The long-term effects of childhood neglect or abuse. Implications for child and family services in the UK

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Abstract

Childhood neglect or abuse is damaging, with lifelong impacts on functioning, clinical and physical health. It can also transmit risk to the next generation. Child abuse is related to social deprivation, a source of family breakup, common in families under stress and is associated with other social ills such as domestic violence, and parental mental health problems. It is therefore costly to society financially, emotionally and in terms of family wellbeing. It is increasingly seen as a major public health issue given its wide prevalence. Contemporary issues in the UK concern not only ongoing neglect or abuse of children, but also the impact of historical abuse, a psychological burden to a significant number of adults. Often untreated, and occurring before adequate child protection policies were in place, the impacts of historical abuse is an ongoing concern both for health and social care services. This paper will describe the Childhood Experience of Care and Abuse (CECA) interview research findings and application in child and family services. It enables an accurate assessment of historical abuse, and its scoring system can be used on ongoing case files for children for better classification. A social and attachment model are described as explaining how damage from neglect and abuse can extend into later life.

Keywords: childhood, neglect, abuse**,** CECA, child, family services

INTRODUCTION

Research evidence over a number of decades, consistently shows that neglect or abuse in childhood is damaging to health, both physical and psychological, with effects lifelong (Felitti, 2002; Fergusson, Boden, & Horwood, 2008; Goodwin, 2004; Wainwright & Surtees, 2002). The linkages are complex, and the models developed need to be biological, social and psychological since all elements are affected by maltreatment in the developing child (Bifulco & Thomas, 2012). We are only recently becoming aware of later life impacts and the effects on the brain, nervous system and endocrine system (McCrory, Gerin, & Viding, 2017) and common midlife illnesses (Widom, Czaja, Bentley, & Johnson, 2012). It is a public health issue which requires awareness from a range of professionals in health, education, social care and criminal justice. All professionals, as well as the public and parents, need to have awareness in order to minimise if not eradicate child maltreatment in society. The basis for safeguarding and protecting children is two-fold: first the human rights aspect which require children to be free from harm in civilised society; second the need for healthy child development in ensuring a well-functioning society and preventing future behavioural dysfunction and clinical disorder.

RIGHTS OF THE CHILD

A basic underpinning of our notion of child protection and safeguarding children is based in the United Nations Convention on the Rights of the Child (UNCRC, 1989). This comprises 54 articles that cover all aspects of a child's life and set out the civil, political, economic, social and cultural rights to which all children everywhere are entitled. It also sets out the need for adults and governments working together to ensure these are followed. It states that every child has rights, whatever their ethnicity, gender, religion, language, abilities or any other status. The rights listed are linked and no right is more important that another. The right to be safe from violence (Article 19) and the right to education (Article 28) are given equal status as the right to relax and play (Article 31) and the right to freedom of expression (Article 13). All UN member states except for the United States have ratified the Convention which came into force in 1992.

Polish practitioners all know the influence of Dr Janusz Korczak, a paediatrician who instigated novel methods of education in Poland early in the 20th century and went on to formulate human rights for children, the basis for modern legislation (Eichsteller, 2009). He ran a Jewish orphanage in Warsaw along experimental lines involving social pedagogy. This included identifying rights of the child, such as, the right to live for today and the right to be oneself. Whilst written before the invasion of Poland in World War II, these were prescient of later events, with Korczak forced by the Nazi's into the Warsaw Ghetto and subsequently to death in Treblinka concentration camp with the children he had taught. His work, led to the UN 1989 Convention.

Central to these rights, is the concept of the child having a 'voice' i.e. that children should be able to disclose abuse, to explain their preferences for care and treatment and to be helped to make sense of their experience and work through it therapeutically. In the UK Childline[1] a confidential and free telephone line started in 1986 and became international within three years[2]. Its aim was to offer free counselling and a confidential way for children to disclose abuse without fear of recognition or 'reprisal'. It now has a million calls a year dealt with by volunteer counsellors (NSPCC, 2006).

There are a number of barriers to children disclosing abuse (Home-Office, 2002; Scott, 2000). Apart from the conflict of loyalties where a parent is involved, there is also fear of threatened harm if the secrecy is not maintained. Abused children are often schooled by the perpetrator in the secrecy of the abuse and its normalisation, and the ensuing mistrust of adults can hamper seeking help elsewhere. For young children there is often no adequate frame of reference and language for describing the nature of the abuse. In many cultures, speaking against the family is taboo, silence is proscribed. For this reason, teachers, social workers and others are trained to look for signs of possible abuse in the child's changed behaviour or symptoms, or through external evidence of poor care or physical harm. However, these signs can sometimes be wrongly attributed. There are well known cases where child illness or accident were not the result of parental behaviour but had other constitutional or other causes (Wrennall, 2014) It can therefore be critical to listen to the child and to develop a trusting relationship to learn of their experience. It is necessary to collect information systematically from a range of witnesses and viewpoints.

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[1] https://childline.org.uk/
[2] www.childhelplineinternational.org

RATES OF ABUSE IN THE UK

In the UK the procedures in place for child safeguarding and protection are substantial and permeate domains such as education, leisure-based child activities such as youth work, paediatric and antenatal practice and the police (Bentovim, Cox, Bingley Miller, & Pizzey, 2009). There is some evidence that reported rates of abuse (physical and sexual) are declining somewhat and this maybe the result of such attention (Department of Education, 2015) . However, neglect remains at high levels, and associated emotional abuse is increasing, so many agencies are focusing on greater clarity of definition and assessment of neglect and abuse for care planning. The total number of children involved in child protection plans has increased.

Table 1 shows the rates of child abuse cases 2011-2016 in the UK, those placed on Child Protection Registers. Type of abuse relates to initial categorisation. Whilst some experiences some decrease in rate, neglect and emotional abuse are increasing. They are also by far the most common causes of children being put on a child protection plans.

Table 1 England[3,4] 2011-16 Child Protection Registers

Category of abuse	2011	2012	2013	2014	2015	2016
Neglect	18,600	18,220	17,930	20,970	22,230	23,150
Physical abuse	4,800	4,690	4,670	4,760	4,350	4,200
Sexual abuse	2,400	2,220	2,030	2,210	2,340	2,370
Emotional abuse	11,400	12,330	13,640	15,860	16,660	17,770
Multiple	5,500	5,390	4,870	4,500	4,110	2,810
Total	**42,700**	**42,850**	**43,140**	**48,300**	**49,690**	**50,310**

One aspect which social workers find problematic is that of grading experiences of maltreatment – at which point does it move from a 'case for concern' which might require family support, to one of 'significant harm' where the child has to be removed from the family for its own protection (Moran, 2010)? This requires careful assessment and as much information collection as possible. This is difficult when children themselves have barriers to

[3] Department for Education (2015) Characteristics of children in need in England, 2014-15. London: Department for Education (DfE). Table D4. Available online at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469737/SFR41-2015_Text.pdf
[4] https://www.nspcc.org.uk/services-and-resources/research-and-resources/statistics/

providing information which could condemn their parents and parents themselves are not motivated to describe their own culpability.

Most neglect/abuse is perpetrated by parents or carers living in the household with the child and responsible for their care (Bifulco, Moran, Ball, Jacobs, et al., 2002). However sexual abuse is more often perpetrated by those outside the home, including friends of the family, other relatives, people in positions of power over the child (teachers, priests etc) and strangers (Bruni, 2002; Fergusson et al., 2008; Finkelhor, Ormrod, Turner, & Hamby, 2005). In the UK sexual abuse is more often primarily a police rather than social work concern, first because of the nature of the offence but also because of the wide range of perpetrators in the community and the greater likelihood of sexual abuse being organised by groups of offenders, including male paedophiles or other sexual abusers. Each perpetrator may be responsible for many victims and high frequency of abuse. Recent cases highlighted in the UK media concerned organised abusers targeting adolescent girls in residential care homes (Department for Education, 2012). These recent cases had certain features in common. First, the perpetrators were often (but not exclusively) Asian men who systematically groomed, sexually tortured and trafficked (mainly White) teenage girls under the aged of 18. This was partly explained by their occupations as night workers (in restaurants, minicab drivers). Second, the police did not believe the victim's prior complaints or take any action. Third, parents or social workers did not distinguish what they considered 'typical' teenage behaviours from signs of abuse and even referred to the victim's 'life choices' in being prey to abuse. Fourth, social workers were not monitoring children's missing days from home or school carefully and largely unaware of the extent or chronicity of the abuse. This has led to a public discussion about race and child abuse, and about the treatment of teenagers in the care system and their voice in being able to disclose abuse (Jay, 2014).

Police approaches to assessing sexual abuse in the UK (Ministry of Justice, 2011), involve the 'Achieving Best Evidence (ABE) approach to interviewing and assessment. Guidance is provided to assist those responsible for conducting video-recorded interviews with vulnerable, intimidated and significant witnesses, as well as those tasked with preparing and supporting witnesses during the criminal justice process. However, training for officers who work with abused children appears to vary widely across police forces and the previous system of training with social workers has now ended. Also, such assessment is not sensitive to other related forms of abuse, such as psychological abuse associated with sexual abuse,

through grooming processes. Research in the community shows these abuses commonly go together, with threats of violence, of blackmail, of harming others, and even the 'normalising' process of sexualisation forming a type of brainwashing of the child which itself constitutes abuse and can harm development (Moran, Bifulco, Baines., Bunn, & Stanford, 2003). In addition, sexual abuse is often related to earlier or concurrent neglect (Bifulco & Moran, 1998), so a comprehensive assessment for use both social workers, rather than for police investigation would require additional elements.

There has also been recent concern in the UK about organised historical abuse, by networks of entertainers and celebrities and members of the establishment. In 2015 the uncovering of historical sexual abuse[5] by politicians and those in eminent social positions following the Savile case came to light. This involved more than one and a half thousand suspects, many high-profile. Those implicated included politicians, those from the music entertainment or sport industry. Many historical abuses relate to institutions including schools, children's homes and religious institutions. They also include medical establishments, community institutions and guest houses. The Savile investigation was undertaken by the Metropolitan Police and named operation Yewtree and has led in turn to a national Inquiry still underway (Erooga, 2015).

'Giving Victims a Voice'[6] was published jointly by the Metropolitan Police and a concerned voluntary organisation, the National Society of Prevention of Cruelty to Children (NSPCC) both involved in Operation Yewtree. There could be no criminal investigation into Savile, since he was no longer alive. This large investigation considered abuse allegations which were often historical ones, pertaining to many years previously, the earliest in 1955 in Manchester. The peak of Saville's known offending was between 1966 and 1976 when Savile was 40-50 years old with 73% against those aged under 18 years. The victims coming forward with evidence were between 8-47 years old (at the time of abuse). Of those, 82% were female and most were in the 13 to 16 age group. Many issues were raised. It is now clear that Savile was 'hiding in plain sight' and using his celebrity status and fundraising activity to gain uncontrolled access to vulnerable people across six decades. For a variety of reasons, the vast majority of his victims did not feel they could speak out and it's apparent

[5] http://www.bbc.co.uk/news/uk-32812449
[6] https://www.nspcc.org.uk/globalassets/documents/research-reports/yewtree-report-giving-victims-voice-jimmy-savile.pdf

that some of the small number who did, had their accounts dismissed by those in authority including the police, parents and carers.

This in turn has led to the 'Independent Inquiry into Child Sexual Abuse', currently led by Professor Jay and underway since 2016[7]. The remit is to investigate whether public bodies and other non-state institutions in England and Wales have taken seriously their responsibility to protect children from sexual abuse, and make meaningful recommendations for change in the future. Its first report in December 2016[8] set out its brief and progress. It includes both criminal and research investigation, incorporating the Truth Project which listens to the voices of victims. The recommendations for change will revolve around cultural, structural, financial and professional/political domains.

These cases are outlined in order to highlight the importance of historical abuse in society. The fact that much historical abuse has gone 'untreated' means that many of the 30% or so of the population who are likely to have experienced abuse (Radford et al., 2011) are burdened with its impacts of poor health, functioning and quality of life. Poor functioning includes problems in making relationships and forming attachments and thereby reducing possible support, in negative cognitive schema (of the self, others and the future) which damage self-esteem, trust in others and coping with stress, and poor emotional control invoking anger and violence or anxiety and distress. There are also mechanisms whereby trauma in parents can be imparted to offspring. For example, through their own distorted parenting practice and incapacity for attachment; through their problem choice of partner who can be a danger to the children either directly or through witnessing violence; through social disadvantage, for example with single parent families or deprivation and poor neighbourhood the result of poor educational opportunities. There are even argued to be epigenetic channels whereby trauma can make changes to gene expression which can be transmitted to offspring and increase depression and anxiety rates (Meaney & Szyf, 2005; Yehuda & Bierer, 2009).

Assessment for neglect and abuse, therefore has to have the potential of being undertaken retrospectively, as well as on current cases. For current cases in the UK, it also needs to be able to measure neglect and emotional abuse accurately, since this is now a priority in many services. Neglect and emotional abuse is more likely to be in the home from parents' or

[7] https://www.iicsa.org.uk/
[8] https://www.iicsa.org.uk/key-documents/935/view/IICSA%20Review%20Report_Final_alt_v4_ACCESS.pdf

carers' and problems with care (neglect or emotional abuse) are the most common in the UK (Radford et al., 2011) . Such neglect/abuse needs to be accurately identified by practitioners (not only social workers, but teachers, paediatricians and others) in order to intervene effectively. Recognising and assessing such abuse will be discussed in the next section.

ASSESSING NEGLECT AND ABUSE EXPERIENCE

Neglect, emotional and physical abuse in the home, tend to be from parents and to happen as part of problematic family dynamics and inept parenting rather than in organised networks. These types of abuse are highly related, with many children suffering from a range of abuses at different ages. The greater the number of abuses the higher the rates of later dysfunction, clinical disorder and ill-health (Felitti, 2002). It is also evident that the more severe an individual abuse the more it is associated with later difficulties (Bifulco & Moran, 1998). Therefore, the definition of abuse, its grading as to severity as well as the accurate identification of number, frequency and range of abuse is important in understanding the extent of abuse and its likely prediction of future disorder.

Assessing abuse is difficult with children. In social services information is usually collected from a range of sources – parents, school, other relatives, friends and neighbours – including the child. However, children themselves have difficulties for a range of reasons – their comprehension of abuse; their conflict of loyalties; their limited cognitive and narrative development (Scott, 2000). Here, information is collected from several sources following the initial referral, and requires a reliable method of collation and interpretation. Definitions in policy documents are used to substantiate abuse and various assessment tools can be used, although no one procedure has been advocated.

However, assessing historical abuse with individuals over age 18 is more effective and methods have been developed in research which can also extend to practice settings. This includes both questionnaires and interviews, both reliable, but interviews have an advantage in collecting a full range of experience; providing a time frame and chronology; focusing on facts rather than feelings; with the ability to probe for multiple abuse and for frequency and severity of experience. The Childhood Experience of Care and Abuse (CECA)[9] interview has

[9] www.cecainterview.com

these features, is reliable and valid (Bifulco, Brown, Lillie, & Jarvis, 1997; Bifulco & Jacobs, 2012a) and used internationally (Gianonne et al., 2011; Kaess et al., 2011). It consistently shows association of experience with adolescent and adult emotional disorder in arrange of studies internationally (Infurna et al., 2016).

The interview takes an hour or more to complete and questions first about household arrangements in childhood with different parent figures to identify loss of parent as a risk factor. It also structures the number of substitute parents who need to be questioned about. The care sections questions about closeness to each parent, and then leads into questions about 'antipathy' involving parental coldness, hostility, rejection and criticism. Following this are questions about day-to-day care by parents in terms of household routines, meal times, adequate housing, hygiene, around medical care and regular school attendance. Respondents are asked to describe a 'typical day' when they are aged around ten years old to establish a picture of how the household was run. Care provided by each parent is established, for each household arrangement with different parent figures. An optional scale includes role reversal (where the child is required to care for parents and younger siblings). Questions about discipline in the household then lead into ones on being hit, and physical abuse. This involves eliciting details of any attacks on the child, how they were hit, how frequently, at what age, by whom, and when it stopped. This section is repeated where appropriate for mothers, fathers and other adults in the household. Finally, a section on sexual abuse asks a range of screening questions for the presence of abuse and then asks similar details of incidents, perpetrators, frequency, age at start and end. Respondents are also asked about disclosure of abuse.

On the basis of detailed factual narrative elicited, the information is rated on schedules with clear definitions of each type of neglect or abuse and items which could contribute to the rating. Severity of all the experiences is on a 4-point scale (marked, moderate, some, little/none) and these repeated if necessary when changing over time. 'Benchmark' examples of ratings are provided for reliable scoring, during a 3-day training course. 'Marked' or 'moderate' levels of neglect or abuse are considered 'severe' and highlighted in research analyses. These also align with policy definitions of 'concerns for serious harm'.

Table 2: CECA definitions

CECA neglect and abuse definitions (Bifulco & Moran, 1998)
Antipathy – cold or critical parenting – items include critical comments, angry hostile interaction, scapegoating, rejection. This is sometimes considered emotional abuse.
Neglect – indifference to the child's physical, material and emotional needs in domains of feeding, clothing, hygiene, medical care, education, friendships and sympathetic support are recorded. Parent figures are rated individually in each home arrangement. Duration of neglect reflected in length of household arrangement, and by changes over time.
Physical Abuse – attacks on the child which have the potential for harm by older household members. Severity determined by frequency, chronicity and intensity of attack for example whether with an implement or weapon. Age at start and end of each abuse recorded.
Sexual abuse – inappropriate sexual contact, or solicitation, by adult or older peer, either family or nonfamily. Severity determined by extent of sexual contact, power exerted and closeness of prior relationship. Frequency and duration, age of onset and offset are recorded for each perpetrator.
Psychological abuse – coercive control exerted through psychological or emotional means to confuse and disorientate and create submissiveness. It covers a range of techniques including dehumanisation, terrorising, emotional blackmail, deprivation of basic needs and valued objects. Severity determined by intensity, chronicity and range of strategies used. Limited to parental figures and rated separately for mother and father figures. Age at start and end of each abuse recorded.

CECA CHILDHOOD NEGLECT/ABUSE AND ADULT CLINICAL DISORDER

In London samples of women, abuse measured retrospectively is shown to be significantly related to depression. These comprised women selected for study from family doctor patient lists. The adolescents were selected as sons and daughters of the mothers studied. Table 2 shows the odds-ratios (increased rate of disorder given the presence of abuse) of severe (rated 'marked' or 'moderate') neglect and abuse. This was examined in relation to lifetime recurrent major depression in adult women and 12-month disorder (emotional and behavioural) in their adolescent offspring.

Table 3: Severe childhood neglect/abuse and adult disorder in London samples

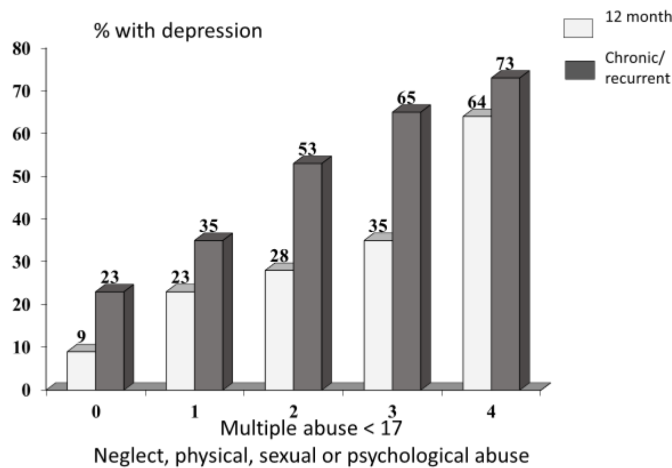
CECA variable (severe) Odds-ratio	**Midlife women (n=204) Recurrent major Depression**	**Adolescents (n=277) Any 12-month disorder**
Antipathy mother	2.52**	3.16**
Antipathy father	2.55**	2.49*
Neglect	2.88**	5.27***
Physical abuse	2.76**	5.03***
Sexual abuse	2.00*	7.88***
Psychological abuse	5.66**	-
Any abuse (apart from antipathy)	3.58***	5.00**

*p<.02 **p<.001 ***p<.0001

In a sample of 204 adult women, highest rates were for psychological abuse, with other rates showing significant odds ratios of 2 to 2.7. An adversity index of any one experience of neglect, physical, psychological or sexual abuse showed childhood neglect or abuse raised risk of depression by 3.5 times (Bifulco, Moran, Baines, Bunn, & Stanford, 2003). In adolescents, odds-ratios were higher with 2.49 to 7.88 risk for disorder, with sexual abuse showing the highest relationship, and with the index of neglect, physical or sexual abuse having a 5-fold increase in disorder rating in the previous 12 months. This included major depression, anxiety, conduct disorder or substance abuse (Bifulco, Moran, Ball, Jacobs, et al., 2002). It could be argued that the proximity in age to the abuse may account for the higher odds-ratios in adolescents, or it could be due to the wider range of disorders investigated.

It was also evident from the data that the more types of abuse experienced, the higher the rate of disorder experienced (see figure 1). This echoes the ACE findings in the USA, with the exception that only abuses to the child are represented here. Other familial factors (domestic violence, parental mental health issues etc) are examined as contributors to neglect/abuse in the ACE study but not added here into the dose-response effect (Bifulco et al., 2003). This is because such factors do not add to the direct impact of neglect/abuse on disorder and are seen rather as preconditions for abuse.

Figure 1: Dose-response effects of childhood neglect and abuse and major depression (204 London women)



In a high-risk adolescent sample significant dose-response effects were also shown for behavioural disorder (conduct disorder or substance abuse) and for deliberate self-harm (Bifulco et al., 2014; Schimmenti & Bifulco, 2015).

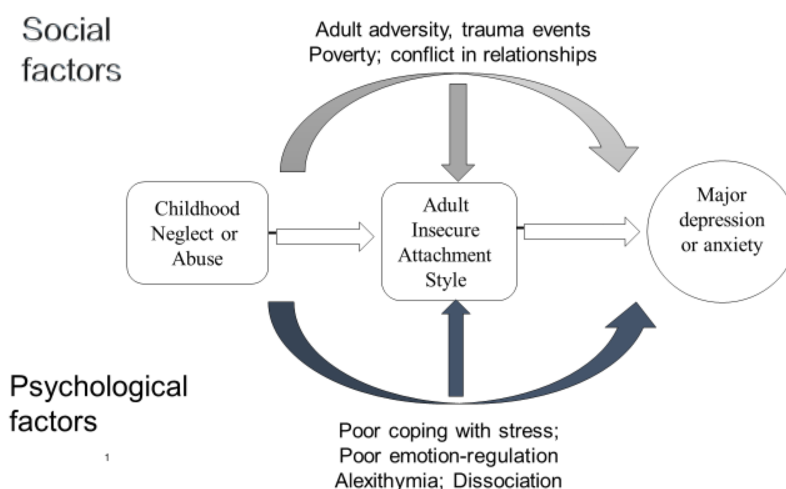
LONG TERM IMPACT OF NEGLECT/ABUSE

The long-term impacts of childhood neglect and abuse have been examined in two inter-related models, one social and one psychological. The socio-ecological model emphasises the disadvantage caused by early adversity on social class, poverty and housing and stressors (Spence, Nunn, & Bifulco, in press). This accumulates as adversity in adult life which increases risk and adds to the dose-response effects (Bifulco, Bernazzani, Moran, & Ball, 2000). Here the resulting clinical disorder is viewed in relation to greater levels of stress or trauma experienced and with fewer social resources, due to low social class and exclusion.

The psychological model, involves attachment. This approach developed by John Bowlby in the UK in the 1950s is based in child development, and describes how close bonding with the mother or main carer in infancy sets the condition for normal Secure attachment development. However in conditions of neglect or abuse, or absence of attachment figures, the child develops insecure attachment patterns which can become set into adulthood (Bowlby, 1988). The styles were developed by Mary Ainsworth who worked with Bowlby, in terms of anxious or avoidant insecure attachment style, with the later disorganised style also identified (Solomon & George, 2011). In terms of adult experience these have been further

elaborated in terms of the Attachment Style Interview; anxious styles including Enmeshed (dependent, clinging) and Fearful (afraid of rejection). Avoidant styles include Angry-dismissive (mistrustful avoidance) and Withdrawn (independent) styles (Bifulco & Thomas, 2012). Disorganised style has variously been linked to two simultaneous insecure styles (Crittenden, 1997) and to unresolved loss or trauma (Main & Hesse, 1990). Insecure attachment style as measured by ASI in the London female samples was significantly related to recurrent depression (OR= 2.53, p<.001) (Bifulco, Moran, Ball, & Bernazzani, 2002). Childhood neglect or abuse as measured by the CECA is significantly related to insecure attachment styles in adulthood (OR=3.47, p<.0001) and shown to mediate the relationship to new onset of depression (Bifulco et al., 2006). Fearful and Angry-dismissive styles were those most related to childhood adverse experience and acted most clearly as mediators. They were also related to anxiety disorder (op cit). Attachment models emphasise the importance of adult relationships in vulnerability for clinical disorder. Thus difficulties in partnership, including domestic violence, lack of close support and problems with parenting all constitute vulnerability associated with insecurity (Bifulco & Thomas, 2012). Problematic relating can involve conflict, or apathy, entrapment in damaging relationships or isolation. These all contribute to the experience of depression, and have the added issue of barriers to help seeking and service-use. Figure 2 combines both models in a social-psychological lifespan model.

Figure 2: A social and psychological lifespan model of depression (Bifulco & Frost, in press)



There is now a growing body of international research concerning physical health impacts of childhood neglect and abuse (Dubowitz, 1991; Flaherty et al., 2006; Walker EA, 1999). This includes a meta-analysis of the various studies to establish effect sizes (Wegman & Stetler, 2009), which compared 24 studies and 78 effect sizes and 48 thousand individuals. It showed that experiencing child abuse was associated with an increased risk of negative physical health outcomes in adulthood (effect size d = 0.42, 95% Confidence Interval = 0.39-0.45). Neurological and musculoskeletal problems yielded the largest effect sizes, followed by respiratory problems, cardiovascular disease, gastrointestinal and metabolic disorders. In terms of common illnesses in middle age, child abuse is shown to relate to raised risk of heart disease (Dong et al., 2004), adult inflammation (Danese, Pariante, Caspi, Taylor, & Poulton, 2007), obesity (Lissau & Sorensen, 1994) and Type II diabetes (Rich-Edwards et al., 2010). The latter is also linked both with depression and avoidant attachments style mimicking a depression model (Lloyd, Dyert, & Barnett, 2000; Turan, Osar, Turan, Ilkova, & Damzi, 2003). Further risks are incurred from a poorer uptake of health services of those with childhood adversity (Chartier, Walker, & Naimark, 2007). The ACE study of childhood adversity also showed child abuse and related experiences to be a leading cause of early death in adults (Felitti, 2002; Felitti et al., 1998). The ACE study showed a range of health outcomes. In researching over 13 thousand adults, they found those who had experience of four or more categories of childhood adversity exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship (dose-response) to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.

USE OF NEGLECT/ABUSE ASSESSMENTS IN SERVICES

Social workers are caught in the dilemma when working with families, of providing care with frameworks like Attachment theory advocating keeping the family together but also investigating harm and child removal as a major safety issue. They need to manage the inherent uncertainty in the child protection role (Munro, 2010). In her review of UK services, Eileen Munro made recommendations concerning the role, but reminding social workers to

be committed to always ‘having the child in mind’, talking to the child and allowing their voice to emerge. She criticised the over-use of technology in processing case material to the exclusion of talking to the child and family as the focus of any investigation or support.
Social workers themselves identify neglect and emotional abuse in particular as experiences maltreatments difficult to assess with confidence about the thresholds for intervention. Many standard assessments such as the Assessment Framework popular over ten years ago (Gray, 2001) do not provide actual measures and items for developing neglect matrices although these are now being developed [10]. Definitions of psychological or emotional abuse remain unclear to some, and can be subtle and complex (Bifulco et al., 2003; Glaser, 2002). One of the key aspects of grading experience into a measure of severity is to have a list of indicators that can be combined to form a score. The CECA gives reliable instructions for this.

An action-research project involved training social workers on how to score their case material in terms of the CECA scoring. This showed improved expertise in assessing both neglect and emotional abuse, with more cases being taken to denote maltreatment by the family courts, which aided decisions about care planning (Bifulco & Jacobs, 2012b). Social workers were able to learn the rating scheme reliably with a few days training, and applied it to their ongoing cases. A pilot evaluation of such cases showed these benefited from more accurate chronologies, were better able to collate information specific to each type of maltreatment, and gave more stringent attention to parent behaviour rather than victim response. One example concerned a couple who misused drugs and had neglected their 5-year old son intermittently for years, despite being affectionate towards him. Having started school, it was possible for the social worker to bring together indicators which included inconsistent school attendance, failure of the parents to take up speech therapy for the child, lack of socialisation with other children, lack of stimulation with toys or games, leaving him unattended when drugtaking, which together added to a ‘moderate’ level of neglect on the CECA scales. When presented to the family court in this form it was recognised as neglect, and care from grandparents put into place. Previous attempts by the social worker to highlight such neglect had failed to be recognised which had led to ‘drift’ and increased demand on service resources. Another complex case from an immigrant mother with psychosis was able to highlight psychological abuse in her dictates to her child to ‘hate all authority’ and ‘revenge her’, to be disrespectful to religious leaders and to refuse to speak English in school.

[10] http://www.childandfamilytraining.org.uk/sites/9/pg/81/CFT_021213_Neglect_Trainers_Manual_intro.pdf

This added further weight to the existing neglect already identified, and was attributed to her mental health difficulties. This approach using the CECA in services is further being rolled out to statutory services on the Isle of Man to aid in accurate assessment of neglect and emotional abuse among children and adolescents.

DISCUSSION

Society has to manage childhood neglect or abuse in order to provide greater wellbeing and health and to tackle human rights issues for children. It also has the potential to cut down on health and social care costs on a lifetime basis and inter-generationally. In order to do this, various social policies invoke child protection and safeguarding legislation to reduce maltreatment in the recent generation. However, society also has to manage the impacts of previous generations' early life abuse, some of which involves secret but large scale organised sexual abuse, and this invokes a heavy burden on clinical and health services as well as those dealing with relationship and parenting problems.

In order to understand neglect and abuse as the basis for later health difficulties it is important to be able to both assess these accurately and to develop models to understand lifelong impacts. Assessment requires detailed information about the experience, its severity, frequency and relationship to perpetrator. It also requires identification of multiple types of abuse for higher risk. For historical abuse it requires careful factual questioning about the past to avoid bias. Understanding the impacts invokes social, psychological and biological models. Society needs to put resources into combatting both past and present abuse for the wellbeing of society.

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