parenting skills, prevention of child abuse and neglect, and promoting optimal development in children with physical and intellectual disabilities.

The current focus for child care and protection is early prediction and prevention, as well as timely interventions through preventative services. This can most appropriately be achieved by considering child care and protection in the wider context of child welfare. Each local community is planned to have child and family centres and closer involvement with schools to address the needs of children and their families. However, there is still an emphasis in the UK on social care and education being the key agencies for child care and protection. The public health approach has been neglected, with the role of health professionals limited to inter-agency collaboration on health and medical issues. This chapter advocates refocusing the debate, putting the health sector first as the key agency in the early prediction and prevention of child adversity. Indeed, health professionals are the front line in promoting children's optimal health and development.

THE PUBLIC HEALTH APPROACH

The World Health Organisation (1998a, 1999) defines a public health approach as the viewing of child abuse and neglect within the broader context of child welfare, families and communities. From a Health Service perspective, this requires the integration of good practices within three areas of service provi-

sion to families and children: safe pregnancy and childbirth, the management of childhood health and illness, and targeting services for families who have a high number of risk factors associated with child abuse and neglect.

Safe Pregnancy and Childbirth

The following guidelines are adapted from the World Health Organisation (1998b) as ways of providing services to ensure safe pregnancy and childbirth:

- Pre-birth: prenatal screening of the foetus for abnormalities (using ultrasound) and the promotion of healthy life-styles in the mother in order to protect the foetus (e.g., reducing maternal substance misuse, managing physical and mental illness) should be undertaken.
- During birth: natural delivery and the use of appropriate technology should be promoted, as should encouraging significant others (usually the father) to be present to support the mother and skin contact between mother and baby immediately following birth. The aim is to promote positive birth experiences for parents, which in turn encourage parental bonding to the infant.
- After birth: 24-hour access of significant others to the mother and child in the maternity unit, appropriate neonatal care and advice on practical parenting skills (e.g., breast feeding, bathing, etc.) should be standard because promotion of sensitive parenting can occur through positive post-birth experiences.

Midwifery nurses are best placed to provide continuity of care to pregnant mothers. This involves the same midwife offering individualised support with pre-birth home visits, assistance in childbirth and infant care throughout pregnancy until 10 days after birth. This is regarded as the 'best practice' model for promoting natural childbirth and parental bonding. In terms of child protection, such an approach increases the likelihood of positive parenting and thereby limits the possibility of infant abandonment, poor parenting, insecure attachment and child maltreatment.

Integrated Management of Childhood Health and Illness

The management of child health and illness by primary health care teams and community health nurses is aimed at the prevention of child disability, morbidity and mortality, as well as at limiting the stress to parents in caring

for a sick child. However, children coming to the attention of health services through home or clinic visits also offer the potential to screen for the possibility of maltreatment.

All children having contact with the health service can be observed and checked in the normal way for physical injuries and illnesses. However, during the examination, the possibility of non-accidental injury and illnesses occurring because of abuse and/or neglect should be kept in mind. In the absence of a standardised screening tool, history taking by doctors and nurses on the condition of the child should include the following components to promote identification of and protection from child abuse and neglect:

- history of family circumstances (e.g., presence of isolation, violence, addiction or mental illness)
- history of child's condition (e.g., story doesn't explain injury, delay in seeking help)
- child's physical condition when undressed (e.g., presence of disability, lesions or genital discharge)
- child's physical care (e.g., cleanliness, teeth, hair, nails, hygiene)
- child's behaviour (e.g., frozen hyper-vigilance or aggressive hyperactivity)
- parent's/caretaker's behaviour and demeanour (e.g., low self-esteem, depressed, over anxious, insensitive, careless, punishing, defensive).

Child Care and Protection

It is suggested that child protection services should focus on preventative and protective strategies, offering interventions to families with a high number of risk factors associated with child abuse and neglect. If possible, the services should be targeted to these families before maltreatment begins. According to the Department of Health et al. (2000), health and social care services should assess families in the following holistic way:

- assessment of children's development needs in general
- assessment of the capacity of the parent(s) to respond appropriately to their child's needs
- assessment of the wider social and environmental factors that impact on the capacity to parent.

This is known as the 'Lilac Book' assessment format. Risk factors are identified from 'undesirable' characteristics associated with the child, the parents and the family environment.

RECENT DEVELOPMENTS

Following the public health approach advocated by the World Health Organisation (*Health in the 21st Century*, WHO, 2000), recent government guidelines (Dept of Health, 2004) have adopted a similar perspective in their 10-year plan for integrated services offered to children and their families. The national standards outlined are applied to the following topics:

1. Promoting health and well-being, identifying needs and intervening early.
2. Supporting parenting.
3. Child, young person and family-centred services.
4. Growing up into adulthood.
5. Safeguarding and promoting the welfare of children and young people.
6. Children and young people who are ill.
7. Children and young people in hospital.
8. Disabled children and young people and those with complex health needs.
9. The mental health and psychological well-being of children and young people.
10. Medicines for children and young people.
11. Maternity services.

The implementation of the National Service Framework for Children is part of a broader commitment ('*Every Child Matters*') to promote a programme of 'Change for Children', improving standards of care and support that will enhance optimal outcomes for children and their families (Dept for Education and Skills & Dept of Health, 2004; Dept for Education and Skills, 2004b). This commitment promises to support all children to achieve the following outcomes:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

The best way to promote these outcomes is to prevent problems from beginning through effective intervention and support for children and their families. This gives children the best possible chance to realise their optimal potential and ensure they make a positive contribution to society and achieve a happy life with economic well-being as they grow older. In addition, the

NSF for Children acknowledges that such children will grow up to be better equipped for parenting their own children. The Every Child Matters initiative (DfES, 2004c, d) further recognises the well-established premise that positive parenting and early intervention may contribute to reducing the number of children who engage in delinquency and crime as teenagers (Browne & Herbert, 1997; Patterson, DeBaryshe & Ramsey, 1989). The topic of child protection exemplifies the way early interventions can promote the health and safety of children, and set them on the right developmental path.

ADVANTAGES OF EARLY INTERVENTION

The importance of early intervention can be considered from two, very different perspectives: the impact on children and the financial cost to society.

In the UK, it is generally agreed that at least two children per week die as a result of child maltreatment, with a further two suffering permanent disability, with infants most at risk of fatal injury (Browne & Lynch, 1995; Reder & Duncan, 2002). However, younger children are particularly vulnerable to abuse and/or neglect. Indeed, in 2003 the highest rate of registration on the Child Protection Register in England and Wales was for physical abuse and neglect in young children under one year (51 per 10,000; Dept of Health, 2004b). Therefore, it is essential that prediction and prevention occur from birth.

The financial costs of child abuse and neglect include both costs for the short- and long-term treatment of victims and the less apparent impact on other areas of society. The World Health Organisation (1999) highlighted a number of areas for inclusion in calculations of cost. These were medical care for victims, mental health provision for victims, legal costs for public childcare, criminal justice and prosecution costs, treatment of offenders, Social Work provision and specialist education. Overall, it has been estimated that the total economic cost in the United Kingdom is £735 million per annum (National Commission for the Prevention of Child Abuse, 1996), compared to $12,410 million per annum in the USA (WHO, 1999). These costs may have increased over the past ten years, since both estimates relate to 1996 figures.

The incredible cost of child protection once child abuse and neglect has occurred justifies more expenditure on preventative measures and services to support children and their families.

PREVENTION OF CHILD ABUSE AND NEGLECT

Strategies for the prevention of child maltreatment fall into three categories: primary (aimed at the whole population), secondary (targeting groups) and tertiary (after maltreatment has occurred).

Primary Prevention

Primary prevention is aimed at the whole population. Teachers, General Practitioners, practice nurses, health visitors and nursery workers are all important in providing appropriate advice and support. For example, community nurses (health visitors) have on-going contact with all children less than five years old in terms of providing advice on practical parenting skills, health and parental well-being.

Primary prevention services offered to everyone within the population include home visits by health workers, education of parents and care-givers, school programmes on parenting and child development, day nursery places, telephone help-lines and drop-in community centres. The purpose of this support is to assist positive parenting skills and to encourage the development of a secure attachment between parent and child. Secure attachments are highly significant in the early prevention of child maltreatment, first, because of the long-term positive impact on child development it engenders (e.g., positive self-image). Second, in situations where a high number of risk factors for child maltreatment are present, child abuse and neglect are more likely to occur in the absence of secure, positive attachments (Morton & Browne, 1998).

Many initiatives aimed at promoting positive parenting now exist (Sure Start in England; Triple P in Australia, Sanders & Cann, 2002). However, other strategies can be used regularly by primary health professionals, even in the absence of a full programme. Indeed, promoting positive parenting skills and sensitivity can be achieved in a straightforward manner, for example, just by raising awareness of verbal abuse and the implications of this on the development of a positive self-image in the child (see Table 1.1).

From a public health perspective, prevention begins with professional awareness of issues such as the mental health needs of the parent(s), negative aspects of peri-natal care and the importance of secure attachments. In turn, primary care professionals can utilise this information in their work

Table 1.1 Primary prevention by promoting positive parenting

Harsh words hurt	Kind words help
• SHUT UP	• PLEASE
• STOP IT	• WELL DONE
• GO AWAY	• YOU'RE CLEVER
• YOU'RE STUPID	• YOU'RE GOOD
• YOU'RE BAD	• I LOVE YOU
• WISH YOU WERE NEVER BORN	

with parents and pass on appropriate knowledge to those parents. For example, providing information to parents on how to cope with post-natal depression; the dangers of shaking or roughly handling a newborn; and educating parents about the development of attachment processes.

The development of secure attachments, being complex, will be considered in more detail. The importance of imparting knowledge of this process to parents is to assist them in understanding the needs of their child and temperamental differences. For the purposes of parental understanding, this can be separated into three stages:

- Birth: parent to infant bonding is a result of the psychological availability of the parent and the genetic pre-dispositions of the child to respond to the parent. This may occur immediately after birth or take some time to develop within the first six months (see Sluckin, Herbert & Sluckin, 1983).
- 5–12 months: formulation of infant to parent bond (infant attachment) with maturity where the child shows a preference for the primary care-giver, demonstrates some distress when left by the primary care-giver and is comforted by the presence of the primary care-giver. The infant uses the primary care-giver as a base for exploration and as a source of imitation (see Bowlby, 1969).
- 12–24 months: infant attachment quality (secure/insecure) is measurable and observable, and can be classified into a) insecure and avoidant, b1) secure and independent, b2) secure and dependent, c) insecure and ambivalent, d) disorganised (see Morton & Browne, 1998).

It is important, however, for professionals to remain aware that, whilst providing simple explanations to parents might assist in development of attachment, the assessment of attachment is not simplistic and requires appropriate training. A common misperception is to refer to a child as 'attached'. Nearly all children are attached in some form, it is the quality of infant attachment which is of interest, i.e., secure or insecure. Maccoby (1980) describes how the quality of attachment in a child is dependent on the levels of acceptance, accessibility, consistency, sensitivity and co-operation of the primary care-giver (usually the natural mother). Whilst at times this can appear to be 'common-sense', it does not *always* follow that a maltreated child is insecurely attached to their primary care-giver, or that a child who clings to their mother is securely attached. However, it is more common for maltreated, abused and neglected children to be less securely attached and usually to show patterns of insecurity and stranger anxiety. Indeed, a meta-analysis of 13 studies showed insecure attachment to the mother in 76% of maltreated samples compared to 34% of non-maltreated samples (Morton & Browne, 1998). The long-term consequences of insecure attachments in early child-

hood have now been clearly recognised and described. They may be summarised as follows (Cassidy & Shaver, 1999; Simpson & Rholes, 1998; Solomon & George, 1999):

- The early carer-infant relationship is internalised by the child and may be the 'prototype' or 'model' to which all future relationships are assimilated and are based upon.
- The child is likely to develop an image of him/herself as unworthy of love and affection and lacking control over his/her environment.
- Maltreated, abused and neglected children may have greater problems forming relationships with siblings, peers, intimate partners and their own children in future.

It is important to recognise that the transition to parenthood is a critical period in adult psychological development. Support should be provided to parents who are unable to cope, by primary care teams who may refer to telephone help lines, drop-in centres, community support groups and voluntary groups, as well as specialist health and social services. Hence, multidisciplinary training is required to enable primary care professionals to recognise and intervene with parental low self-esteem, anxiety, depression and alcohol/drug misuse. All these factors strongly influence the quality of parental care and infant attachment. This, in turn, increases the risk of child maltreatment and development in the child of poor internal models of relationships and feelings of low self-worth.

Secondary Prevention

Secondary prevention involves targeting resources to families identified as being 'high priority' for additional services. The aim of the 'risk approach' of proactive surveillance is to identify children at risk and offer health services and referral to social services before maltreatment occurs. Such an approach has the potential to prevent victimisation from ever beginning. Again, primary care professionals and teachers provide the first point of contact with the child and can be alert to signs of potential child maltreatment. For example, doctors and/or community nurses make home visits to monitor child health. At the same time, they have the opportunity to screen for socio-demographic and psychological risk factors for child abuse and neglect.

When the number and severity of risk factors present pass a threshold, child protection services are offered automatically. However, it is important not to stigmatise families who have yet to harm their child(ren) and targeting these families should be based on the principle of priority for services.

Therefore, families should be considered as 'high priority' or 'low priority' for social service referral and/or health service input (e.g., substance misuse programmes or mental health care), rather than regarded as 'high risk' or 'low risk' for child abuse and neglect.

Browne and Herbert (1997) describe additional assessments that go beyond a simple risk factor checklist to be more 'sensitive' to families with the potential for child abuse and neglect (hits) from those who have a high number of risk factors in combination with protection factors that reduce their chances of child maltreatment (false positives). This is based upon an evaluation of the parent-child relationship. These included:

- caretaker's knowledge and attitudes to parenting the child
- parental perceptions of the child's behaviour and the child's perception of the parent
- parental emotions and responses to stress
- style of parent-child interaction and behaviour
- quality of child to parent attachment
- quality of parenting.

Tertiary Prevention/Intervention Strategies

Tertiary prevention is the offering of services to children and families where abuse and/or neglect have already occurred. On 31 March 2004, 24 in 10,000 children under 18 years were on child protection registers for actual or likely child abuse and/or neglect in England and Wales (Dept for Education and Skills, 2005). Of these, 41% were registered for neglect, 19% for physical abuse, 9% for sexual abuse, 18% for emotional abuse and 14% for cases of mixed abuse and/or neglect. Overall, 68% of the children on registers were 10 years or younger, with a similar number of boys and girls registered. However, girls suffered more sexual abuse (11%) compared to boys (8%), while boys suffered more physical abuse (16%) than girls (15%). Following the child protection conference, 13% of the children were taken into public care; of these, 79% were placed with foster carers (mainly younger children), 5% were in children's homes or a secure unit (mainly older children), 13% were placed with parents and 3% in other types of placements (Dept for Education and Skills, 2005).

Therefore, reactive surveillance and identification of abused and neglected children leads to intervention both to stop the current maltreatment and to prevent recurrent victimisation. However, intervention at this late stage is not always successful. It has been shown that one in four children referred to police child protection units is re-referred within 27 months for a new incident of child maltreatment (either by the same perpetrator or a different