Children's Social Care Services' Response to Children who Display Sexually Harmful Behaviour

DEACON, LESLEY,ANN

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Lesley Ann Deacon

Abstract

Responding to referrals regarding children who display sexually harmful behaviour (SHB) is a complex area of practice for qualified social work practitioners working in generic social work intervention, for example in Local Authority safeguarding teams. The government guideline *Working Together to Safeguard Children* (2006) was the first document to officially recognise this particular group of children in policy and suggest guidelines for intervention. It confirmed that children who display SHB were classified, and so should be responded to, as *children in need* and therefore required at least a Section 17 Child in Need Assessment (*Children Act, 19*89). This thesis examines the extent to which these guidelines were followed within a Local Authority by accessing 30 cases from their Integrated Children's System (ICS) – examining the recordings made by the social workers to explain their decision making and action taken.

Taking a critical realist grounded theory approach for social work research as recommended by Oliver (2012), ethnographic content analysis was used to analyse qualitative data from these recordings. Following this, semi-structured narrative interviews were used to explore the experiences of generic social work practitioners in this area of practice (children who display SHB), as well as the experiences of parents and other carers. These are presented in the form of thick description (Geertz 1973) in order to interpret the meaning of the actions and behaviour of the participants (Ponterotto 2006). This was completed from the perspective of a social work practitioner-researcher embedded in social work practice during the research process. There is value in practitioner participation in research as this, in effect, values the opinions and theories of social workers and ensures that the research conducted in local and specific (Oliver 2012).

These two areas of research reveal the individual journeys of children displaying SHB showing how they can be invisible to CSCS concluding that, initially, this was because when they were referred to CSCS they did not receive a consistent response, and it was difficult to find information regarding these children within ICS. The thesis went on to conclude that specifics about the children's behaviour were not recorded accurately, e.g. 'inappropriate sexualised behaviour' was a common term used. Finally, in relation to intervention, there was evidence of delays, and referrals to specialist services not being followed up – because sexually harmful behaviour was not always identified as such, opportunities for early intervention were missed.

Following these findings are recommended guidelines for how CSCS can work with children who display sexually harmful behaviour to ensure they become more visible and go on to receive the appropriate intervention. Generative mechanisms (i.e. the *what*) were identified for further research, in order to develop a theory using grounded theory. These include: societal norms; gender; age; class; professional judgement; focus of child protection; and bureaucracy.

Keywords: children who display sexually harmful behaviour; social work practitioners; parents; carers; policy; social work intervention; child in need; Integrated Children's System (ICS).

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Lesley Ann Deacon

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List of Abbreviations

AIM	Assessment Intervention Moving on Project
CJJIR	Criminal Justice Joint Inspection Report
CSCS	Children's Social Care Services. This term refers to the department in a Local Authority responsible for safeguarding children.
DCT	Data Collection Tool
ECA	Ethnographic Content Analysis
LASSA	Local Authority Social Services Act 1970
NPM	New Public Management
PBR	Practice Based Research
SHB	Sexually harmful behaviour
Social work practitioner	This broad term has been used when referring to any professional working within the social work environment. In this study this includes social workers, senior social work practitioners, social work team managers and independent reviewing officers (those who chair child protection conferences).
YOT	Youth Offending Team

Statement of Copyright

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Dedication

This thesis is dedicated to David Staward.

1 Introduction

Between 2005 and 2007 I trained as a social worker completing a Masters' degree in Social Work at Durham University. During this training I completed two social work placements within the same Local Authority and then went on to work for that Local Authority as a qualified social worker in Children's Social Care Services (CSCS), a term for the social work department responsible for 'protecting' and 'caring' for children in their area, and the term that will be used throughout the thesis.

Whilst working part time as a social worker I began researching for my PhD thesis. This developed through my work as a practising social worker and my encounters with service users, parents, carers and other professionals. I became particularly interested in how children who display sexually harmful behaviour are responded to by CSCS. Two weeks into my career as a qualified social worker I was involved with a family where a thirteen year old boy was referred to CSCS following what was reported as *inappropriately* (a generic term addressed later in this study) kissing his sister. It was this incident that led to my interest in how such children are responded to by CSCS and how social work practitioners are prepared for this area of work.

Ferguson (2014) suggests there is a considerable lack of research conducted by social work practitioners for social work practitioners, particularly in relation to everyday child protection practice taking place. In her research with social work practitioners in 2011, Beddow reported that this can be caused by a lack of confidence in social work practitioners of their research skills; a lack of time caused by high caseloads; lack of support from managers around research and instead a focus on training to meet specific needs of the job at the time. It is important however that the need for this not to be about the individual choice of practitioners but for it to become imbedded in the role of the social work practitioner (Becker and Bryman 2012). This is possible through the development of Practice Based Research (PBR) within social work practice. PBR is 'research conducted by practitioners for practice purposes' and 'takes into account the ethical priorities of the

practitioner who initiates the study' (Dodd and Epstein, 2012, p. 5). It is from this position that this research takes place – being conducted by a social work practitioner for the purposes of developing knowledge and improving practice in social work. There is a benefit in social work research being conducted by those immersed in practice. As suggested by Anthony Giddens, 'all social research is necessarily anthropological; it requires immersion in a form of life' (Blaikie 2007, p.163). So to be immersed critically in the practice of social work aids in the identification of how the view of that reality is maintained. Active participation in research in this way in effect values the opinions and theories of social workers and ensures that the research conducted in local and specific (Oliver 2012).

With this in mind, I was interested to explore i) how sexually harmful behaviour (SHB) is defined, ii) how the children who display SHB are understood, iii) how they are responded to by CSCS, iv) how their parents and carers experience social work intervention, and v) how practitioners are prepared for these interventions. I present information from 30 electronic case records accessed from a Local Authority where they received a referral specifically relating to a child who had displayed SHB, and plot the journey of these cases through the Integrated Children's recording System (ICS) from initial referral to the outcome of that particular referral. Following this I present findings from interviews with parents, carers and social work practitioners to understand their experiences of these referrals.

As part of my research I looked into the training at the Local Authority involved in this study and how it was implemented. Mir and Oakie (2007) suggest that 'training of social work practitioners is very important' but that they often receive 'very little and sometimes no formal training before commencing work' (p. 30). For the purposes of the study the Local Authority allowed me to participate in their training so I could experience the training provision as other practitioners would. The training course on children who display sexually harmful behaviour lasted one day, and was supplemented by a document from the Local Safeguarding Children Board. The focus of the training was on understanding that different professionals have different views as to whether sexual behaviour is harmful, but it did not address the issue of how to present a consistent approach, either through procedures or a common theoretical framework. It did not include training or information on how to indentify SHB or signposting for further intervention. Also, the course was not run by the

Local Authority itself, and it was not compulsory at the time for practitioners at that Local Authority. I attended this course as preparation for my research. There were no social work practitioners from the Local Authority in which I was researching. At the same time I asked to attend the AIM[1] training, a two-day course. However it was four years before this course was available to attend – not because of my role as a researcher but simply because the course was run by an outside agency and was not arranged regularly. This two-day course involved a repetition of the previous training day with more detailed information on how to complete an AIM assessment with older children.

1.1 Questions arising from prior studies

The majority of previous research studies involving children who display SHB focused on children who were receiving specialist intervention, with experiences mainly sought from practitioners who had specialised knowledge/experience in working with children displaying SHB. For example, Hackett and Masson (2006) reported clarity among the specialist community that these children were not different to other groups of children with behavioural problems but that due to the risks they may pose, then different responses might be needed. Through accessing these studies it became apparent that what was missing were the experiences of social work practitioners who were not specialists in the area of SHB, but who worked within CSCS departments in Local Authorities where they were expected to respond to initial referrals concerning children displaying SHB with little or no prior experience of working with this particular group of children.

1.2 Foundations and aims of research

The aim of this research therefore has been to understand how CSCS in a Local Authority responds to referrals regarding children who display SHB. Since the 1980s there has been an increase in academic research into child sexual abuse in general, but little on the topic of children as alleged perpetrators, and even less with their families (McKeown and McGarvey, 1999, pp. 186–7). Perhaps this is because this area is fraught with stigma, and there is a tendency for parents/carers to be covertly, or even sometimes overtly, accused of sexually

[1] *Assessment Intervention Moving on Project*, established in January 2000. Its aim was develop a more focused and co-ordinated approach for young people who committed sexual offences.

abusing their child themselves? But as Hackett suggests, the 'sexual abuse experience alone is a poor single explanation for why a young person goes on to victimize others' (2004, pp. 33–5). While the possible answer to understanding the child's behaviour may lie within their family environment, to suggest that the parents/carers *must* be sexually abusing this child is a potentially damaging misconception. This is the foundation from which this research has developed, in order to understand how CSCS responds to referrals regarding children displaying SHB and how, in practice, social work practitioners deal with these cases – how decisions are made, what action is taken and what tools and research they access in order to assist them during any assessment process.

Current government policy has been adapted to include guidelines for professionals dealing with children who are accused of sexually abusing other children – for example, *Working Together to Safeguard Children* (Department of Health, 2010) has been significantly updated in relation to children who display SHB, who are now deemed to be *children in need* and therefore require at least a Section 17 assessment (*Children Act*, Department of Health, 1989). However, the 2010 version goes further and gives more detailed information about children who display SHB and what their needs may be. This version came out during the course of this thesis, so it is not possible to know at this stage what its impact will be and whether it will be instrumental in improving assessment and service provision for these children. There is emphasis in this document is on the need for appropriate training and for staff not to dismiss concerning behaviour as just 'normal' (p. 302). There is also recognition of the complexities of the children's backgrounds and the danger in focusing on them having been sexually abused themselves.

In terms of how to work with these children the 2010 version recommends:

- a co-ordinated multi-agency approach including youth justice (where appropriate), CSCS, education (including educational psychology) and health (including child and adolescent mental health) agencies and police;
- the needs of children and young people who abuse others should be considered separately from the needs of their victims;

- a multi-agency assessment should be carried out in each case, appreciating that the children may have considerable unmet developmental needs, as well as specific needs arising from their behaviour.

Department of Health, 2010, p. 303

The difficulty here is that while the new guidelines are much clearer, they still leave implementation at local agency level and do not recognise the individual perception of social work practitioners as to what constitutes sexualised behaviour that is not 'normal'. So, while there are more specific recommendations for responding to children who display SHB in the 2010 version, there is no real national approach to working with this group and the specifics are left to Local Safeguarding Children Boards and individual social work practitioners (McGarvey and Peyton, 1999, p. 90). The guidelines do confirm that social work practitioners should treat the children like any other child in need, but whether social work practitioners are aware of this in practice, and able to act upon it, is unclear.

The guidelines provided by the Local Authority in this study state that the process for dealing with children who display SHB is directed in the same way as other safeguarding children referrals (Local Regional Inter-agency Procedures Project, 2005). The document as a whole is clear that safeguarding procedures must be applied to the alleged perpetrator as well as the alleged victim. The responsibility is with the individual social worker to recognise the behaviour as SHB and to be aware of the appropriate designation of child in need status.

Another challenge is that the document contains no guidance to support an understanding of the blurred boundary between sexualised behaviour and sexually abusive behaviour. Considering the complexity of this area of social work, social work practitioners would be likely to find it useful if more clear information was given. For example, possible agencies that could help or specific advice that could be given to families as well as information about what behaviour is concerning so they know when to take action and what action to take.

With these areas of interest in mind, the following area of study was identified: CSCS's response to Children who display sexually harmful behaviour. This led to the following research questions which will be addressed throughout the study.

1.3 Research questions

1. How do CSCS deal with referrals of children who display SHB?
2. What are the reflections of social work practitioners on their practice in relation to working with these families?
3. What does a small group of users (parents and carers) say about how their cases were managed? How do parents/carers experience social work interventions?
4. What best practice recommendations can be developed to inform effective intervention by social work practitioners, and what appropriate training should be offered?

These questions are aimed at revealing how CSCS from one Local Authority responds to children who display SHB and how this is experienced by parents, carers and social work practitioners. It is intended that through this research recommendations will be made for good practice guidelines for social work practitioners within the statutory sector and elsewhere.

1.4 Methodology adopted

This research is based upon a critical realist perspective, i.e. meaning as well as reality is found both in the actor and in the object. A critical realist paradigm is necessary in social work research as the reality for service users, such as the physical act of SHB, takes place and is therefore an objective reality regardless of whether or not it is acknowledged by the service user or witnessed by the social work practitioner (Oliver 2012). So in this study, the organisation of CSCS exists as real, outside of the actor's interpretation of it based on the power mechanisms of policy and guidance and manifested through ICS (Danemark 2002). Also, to understand how this is experienced by the people involved this was combined with interviews with those who had actually experienced it, in order to know how they understood and interpreted it.

Critical realism has been criticised as being a 'philosophy in search of a method' (Yeung, 1997, p.51). For the purposes of this research a grounded theory approach will be applied following the guidance of Strauss and Corbin (2008) in which generative mechanisms are identified firstly, before further research is required in order to develop an abstract theory. Grounded theory is adaptable and can be applied to different methodological approaches. By combining it with critical realism, this enables the exploration of 'broader social structures' in order to identify 'analytical categories like gender and class' (Oliver 2012, p.378).

For the presentation of the data thick description is used. Geertz (1973) suggests that culture does not exist within people's minds, but is explicit through their actions and their interpretation of meaning. Therefore the role of the researcher is to present thick description of the data from the participants which includes a hermeneutic interpretation, rather than just thin description which presents the fact. Therefore the researcher engages in the participants' meaning i.e. with recognition of the participants' position and the context, and presents this in the form of thick description (Ponterotto, 2006).

1.5 Layout of the thesis

The background research into this thesis takes place over two chapters. The first is the Literature Review (Chapter 2), which consists of an evaluation on existing research regarding children who display SHB. Chapter 3 then considers the role of CSCS from a brief historical summary through to a more detailed consideration of how CSCS are expected to respond to children who display SHB. This is achieved through an evaluation of existing legislation, as well as government guidelines and policy. Chapter 4 sets out a summary of chapters 2 and 3 in terms of their implications for this research study. The Methodology, Chapter 5, is divided into three sections showing how data was identified, the issues and approach to analysis, and concluding with a justification of the methodological position of the research. Following this there are two findings chapters: Chapter 6 consists of the findings from 30 Local Authority (LA) case files; Chapter 7 details the findings from the semi-structured interviews with parents/carers and social work practitioners. Following these is Chapter 8, the Discussion chapter, which draws together the findings from these two different data sets.

Finally the Conclusion in Chapter 9 discusses some of the limitations to the study as well as making recommendations to avoid erratic practice.

2 Literature Review

2.1 Introduction

Whilst there is growing literature in understanding and working with children who display SHB and the development of policy for working with these children and their families, most empirical research has been conducted within clinical and/or specialist settings (as discussed later in this chapter). This year (2013) a Criminal Justice Joint Inspection Report (CJJIR) (2013) was completed focusing on the way in which children who display SHB are responded to within the criminal justice system. Prior to this, there has been little focus on investigating how cases of children displaying SHB are managed within mainstream criminal justice or safeguarding arenas. There is value in looking at how children who display SHB are viewed and responded to by mainstream CSCS as those who encounter specialist services have either been found guilty of, or admitted to, their SHB. Therefore this chapter begins by setting out the search strategy devised to find relevant literature before focusing on definitions of SHB in children and possible 'causes'. Chapter 3 follows considering current guidelines for how general social work practitioners should respond to referrals relating to these children. This also consists of a summary of the findings from the Joint Inspection Report (2013) and aspects of this that are explored in the Findings and Discussion chapters.

2.2 Search strategy

SHB in children is a highly contested area characterised by a substantial variation in terminology used. Such behaviour is variously referred to as: 'sexually harmful', 'sexually abusive', 'sexually aggressive', 'sexual offending', 'sexual problems' among other terms. This posed a challenge in identifying key source material. During this study however, the term 'sexually harmful behaviour' has been be used (abbreviated to SHB) as this was predominantly used in the UK at the time of writing. There was also ambiguity in descriptions of 'children' and 'parents', with various different terms used, and these also had to be accounted for in the search strategy. Thus, based on extensive prior reading and in consultation with colleagues and other professionals (experienced in working with

children who display SHB), an intricate strategy was developed to determine what literature was available in relation to children who display SHB.

The following search strategy was devised in order to capture results where (a) at least *two* of the terms were present together, and (b) one term related to the sexual behaviour:

Criterion 1

(kw: child* or kw: adolescen* or (kw: young and kw: people) or kw: youth* or kw: juvenil*) and ((kw: sexually and kw: harm) or (kw: sex* and kw: abus*) or (kw: sex* and kw: aggress*) or (kw: sex* and kw: offend*) or (kw: sex* and kw: harm*)) and not ((kw: parent* and kw: abus*) or (kw: adult and kw: abus*))

Criterion 2

(kw: parent*) or (kw: care*) or (kw: *mother) or (kw: *father) or (kw: *family) or ((kw: social work*) and (kw: professional) or (kw: practitioner))

Criterion 3

((kw: sexually and kw: harm) or (kw: sex* and kw: abus*) or (kw: sex* and kw: aggress*) or (kw: sex* and kw: offend*) or (kw: sex* and kw: harm*)) and (not ((kw: parent* and kw: abus*) or (kw: adult and kw: abus*))) or (kw: sex* and kw: problem*)

Criterion 4

(kw: child* or kw: adolescen* or (kw: young and kw: people) or kw: youth* or kw: juvenil*) and ((kw: sexually and kw: harm) or (kw: sex* and kw: abus*) or (kw: sex* and kw: aggress*) or (kw: sex* and kw: offend*) or (kw: sex* and kw: harm*)) and (not ((kw: parent* and kw: abus*) or (kw: adult and kw: abus*))) and (not ((kw: parent* and kw: abus*) or (kw: adult and kw: abus*)))

The following databases were used:

- Worldcat
- Google Scholar
- Web of Science

- Web of Knowledge/Science

This strategy ensured that as many relevant articles and publications were found as possible. But it became evident that existing research focused mainly on children's experiences within a clinical or specialist setting, not how they encountered professionals within generic social work. The search was therefore refined to focus on these experiences by searching all articles from the last five years in the following journals:

- *Child Abuse Review*
- *Sexual Abuse: A Journal of Research and Treatment*
- *Child Abuse and Neglect*
- *British Journal of Social Work*
- *Journal of Sexual Aggression*
- *Journal of Interpersonal Violence*

2.2a Search strategy research findings

There are two key themes in the methodological focus of previous research into children who display SHB. Firstly in the methods used, and secondly in the focus of the studies. The majority of the research found in this thesis (particularly those focusing on children experiencing the criminal justice system as discussed later) were quantitative in nature (for example, Parks and Bard, 2006; Hummel *et al.*, 2000; Chaffin *et al.*, 2002, 2008). Whilst there is benefit in generating knowledge at a whole-population level, the problem at a practice level is that it may not assist in how to apply this knowledge at the individual level to a child that is not representative of the whole population – for example, what risk factors were evident in *one* child's life that may have led to them displaying SHB? What specific differences were there between those offending against children and those against adults? Payne (2009) advises that when considering the validity of research, we should also consider the background of the researchers and how that may direct their focus. With this in mind, the research studies found primarily focused on children who were in receipt of specialist support in relation to their SHB (e.g. Erooga and Masson, 2006, 2006a, 2006b; Hackett *et al.*, 2002; Scott and Telford, 2007), or who had experienced the criminal justice system (e.g. Chaffin *et al.*, 2002, 2008; Johnson and Doonan, 2005; Friedrich *et al.*, 2005).

Scott and Telford (2007) emphasise the importance in taking a 'holistic view of young people involved in sexually harmful or abusive behaviour' (p. 175). When applied to research, this cannot be achieved by applying generalisations to this group of children. All the research completed provides some evidence regarding children who display SHB but they are completed at different ends of the spectrum – from generalised statistical information to detailed observations following therapeutic or criminal justice intervention. Taking these together, this extensive literature search revealed three principle foci of research:

- how problematic sexual behaviour should be viewed and defined;
- the possible reasons why some children display SHB; and
- treatment models for supporting these children.

The following sections address each of these in turn.

2.3 Defining SHB

In order to understand how children who display SHB are recognised and treated, the first step was to develop understanding of how SHB is defined and described. The literature published in English encompasses field research in North America as well as the UK, New Zealand and Australia, and it is this body of literature that forms the basis of the following review.

2.3a Sexualised behaviour or sexually harmful behaviour?

There is limited agreement in the research literature about the boundary between sexualised behaviour and SHB. Lovell (2002) suggests that SHB occurs where there are issues of power and exploitation, although there remains a lack of consensus as to how to define sexual exploitation or coercion of one child by another and in particular this becomes less clear as the age gap between the alleged perpetrator and alleged victim narrows (Lovell, 2002, p. 1). More specifically, The National Children's Home (NCH) Report suggests there is cause for concern if there is an age difference of more than two years, or if one of the children is pre-pubertal and the other post-pubertal (NCH, 1992, p. 4). However, while this is

a clear statement, there are issues in terms of how this can be applied in practice, as children go through puberty at different stages and leads to the question of whether social work practitioners would know enough about the intricacies of each individual's biological development to be completely certain that one child was pre-pubertal and another post-pubertal – especially if the age of the alleged victim and alleged perpetrator were very close. But questions of what constitutes 'normal' behaviour, and the extent of the child's knowledge/understanding of their behaviour, are more complex and present further challenges for practitioners in establishing each child's understanding of what is appropriate and what is inappropriate. SHB is addressed by adults based on *their* understanding – but how are children to know which behaviours are acceptable and which are not? How much of their behaviour is experimentation? Where sexual participation is voluntary and involves mutual exploration, this would not always be considered as sexually harmful, but part of 'normal' behaviour, particularly among adolescents (Chaffin *et al.*, 2002, p. 28). Therefore social work practitioners need to feel confident in determining whether the exploration was mutual and not coercive. Vosmer *et al.* (2009) found, in interviews with twenty-four UK professionals (mainly from a social work environment) about sexually inappropriate behaviour in the under 10s, there was a lack of consensus regarding what could be viewed as 'normal' and what might be 'inappropriate'. There was some agreement that it would be unusual and concerning if children under the age of 10 talked explicitly of sexual intercourse or if threats, violence or secrecy accompanied sexualised behaviour. Other research suggests that behaviours must be taken in the context of those participating and that 'normal adolescence [puberty] is often a stressful time in the development of sexuality' (Gonsiorek *et al.*, 1994, p. 117). Zolondek *et al.* (2001) suggest that there are risks associated with the onset of adolescence that can cause young people to act out sexually. In the UK in the past, underage consensual sex was considered *misbehaviour*, which it would not be today. Furthermore, 'what constitutes an atypical or concerning sexual behaviour may vary between cultures' (Chaffin *et al.*, 2002, p. 208). These cross-cultural differences, along with changing notions of childhood over time, cause difficulty in defining appropriate behaviour. This research study draws primarily on contemporary thinking in the UK, but in the USA Chaffin *et al.* provide a general definition for what could be seen as concerning behaviours, those that:

occur at a frequency greater than would be developmentally expected;
interfere with children's development;
occur with coercion, intimidation, or force;
are associated with emotional distress;
occur between children of divergent ages or developmental abilities; or
repeatedly recur in secrecy after intervention by caregivers

Chaffin *et al.*, 2002, p. 208

Whilst taking this into consideration, it is important that children are not judged by adult standards regarding their sexual behaviour (Johnson and Doonan, 2005, p. 39). It is the view of this researcher that context should be considered before allegations are made, as the consequences can be far-reaching. For example, there is the potential that a child could be labelled as a 'sex offender' for the rest of their life because of possible 'experimentation' or 'exploration' (see section on Labelling, stigma and terminology). Children often touch each other's body parts by way of exploration, although it could feel abusive if one child was more insistent and the other wished to stop (Johnson and Doonan, 2005, p. 38). This raises further questions. If this child was asked repeatedly to stop by adults but failed to, then this could constitute SHB. But at which point would this be identified? How many times would be *too* many? And after 'several' times would this *already* had have a negative effect on the other child (and on the alleged perpetrator themselves)?

Many researchers challenge the notion of the 'cycle of abuse' (i.e. victims growing up to become abusers) in order to dispel the myth that children who display SHB were victims of sexual abuse themselves (Widom and Wilson, 2009). In Australia, Boyd and Bromfield (2006) suggest that if this cycle were pertinent then there would be many more female children displaying SHB than males, as they were predominantly the victims of sexual abuse themselves. This issue was also raised by US researchers Friedrich *et al.* (2005) to ensure that the cycle of abuse misassumption does not serve to prevent investigation to identify causal, or associated, factors. Chaffin (2008) raises serious concerns about public policy, which he perceives as being punitive and failing to recognise perpetrators as children first and foremost. This was further highlighted by changes in US law with the introduction of the

Adam Walsh Act (2006) in which convicted sexual offenders aged as young as 14 are required to sign the public sex offenders register. Concerns have been expressed that this could lead to a lifetime of labelling and stigmatisation, and that it does not acknowledge the reasons for sexually offending behaviour in children, nor that their behaviour may be addressed through skilful interventions. The Act presumes that sexually offending behaviour is resistant to change, yet rates of recidivism suggest otherwise (Chaffin 2008). As Chaffin argues, 'assumptions [are] drawn from adult pedophilia [sic]' (2008, p. 111), and the concerns for researchers are that *accurate information* is not used as the basis for the development of public policy with regard to young people who sexually offend. These researchers also strongly advocate multi-systemic therapy (see p. 22), which examines the family environment to identify risk factors and support change (Chaffin (2008) and Letourneau *et al.* (2008)). In Australia issues were raised concerning the age of criminal responsibility, which is 10 (as it is in the Great Britain, excluding Scotland which is 8), and its impact on the focus of treatment of offenders – punitive or therapeutic depending on whether they are older or younger than 10 (Allen, 2006).

What is clear from this literature is that defining SHB is far from straightforward, and if there is little commonality within research then it correlates that it is likely there will be commonality in social work practice. There is, however, one area of agreement – '[o]ne of the most strikingly consistent findings across studies of young people demonstrating harmful sexual behaviours is, of course, the gender bias towards boys and young men' (Hackett, 2007, p. 10).

2.4 Labelling, stigma and terminology

The advantages of consistent terminology are that it can help to avoid *in*consistency in how guidelines are accessed and how children are treated. However, as already indicated, labels can be stigmatising and abusive (as suggested by Goffman, 1968 cited in Allan, 2013), for example the act of labelling a child as a 'sex offender' could carry with it a negative public perception of them as 'untreatable' (Parks and Bard, 2006). This may also influence the way in which social work practitioners treat a child – using a labelling the term 'sex offender' in itself suggests meaning such as delinquency and concerning behaviour, so it is perhaps less

likely that they would be treated and/or assessed as a victim as well (Allan, 2013). As suggested by Chaffin *et al.* 'criminal justice definitions or labels are inappropriate for young children because children are not usually held criminally responsible for sexual misbehaviour' (2002, p. 208). The US literature demonstrates different ways of conceptualising children who engage in SHB. For example, there is disagreement between Friedrich *et al.*, who refer to *children with sexual behaviour problems*, and others who still refer to this group as *juvenile sex offenders* (2005). The difficulty with Friedrich *et al.*'s description is that it does not acknowledge that harm can be done to others, and neither does it ensure there is a balance between the perception of *both* the alleged victim and alleged perpetrator. In comparison, literature from Australia and New Zealand refers to the behaviour as *sexually violent behaviour* (e.g. Allen, 2006), which is the other extreme, as using terminology such as 'violent' when referring to children carries connotations and could be viewed as damaging. This term may be in common usage in Australia and New Zealand, but using the term *violent* suggests that the actions of these children were violent, and could create a perception that more punitive measures would be necessary. This may then influence professionals working with these children to have a more negative view of them, and possibly to feel there would be less they can do to effect change in the behaviour. In Australia, Allan (2006) found that practitioners seemed to recount their most difficult cases when asked, but this may also be connected with the negative view people naturally have of 'violence'.

In their research of incarcerated 'juvenile sex offenders' in the US, Parks and Bard found that 'the public perception that sex offenders are untreatable often extends to adolescents and continues to be perpetuated in the absence of empirical support' (2006, p. 337). As this quote suggests there can be a public image of sex offenders that extends to young people and perhaps even to young children, which can be a dangerous assumption that could lead to punishment rather than treatment and rehabilitation. These researchers further suggest that a 'punitive approach to juvenile sex offender treatment, often accompanied by public humiliation, may only serve to alienate such adolescents further and hinder the normal social development that might otherwise contribute to the prevention of additional victims' (Parks and Bard, 2006, p. 337). Even if the emotional impact of punishment on the young person was not considered, the effectiveness of their treatment could be adversely

affected, which is counter-productive if the goal is avoiding repeat offending. What is important is that 'human dignity of adolescents who sexually offend is valued and the social expectation that they will mature into productive adults can be cultivated without compromising accountability for their actions or quality rehabilitative treatment' (Parks and Bard, 2006, p. 339).

As suggested previously, in the UK the term SHB is commonly used, a term that acknowledges that harm can be done without labelling children as sex offenders. While there are continuing discussions in researcher circles about labelling and terminology, there remain concerns in the wider public as to how any form of sexualised behaviour should be viewed and reported (Mitchell *et al.*, 2007).

2.5 Reasons why children display SHB

When social work practitioners assess a child who has displayed SHB, it is possible that they may try to find a 'cause' for the behaviour – asking 'why have they done this, this behaviour is not "normal"' (this is discussed in more detail later)? This section presents research that explores the 'causes' of SHB. There are of course many interacting factors that influence a child's behaviour, but the majority of children do not display SHB, so this leads to the question of which factors may contribute to causing this behaviour. In Australia, Allen (2006) connected contributory factors to poverty, but there are many people living in 'poverty' who are not neglectful of their children and who do not abuse them. The following sections discuss a number of factors that have been argued to be associated with SHB in children, although it should be noted that there is little consensus about the relative contribution of each of these factors, or indeed if there are *any* discernible factors.

2.5a Sexual abuse

Hummel *et al.* (2000, p. 305) suggest that '[o]ne of the models often put forward to explain sexually aggressive acts committed by adolescents (and by adults) is the sexual abuse suffered by these later offenders in their childhood or early youth'. This is also suggested by other researchers, in the case of children who display SHB (Johnson and Doonan (2005) and in the case of adolescents (Drach *et al.* (2001)). However Johnson and Doonan argue that it

is necessary 'to counteract this belief in professionals, as some may influence children with sexual behaviour problems to make a disclosure of sexual abuse when there has been none', and this will not get to the heart of the difficulties in the child's life which are influencing their behaviour (2005, p. 34). It is important to note that most children and young people who display SHB are male (NCH, 1992, Hackett and Masson, 2003). As most victims of sexual abuse are *female* then it does not necessarily correlate that prior sexual abuse would be a factor in SHB (Tudiver *et al.*, 2000). While seeking reasons for the behaviour is understandable, the danger of assuming that SHB must be associated with earlier experiences of being sexually abused is that it could lead to presumptions that a child was simply mimicking behaviour, or even that they understood what they were doing was wrong and were exerting power over other children, consciously or subconsciously. This could effectively close the door to other possible explanations, including their sexualised experimentation being affected by experiencing or witnessing emotional problems within the family environment (see Domestic violence section below) (Johnson and Doonan, 2005, Friedrich *et al.*, 2005).

2.5b Domestic violence

While there are several categories of direct abuse with regard to children (including physical abuse, emotional abuse and neglect), several researchers suggest that children who display SHB have predominantly been *witnesses* to domestic violence (Johnson and Doonan, 2005; Pithers *et al.*, 1998; Friedrich *et al.*, 2005; Merrick *et al.*, 2008; Boyd and Bromfield, 2006). There is general agreement across the field that children exposed to domestic violence are at risk of developing both internalised and externalised behaviour problems (Pepler *et al.*, 2000). Someone who does not display respect for their partner could also show no respect for their child, although the way that child reacts to this depends on other environmental factors, as suggested by Friedrich *et al.* (2005).

2.5c Loss of parent / insecure attachment

In safeguarding work with children it is usual to consider issues of loss and attachment issues in order to assess a child's needs. Researchers such as Hummel *et al.* compared a sample of adolescent sex offenders with a history of sexual abuse with a group with no

history of sexual abuse. Their findings showed that there were 'no statistically significant differences' except for a 'marked' difference between the groups in one key area – 'experiences of loss before… and after… the age of 14 years' (2000, pp. 310–311). Loss was defined as 'loss of a parent due to death, separation, divorce, fostering before or after the age of 14' (2000, p. 311). In contrast, Marshall *et al.* found in their study of childhood attachment that there was 'no relationship between childhood sexual abuse and either poor coping or insecure attachments' (2000, p. 23). So what can be the cause of poor coping? In their research, Smallbone and Dadds found that 'insecure childhood attachment, especially insecure parental attachment, was associated with antisociality, aggression, and coercive sexual behaviour' (2000, p. 3), while Glaser (2007, p. 4) argued that if children were denied the '… opportunity for forming an attachment before the age of three [they] may not develop the normal aspects of these functions' (Glaser, 2007, p. 4).

Johnson *et al.* (2007, pp. 103–104) have argued that insecure attachment can lead to children developing negative images of themselves which can impact on their ability to socialise appropriately with others. Drawing on neurobiological explanations, Glaser goes further suggesting that '[c]hildren who have been abused continue to respond more angrily to a perceived threat… related to diminished noradrenergic behavioural inhibition system, leading to continued arousal. Young children who are securely attached to their mothers have been found to show a less intense stress response' (2007, p. 4). Glaser also defined a child's stress response as a 'psychological coping response' caused by an 'elevation of serum cortisol' levels (Glaser, 2000, pp. 103–104). However, it is not clear how or why such insecure attachment manifests itself in SHB. The two case studies reported by Johnson *et al.* (2007) reported on missing fathers in the lives of the children, which potentially impacted on their attachments with their mothers. Absent fathers, or difficulties in engaging them, are common among all children accessing CSCS (Featherstone *et al.*, 2010).

Insecure attachment is a very broad issue, one which can potentially lead to any kind of anti-social behaviour in children and young people, and therefore is not a clear indicator in itself of the development of SHB. The founder of attachment theory, Bowlby, studied various issues that could impact on attachment to parents, in children and and in later life, initially *maternal deprivation* (Beckett and Taylor, 2010, p. 44). Having a secure attachment to a

parent (or parent figure) was found to be important because it created an *anchor* for the developing child – a secure base from which they could grow and develop in order to be able to form relationships in later life. Issues with attachment are a good indicator of a difficulty within a child/young person's home environment which may have impacted on their ability to develop appropriate relationships, which could explain difficulties in their behaviour towards others.

2.5d Pathways model

Australian researchers Ward and Siegert argue that 'there are multiple pathways leading to the sexual abuse of a child' (2002, p. 320). They suggested that is not possible to identify single triggers for this behaviour, but multiple psychological factors, as follows:

> *intimacy and social skills deficits;*
> *distorted sexual scripts;*
> *emotional dysregulation; and*
> *cognitive distortions*
>
> Ward and Siegert, 2002, p. 331

They argue that, outside these areas, '[l]earning events, biological, and cultural factors exert an influence through their effects on the structure and functioning of these set mechanisms' (Ward and Siegert, 2002, p. 331). They also discuss whether factors leading to SHB are associated with family support, and that 'child molestation may be caused by multiple factors and offenders can sexually abuse children for very different reasons' (Ward and Siegert, 2002, p. 344). They acknowledged that what they have created is a basic framework and guide to help understand why child sexual abuse occurs, and Chaffin *et al.* agree that there can be 'no distinct… profile or any clear pattern or demographic, psychological, or social factors' for children who display SHB (2002, p. 209). They also argue that there are no profiles for the families of these children, so there could be 'an almost infinite variety of backgrounds and reasons why' (Chaffin *et al.*, 2002, p. 209). When completing assessments (see section 3.2, p. 27) in cases involving SHB by children, Calder advises that '[s]ocial and family histories in cases where juveniles sexually abuse are in general no different from

those usually collected save that a more detailed exploration of a history of sexual or other abuse should be conducted' (2000b, p. 73). The suggestion is that children who display SHB could have similar backgrounds to children from any other cases in the safeguarding children arena. The significant difference here lies in the way parents are treated due to the nature of the abuse, rather than in the information that must be sought (see section 3.4 on Social work intervention and the family context, p. 40).

2.5e Same/different?

The NCH (1992) report suggested that, without intervention, children who display SHB were different to other children with behaviour problems in that they would 'grow into a pattern of sex offending' and would not grow out of that (p. v). However, since the late 1990s, there is little conclusive evidence that children who display SHB are dissimilar to children who have any other behaviour problems, or children who have been abused in some way (Hackett and Masson, 2003). Children who display SHB are expected to have a background of some kind of family dysfunction, but there is disagreement among researchers as to the exact nature of the dysfunction, or why children act out sexually rather than aggressively, for example (Vizard, 2006). Research by Hackett and Masson (2003) found that, in the Delphi survey, there was agreement that 'the vast majority of [children] do not go on to become adult sex offenders' (p. 115). This suggests that children who display SHB *can* grow out of this behaviour, completely counter to the view expressed in the NCH (1992) report. Taking these factors into consideration would suggest that social work practitioners using a general assessment framework would be able to assess these children as effectively as any other child encountering children's safeguarding. However, despite the lack of agreement on the specific causal factors for SHB, it is acknowledged that different causal factors interact in complex ways, so there is a multitude of reasons why SHB occurs. This can make it more complex for social work practitioners to use a theoretical framework to understand why SHB may have occurred specifically in the children they are working with. Messages from research are clear, however, that children displaying SHB should not be treated as mini sex offenders and that the adult sex offender model should not be applied to them (Hackett *et al.*, 2005).

There has been very little research completed with parents of children who display SHB, so determining how they compare to other parents involved with CSCS is difficult. Their relationship with CSCS is fundamentally different from that of parents who have been accused of abuse or neglect themselves – parents of a child accused of abuse are generally involved because they are responsible for their child. There are significant questions about whether CSCS target a particular group of parents and the extent to which some types of abuse are linked with poverty. For example, Allan (2006) investigated the poverty link to parents who accessed public therapeutic resources and found that those parents were the most likely to disengage and to be re-referred with other children at a later date. Conversely, those accessing private support were often middle-class parents, who are often able to keep CSCS out of involvement with their lives. These issues raise several questions for consideration during further research:

> *If parents of children who display SHB do not tend to have CSCS involvement, does this mean they have not committed any kind of child abuse, or is it just that their middle-class status means they are not 'red flagged' by safeguarding children agencies?*
>
> *If their children are not victims of any kind of child abuse then what environmental factors could be triggering the SHB?*
>
> *Do they come to the attention of CSCS in this regard because they themselves are concerned for their child's welfare and believe they need help?*

The parents of children who display SHB could conceivably be demographically different to those who normally come to the attention of safeguarding children services, but due to the lack of research it is difficult to be specific as to the differences or the implications of those differences, so this is something that will be discussed in the Interview findings (Chapter 7, p. 137).

2.6 Intervention

According to policy guidelines (DoH, 2006 and DoH, 2010), once SHB is recognised, then appropriate support would be sought for the child in question. In practice however, there are limited resources for children who display SHB as '[r]esearchers and clinicians have struggled to develop effective interventions' for these children (Karnik and Steiner, 2007, p. 154). In their 2005 study of services for children who display SHB, Hackett *et al.* found that specialist practitioners strongly agreed on four goals of intervention: enabling the child to recognise their behaviour as problematic and to accept responsibility for it by developing coping strategies; community and victim safety; promoting the well being of the child; in doing so, preventing recidivism (2005, p. 13). Whilst the practitioners in this study agreed that interventions should recognise the psycho-social needs of the child and strongly involve the carer, there has been great difficulty in identifying appropriate interventions for young people who display SHB as there is no single, unified *youth offender* model, and so a multi-modal intervention strategy is required (Karnik and Steiner, 2007, p. 154). The difficulty is that applying an offender model could place too much emphasis on the punitive side rather than on safeguarding – not recognising the *dual status* of these children. Hackett *et al.* (2005) found, however, that 99% of professionals involved in their study strongly agreed that young people who sexually abuse other children should not be considered as mini adult sex offenders. In naming the behaviour practitioners responded that the importance is not in the use of jargon but in the detailed explanation of the physical acts. This is necessary to ensure that intervention is aimed appropriately at the particular child, i.e. not using a 'one size fits all' approach but recognising that these children act differently and for different reasons, as well as being a different level risk to themselves and/or others. The same level of intervention is not appropriate for all.

For young children, Butler and Elliott (2006) proposed a strategy called the 'Stop and Think model', which is based within a cognitive psychology approach in order to address problematic thoughts that lead to the sexually aggressive actions (p. 185). The work involves identifying the thoughts that can lead to impulsive sexual behaviour and enabling the child to recognise these in order to focus on more appropriate behaviour. The model recognises

that, while work needs to be carried out with the child directly, the carer must also be involved in order to address any concerns around safety and protection. Rather than focusing on the child as an offender, this model recognises the developmental needs of the child as being important during the therapeutic intervention. The model, however, has only been tested with boys and not girls, and has only been used within the specialist setting of Children and Adolescent Mental Health Service (CAMHS) – for it to have been applied the child must first have been identified as having sexually harmful behaviour and been referred to this service.

Another possible treatment model is multi-systemic therapy, which looks at the risk factors of the behaviour and then involves the family in addressing these and supporting change (Curtis and Ronan, 2004, p. 411). The focus here is on identifying major influencing factors in the lives of young people, such as their family and social environments, and recognising that it is here that problems can be addressed and understood. In this method it is accepted that addressing the young person's behaviour in isolation will not lead to a successful intervention. As indicated by Karnik and Steiner, individual therapies are the weakest as 'offenders are embedded in powerful social and family networks' (2007, p. 157). Even if it appeared that treatment was successful, in returning to the same environment they could return to the same pressures that may have triggered the behaviour, potentially leading to a reoccurrence. The focus here is on empowering 'parents to facilitate pragmatic changes in the youth's and the family's natural environments' (Curtis and Ronan, 2004, p. 411). In their study of various forms of intervention, Curtis and Ronan found that multi-systemic therapy led to young people 'functioning better and offending less than 70% of their counterparts who received alternative treatment or services' (p. 416). However, Karnik and Steiner argue that research has not been able to establish 'conclusively that multi-systemic therapy was advantageous compared to [other] treatment' (2007, p. 156). The important implication of the theory behind the multi-systemic model of intervention is that children and young people differ in their family and social environments, further suggesting that a single, 'one size fits all' approach is unlikely to be effective.

While some kind of therapeutic intervention could be seen as an appropriate response to children displaying SHB, access can be variable. Munro (2011) found that 'particular groups

were not receiving services adequately adapted to their needs', and some practitioners reported that it was as though support was completely reliant on form filling rather than need. In the Local Authority involved in this study provision of therapeutic intervention can depend on whether a 'service level agreement' is in place between the Local Authority and the therapeutic supplier, due to costs. For example, Kaleidoscope is a part of the NSPCC (the National Society for Prevention of Cruelty to Children, one of the most prominent UK children's charities) which works with young people who have admitted to or been convicted of SHB (NSPCC, 2012). They have service agreements with certain Local Authorities, but for those without the cost of referring to the service is much higher and must be justified on a case-by-case basis, therefore depending on the social worker agreeing the level of need with their team and service manager.

2.7 Conclusions

This section has explored evidence and argument about the causes of SHB in children, but it is clear from the number of issues that these 'causal factors' are also common among children with other behaviour difficulties. So while understanding of these factors can still be important for social work practitioners in order to help an individual child to prevent future episodes, they do not actually give a causal explanation for why a child has specifically displayed SHB. What this suggests is that there is no clear explanation for the cause(s) of SHB. In essence children who display SHB do not appear significantly different from children with other behaviour problems, or from children who are the victims of some form of child abuse themselves. Rasmussen and Miccio-Fonseca suggest an empirically guided tool for 'assessing risk of sexually abusive behaviour in *all* youth under the age of 19, male or female, child or adolescent' (2007, p. 177). However, this area is still in a state of flux with no real agreement on causes or treatment of SHB and how it differs from other non-sexual abusive behaviour. Absent fathers appears to be the only suggested difference associated with young people demonstrating sexualised rather than physically (or other) aggressive behaviour, but this is an area that needs further exploration in a focused study around absent fathers.

Consideration of all these environmental factors indicates that the answers lie with the family contexts and more specifically with the parents, as suggested by the focus of intervention being not just on the child but also the family and environment. This is not to suggest that they are responsible, but that the child's environment has impacted on their behaviour, and the parents are the best people to work with to determine the causes and provide support. In particular, as stated, because there are a number of potential factors it is essential to work with parents to determine what these might be for their particular child. With this in mind the following section will first look at what policy recommends social work practitioner do in response to children who display SHB, and then address the existing research into the social worker/professional experience of this parental group.

3 Children's Social Care Services: Its Role

In order to understand how children who display SHB are responded to by Children's Social Care Services (CSCS), first the purpose of CSCS must be considered: what is their role and focus; what are practitioners expected to do in terms of legislation, policy and intervention? This section will look initially at what social work is, leading into the changes brought in by New Public Management and, following this, Munro's reviews concerning the child protection system (2010a and b).

3.1 Social work and New Public Management

Over the years, the perception of the government and policy makers is that 'social work' was concerned with the 'control [of] deviant populations' (Dominelli, 2004, p. 1). In the 1980s the focus for social work shifted from the *provision* of services to the *justification* of outcomes. This was in the development of the umbrella term of *New Public Management* (NPM) brought in by Margaret Thatcher and her Conservative government. This refers to the provision of services which are in effect cost-effective, market-friendly and accountable in terms of expenditure and outcomes (Heffernan 2006). Under this direction, 'politicians and policy makers turned to the principles of the market to inform welfare policy and practice' (Hughes and Wearing, 2007, p. 21). This also guided the way in which social work (as a human service organisation) would be run and the way in which it would have to justify outcomes for the services it provided. As suggested by Mary Langan (in Parton 1997, p.xv) 'the result has been a substantial shift in the "mixed economy" of welfare towards a more market-oreintated approach'. The idea of being customer-led and market-driven was to avoid simply providing services for the sake of providing services, and to focus instead on what worked and what did not. According to Dominelli, Britain became focused on 'Fordist methods of mass production', meaning the intention was to make complicated tasks simple by recoding into key activities and therefore removing the professional authority of the social worker (2004, p. 13). Thompson refers to this as the socio-technical approach where people (the social work practitioners) and technical (policy) aspects become one (Payne, 2009a). Practitioners also became responsible for how resources were being used. However,

social work was already an existing profession, and had worked within the classical bureaucratic management framework identified by Max Weber focusing on the 'efficient handling of clients... through methods of staffing and structure' rather than on economic efficiency (Weinbach, 2008, p. 54). Bureaucratic organisations function on a set of rules that are known and understood by people working in them, and it is through this that efficiency is achieved. For example, promotion would be based on an employee's success at the current job they were doing rather than any proven ability to do a more senior role (Weinbach, 2008, p. 56). In terms of social work this means that a social worker could be promoted to manager based on their abilities as a social worker rather than on any management experience or skills. So NPM, which focused onto outcomes and how to achieve them, was introduced onto the existing system with a different focus – clients now became customers, services cost-effective and outcomes measured (Heffernan 2006).

However Featherstone et al. (2012) identify how such neo-liberalist policies lead to inequalities by seeking to restore class power. For example through their lack of recognition of how the gap between the rich and power had widened in the 1980s and the refocus took place where by parents were no longer seen as subjects of welfare but as the means of the welfare for their children. Parenting thus refocused on their responsibility to effectively parent their children. The focus on the child within assessments would act to the detriment of parents and their needs. Further to this evidence in the 1990s onwards suggests a shift towards rationalisation in terms of thresholds for working with these families i.e. threshold criteria acts as a *gatekeeper* to determine whether action/resources will be allocated or not.

With this focus in mind, research questions (and continues to do so) how it is possible to measure the outcomes of these services. Deciding what can be considered evidence of achieved outcomes 'has a highly subjective element to it' (Dominelli, 2004, p. 5), and whether a service has worked depends very much on the perception of the individual service user and their ability to sustain this. The focus of this study is on the process of service users' involvement with social work and the short-term outcome from the perspective of the social work practitioner. Hughes and Wearing point out that one of the biggest difficulties faced by the change to NPM was the way in which practitioners began to be managed by those without social work experience, 'who may have little affinity with the

profession and its values' (2007, p. 22). However, it is not just practitioners and service users who are concerned with outcomes in social work practice but *a range of people* who may include academics/educators, policy makers, politicians, the wider population, and a variety of professionals including health, education, criminal justice and social care, to name but a few.

3.2 What should practitioners do when receiving a referral?

Professional social work occurs within a 'particular social context' (Dominelli, 2004, p. 6). It is guided by a variety of factors including legislation, policy, cultural practice and the social worker's own professional knowledge. Therefore it is the combination of these broad factors, joined together in the actions of the social worker in practice, that represent the 'system'. Although by no means an exhaustive list, Table 3.1 below shows various factors which influence the work of practitioners in practice.

Table 3.1 Factors influencing social work practitioners

Legislation	*Children Act (1989)* *Children and Adoption Act (2004)*
Policy	*Every Child Matters (2004)* *Working Together to Safeguard Children (2006 and 2010)* *Framework for the Assessment of Children in Need (2000)*
Cultural practice	*Expectations of what is acceptable e.g. smacking*
Professional knowledge	*The knowledge of the social worker from their training, professional and life experiences. As well as that of their manager and those above them within the hierarchy.*

> *It is the general duty of every local authority (a) to safeguard and promote the welfare of children within their area who are in need, and (b) so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.*
>
> *Children Act* (1989), Section 17(1)

As this extract shows, the Local Authority (the statutory organisation) has a 'duty' to safeguard children and to provide services. The Children Act 1989 also sets out a definition of what constitutes a 'child in need':

> *A child shall be taken to be in need if – a. he is unlikely to achieve or maintain or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority … b. his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or c. he is disabled, And "family" in relation to such a child, includes any person who has parental responsibility for the child and any other person with whom he has been living.*
>
> *Children Act* (1989), Section 17(10)

Therefore each Local Authority has a responsibility to support children who are identified as being in need. The legislation, however, does not explain how this should be done by the practitioners, which is where each Local Authority must then follow recommended policy guidelines. Children can be identified as 'in need' if they are, or are likely to, suffer significant harm (DoH, 2000, p. 7), and the *Framework for the Assessment of Children in Need* (FACN) document emphasises that the assessment should 'concentrate on the harm that has occurred or is likely to occur to the child' and, after this is completed, what action should be 'taken to safeguard and promote the child's welfare' (DoH, 2000, p. 8). One aspect that is suggested as important for this work is that the assessment should be grounded in evidence – up-to-date knowledge, research and guidance.

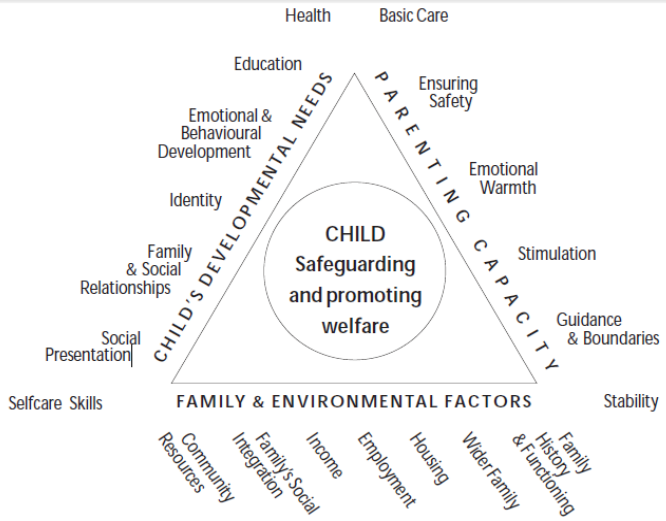

Figure 3.1 The Assessment Framework, DoH, 2000, p. 17

Overall the assessment process sees the child as being part of a system and focuses on three main areas that impact on the child – the child's development needs, parenting capacity of the child's parents, and family and environmental factors (see Figure 3.2 above). The focus on parental capacity demonstrates the change in focus with neo-liberal policies in which parents are judged not on their needs but on their capacity to parent their child effectively (Featherstone et al. 2012). Langan (1996) referred to this shift as the 'diligent pursuit' (p.xv) of the clues of abuse and that the thresholds for involvement act in essence as a legitimate means in which resources could be rationed. This refocused working with families in the investigation of abuse rather than the support of families in need.

The Framework itself is a **'**conceptual map which can be used to understand what is happening to all children in whatever circumstances they may be growing up' (DoH, 2000, p. 26). However, it is acknowledged that there will be some children who have more specialised needs, who will not fit into this generic assessment and will need a more specialist one. The process of the assessment should be as follows:

- *acquisition of information;*
- *exploring facts and feelings;*

- *giving meaning to the situation which distinguishes the child and family's understanding and feelings from those of the professionals;*
- *reaching an understanding of what is happening, problems, strengths and difficulties, and the impact on the child (with the family wherever possible);*
- *drawing up an analysis of the needs of the child and parenting capacity within their family and community context as a basis for formulating a plan.*

DoH, 2000, p. 29

There is an emphasis here on the importance of how referrals are dealt with and an acknowledgement that this can influence greatly the way in which the work will continue in relation to this referral and any subsequent ones with the same family. Research by Thorpe and Bilson (1998) suggested that if were referrals were initially identified as in need rather than as child protection then this could influence the way in which the work with families progressed. In need suggests a more family and preventative focus rather the more punitive focus of child protection. The guidelines state that a decision about what to do in relation to the referral must be made within one working day therefore decisions are made quickly. If the referral information suggests the child is suffering or is likely to suffer immediate significant harm them a Strategy Meeting must take place in order for professionals involved with the child to get together, share information and agree a course of action. If an initial assessment needs to be completed then the outcome of that must be determined within seven working days (DoH, 2000, p. 31). An initial assessment is needed if the Local Authority feels they need more information before a decision can be made in relation to the referral information and the initial investigation. It is therefore likely for situations that appear complicated that an initial assessment will be conducted. This assessment is then completed by speaking to other people in the child's life to gather more information, such as their family members and other professionals. Most importantly the assessment requires that the social worker speak to the child themselves so their views can be ascertained. It also involves the social worker's observation of the child and their relationship with family members in order to make a professional judgement. After this initial assessment, if the social worker, in agreement with their manager, feels that more information is needed then a Core Assessment may be conducted. This is similar to the initial assessment but is more in-depth so that specific areas of concern can be focused on. It also gives the social worker

more time (35 working days) so that they can observe the family and meet with the child a number of times to gather a more holistic view of the child and their life and needs (DoH, 2000, p. 32).

Whilst the Assessment Framework does refer to the needs of more specialised cases, it does so in reference to bringing in other professionals, for example in relation to assessment of attachment. However, there is no specific reference to children who display SHB until 2006 when *Working Together to Safeguard Children* was published (DoH). This document (along with *Every Child Matters,* 2004) emphasises the importance of understanding, and being clear about, the purpose of the assessment and possible outcomes. The 2006 version was the first document to officially recognise that children who display SHB were both in need *and* a potential risk. This document therefore confirmed that these children were classified, and so should be treated, as *children in need* and therefore require a Section 17 Child in Need Assessment (*Children Act, 19*89). In 2010 this policy was updated and gave more detailed information about children who display SHB and what their needs may be. There is emphasis in this new document on appropriate training being needed and on the need for staff not to dismiss concerning behaviour as just 'normal' (DoH, 2010, p. 302). There is also recognition of the complexities of the backgrounds of children displaying SHB, and the dangers posed by focusing on them having been sexually abused themselves. Holland (2011) however refers to assessments as assessing the '[r]isk to children' (p.31). By this she refers to the risks posed to the children by people or the environment around them, rather than the risks of the children themselves. Guidelines such as these are for generic social work practitioners and do not detail the complexity of dealing with children with more specialist needs.

In terms of how the government recommends these children should be dealt with, the 2010 version recommends:

- *there should be a co-ordinated multi-agency approach including youth justice (where appropriate), CSCS, education (including educational psychology) and health (including child and adolescent mental health) agencies and police;*
- *the needs of children and young people who abuse others should be considered separately from the needs of their victims;*

- *a multi-agency assessment should be carried out in each case, appreciating that these children may have considerable unmet developmental needs, as well as specific needs arising from their behaviour.*

DoH, 2010, p. 303

While these new guidelines are more detailed, they still leave actual implementation at Local Agency level to the Local Safeguarding Children boards, and do not recognise the potential significance of the individual perception of practitioners as to what constitutes sexualised behaviour that is not 'normal'. As suggested earlier in the literature review (see section 2.3, p. 10), there is little agreement as to what sexualised behaviour is harmful. Therefore, as no specific guidelines are given, the decision regarding this is left to the social work practitioner's (and their manager's) perception or interpretation of the behaviour.

The previous 2006 version recognised that parents/carers needed help in safeguarding the child and promoting their welfare, but this has now been removed from the 2010 version. While there were no specific suggestions made for providing parents/carers with support or therapy in their own right in the 2006 version, there was at least some recognition of their involvement. It is not clear why this was removed when it is possible that if parents are struggling with emotional difficulties themselves this could impact on their ability to focus on safeguarding the child. While there are clearly more specific recommendations concerning how to deal with this group of children in the 2010 version, there is still no real national approach to dealing with this group and the specifics are left to Local Safeguarding Children Boards and individual practitioners (McGarvey and Peyton, 1999, p. 90). These guidelines do confirm that practitioners should effectively treat these children like any other child in need, but do practitioners know this? Are they aware that a child who is an alleged perpetrator of SHB is also a child in need? Thorpe and Bilson (1998) raised concern that when social work practitioners focus on investigation then often the welfare focus on needs in lost. With this particularly complex group of children there is a need for specific guidance on how to identify these needs. While there is an acknowledgement from the government and Local Safeguarding Children Boards that guidelines are needed for dealing with these children, they are not detailed, and specific information is not set out for working with this

particular group of parents. The specifics are left completely open to the decisions of each Local Authority, so it is difficult to see how consistency will be applied.

The Munro Review of Child Protection: Interim Report (2010b) however suggests that assessments are more complex than this and need to allow greater flexibility for practitioners when assessing the needs of children (2010b). These assessments should also 'provide the practitioner with the information they need to make a judgement about helpful and safe next steps' (Munro, 2010b, p. 31). She goes on to explain that children are a key source of information about their own lives and so practitioners should ensure they spend time alone with these children. However just spending time with them is not enough – what is imperative is in the practitioner's ability to communicate effectively with the child. Practitioners need specialist skills and knowledge in order to do this with children of all ages, with different experiences, different needs, different temperaments, and different emotional responses. Is it realistic however to expect practitioners to have the necessary skills at all these levels if they are working within a generic child protection environment and do not know what situation they may be encountering? Can they be expected to know (wither intuitively or through training) how to communicate effectively with a specific group of children who display SHB?

3.2a Referrals relating to children who display SHB

As already indicated, according to the policy guidance it was only in 2006 that reference was made to children who display SHB as being children in need and requiring an assessment. However research in this area is relatively new (the last twenty five years). In 1992 NCH *Action for Children* commissioned research concerning children who display SHB – their report expressed concern about a number of issues where improvements needed to be made:

- *denial and minimisation, i.e. not enough acknowledgement in policy of children who display SHB as an issue;*
- *varying terminology that was used to describe this group;*
- *various ways in which SHB was defined;*

- *the notion that these young people were different from those with other behavioural difficulties;*
- *how these children were managed through safeguarding procedures;*
- *the lack of consistent approach from professionals;*
- *what assessments, intervention and treatment was provided;*
- *the continuum of services available; and*
- *the training and supervision of professionals.*

NCH, 1992

Following this Hackett and Masson (2003) reported on a two year research project to determine what may have changed since this first study. They found that, while there had been some developments in the field since this initial study, some issues remained concerning. For example they talked of a raised profile in government policy guidelines in relation to children who display SHB, but there remained confusion and a lack of consensus regarding the terminology that should be used. In reference to the NCH (1992) report, Hackett and Masson (2003) state time was spent 'discussing what terminology to use to describe the population they were studying' (p. 112). Ten years on, this uncertainty remained. The authors also found that authorities needed to *dovetail* their management of young people who encountered the criminal justice system as well as the children's safeguarding. They found there was a more consistent approach when agencies joined together to set procedures for practice, but that training and support remained a problem with only 19% reporting it as *fully adequate* (p. 119). Therefore whilst the authors found some improvements in understanding of this area, there were still inconsistencies in how children who display SHB were being responded to, including differences in assessment tools used – some generic to all children, some specific to sexualised behaviour.

In 2006 Erooga and Masson suggested that, as a group, these children were now 'firmly established within the professional community... as a problem which requires a response' (2006, p. 3). However the work by Butler and Elliott (2006), Erooga and Masson (2006), Hackett and Masson (2003) and Hackett *et al.* (2005) all looked at the responses of *specialist* practitioners who work directly with these children and who are already aware of the issue

and are addressing how to deal with this heterogeneous group, rather than frontline general practitioners. Therefore the practitioners involved in their research already knew about this group of children and had existing knowledge about some to the difficulties in recognising the behaviour and how to support them. Practitioners in CSCS who deal with all types of referrals regarding children in need may not have this knowledge. As previously suggested they are offered a one-day training course on how to recognise SHB but are not given information regarding indications of SHB. Therefore they have no choice but to fit these children in with existing processes. Erooga and Masson found that 'in some local areas, at least, there was considerable inconsistency as regards when formal meetings such as child protection conferences or multi-agency meetings or their equivalents might be convened to consider the needs and risks presented by a child or young person alleged to have sexually abused someone' (2006, p. 16). After considering the various assessment frameworks that are used by social work practitioners, e.g. *Framework for the Assessment of Children in Need* (FACN) which is not a specialist assessment tool that can be used for these children, they concluded that local assessment services were largely inadequate.

Before the assessment stage, consideration needs to be given to how the decision of the social worker and their team manager is made as to whether a referral requires further investigation. There is a complexity when dealing with referrals in relation to SHB, particularly for children aged 10 or over, due to the divergent philosophies of the safeguarding system and the youth justice system. In England, Northern Ireland and Wales the age of criminal responsibility is 10 and in Scotland it is 8 (Masson, 2006, p. 19). Therefore these children have what Masson (2006) refers to as 'dual status' in that they are both in need of care and support as well as in need of some sort of control. It is this confusing 'dual status' that can lead to an inconsistent and confusing response at the local level in relation to safeguarding. Grant (2006) emphasises the importance of understanding the purpose of the assessment in order for it to work correctly and Holland (2011) suggests it is important to question whether the social worker is 'making some kind of informed or professional judgement' (p.48)?. So in using a generic assessment tool is it possible to ensure that the needs of children who display SHB are recognised? Is it possible for practitioners to understand that they need to both assess to safeguard and to assess risk? Legislation requires that all children are protected from abuse and subject to criminal justice

(*UN Convention on the Rights of the Child*, 1989). But how does this work with children who encounter both the criminal justice system and the social work system at the same time? Is there a difference in outcomes for these children as well as in terms of assessment? The difficulty here, as already indicated, is in the differing philosophies of these two systems which can make it harder to recognise what the needs of the child actually are. Masson suggests that, as SHB is related to 'developmental, relationship and familial problems', there is a need for both safeguarding and protection – the children displaying SHB are both at risk and a risk (2006, p. 25). However, while issues of risk will naturally occur for children over the age of ten because of possible youth justice involvement, the generic assessment does not comfortably recognise the issues of risk in relation to children under that age. Also, if the child is over the age of ten, it is possible that too much emphasis will be given to the risks rather than safeguarding because of the involvement of youth justice professionals whose focus is on the offence, as 'practitioners interact with... criminal justice practitioners who may not hold similar views on criminal justice perspectives' (Patterson, 2012 p. 11). There can be more of a focus on justice and imprisonment rather than therapy and rehabilitation (which should be the focus of a safeguarding system). This emphasises the different perspectives and why it is important for practitioners to understand that their focus and responsibilities are different from that of the criminal justice system. Practitioners can 'advocate for services to enhance well-being and social functioning' rather than focus on justice and punishment (Patterson, 2012, p. 19). In addition, Munro found that when risk assessments were completed in general by practitioners, they were flawed in either over- or under-estimating the risks involved. She found that they were not realistic, and often reflected public views rather than sound professional judgement (Munro, 2011).

It is difficult for practitioners because of the aforementioned lack of a national strategy for dealing in a *specialist* way with referrals relating to children who display SHB. Munro found that children's needs are varied and therefore the system of child protection needs to mirror this by responding in varied but appropriate ways (2011). In 2000 however the Youth Justice Board decided to 'develop a consistent and effective inter-agency assessment and treatment response' and 'holistic framework' for children who display SHB – the AIM assessment (Assessment Intervention Moving on) (Morrison and Henniker, 2006, pp. 32–3). An assessment was devised that should be used to complete a specialist assessment after

the referral and investigation or after the Child Protection conference or Multi-agency strategy meeting. They therefore saw that initially work would be completed with these children within the general system before practitioners would recognise the need for a more specialist assessment in relation to SHB (in line with government policy). Whilst this strategy was developed nationally with the intention of it being used nationally for a consistent approach to this particular group of children, it is not evident that this has in fact happened. How do practitioners know that this specialist assessment is available for them to use in relation to this issue? The Local Safeguarding Children Boards Regulations (2006) created Local Safeguarding Children Boards which existed to develop 'policies and procedures for safeguarding and promoting the welfare of children in the area of the authority' (DfES, p. 2). Therefore practitioners have accesses to their guidance, but due to paper saving, currently a common practice in many Local Authorities, these documents are only available on the Board's website. In order to be able to search for the appropriate document practitioners must know the correct (or, more appropriately, current) terminology for the behaviour of these children. While the term 'sexually harmful behaviour' has been used in this study as a general term relating to all children, Morrison and Henniker (2006) use the term 'problematic sexual behaviour' for children under the age of 10 (p. 38). But a search using that term on the Local Safeguarding Children Board for the Local Authority involved in this study will not lead to any results. The term they have used is 'sexually harmful behaviour', and therefore *only* using this term (or a derivative of it) will bring up the procedural document for practitioners.

The guidelines provided by the Local Authority involved in this study state that the process for dealing with children displaying SHB is directed in the same way as other safeguarding children referrals (Local Regional Inter-agency Procedures Project, 2005). The document as a whole is clear that these procedures must include the alleged perpetrator as well as the victim, but the initial flow chart is not clear about this. It therefore requires social work practitioners to read the whole document in order to understand this fundamental approach. Practitioners tend to access guidance when they encounter a situation they have not dealt with before – so one would presume that if they encountered a case of a child displaying SHB, and this was new to them, they would seek out relevant guidance. However this also presumes that they recognise the behaviour that they are viewing as SHB, and that

they understand that the alleged perpetrator should be considered as a child in need in their own right. But the reality of the situation is that they are more likely to look at the situation first from the point of view of the alleged victim who is more easily identified as a child in need and will begin to assess their needs – to do this they will use normal safeguarding procedures and so will not be looking at other guidance. Therefore the likelihood of them looking for the appropriate guidance is reduced.

The document from the Local Authority also makes reference to giving support to families as well, but as with the Department of Health Guidelines (2006, although no longer in the 2010 version) no indication is given as to what support this could be. Nor does the document contain indications of when sexualised behaviour should be considered abusive behaviour. Munro suggests that information needs to provided at local level to help support policy makers and practitioners in their 'value judgements' (Munro, 2010a, p. 23). Considering the complexity of this area of social work, social work practitioners might find it useful if more clear information was given about, for example, possible agencies that could help, or specific advice that could be given to families, along with information about how to recognise behaviour that is concerning so they know when to take action and what action to take. Part of this, as suggested by Munro, would be through reflective supervision with their team manager (2011, p. 37). She does not suggest that intuition or value judgements are necessarily inappropriate in themselves but that they should be challenged and become 'guided judgement' (2010a, pp. 31).

3.3 Munro Review of Child Protection (MRCP)

Whilst reference has already been made to some of the MRCP reports, the context in which they were commissioned and detailed information from the reports is relevant to this research.

In August 2007, a child initially known as 'Baby P' (Peter Connelly) died having sustained a high number of injuries from his mother, her partner and lodger while he was known to CSCS and on the 'at risk' register (as it was referred to at the time). On 12 March 2009 Lord Laming published a report which he was commissioned to complete following this child's

death amid concerns that the internal serious case review report completed by the Local Authority concerned was not sufficient (Ahmed, 2010). Part of Laming's recommendations included the setting up of a social work task force in order to implement and review his findings. Following this, on 10 June 2010 Eileen Munro was commissioned by the government's Education Secretary Michael Gove to build on the work of Lord Laming's report and to suggest reforms so practitioners can be 'in a better position to make well-informed decisions' and be 'free from unnecessary bureaucracy and regulation' (Gove, 2010, p. 1). In effect, the intention was to 'conduct a review of the system, with a focus on strengthening the social work profession' (MRCP).

Munro's reports began by establishing the need to look at the whole process of child protection rather than just individual parts in order to consider how they all interact and work together in providing services. Her initial findings raised concerns about the 'poor design' in parts of the system which made it less likely to function effectively and for the service to be of a high quality, and that the current guidance documents are too long and overly prescriptive (2010a and 2011). In essence this was the result of the high number of guidance documents produced by various governments since the LASSA (1970), as well as changes in the governing bodies of CSCS. Whilst Munro suggests that the intention of each of these policies taken individually was good, the result was them being placed one on top of another (a cumulative effect) leaving practitioners in a state of confusion as to how to follow all the guidance. She refers to these developments as becoming a compliance system, becoming too focused on case management, with children becoming invisible to professionals (Munro, 2010a, p. 12). That practice has become constrained and even 'stifled' by statutory requirements to produce statistics as evidence of meeting targets (2010b). She suggests that what has been lost is the essential nature of social work practice – that of a 'social' and complex activity of the human occupation, needing a socio-technical approach (2010b). In other words, the primary focus of social work being on the individuals involved and how they work together has been obscured by bureaucracy. She is not suggesting that compliance or use of technical support (rational-technical approach) is not necessary but that it should be secondary to the work with individual people, and that there has been insufficient focus in recent years to 'how they influence what workers do' (Munro, 2010a, p. 16). This is further supported by Featherstone et al. (2012) who refer to how the neo-

liberalist focus has led to practitioners being 'constrained by an increasingly conditional and behavioural focused approach to family work' (p.624). A prime example of this is in the implementation of the Integrated Children's System (ICS).

3.3a Integrated Children's System (ICS)

When implementing government policies practitioners are required to responsibly document the work they complete with these families via a computer program. Wastell and White (2014) suggest that there has been (and remains) a focus and increasing shift towards conformance and standardisation and specifically through the use of electronic documentation within professional practice. The Integrated Children's System was set up in 2007 and 'provided a framework for the development of electronic recording systems for CSCS in accordance with the assessment framework and other guidance and regulation' (DoE, 2011, website). The system was set up to mirror the referral, assessment, planning and monitoring process for practitioners working with families. However, a review by Bell *et al.* in 2007 found serious flaws in the system. Practitioners and their managers found it too prescriptive, long, repetitive and focused on tick boxes. The complex needs of specific children could not easily be slotted into the system, and it was not clear in the system where risk assessments should be completed.

Practitioners perceived that their role had changed to that of an office-based worker rather than being out in the field and actually spending time with children and their families. The authors also found that whilst some information might be easy to find (e.g. the date of referral), other information often appeared to be missing (e.g. the reason for the referral) (p. 9). They also found some sections completely blank and '[r]ecording practice was variable as there were differences between social worker and work groups in the ways in which they entered the data' (p. 9). Further concerns were raised about the actual content of the recording and the way it was written, being descriptive rather than analytical. It was not easy to get a 'holistic' view of a child and their family because of the way the system was segmented and therefore it was difficult to see the route the child took through the social work process. Overall questions were raised as to whether this electronic system was in fact fit for purpose and, as Dominelli suggests, social work is 'locality-driven' therefore

does not function so well within such a prescriptive system (2004, p. 15). Generally the authors felt that the system needed to be more flexible and user-group specific. Initially it was mandatory to use this system but these regulations were relaxed in 2010 following the Munro report. She recommended that the systems be flexible so they could be adapted to different family situations with ease, and that this system should be kept clear of information for management reporting so that it did not affect the flow of the recording in the human-based system. She recognised that technology was still important but that it should support and not obscure social work decision making (Munro, 2010a, p. 31). The focus of the system must be on the child and the family and how to record their progress, not for gathering statistics as it is currently, according to Munro, who describes it as a 'very poor tool' making it difficult to 'see the child' (2010b, p. 59).

While statistics could be used to demonstrate that performance targets are being reached this should not be confused with demonstrating how well the system actually works in terms of sustained positive outcomes for children and their families. So although ICS was brought in with the purpose of aiding the assessment process, practitioners have argued that it has in fact hindered this process (Munro, 2010). This is something also found by Lord Laming in his 2009 report following the death of Peter Connelly. The important aspects of social work practice, i.e. the needs of the child, have been obscured by practitioners' adherence to standardised procedures rather than allowing them to be reflective and adaptive to each individual case (Munro, 2010a, pp. 31 and 37).

3.4 Joint Inspection Report (2013)

Towards the end of this research, in February 2013, a Joint Inspection Report was published titled *Examining Multi-Agency Response to Children and Young People who Sexually Offend*. Six Youth Offending Teams (YOTs) were visited, and 24 cases were examined in depth. Each child's journey was followed from the initial disclosure of the sexual offence to community supervision. The children in this study were those who committed sexual offences, some of which were against other children. As the research focused on YOTs the children in this study were those who were convicted of criminal offences. The inspection focused on the

'quality' of work undertaken with these children, including how agencies and professionals worked together and how the child was responded to.

Regarding assessments, they found limited examples of holistic, shared assessments among professionals. Reasons or triggers for the sexualised behaviour were not fully explored in the assessment documentation. One social worker reported to the committee '"We didn't consider it to be necessary to look deeply into the sexualised behaviour in our assessment"', instead they referred to this not being part of their remit (p. 26). A positive finding was that children and young people were involved and consulted during the assessment process and were aware of the roles and responsibilities of the various workers. In terms of joint planning, they found this became more evident where a formal process was being followed, such as child protection. However more detailed assessments, specifically in relation to the sexualised behaviour, were not completed until post-sentencing. There was a lack of these specialised assessments being completed pre-sentencing if the behaviour was denied. If an allegation was denied, they found workers were unclear what action to then take. Workers appeared to be confused about how this impacted on their remit in terms of protection. If the allegation was denied, what was there to protect?

The report's findings showed that the needs of this particular group of children were complex but that with support they could achieve a positive outcome. The rate of recidivism in the 26 cases examined was only 1 – indicative of the findings of Hackett and Masson (2003) that the vast majority of children who sexually offend do not go on to become adult sex offenders. However they did find that almost half of the cases they evaluated showed evidence of previous concerning sexual behaviour from the child that had not been identified as concerning at the time of the referral. Opportunities were missed for earlier intervention as concerns were either not understood, or not acted upon (p. 20). A particular area where some of these concerns were missed was in education environments. The question was not asked as to *why* the child was displaying SHB. They highlighted the possibility that the social workers, to whom referrals were made, may not have been appropriately trained in order to recognise the behaviour as potentially problematic.

The authors of the report expressed 'surprise' that, considering the complexities of the home environment of many of these children, s47 (CA(1989)) enquiries were not initiated except in relation to possible reprisals against the alleged perpetrator (p. 23). They were also 'surprised' by the lack of further action following referrals and that the adherence to policies was not monitored. Also, that the strategic managers were 'surprised to hear about a lack of inter-agency work' (p. 23). They referred to 'a lack of clarity' concerning where these children were if the behaviour was denied. That is, what happened to these children after referral if the allegation was denied and there was no further intervention?

This report clearly identified areas where children who display SHB were not being responded to according to policy guidance, where their sexualised behaviour was not being assessed and where professionals appeared confused about their remit. The findings of this report have been considered in the Findings and Discussion sections of this thesis.

3.5 Social work intervention and the family context

Having set out the current research regarding children who display SHB and what is expected during the assessment process from practitioners, this section will look more specifically at social work intervention and the family context, i.e. how practitioners work with parents and carers in order to understand how they put the assessment process into practice.

3.5a The social work process

Payne uses the term 'process' as being 'an accepted way of doing things' which is complex, connected and time-based (2005a, p. 23). He refers to the act of social work practice as a *process*: the intervention with a child and their family is **one** activity which is interpreted as a single, individual and complete process, rather than a series of separate events. 'A social work process is one human event made up of elements' (Payne, 2005a, p. 29). In order for the process to occur there must be accepted ways of doing things so that it becomes a whole. He refers to the way in which narratives are used to connect seemingly unrelated matters together in people's minds. So in this case the social work intervention is in itself 'living' – it is alive and it exists, it is in the process of being. For this Payne draws on a

psychodynamic perspective incorporated with different aspects of systems theory in that the process consists of the person, the situation, the social experiences and how the person feels about those things (their narrative). The aim of this process is to 'achieve unity of purpose', to get different professionals to work together with the service user to a common theme (Payne, 2005a, p. 26). Therefore the actual social work process is what takes place between the social worker and the service user – to understand what is going on in that person's life and how the social worker can co-ordinate services to intervene and support them.

In order for social work to function successfully, the practitioners who engage with the service users at the beginning of the referral process should have the appropriate experience in order to deal with any situation that occurs. In reality this would mean they would not be expected to know about every possible eventuality for dealing with a referral, but they would know where to signpost to if they needed more specialist information or advice. So in referring to the 'social work system' response in this research, what this means is that practitioners are an *agent* of this response. What happens during the social work process is brought together by the social worker and service user.

What this shows is that practitioners are bound by legal, policy and organisational processes as well as their own experiences. Accordingly the social worker, who represents the state in the interaction, has a duty to safeguard children who display SHB as children in need in order to provide support. Based on the legislative, policy and organisational guidance this should mean that, when a referral is received in relation to SHB, the social worker initially discusses this with their team manager and makes a decision whether to investigate. They then decide whether the information they have is enough in order to make a decision or if they need more information. This may be through an initial assessment, as previously indicated. If they need more information then they may conduct an in-depth core assessment, or if the referral suggests immediate significant harm then a strategy meeting may be convened. This research will therefore look into the process that practitioners followed in relation to the referrals they received in relation to children displaying SHB only. The social work process is about the relationship and interaction between the social worker and the service user – it is about what actually *happens*.

3.5b Working with and involving parents and carers in the social work process

Where children and young people are accused of SHB towards another child, their parents' involvement in social work intervention tends to be at best 'limited to their involvement in intermittent planning meetings or reviews' (Hackett *et al.*, 2002, p. 150). At worst they have been 'held in suspicion' and 'blamed or directly excluded by some professionals' (Hackett *et al.*, 2002, p. 158–9). This suggests that, despite research to the contrary, professionals still look to parents sexually abusing their child as the reason behind the child's behaviour.

As Johnson *et al.* suggest, '[u]nless parents have directly sexually abused their children we do not hold them responsible' (2007, p. 103). This article by Johnson *et al.* (2007) emphasises the need to involve parents in the assessment process.

> *Parents and caregivers have extensive knowledge and information to share about their child's experiences and behaviour*
> *There are often changes that parents need to make in meeting their child's need*
> *They often play a key role in supporting their child and ensuring appropriate supervision*
>
> Johnson *et al.*, 2007, pp. 103–104

While their article was not based on an empirical study, it was based on their observations as practitioners working in the field. It confirms the need to completely involve parents, and that 'workers do need to acknowledge the centrality of parents in work … [and] do some work with parents first' (Calder, 2000a, p. 35). Ensuring that issues around insecure attachments (or any other environmental factors) are addressed can only be done successfully by developing a cooperative working relationship with parents – making sure they are treated fairly so that they can begin to understand how to help their child address their behaviour. Johnson *et al.* suggest that '[r]ecognising the potential impacts for parents and involving them in the work is essential' (2007, p. 104), as is allowing 'them the opportunity to raise issues on their own agenda, and deal with any feelings of anger, denial and confusion' according to Calder (2000a, p. 37). This suggests that these parents are

experiencing difficulties in their own right, so if those difficulties are not addressed how can they then focus on safeguarding their child? This is also something that should be considered when dealing with foster carers who care for a child displaying SHB. Because they are considered as professional carers there is a tendency to presume that foster carers can cope with whatever risk management is required for this child (as is expected of parents), but are practitioners being realistic about foster carers' ability to manage risk twenty four hours a day, seven days a week? It is very important that they understand and accept the reality of this, for parents and carers alike (professional or otherwise).

It can be difficult for parents in general to understand how their behaviour links to their children's. Many do not understand that, to take one example, domestic violence or disputes (or perhaps arguments as they see it) could have such an impact on a child that it could lead that child to display SHB. But if it is something not fully understood and still debated in the research, then how can parents be expected to understand it? This suggests that practitioners must be able to justify this to parents, but practising social work practitioners are not therapists, and more work needs to be completed with them so that they can understand the potential reasons behind SHB in order to work with parents more effectively. They also need more appropriate signposting so they can better identify appropriate support.

This research is therefore aimed at looking at how parents, carers and professionals experience the response of CSCS to SHB. Hackett (2001) suggests that parents (and carers) can feel:

like a failure as a parent
in shock and denial
guilt, shame and blame
isolation and stigma
loss and grief
confusion and uncertainty about sex – with regard to their child and in their own intimate relationship
totally overwhelmed
out of control and powerless especially with professionals

particularly concerned if the abuse has been perpetrated by one of their children against a sibling

in denial

depressed (suffer flashbacks)

a reoccurrence of their own sexual abuse

their relationship with their partner is strained – perhaps they have differing opinions or ways to deal with the situation

Hackett , 2001, pp. 109–12

It is clear that they experience issues of stigmatisation and isolation and that it is not an easy topic to discuss. Parents and carers could feel concerned about the information getting out among other people in their area, and 'some families are forced to move or go into hiding' (Hackett, 2001, p. 32). If parents are not properly supported and have unresolved feelings then (as already discussed) how can they effectively support a child when the intervention is over? And it's not just a matter of supporting that child, but supporting (and protecting) other siblings within the home, or other children who come into contact with the home. Parents' feelings must be acknowledged to ensure the welfare of the child and other children they encounter in the future. Hackett also observes that parents and carers are expected to:

provide details and/or historical information

support and encourage the child to participate in what is offered e.g. assessment and/or therapeutic intervention

ensure the child is living in safety

be alert

report concerns if there are further signs of abuse

keep in touch with professionals

And professionals are expected to:

give information to parents about what is happening at all points

explain everything clearly and allow parents to ask questions if they are unsure

not pressurise parents into agreeing with something that they are uncomfortable with

include parents so they can have a say in decisions

treat parents with respect

give parents an opportunity to give their views on their child and his/her behaviour

support parents with the job of being a parent of a child who has a sexual behaviour problem

Hackett, 2001, pp. 109–12

But do professionals feel able to do this effectively? Do they feel supported by their managers and appropriately trained to deal with this area of social work intervention?

3.6 User involvement in service provision

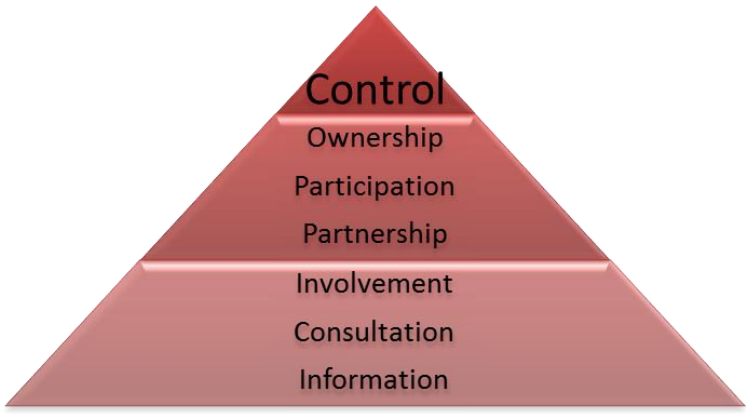

Figure 3.2 Continuum of Participation, adapted from Aldgate, 2007

Reference to NPM has been made earlier in this chapter and the complications caused by layering it on top of the pre-existing bureaucratic system in social work. However one aspect that was particularly welcomed was the involvement of service users in service provision – the view of service users as *customers*. As Aldgate suggests, '[s]ervice-user views are seen by government as a powerful component of shaping and evaluating... services' (2007, p. 200). Previously service users were seen as 'passive recipients' but this has changed to seeing them as 'customers', 'clients' and recently 'active citizens', leading to a greater choice and level of control for service users (Aldgate, 2007). Aldgate suggests a continuum

of participation, based on Arnstein's original ladder of participation. Figure 3.2 shows the different levels at which service users can be involved with service delivery from just receiving information to full control over the running of the service.

Despite user involvement being seen as critical in the development and planning of most services today, there remain difficulties. Research by the Joseph Rowntree Foundation found that service users in general felt their knowledge was devalued, their involvement was tokenistic, the organisations themselves were slow to accept their involvement, and limits to resources led to service users struggling to practically share their knowledge (Branfield and Beresford, 2006). Further to this, in reference to the 'sex offender' field, Hackett and Masson (2006) reported that user perspectives were underdeveloped.

D'Cruz and Jones, however, suggest that the purpose of all social work research is to 'find out what our clients think of our services' and 'change the ways in which things are done' (2004, p. 7). Orme and Shemmings, emphasise how the involvement of service users in social work research has become an 'important and distinctive theme' (2010, p. 25). This can also be applied to social work practitioners and foster carers, as Local Authorities follow government guidelines for service provision and believe they are doing so appropriately. But do social work practitioners actively know what is expected of them in relation to specific areas of social work practice? Do they feel supported and able to follow guidelines? And do foster carers feel they have been appropriately trained and are supported to manage risk? In 2006, Hackett and Masson completed a small-scale study of user perspectives involving young people who displayed SHB and their parents. In their research they distributed questionnaires, which were returned by ten sets of parents. The authors found that parents valued involvement with specialist service providers. This was referred to in particular, in contrast to their more negative experiences of general CSCS. Parents reported the importance of professionals being clear and open with them about timescales, for example waiting a year for specialist support was made worse because of lack of clarity about the situation. Parents also reported feeling that the intervention lasted too long, and there were also reports of how unhelpful it was when workers changed during the process leading to a lack of continuity for the family. One of the most difficult issues parents reported was the emotional pressure placed on them to actually accept the abuse that had happened.

Significantly, Hackett and Masson (2006) reported that seven of the parents in the study agreed that 'professionals should treat parents with more respect' (p. 191). Whilst this was a small-scale study the findings will be considered against the findings of this research study (see Chapter 7 – Interview Findings).

In previous research there has been some difficulty in finding as many fathers as mothers who are willing to participate (Deacon, 2007). Therefore more attempts will be made to get their participation – for example, where a mother has agreed to participate they will be asked directly if the father/partner would also be prepared to participate (see Chapter 5 – Methodology). In addition, for foster carers and social work practitioners the focus will be on whether they feel they understand what is required of them, whether they have been trained, and whether they know what qualifies as abuse in relation to SHB.

In previous unpublished research Deacon (2007) found that parents' views of the safeguarding children process were very negative, but their experience of it depended on their relationship with their social worker. This was not just about the actual personality of the social worker, as found by Holland (2000) and Spratt and Callan (2004), but about their *actions*. Parents perceived the relationship as positive if the social worker listened and responded to them. The practitioners involved in the 2007 study all talked of how they *intended* to do this with parents, but the reality for those parents was sometimes different (Deacon, 2007). This shows that the lived experience can be different to what is intended. But this also indicates that user-participation in evidence-based research is imperative for developing good practice guidelines. Without the views of parents it would have appeared that practitioners were doing everything they should be doing, yet the reality for parents was much different. Also, if practitioners were not able to give their views then it would not be clear whether the Local Authority's intentions were being put into practice. This research also showed a lack of inclusion for fathers at the safeguarding children initial conference and in the safeguarding children process in general. This 2007 research is taken further in this study to understand how CSCS documents its response to Children who display SHB and then in turn how this is experienced by parents, carers and practitioners – in doing so this will be presenting a *holistic* view of the response to SHB.

This study ties in with other research on user perspectives, where the key variables identified that what affects parents' experiences of social work intervention are 'a clear understanding as to the reasons for… visit', an understanding of the assessment process and the reason(s) for continuing visits (Spratt and Callan, 2004, p. 215). From their literature review Shemmings and Shemmings found that 'honesty, answerability… even-handedness… and sensitivity' were important from families' perspectives in the engagement with professionals (2001, p. 117). Holland found that the perceived personality of the parent by the professional was key in developing a good working relationship (2000, p. 152). Conversely, Spratt and Callan found that parents referred to the personality of the professional as key in developing a good relationship (2004, p. 217). These findings taken together suggest that the success of social work intervention can depend on the perceived personality of professionals and parents, and how well these gel together. Taking this further, because personality is individual and subjective, this study will look at how CSCS's response is affected by the perceptions of individual practitioners.

> *In the process of finding out what is happening to a child, it will be critical to develop a co-operative working relationship, so that parents or caregivers feel respected and informed.*
>
> Department of Health, 2000, p. 13

As this extract suggests, it is important for practitioners to develop a good working relationship with parents and carers. The emphasis here on working co-operatively is essential for safeguarding children. Therefore it is clear that user perspectives, both from the parents and carers and from the practitioners in this area, are very important to research, as the situation parents, professionals and young people find themselves in is very complex and time should be taken to develop best practice guidelines and service provision. It is within this context that this study is placed – to allow parents, carers and practitioners the opportunity to express their views and give examples of their lived experiences of the professional system. Through this information key themes will be identified that worked well, and those that did not work and how they might be changed. It is important to iterate that the views of children/young people are not being ignored in this research, but the focus

is on ensuring their needs are met through effective working between professionals and parents/carers.

It is clear that user perspectives are imperative in developing effective service provision and best practice guidelines. However, as with other areas of social work intervention, only limited work has been carried out in gathering these perspectives. This will be addressed by seeking the lived experiences of parents, carers and practitioners of the CSCS response to children who display SHB.

4 Implications for this Research Study

This literature review has highlighted a number of areas for further investigation. The NCH report (1992) suggested that practitioners should be able to make informed professional judgements to fully understand when the presenting sexualised behaviour is harmful so that appropriate action can be taken. There are a number of possible causal factors for children displaying SHB and therefore practitioners will need to assess each child as an individual. They will do this by following policy guidelines, by considering each child referred as a child in need and therefore conducting a Section 7 initial assessment in order to gather more information. Practitioners will need to work well with parents in order to complete this investigation as well as provide support for the child.

The literature review has highlighted a lack of research into how children who display SHB are responded to when they are first referred to CSCS. There are contradictions within this literature in terms of how these children should be viewed and then how they should be treated. On the one hand they should be recognised as children that share similar background and characteristics to any other child with behavioural difficulties and so a general assessment framework can be applied. On the other hand, they are individual and different in terms of their treatment needs so a one-size-fits-all approach cannot be used. Further to this, the recent CJJIR (2013) has highlighted a lack of consistency in the assessment of children who display SHB, missed opportunities for earlier intervention, confusion from social workers regarding their remit in relation to these children and how to understand if the behaviour was concerning or not.

Research into the causal factors, terminology and definition of SHB (e.g. by Erooga, Masson, Hackett) has been based on children who are being supported within specialist or clinical environments. In this sense they are those that are definitely confirmed as displaying SHB and are being supported by specialist practitioners, but what about when this has not been confirmed? Tying this with the findings of the Joint Inspection Report, what happens when children are referred to CSCS and are accused of SHB but this has not been confirmed at

that time? How do practitioners respond to this? How do they recognise this behaviour as being concerning? Do they implement a s7 initial assessment? How do they define the behaviour and how do they evidence decisions regarding intervention? If they do recognise the behaviour as concerning do they know about specialist assessments that can be used?

Taking on board the findings from the MRCP reports, the CJJIR, and focusing on a socio-technical approach, where people (the social work practitioners) and technical (policy) aspects become one (Payne, 2009a), social work practice should have a primary and secondary focus. The primary focus is on how the experience is viewed by the individuals concerned, and the secondary focus is on how practitioners have complied with guidance and procedures (2010a, 2010b, 2011). When considering this with the findings of Hackett and Masson (2006) concerning parents' experiences of the intervention by practitioners, this highlights the importance in considering how government reforms have impacted on social work practice and whether those reforms have aided or hindered them in their forming working relationships with families. These relationships are key when considering referrals in relation to children who display SHB because these children are both a risk and at risk, and therefore practitioners need to develop a working relationship in order to establish what support and safeguarding may be needed. It is necessary for practitioners to be both compassionate as well as open minded in order to both support and challenge, in effect Munro suggests that this relationship is the 'key contributor to effective helping' (2011, p. 35; 2010a, p. 17). To do this, Munro suggests practitioners need to have expertise in relationship skills, recognise the basis of their intuition when working with families, and use evidence to continually reflect through supervision in order to ensure the practitioner does not lose focus on important issues (Munro, 2011, pp. 88–95). This supervision should be focused on reflection rather than dominated by managerial need, as found by Munro (2011). As an example, in the Laming report (2009) practitioners were criticised for focusing on Peter Connelly's mother and accepting her explanations rather than remaining open minded and challenging those views. This was also a criticism of the practitioners' line manager who did not challenge this acceptance.

The following are the key areas in relation to social work practice as found in this literature review, and which will be taken into consideration in this study:

- Relationship skills of practitioners – their views of children who display SHB and their parents/carers
- Communication skills – practitioners communication with the children and whether they were seen alone during the referral and assessment process to ascertain their views
- Training offered to practitioners and whether they feel appropriately trained
- Supervision offered by line managers to practitioners during cases of children with SHB and whether that supervision involves reflection
- Do practitioners feel they had enough time to complete quality assessments?
- Do parents/carers feel they were listened to?
- Do parents/carers feel risk management required of them was realistic?

4.1 Research questions

Based on these further areas for investigation the following research questions have been developed:

1. How do CSCS deal with referrals of children who display SHB?
2. What are the reflections of social work practitioners on their practice in relation to working with these families?
3. What does a small group of users (parents and carers) say about how their cases were managed? How do parents/carers experience social work interventions?
4. What best practice recommendations can be developed to inform effective intervention by social work practitioners, and what appropriate training should be offered?

These questions are aimed at determining how the social work process responds to the *dual status* of children who display SHB and how this is experienced by parents, carers and social work practitioners. It is intended that through this research recommendations will be made for good practice guidelines for social work practitioners within the statutory sector and that generative mechanisms will be identified for further study (*see* Methodology).

4.2 Conclusion

While there is a growing literature around the subject of children who sexually harm, there is still very limited research around the parents of these children and how practitioners are trained and supported by CSCS. There is also limited research on potential typologies of young children who display SHB because they are below the age of criminal responsibility and therefore referral information about them does not tend to come out into the public domain. What has also been shown is that the causal factors of SHB are variable and not yet established, which can make it very difficult for parents and carers to accept or understand the behaviour, and for practitioners to assess the child. Also, in practice, guidelines are not clear on how social work practitioners can best support and assess these children and their families. Therefore the intention of this research is to assess the social work response to SHB and to consider this along with the lived experiences of parents, carers and social work practitioners in order to gain an understanding of the holistic reality of the process.

5 Methodology

This chapter will be divided into three sections. Firstly it will begin by setting out the way in which data was identified, followed by the issues and approach to analysis, and ending by justifying the methodological position of the research. The aim of this study is to identify working practice within Children's Social Care Services (CSCS) using in-depth data from a Local Authority (LA) in response to 'new policy initiatives' and 'an evaluation of practitioners' performance' (Dominelli, 2005, p. 223). To answer the research questions raised, qualitative research methods will be used, as the intention of this research is to 'enable [a] detailed exploration and understanding of' the social world and following a grounded theory method (Ritchie *et al.*, 2003, p. 78). Specifically, to develop an understanding of how CSCS responds to children who display SHB. To do so, different sources of data have been combined to show how CSCS responds and how this is then experienced by parents, carers and social work practitioners. The research methods used were mainly qualitative – combining document analysis (for the CSCS ICS response) and narrative interviewing (for the lived experience of the participants). Some quantitative methods were used in order to gather basic statistical data from ICS files such as age, gender etc. These are for interest only and cannot be considered as statistically significant as they are not a representative sample of the population (Williams, 2003).

This research study began in October 2007, with the first year consisting of researching for the literature review and methodology as well as determining the research questions and completing the university's ethical approval process. Documents were completed and sent in to the Durham University Ethics committee. These included two research ethics and risk assessment forms as well as copies of information sheets for participants, a consent form signed by the LA to be involved in the study, and a list of research areas for the interviews and electronic access. A Commissioning Manager was approached at the LA and she liaised with the Head of Service. A CRB check and Local Authority Social Services check was completed to enable the researcher to have access to ICS. Following this, they confirmed that ethical approval from the University's Ethics Committee was sufficient to conduct the

research at their LA (this was completed by August 2008). Access to the Therapeutic Service required information to be provided to their own Ethics Committee as they are part of a charity. They required similar information to the University but also required a copy of the research proposal for the PhD and confirmation of the intention of the research. The full ethical approval process was completed by December 2008.

In September 2008 the identification of cases began at the LA and the pilot study was completed by March 2009. Following six months of maternity leave the case file analysis was completed in November 2009 and interviews completed by March 2010. The LA involved in this study covered a mainly urban area in England with a population of approximately 200,000 (according to the 2011 National Census). They provided social care services for children in order to offer support and to safeguard. They consisted of three main children's safeguarding teams – a duty team for taking referrals, a long-term team to work with families on a longer term basis, and a looked-after team for working with children who were in long-term foster care or who would be going through the adoption process. The Therapeutic Service was run by a National Charity and they took on cases from any Local Authority in the local area (this covers eight counties). They had service-level agreements with three Local Authorities, but any other could refer children to this service at a cost of approximately £2000 per child for the intervention. They completed therapeutic work with children who displayed SHB, and with their families. This involved one-to-one work with the children themselves, and this was always conducted by one social worker with another in support so they could reflect on any issues raised. Safety plans were also completed and reports given to LA social workers. The work took place usually over a few months and they often requested that alleged perpetrators were not living in the same home as alleged victims during the time of the therapy due to the high risks of opening up emotions in the young person (Anon Charity Website, 2012).

This chapter is divided into three sections for clarity. Section 1 sets out the data collection exercise including: selection criteria, development of data collection tools, negotiating problems and piloting for all the data sets; and the challenges as well as the resolutions concerning ethical and methodological issues. Section 2 discusses: the pertinent issues for analysis; the concepts used (CiN response and Other response) and how were they

developed; and the parameters for the analysis. Finally Section 3 engages in a critical debate concerning methodological issues in general and then how these applied to the research.

5.1 Identification of data

In order to answer the research questions raised three different data sets were collected: 30 LA case files from the ICS, **Data Set 1 (ICS)**; eight semi-structured interviews with parents or carers, **Data Set 2 (P/C)**; and eleven semi-structured interviews with different professional levels of social work practitioners, **Data Set 3 (SWP).** Corbetta (2003) proposes that one of the first questions raised at the beginning of any research is how big the sample should be. In this thesis, the sample numbers were based on a combination of direction from previous research from the literature review, as well as practical elements suggested by O'Leary (2004) such as accessibility of data as well as time constraints.

5.1a Data Set 1 (ICS) – Local Authority (LA) case files

As discussed in the Literature Review, the Integrated Children's System was an electronic database framework designed by the government which LAs were required to use to set up their own electronic database for recording information on case files of children and their families (DfEs, 2011, website). As this was a framework, different LAs could have different ways in which they could adapt this database therefore only one English LA was approached to be involved in the study in order to have quality time to spend immersed in the field of frontline social work, to have access to a deep level of meaning for what this means for social workers, carers and/or parents (Patton, 2002). As suggested by Anthony Giddens, 'all social research is necessarily anthropological; it requires immersion in a form of life' (Blaikie 2007, p.163)

Referrals to CSCS are information received either from the general public or a professional where concerns are raised about the welfare of a child, and these come either in the form of information shared verbally or the completion of a 'Referral and Information' form by other professionals (DoH, 2000). In order to select 30 cases where a referral was made in relation to the SHB of a child, no discrimination was made between referrals where the SHB was proven or not as the focus of the research was on *how* the referral was responded to not

the actual outcome. In order to select cases 'purposive sampling' was used (Ritchie *et al.*, 2003, p. 78). Purposive sampling allows for participants to be 'selected to reflect particular features' of groups (Ritchie *et al.*, 2003, p. 78).

5.1a(i) Selection criteria

Selection criteria were prepared in order to determine which cases would be appropriate for the research, so each case had to meet the following requirements:

- The alleged perpetrator was under the age of 18 at the time of this accusation (the legal definition of a child, since this study is concerned with children).
- The behaviour referred to CSCS was that the child had displayed SHB either towards another child or their behaviour was viewed as a risk towards other children – the case may or may not have already been open to CSCS. (This was to see the way in which referrals in relation to SHB only were responded to.)
- The referral was made to CSCS within the last five years (to access current research).
- There may not have been any further action taken by CSCS. (This was because the focus of this research was on the response of CSCS whether this was followed up/proven/not.)

The electronic system used by the LA involved in this study did not have a specific referral category for SHB, only for 'sexual related issues/exploitation/abuse' which was used to cover any referral that related to sexual misconduct, but this presumed that an allegation of SHB triggered a referral event. Referrals for this Local Authority were normally made to their duty team, and when they received the referral they opened a 'contact record' on ICS, so anyone accessing the electronic files could see these contact records. The LA had an employee who was responsible for the electronic statistics and they provided two sources of information in order to identify referrals – (i) all the cases in the last two years where an *event* was logged for 'sexual related issues/exploitation/abuse', and (ii) all cases in the last five years where a child was registered/subject to a child protection plan for sexual abuse. (These were based on the availability of data within ICS.) The former (i) consisted of 515 cases and the latter (ii) 79 cases. Out of the 515 referrals (i), 52 met the criteria for inclusion

in this research; of those who had a child protection plan for sexual abuse (ii) only two cases met the criteria.

However, if a child's case was already open (i.e. they had a social worker already working with them) then the referral regarding SHB would go direct to the allocated social worker. These were usually based within the LA's long-term team (social workers who work with families on child in need, child protection or looked-after plans over a period of months or years) and because they did not normally deal with referrals this meant they did not always open a contact record for the referral. Instead they entered the information into an *activity* or *observation*, which were not differentiated from any other activities or observations logged onto the child's file. This presented a difficulty in identifying the referrals in relation to SHB for children who already had a social worker at the LA. To get round this all social workers in the LA were contacted directly to ask them if they had worked on any cases in the last five years involving SHB. If they had, they were requested to email the case ID. After contacting the social workers for their cases, thirteen cases were identified all of whom met the criteria for the research.

Table 5.1 below therefore shows the origins of the thirty cases that made up **Data Set 1 (ICS)**:

Table 5.1 Origins of 30 cases in Data Set 1

Details provided by social workers	***Contact records***	***Child protection plans for sexual abuse***
Cases 1 – 13	Cases 14 – 29	Case 30

All the cases that were raised by a social worker were used to increase the likelihood of being able to include those social workers in the interview data set (these became known as cases 1 – 13). This was justified because, as suggested by Cooper (2012), frontline practice in CSCS has a high turnover of staff therefore these 13 cases would be likely to still have the social worker available at the LA. There were two cases that met the criteria through the child protection plans – both these cases were used, one of which was also referred by a current social worker so was included in that figure. Due to the large number of contact

records that met the criteria, sixteen cases were randomly selected to be included from this group to make the number of cases up to 30. This figure is not a representative sample but a realistic figure based on the high volume of data each case file contained that would need to be analysed. These 30 social work cases accessed from this one LA were used to show each child's experiences journey through their involvement with CSCS, as well as provide some basic statistical information about those cases.

5.1a(ii) Finding cases of SHB in ICS

As indicated above, and discussed in section 3.2 (p. 27), in setting out how referrals regarding SHB were dealt with by CSCS the first difficulty encountered was in *finding* the cases. Further to the issue of the discrepancies in how referrals were made and documented, the LA did not flag cases of SHB within CSCS. It was not possible for to say 'I want to look at all cases of children displaying SHB in the last five years', set up a search in ICS and have the information brought together – nor was it possible to ask a member of the IT department to do this. As indicated, when a general referral was received for an open case this information was flagged on ICS and a 'contact record' was created. However, these have different categories such as neglect, physical abuse, sexual abuse and emotional abuse, and these categories were very broad and did not categorise more specific examples of abuse, such as SHB by children.

An alternative plan was needed in order to find relevant cases, so the problem was discussed with the liaison manager at the LA, and it was agreed that an 'information sheet' should be prepared about the research and arrange for it to be emailed to every social worker working with children at that Local Authority. The social workers were asked to respond about any cases they had worked on that were relevant to the research. There were limitations in using this approach, as the request did not get to social workers who were no longer working at the LA, and also any responses were dependent on the social workers actually contacting me themselves. Considering the high workloads of social workers it was anticipated that the response rate would not be high enough for the research – and, through this method, information was received concerning thirteen cases which were relevant. As this was not sufficient the IT department was contacted to see if there was any way to find cases relevant to the research.

There was no category for children who display SHB in ICS, so together with the IT employee two alternative ways were developed in which relevant cases could be found:

1. A list of all referrals in the last five years where it was categorised in CSCS as sexual related issues/exploitation/abuse.
2. All cases in the last five years where a child was registered for sexual abuse.

The problem with these categories was that they would also generate a very high number of cases that were *not* relevant to the research, and the only way to determine which were relevant would be to (1) read each referral and (2) complete a chronology for each case, i.e. all the activities, observations, reports etc. In order to enable access to this information the IT employee had to extract the filtered information from CSCS, and this took a long time to generate. Furthermore, because there were such a high number of referrals for this category (1) he was only able to provide this information for the last two years. This generated a list of 515 referrals, and each one had to be read to check it was relevant. Of these 515 referrals only 52 were applicable to the research.

This then led to a further encounter with how children who display SHB are invisible to CSCS. These referrals were made under the alleged victim's name, and 24 of the 52 relevant cases did not have enough details given about the alleged perpetrator, so it was not possible to find their case file. In some cases no information about the alleged perpetrator was given at all, and in others only a first name with no ICS ID number given. In the cases where full names *were* given, no ICS ID number was given at all except on one case. This presented a difficulty in finding out the details of the alleged perpetrator in each case and ensuring the correct file was accessed. There is a section in ICS where a list of relevant people can be given who are connected to the person whose file it is, however this section had only been completed for two of the cases. This act suggests missed opportunities for supporting these particular children. (This was also found by Harries et al. (2014) in their study over a sixteen year period.)

Of the cases where there was a registration for sexual abuse, ICS was accessed and a chronology prepare to more easily find documents that could indicate whether the case was

relevant to the research. This involved reading through conference reports, core assessments, observations, activities and referrals to see if any information indicated their relevance. To do this, contact records, conference reports, initial assessments and core assessments were read, as in theory these should give enough background information to show if there was anything relevant to SHB. Activities were also read where they were shown to be a statutory visit to a child in case this was in relation to SHB. What these difficulties showed again was how invisible SHB was to CSCS based on just how much had to be done and how creative I had to be in order to just *find* the cases. There were 79 cases accessed and only two cases were found to be relevant. So while significant difficulties were encountered in identifying children who display SHB within CSCS, it was possible to generate 30 cases that were relevant to the research. These have been used to show each child's journey through CSCS. Table 5.2 below sets out a brief summary of the information from the 30 cases.

Table 5.2 Brief summary of information from the 30 cases

Case	**Alleged behaviour**
Child1	Male (12) sexually assaulted his seven-year-old male cousin
Child2	Male (13) raped his twelve-year-old sister
Child3	Female (12) exposed herself to friends in the street and from her bedroom window
Child4	Male (11) 'sexually assaulted [his six-year-old sister] by touching' (Supervision record 10/2/10)
Child5	Male (10) sent a fellow pupil a love note and drawing on which he wrote 'let's have sex' and that later he 'aggressively pursued [a female pupil]'
Child6	Male (13) and friend sexually assaulted a fourteen-year-old girl (unknown to them) on the metro
Child7	Male (13) was accused by a twelve-year-old child in his foster placement of sexualised behaviour towards him
Child8	Male (12) sexually abused his five-year-old niece
Child9	Male (9) accused of sexually assaulting his four-year-old female cousin

Child10	Male (14) had sex with a twelve-year-old girl whom he had known for several years, she was under thirteen therefore not legally able to give consent
Child11	Male (11) sexually assaulted his seven-year-old sister
Child12	Male (14) was charged with possessing indecent images of children on his computer
Child13	Male (4) sexual touching of other children at nursery
Child14a	Female (3) 'masturbation' in front of others
Child14b	Male (7) sexual touching of sister (5)
Child15	Male (11) sexual assaulted five-year-old male neighbour
Child16	Female (8) was simulating sex with her seven-year-old sister, but said another eight-year-old child had shown her how to do it
Child17	Female (6) went into the bushes with a six-year-old boy and kissed him and said 'if you touch my fairy and I touch your will we can have long sex'
Child18	Male (14) sexually assaulted his older sister (15) and eight-year-old cousin
Child19	Female (3) rubbing her own genitals and her parents' and putting her hand down cousin's underwear
Child20	Male (11) videoed his eight-year-old niece pulling her trousers down, exposing her genital region, doing a short dance and waving her hand over her vagina
Child21	Female (3) found in nursery toilets with a male child – both were naked and Female was on top of male
Child22	Male (15) was found in possession of child pornography on his mobile phone
Child23	Male (12) was watching his sister (14) undress and the school were concerned re him attempting to masturbate at school
Child24	Male (8) is alleged to have touched another boy's (8) penis
Child25	Male (8) touched a female child (8) inappropriately and a male friend (7), child counter-accuses the male friend of touching his private parts 'loads of times'
Child26	Male (15) raped a thirteen-year-old girl
Child27	Male (7) has been 'sexually inappropriate' with a four-year-old neighbour and another child
Child28	Female child (8) used sexual language towards another female child
Child29	Male (7) 'inappropriately touched' a girl (9)
Child30	Male (11) sexually assaulted foster carer's six-year-old grandson

5.1a(iii) Development of Data Collection Tool (DCT) for Data Set 1 (ICS)

Hutton and Whyte (2006) developed a DCT to collect information in relation to children who display SHB from records held by the criminal justice system and therapeutic services in Scotland. This DCT was therefore used and the categories adapted in order to gather

information from ICS. The initial aim of this was to gather information systematically from the case files. This was necessary in order to begin to develop a journey for the children through their involvement with CSCS. However, as this tool was largely statistical it immediately had to be adapted to add sections to provide more detail where needed. This was then explored through a pilot study, discussed later.

5.1b Data Set 2 (P/C) – interviews with parents/carers

Criteria were also set for the meaning of 'parent' or 'carer' to ensure that only those with background knowledge of the child (in the parental role) were involved. The criteria set were as follows:

- biological/adoptive parent/s who cares for the child;
- any other relative who was caring for the child;
- foster carers who now have responsibility for caring for the child;
- non-biological step-parent who has cared for the child since the Local Authority referral of SHB and therefore participated or was aware of the professional intervention; or
- 'parent' who was caring for the child when the incidents occurred and was present during the intervention process.

5.1b(i) Selection criteria

Two different sources were used in order to identify parents/carers to take part in this research. (Reasons are discussed later in this chapter and in Chapter 7 – Interview Findings.) One set of parents/carers came from the LA but most from a local therapeutic intervention service. For parents/carers from the LA the criteria for inclusion were as follows:

- parent/s and/or carer/s where they were not charged/convicted with sexual abuse against the child or any other child in the household now or at any previous time. However, if only one parent/carer was charged/convicted of SHB towards their child then the other parent/carer would be interviewed. (It was important for the purposes of this research to separate out the issue of the sexual abuse by an adult being viewed as a possible cause for a child's SHB as influenced by the findings of Hackett (2004).)

As well as accessing participants for the interviews from the LA, ethical approval was also given to talk to parents whose children were involved in a local therapeutic intervention in relation to their SHB. These families were involved with CSCS over a long period of time and some had experience of different Local Authorities. The selection criteria for interview participants from the therapeutic service were:

- parents/s or carer/s of any child accessing the therapeutic service in relation to their child's SHB who had had involvement from CSCS in relation to this;
- foster carers who were now caring for the child but may not have been at the time of the alleged incident;
- parent/s or carer/s must not have been charged/convicted of sexual abuse against the child;
- the child must still be accessing therapeutic support at the time of referral to participate in the research. (This was in order to ensure safeguarding was available for parents' and carers' emotional wellbeing.)

By setting the criteria in this way the parents/carers involved would have experienced a range of intervention. For some this was an accusation made against their child where a referral was made to CSCS; for others it had gone much further, for example to a conviction and/or more extensive intervention, perhaps from a therapeutic service. In having this range of access it was possible to look at the range of responses by CSCS to SHB, from accusations to convictions and therapeutic intervention.

5.1b(ii) Interview participants

In order to understand how CSCS is experienced a number of people were interviewed who had encountered it in various different ways in relation to a child in their care who had displayed SHB. Initially parents and carers were approached through the 30 LA cases in the previous section as well as through a therapeutic service run by a charity for children who display SHB. The analysis of the 30 LA cases was completed in three phases of ten cases at a time, and so at the end each phase, the parents and carers were contacted, where contact details were available, and it was safe to do so. Approval was given by the Local Authority to

contact the parents and carers directly, and the cases could be still open or closed. As access to the ICS information was available it was possible for to see if there were any warnings about visiting or contacting families, for example if there was the risk of violence, so that I could safeguard myself. A decision was made not to contact any families where there was domestic violence confirmed and the perpetrator was still living in the family home due to issues of risk.

The positive response rate from the first twenty cases was only one out of twenty families therefore it was necessary to reconsider the ways to access parents/carers. The responses that were received from families were that they did not want to talk about their experiences again in relation to their child's SHB or their encounter with CSCS. It became clear that raising these issues again was distressing for some of the parents and carers therefore a sensitive decision was made not to contact more parents and carers in this way. Cassell and Symon emphasise the need for flexibility when conducting qualitative interviews and these needed to be considered in terms of the emotional needs of the participants and to ensure ethically that they were not harmed by the research (2004, p. 17).

The response rate from the parents and carers who were involved with a Charity therapeutic service was more positive and therefore a practical decision was made to continue to access parents through this charity. The parents and carers who were currently receiving support from this charity were not connected to the Local Authority from which the 30 cases were drawn. The charity's Ethics Committee required that the allocated worker pass on contact details to the researcher rather than the researcher contacting the parents and carers directly. D'Cruz and Jones confirm that it is a reality in social work research that gatekeepers will be encountered which may lead to difficulties in accessing participants (2004, p. 106). However due to the concerns raised in the research about the emotional wellbeing of participants it was felt appropriate that a worker be aware of the parents and carers involvement so if concerns were raised then this could be passed on to the worker. From the charity the following agreed to be interviewed: two mothers, one father, an adoptive mother and two foster carers. An adoptive mother who was accessing a therapeutic service in another part of the country became aware of this research and contacted me directly to offer to be interviewed. Because some of these parents and the

two foster carers were still accessing a therapeutic service for the child they were responsible for, it was possible to return to talk to them and discuss with them the other interviews and any preliminary findings – to get their input on the themes that were emerging from the research findings.

The main issue raised with them initially was about the lack of response encountered when trying to get parents to participate in the research. The initial intention was to use these participants from the charity as a focus group where they could share information with me and others about their experiences. However, only one mother was happy to participate in a group therefore it was not possible to do this. Issues were anticipated with parents not wanting to share with other parents due to the stigma attached to issues relating to sexual behaviour (Hackett, 2001). Most of the parents and carers who did participate were approached by a worker they were familiar with and in these instances many agreed to participate. They felt other parents might not want to participate because it would mean another person knew that CSCS was involved with their family, and as 2_Mother said 'I think if people know you have social services involved there is a stigma attached.' However, 3_Father did not have a negative view about being approached to be involved, as he felt that it would be beneficial to other children and that was what counted:

> *Because it is going to help social services and yourself in the future. Where it is going to be better for kids in the long run you are then able to get to real life experiences. So I am not really bothered. Because for the long-term future for other kids it is going to be more beneficial.*

He also felt that, while he and his wife were happy to talk, not all parents were, 'I think other parents may get more embarrassed about other people knowing'. 6_Adotpive Mother felt that she could understand this lack of response as there were times over the last few years when she thought 'if I ever see another professional again I'll get a gun and I'll shoot them!' She felt that there were so many professionals involved with her family and that more professionals knew about her private life than was necessary. She talked of how sometimes she had to agree to visits when she really did not want to have to talk about it. She described a 'complaint file' that she had made which she wanted to address and put the

complaints in but at this moment felt she could not do it as she was actually 'living it' so she did not have any more 'emotional energy' to go through it all again. She agreed to this interview as she felt this was an opportunity to be heard, but fully understood why some parents would not want to do that. These experiences are similar to those found by Hackett (2001) where parents/carers felt stigmatised and judged which means they did not want to talk about their experiences, that they felt powerless and out of control when it came to dealing with professionals.

Using these criteria, the following interviewees were identified and interviewed.

From the Local Authority [one interview]

- one grandmother and one step-grandfather

From the therapeutic service [six interviews]

- two mothers
- one father
- one adoptive mother
- two foster carers

From a professional contact [one interview]

- one adoptive mother

5.1b(iii) Development of interview schedule

The focus for this data set was to conduct in-depth semi-structured interviews using probing questions only, via a narrative interviewing method allowing the participants to tell the story of their experiences (*see* Appendix 7). *Narrative* means 'the ways in which people make and use stories to interpret their world' (Lawler, 2002, p. 242), to give an understanding of their experiences in their words. This is like 'a form of conversation which is an empowering way of interviewing participants, allowing them to tell their story, giving them expert status (Ritchie and Lewis, 2003, p. 138). Such qualitative methods, according to Patton, include in-depth, open-ended interviews, direct observation and written

documents. Actual qualitative data includes quotes, descriptions and extracts (2002, p. 10). Probing questions were prepared in order to ask for participants' perspectives on particular experiences. As few questions as possible were asked in order to allow participants to narrate their own stories. However, there is a danger in using narratives that the experiences are not relatable to others and therefore make it impossible to identify key themes. To counter this, at the end of each interview the list of probing questions were checked to ensure the participant had talked about each one – if they had not come up naturally by that point then additional questions were raised.

With parents/carers in particular there could be concerns regarding the emotional experience of the participants. As reported in the Literature Review, Hackett (2001) suggested that parents can feel likes failures or experience feelings of guilt, shame and blame for seemingly letting their children down. Therefore these issues had to be considered, both in developing the interviews to try to understand how and why these feelings are experienced by parents; but also in consideration of their feelings and how difficult talking about the events could be for them. The questions with parents/carers therefore focused immediately on their feelings and experiences of CSCS, and whether they felt supported. Participants were reassured they could stop the interview at any time if it was too distressing for them.

5.1c Data Set 3 (SWP) – interviews with social work practitioners in relation to the ICS case files

The term *social work practitioner* is used to refer to any social work professional employed by CSCS who would have worked in some way with a child who was referred in relation to SHB. These could be different levels of social workers, from those who were just recently qualified to those who were operating at a senior level, their team managers, or Independent Reviewing Officers who would be responsible for chairing any child protection conferences and/or looked-after child reviews.

5.1c(i) Selection criteria

In order to understand the professionals' experience of the realities of CSCS in practice, employees were contacted from the Local Authority who had been involved in one or more of the 30 LA cases analysed. These were only qualified social workers as ethical approval was not given to contact other professionals from other organisations such as Health and Education. However, as this research involved CSCS response to SHB, this primarily focuses on the work of those in CSCS. Referrals, however, tended to be made from other organisations therefore further research into the decisions made by them when they make a referral would be a useful further study. The only requirement for the involvement of social work practitioners was that they were still working for the Local Authority at the time of the research study so that they could be contacted. Cases were then randomly selected where this could be done.

Five social workers, one senior social worker, one independent reviewing officer and four social work team managers were interviewed. All the social workers and team managers were female and the senior social worker and IRO were both males. There was no intention here to choose candidates because of their gender as the cases were chosen randomly. According to Department of Health statistics at the time of this research, women accounted for 81% of social workers working at Local Authorities, which then dropped to 59.5% at area/service manager level (DoH, 2007). Of those interviewed in this study, the representation of females is therefore slightly higher rates than the statistics suggest. All the social work practitioners were White British, which is higher than the national average of 87% (DfES, 2011). However outside of London, the percentage of white British employees can be much higher. All the social work practitioners contacted agreed to participate in the study (100% response rate). When this was raised with them they said they felt confident that because the researcher was also a practising social worker, they felt more confident that their anonymity would be protected and so they could be honest about their experiences. The NMDSC (2012) found that there is a 9% turnover rate for social workers in CSCS and high levels of sickness with one fifth having ten or more days of per annum and 7% having 40 or more days off per annum. However a requirement for inclusion in this research was that the social worker still needed to be working at the Local Authority so they could be contacted.

The social work practitioners were accessed through the LA from where **Data Set 1 (ICS)** cases were taken and they met the following criteria:

- Social work practitioner was involved with a case in relation to SHB at some point after the initial referral for SHB up to the final outcome. (So they would have some first-hand knowledge of CSCS's response to the SHB.)
- Social work practitioner must still be working for this Local Authority, although not necessarily in the same role. (This was for practical reasons, to ensure that the social work practitioner concerned would be contactable if selected, to ask if they would be willing to participate.)

The social work practitioners were randomly selected from the **Data Set 1 (ICS)** where there was a social work practitioner who had been involved with at least one of the cases analysed from the Local Authority and who was still working there. It was possible to interview the following:

- five social workers
- one senior social worker
- one independent reviewing officer (who was also a senior social worker on one of the cases)
- four team managers.

5.1c(ii) Development of interview schedule

The focus for this data set was to conduct in-depth semi-structured interviews using probing questions only via a narrative interviewing method allowing the participants to tell the story of their experiences (*see* Appendix 7). These were prepared in a similar way to **Data Set 2 (P/C)** but the main difference was there was less focus on the emotional side (as the participants were not talking about their own children) and more focus instead on the case management apsects. In his research, Hackett (2001, pp. 109–12) made suggestions for what parents and professionals are expected to do in relation to children who display SHB, so these suggestions were used as a guide when developing the probing questions (see section 3.5 on Social work intervention and the family context) as well as Appendix 7 for a

copy of the probing questions prepared). For the social work practitioners, questions were also included that were raised during the analysis of **Data Set 1 (ICS)**. These were for clarification purposes, for example to ask a social work practitioner about the meaning behind what they had written in the files, or how they now reflect on the cases concerned.

5.1d Negotiating problems in the three data sets

The main difficulty in accessing information in order to identify cases that met the criterion for inclusion in **Data Set 1 (ICS)** in this research was in relation to negotiating ICS due to the volume of information and the lack of consistency in how and where information was recorded. When working with families in safeguarding children, social work practitioners are asked by the LA to record everything they do onto ICS. This meant recording when a conference took place, a home visit was completed, a telephone call was made or received, letters sent or received, to name but a few examples. This LA's ICS was also able to have PDF files uploaded to it so that letters or reports received from other professionals, for example, could be uploaded, or conference minutes and court reports added to the file. All of this information was recorded on the file of the child to whom it related and they each had a unique ID number. In families where there was more than one child the information was recorded on each child's electronic file individually. (This is discussed in more detail as part of the Findings.)

When the social work practitioners recorded information about the cases they were working on, they often did these as 'activities' or 'observations'. Activities are short pieces of information that have a maximum word limit, and observations have a much higher limit so that more information can be added. Because of the very low word limit for activities social workers appeared to ignore this and circumvent the limit by recording further information in a different part of the activity. Instead of record information in the first box only, as intended, sentences were often split across this box and the box meant for recording the 'outcome'. For example:

Date started: 23 Jan 2010
Telephone call from professional
Activity: Telephone call from HV to request
Date required: 23 Jan 2010

Date completed: 23 Jan 2010

Outcome: a copy of the previous conference report. She will complete a HV tomorrow.

Figure 5.1 ICS activity example

This is a theoretical example to show how social workers would sometimes record information in boxes. It also shows an example of the use of abbreviations – in this instance HV meant both 'health visitor' *and* 'home visit'. This particular example appeared often so that information could be fitted into the boxes within word limits. (The LA had a training day for social workers in recording skills and they advised against the use of abbreviations.)

In terms of **Data Set 2 (P/C),** there were difficulties in accessing enough parents/carers to participate in the interview stage of the research. As previously suggested, SHB is a taboo issue which is not easy for people to talk about. Whilst social work practitioners were willing to discuss their cases, it was a different issue for parents/carers discussing their child. Perhaps naively it was hoped that these interviews would offer parents/carers an opportunity to talk about their experiences and hopefully contribute to recommendations for change. However, this perhaps more reflects the views of a social work practitioner (as the researcher was during the study) rather than an independent researcher. Being the parent/carer of a child/young person accused of sexually abusing another child can be a hugely isolating experience and so methodological challenges were anticipated in negotiating access with these participants. However, due to the very low response rate, this meant that the experiences of parents/carers were weighted more towards those who

experienced more long-term involvement with CSCS rather than those who may have had short-term involvement.

Parents/carers who were accessed via the therapeutic service were first approached by their therapeutic worker before contact details were passed on. The response rate for these parents was 90%, with only one set of parents later deciding not to participate.

In terms of **Data Set 3 (SWP)** however, there were no difficulties in accessing those willing to talk about the cases of children with SHB with whom they had been involved – response rate was 100%.

5.1e Pilot study

> *It is always desirable, if at all possible, to conduct a pilot study... [as they have] a role in ensuring that the research instrument as a whole functions well.*
>
> Bryman, 2008, p. 247

Completing a pilot study can be particularly useful when employing grounded theory as an approach to analysis (discussed later). The pilot study involving the three data sets was aimed at testing and developing the different DCT and interview questions used, in order to look at the ordering of questions and how to cover all areas to answer the research questions. The focus for the interviews (Data Sets 2 and 3) was the way in which the probing questions were worded in order to encourage participants to open up and talk about their experiences. It was also an opportunity to assess the researcher's role as a practising social worker at the time of beginning the research and how this impacted on an ability to be an effective researcher (see section 5.1f(ii), The reflexive researcher, p. 75). A researcher can be considered part of the *research instrument as a whole* and therefore this pilot study allowed this to be considered and how this impacted on the research.

The first step was to analyse the first six cases in **Data Set 1 (ICS)** using the data collection tool (DCT) previously used by Hutton and Whyte (2006). (Only one of these six cases was then used in the main part of the study – Case 3, as discussed later in this section.)

5.1e(i) Findings

Once the appropriate data was entered into the DCT, charts were created to show specific statistical information. For example five out of six cases showed a male alleged perpetrator who was white British. In five of the cases, no assessment tools were used and in all six cases the alleged victim was known to the alleged perpetrator. The background abuse of the alleged perpetrator confirmed by the social worker was predominantly emotional abuse (in five cases) in the pilot study. The other common confirmed abuses identified (i.e. appearing in at least half of cases) were physical, neglect, parental separation and peer group difficulties. However, it is important to note that these findings were only based on six cases from the LA and therefore do not carry any statistical significance.

5.1e(ii) Reflections from pilot study for Data Set 1 (ICS)

The predominant theme in the pilot study was that of the male perpetrator, with only 17% being female. This corresponds with previous research, for example Hackett (2007), but this does raise the question whether this was because there genuinely are more alleged male perpetrators, or could there also be a possibility of lack of reporting of female perpetration? Or perhaps their 'abuse' is not always seen as such by the victim? In the case of the alleged victim, 38% of them were aged six, and in this pilot study the alleged perpetrator was always older. (See Chapter 6 – Journey Through CSCS with regard to the age difference between the alleged victim and alleged perpetrator.)

The social work practitioner's perception of the background abuse was very wide-ranging for each of the alleged perpetrators. However, it is significant to note that they all wrote about abuse of some kind – according to the recordings, none of the children were without a significantly disturbed background. 33% of cases already had involvement from CSCS and were not referred because of the incident of SHB – this happened later. Also, in 50% of cases a learning difficulty was confirmed, but it must be noted that by 'confirmed' this means confirmed by the social worker, and does not necessarily mean they had been subject to a specialist assessment.

5.1e(iii) Analysis of DCT Data Set 1 (ICS)

The main purpose of the pilot study was the assessment of how the DCT worked as a whole and not the specific findings, although the findings were considered as to whether they would assist in answering the research questions. Ethnographic Content Analysis (ECA) was used as devised by Altheide (1996) in order to analyse the data collected and to assess the use of the DCT. ECA requires the researcher to remain reflexive with their approach to data collection in this area, and to continually revise the DCT to reflect the findings. For example, when information in ICS concerning the SHB was less explicit the DCT was more difficult to use, particularly when considering Case 3. This case involved a child who demonstrated a variety of sexualised behaviour, and it was not possible to always establish the 'victim', for example she exposed herself at her bedroom window and there was no clear victim of this in the recordings. This case was also difficult to analyse because there were two alleged perpetrators. The girl in Case 3 displayed sexualised behaviour (one incident involved asking the three-year-old grandson of her foster carer to take his clothes off and dance in front of her – thus showing she met the criteria for inclusion in this research). However, she became known to CSCS as the alleged victim of sexual abuse by her uncle. In the pilot study the information accessed indicated that the uncle was a sixteen-year-old boy. He was not included in the pilot study due to a lack of information, and later it was established that at the time of the alleged incident he was 19 and not 16, and therefore he was an alleged adult offender so did not meet the criteria for inclusion in the research. This raised an issue which was then encountered frequently in accessing the electronic files in ICS at this stage – inconsistent information (see Chapter 6 – Journey Through CSCS). Also, because this girl was involved with CSCS because of this alleged abuse by her uncle it became a stumbling block for getting participants to focus on the reason for my questions – her sexualised behaviour (see Chapter 7 – Interview Findings). This case in particular exposed weaknesses in the DCT and forced information to be categorised, which altered its meaning and led to a more positivist view rather than a way to understand the experiences. In general, while there were advantages to this DCT in drawing together particular information (e.g. age of alleged perpetrator, number of incidents), it was not possible to display the complexity of cases involving children who displayed SHB, showing why a purely quantitative DCT would not necessarily gather enough information for this study. This particular DCT was used because previous research concerning SHB in children had used similar tools, and therefore it was

applied to test its appropriateness. Clearly this was a quantitative tool and so statistical results were not surprising. The testing, however, was to see whether this, combined with semi-structured interviews, would together provide a richness of data. But in this pilot study it became apparent that using a purely quantitative DCT tool for the collection of data from the case files risks missing the richness of cases that did not easily fit into categories, as discussed. Therefore a further qualitative analysis was needed to understand the complexities of the behaviour, so this case was re-examined in the main part of the research and the carers of the girl were contacted to see if they would agree to be interviewed (which they did).

Content analysis is a way to 'objectively' and 'systematically' analyse the data in written documents and is 'firmly rooted in the quantitative research strategy' (Bryman, 2008, pp. 274–5). ECA however is based on qualitative data collection and analysis in order to continually analyse to identify themes and meanings. So in applying this it showed that the initial DCT encouraged too much data that was quantitative in nature, and it needed to be revised. Content analysis requires the testing of a pre-defined hypothesis, which was not the basis of this research, but ECA does not, and it allows theories to be developed from the research itself. This research was guided by only the predefined need to access all the recordings made by the social work practitioners that related to their response to the SHB displayed by the child, but a theory was not identified at the start of the research to suggest what this response might have been. For example, initially there was no category in the DCT for bereavement or domestic violence, but as data emerged these issues continued to arise, so the DCT was revised. By following this process the DCT was continually reviewed as Altheide (2004) advised, so the original concept was not the same as the end product.

5.1e(iv) Pilot interview with a parent Data Set 2 (P/C)

Permission was sought from the Local Authority to interview a father of a family as part of the pilot study. The purpose was to analyse the way in which the questions were worded in order to elicit a response from the participant, and not on the actual responses to the questions.

The pilot interview was also helpful in developing the researcher's style of interviewing participants for the study. As D'Cruz and Jones suggest, social workers 'are very familiar with interviews because it is one of the main ways in which we work with people as clients' (2004, p. 111). However, it was important not to interview participants in this way – to encourage them to talk about and share their experiences rather than complete an assessment. This therefore led towards my decision to suspend working as a practising social worker while completing this PhD research so that I would not have this conflict of roles throughout the interview stage.

5.1e(v) Pilot interview – Data Set 3 (SWP)

The first interview completed with a social work practitioner during the main data collection stage was analysed following its completion, and the interview probing questions evaluated. The social worker concerned was asked for feedback about the interview questions and whether she recommended any changes. She did not recommend any changes so no changes were made to the probing questions or to the way in which the interviews were conducted. She advised that she found the experience very helpful – the opportunity to reflect on her practice with the family concerned and to learn from that. Whilst no changes were made, completing a pilot interview ensured reliability and consistency in the way questions would be asked of all social work practitioners participating in this stage of the research, to strengthen the validity of the research findings (D'Cruz and Jones, 2004).

5.1f Challenges and resolutions

5.1f(i) Ethical issues in completing social work research

D'Cruz and Jones (2004) suggest that an important ethical consideration when completing any research is that of the position of the researcher. This can cause complications for the researcher and the research – this dual role. They argue that social work research is another way of achieving 'social work objectives' (ibid., 2004, p. 32). So this recognition must take place in the mind of the researcher first and foremost in order to then allow the validity of the research to be maintained. The researcher needs to recognise that sound methodological research is not a neat and orderly process, and that there are different interpretations of *social problems* and *morality*. D'Cruz and Jones suggest that this is a

particular problem in social work research because it cannot be assumed that 'everyone shares our interest in a particular problem or the ways in which we understand and explain it or what appropriate services may be' (D'Cruz and Jones, 2004, p. 33). Because of these issues they emphasise the need for the researcher to participate in personal positioning which, for myself, is discussed in the following section.

5.1f(ii) The reflexive researcher

When I began this PhD research I had been trained as a social worker and was still practising within the Safeguarding Children arena. Initially I felt this would give me an advantage in terms of accessing people and information – I had already been checked and vetted by a Local Authority, so I felt this would give people more confidence in giving me information. While this turned out to be true, there were also disadvantages which I had not anticipated, and were ultimately in conflict with my role as a researcher.

By already working for a Local Authority as a social worker I had existing knowledge of ICS, and knowledge of statutory social work (CSCS). This meant that I was quickly able to develop techniques for navigating the electronic systems in order to find information. I also found it easy to interpret information as it was written in a 'shorthand' which I was familiar with as a social work practitioner myself (see the activity example in Figure 5.1 on p. 69). There are certain limitations to the data gathered as it is depended on how well the social work practitioner was able to record what work they completed, and inevitably some recordings were better than others. There was also evidence of recordings not being completed at the time but later, when the social worker had the benefit of hindsight, and possibly recorded what was needed for future decisions. Conversely, where mass recording work had been completed this made it difficult to pick out key information from the sheer volume of information available. Also, having knowledge of ICS meant that once authorised to have access to the LA's electronic system it was possible to log in and access information without showing the employees at the Local Authority which cases were being looked at – so anonymity of anyone subsequently interviewed could be maintained.

Whilst knowledge of ICS was an advantage at first, my training as a social worker also meant that the way in which I read information was as a social worker. For me, this meant

questioning the decision making of social workers and looking for the evidence on which this was based rather than just documenting the data. Also, as a practising social worker, when meeting parents during the assessment process I maintained a degree of suspicion and *almost* interrogation, as my social work job was to assess them and their ability to safeguard their child, as well as identify support and services (linked to the more *investigative* approach). It became clear very early on in my research – during my pilot study (see above) – that this was very different to the role of a researcher. I initially found it difficult to change my interviewing style from that of a practitioner to that of a researcher. My social work role also meant that I was used to attending homes in areas that were socially disadvantaged where, sometimes, I had concerns for my safety. When I went to attend the first research interview at a parent's home I have to admit that I did make pre-judgements about them and their home based on my experiences as a social worker. I realised quickly that I must not go into these situations in that way as it would almost definitely prejudice the way I conducted the interviews. I felt that while I had two roles to fill this would continue to cause complications with the way in which I completed the research, or possibly impact on the way I worked as a practising social worker. Therefore, taking all these issues into consideration, I took the decision to temporarily suspend being a practising social worker while completing this study in order to solely focus as my role as a researcher. I found this did help, and in subsequent interviews I was able to relax into the role of a researcher and allow the participants to lead me through their experiences.

As Alvesson and Deetz suggest, the interpretation process of research needs to be kept open and will differ depending on the values/experiences of the researcher completing the interpretation (2000, p. 135). These personal reflections are given here to assist the reader in understanding me as a researcher and what I have brought to this research. Therefore the findings sections consist of the data collected and my analysis of it, in order to enable the reader to both understand my analysis as well as be free to make up their own. Geertz refers to this as 'thick description' of the data from the participants, which includes a hermeneutic interpretation.

5.1f(iii) Ethical considerations in completing research

O'Leary suggests that ethical considerations for research participants should include ensuring informed consent is received, that no harm comes to them and ensuring confidentiality (2004, pp. 53–4). In addition, Bryman adds that avoiding deception and invasion of privacy are paramount considerations (2001, p. 479). In response to these concerns, informed consent was received from parents/carers and social work practitioners for their participation – they were each given a letter and information sheet to read before participating in the research which gave information about the research and its intentions. (This information was also given to the Local Authority who agreed to participate, so they were fully away of the intention of the research – see Appendix 3 for a copy of the Information Sheet provided to all interview participants.)

To ensure participants were not harmed by the research, parents were not approached where there was a charge/conviction against them that they had sexually abused their child, or who had ongoing serious mental health concerns, i.e. where being involved in the research could exacerbate an existing mental health issue. Participants were advised that the interview could be stopped at any time if they became distressed. Attempts were also made to ensure that the confidentiality of parents and carers, as well as their anonymity, were protected. The issue of 'invasion of privacy' was paramount when attempting to maintain anonymity for all participants. This is difficult when considering the difference between the law concerning Child Protection and Data Protection. The grandparents of case 3 were contacted by a social worker from the LA (but not the case social worker) to ask if they would be willing to participate in the research. Whilst they agreed to this they were concerned that their information had been shared with another professional. A decision had been made not to ask their own social worker to contact them as they too were involved in the research study and it was important that anonymity was protected for both of them. This raised a dilemma and conflict about how to protect their anonymity from CSCS when participating in the research, along with the issue of ensuring they were appropriately informed. It was important that parents/carers should feel able to speak freely about their experiences and not feel constrained by the possibility that this information was being fed back to CSCS.

For the social work practitioners, all were interviewed in different locations so that no other professional working at the LA knew who was participating in the research. Only the researcher and research supervisor were able to view the transcripts of these interviews, and they will be destroyed at the end of the study. Pseudonyms have also been used throughout. As well as the professionals themselves it was important to ensure the anonymity of the LA who allowed me access to their electronic files was also protected, and to ensure they are not exposed to any possible suggestion of bad practice. With regard to Bryman's (2001) suggestions, participants knew they could refuse to answer any questions they felt invaded their privacy or put them at risk in any way. They were also given clear information about the study, and I was open and honest about my intentions for the study. Throughout the research the guidelines were followed as set out in the *Code of Ethics* from the British Association of Social Workers.

During the interviews, if there were any concerns about the welfare of any participants, or that being involved in the research may have an adverse effect on any participant, they would be advised that these concerns would be passed on to their existing worker, so that appropriate support could be offered. (This was discussed with the participants at the start of each interview.) During one interview a foster carer was clearly stressed about coping with risk management (see Chapter 7 – Interview Findings), so this was referred to her linkworker (with her agreement).

5.1f(iv) Risk to the researcher

As well as ensuring any risks to research participants are considered it is also important for researchers to consider the risks to themselves in completing any research. In order to ensure safety, only open cases from the LA and the therapeutic service (or those that had closed very recently) were used so that an up-to-date risk assessment was available. Parents were not contacted where ICS recorded them as violent. If there were any concerns about the actions or behaviour of any of the participants during the interview then it was terminated immediately.

5.1f(v) Limitations of the study

Finding difficulties in accessing enough participants to interview meant that the inclusion criteria had to be adapted. The response of parents/carers at first fell into two categories: (i) that they still had CSCS involvement and did not want to talk about it, or (ii) they finally did not have any CSCS involvement so did not want to talk about it. This response was something that was raised with parents/carers who did agree to participate in the study, and their responses are documented in the research findings. In **Data Set 1 (ICS)** only one set of carers agreed to be interviewed to be included in **Data Set 2 (P/C)**. The sample size is only small due to the access limitations, but for any future work it would be useful to focus on parents' experiences of CSCS if access issues can be overcome. However, the sample size was balanced by the more detailed analysis of **Data Set 1 (ICS)**. In addition, there was an initial plan to have a focus group running throughout the time of the research study in order to work more closely with the participants in the research so they could guide it towards areas that are particularly important to them – to 'understand [their] thinking' (Marvasti, 2004, p. 23). Ethical approval was received to access these participants via a therapeutic service for children who display SHB for **Data Set 2 (P/C)**. However, only one mother was happy to talk in a group setting, and all the other potential participants were happy to talk but only on a one-to-one basis – therefore findings were shared with them throughout the study, but this was not done in a group setting. The reason parents gave for this was that they were concerned about sharing such sensitive information with people they did not know. (See Chapter 2 – Literature Review, section 2.4 on Labelling, stigma and terminology, p. 13.)

5.2 Issues and approach to analysis

5.2a Issues for analysis

Data Set 1 (ICS) was analysed differently to **Data Sets 2 and 3**. A critical realist grounded theory approach was used to analyse the data in this research, with specific methods of analysis used for the case files and the interview data sets. (Theoretical issues will be discussed later but this is the format that was used.) For the 30 LA cases, it was clear from the pilot study that just employing pre-defined categories did not get to all of the rich data

that was written in ICS. By initially coding, then applying focused coding followed by axial coding (Corbin and Strauss 1990) (see section 5.3.), this enabled a continual reassessment of the DCT in relation to the emerging analysis. When beginning research without a pre-defined hypothesis this is an appropriate method for ensuring that any emergent hypothesis is developed from the data itself.

As stated in the Literature Review, according to government guidelines children who display SHB should be treated as children in need and assessed accordingly. Therefore in these 30 LA cases their journeys were plotted through their involvement with CSCS and the cases separated into two groups – those who were treated as children in need and those who were not. This developed from the research completed following ECA. These then became named *CiN response* and *Other response*. The definition of *Other response* is one that was not consistent with a *CiN response*, and in which social work practitioners did not demonstrate that they had used assessment tools or frameworks for making decisions. (These are discussed in more detail in *Findings*.) However, a *CiN response* did not necessarily mean the response was specifically focused to the needs of the child, only that procedures were followed which meant that these children were, at least in appearance, considered as children in need. More specific definitions are as follows:

> *CiN response* – Assessment as children in need procedures have been followed for children who display SHB. However, although CiN procedures were followed in all these cases, some were still technically erratic in their response.
>
> *Other response* – Assessment as children in need had not been followed in relation to SHB. These included cases where CiN procedures were followed at the same time as the SHB referral, but where the assessments focused on another issue and did not assess the SHB itself.

5.2a(i) Approach to analysis

The analysis of the 30 LA cases was completed first followed by the interviews, and each section was revisited for further analysis on two more occasions. In allowing the data to guide the research, the analysis naturally developed into key areas that were similar

between the 30 LA cases and the interviews. Researchers must acknowledge the possibility that they were influenced by the findings on one part and then applied these to the other, but this is not necessarily a problem as it still showed the way in which the data was leading the analysis. Smith *et al.* (2009, p. 84) suggest that, to counter this, the researcher engages in 'analytic dialogue' with the lines of the transcripts. To understand the lived experiences of individuals applying qualitative methods was therefore necessary. Interpretive Phenomenonlogical Analysis (IPA) is a way to research 'in detail... how someone makes sense of a major' event in their life (Smith *et al.*, 2009, p. 3). The role of the researcher is to enable the participants to share their interpretations of their experiences and then for the researcher to interpret them. Smith *et al.* (2009) propose that IPA is a flexible approach to understanding experiences from the perspective of the person who experienced them. The focus of IPA however is just on the narratives of the participants. A critical realist grounded theory approach however is one where 'the researcher seeks participants' theories and beleifs, not just their stories' (Oliver, 2012, p. 381) as, according to Bhaskar (1986), 'reasons are causes for the actions that follow' (p. 70). So employing this framework emphasises the importance of enabling the interview participants to share their experiences with the researcher, for example: why parents/carers believe the child demonstrated SHB; social worker beliefs about parents/carers; and parents'/carers' beliefs about social workers. In order for the participants to share their narratives, narrative interviewing was used. This method suits grounded theory as it allows the participants to lead the researcher through their experiences in their words rather than having a predefined hypothesis (Bryman, 2001, p. 431). Also by completing both interviews and the analysis of the CSCS through the 30 LA cases, this enabled the presentation of findings combined with lived experiences. This began with a pilot study in order to assess whether the DCTs were appropriate for the situation, followed by case analysis and interviews. Data was then broken down from these into component parts, naming each of them.

Focusing on the interviews themselves, notes were made after each one and then once the transcripts were prepared, coding was applied and the researcher's interpretation of the data further shaped the codes that were applied. For example, initially the views of parents and carers, and the views of social work practitioners were completely separate from each other, but when the codes were analysed, similarities were found between them. This

coding process turned the participants' perspectives into the researcher's of those perspectives, and how the researcher understood their social world, especially in the context of the journey found in the 30 LA cases (the interviews were completed *after* the analysis of the 30 cases.)

Content analysis of the 30 LA case files was completed, initially searching for patterns and then developing into themes (Patton, 2002). Once completed the initial codes were assessed to determine which made the most analytical sense. Guidelines, as suggested by Strauss and Corbin (1990), were followed starting with *initial* coding, then moving to *focused* coding where some codes were dropped, followed by *axial* coding where the focused codes were re-explored and evaluated to make sense. As Charmaz (2006) advises, initial coding fragments the data and axial coding then works to reassemble the data, but into the researcher's view (see Chapter 7 – Interview Findings for the specific codes). So using this method of analysing and presenting the data allowed 'explanation and theory [to be] fashioned directly from the emerging analysis of the data' (Mason, 1996, p. 142). (Being able to talk to some parents/carers again during the research process was also an instrumental part of this process.)

When considering the interviews with social workers and parents/carers a key issue was how they made sense of the CSCS intervention. Did they have differing perspectives based on their explanations of the event and/or different views of the outcome? Whilst consideration has been given to the way in which the researcher sees the social world, these considerations were then also applied to the participants' responses. It is impossible to determine exactly how social work practitioners and parents/carers view their world, but inferences can be made regarding the meaning applied by the way in which they talked about their experiences. For example, when the interviews began with parents/carers and social work practitioners the opening probing question was:

> *If I say 'children who display sexually harmful behaviour', can you tell me what this means to you in terms of your knowledge and experience of these children?*

All except one of the social work practitioners and foster carers responded by talking about children who had been sexually abused by an adult. I understood this to mean either that they thought 'children who display SHB' meant children who had been sexually abused, or that children who had been sexually abused would then display SHB themselves. These inferences were made based on further comments made by the social work practitioners and foster carers where they clarified what they meant. The parents responded more explicitly and gave examples regarding what was viewed as SHB concerning their child, but when I returned to the same question several times during the interview with 9_Adoptive_Mother, the understanding I inferred from her avoidance was that she found it very difficult to talk about what her son had done.

The difficulties in actually understanding what SHB is, and in actually naming the behaviour, led to more focus on this issue in the analysis of further interviews and of the LA case files. In the case files this was evident in the use of the term 'inappropriate sexualised behaviour' rather than explicit words to explain what this actually meant. What can be understood from these findings was that this was a common theme concerning SHB – the difficulties both parents and professionals had in being explicit about the nature of the sexualised behaviour as well as the difficulties in understanding what a term like SHB actually means and why children display it.

This is the origin of the thematic analysis and how the raw data was shaped, which is discussed in more detail in the two Findings sections (Chapters 6 and 7). There are some disadvantages to using grounded theory, as Silverman suggests that it 'has been criticised for its failure to acknowledge implicit theories which guide work at an early stage' (1993, p. 47). At the beginning of this research, in effect a hypothesis of sorts was applied – that parents/carers and professionals *have* had an experience to talk about and that CSCS *has* responded to SHB. But what has not been done here is to enter this research presuming what those experiences and responses were. The research was entered with the intention to discover the individual experiences of this set of participants at this time, and to discover how CSCS has recorded its response to SHB. The key to this process was to continue to remain reflexive, to acknowledge what values and experience the researcher brings to the research (for example as a white, working female with a child), and not to act on pre-

judgements. But it is also important to accept that as a researcher we are 'part and parcel of the construction of knowledge' – that the analysis of the research has been through our interpretation and interaction with it (Bryman, 2001, p. 471). To understand the findings, *thematic analysis* was used based within the principles of grounded theory, where theories are developed from the emerging research 'which is part and parcel of interpretative practice' (O'Leary, 2004, p. 195). Grounded theory, in this sense, is 'the creative activity of theory-building' (Silverman, 2004, p. 47) and is discussed in the next section.

5.3 Methodological issues

Having described in detail what the research involved, and some of the analytical issues, this section will frame that with some of the pertinent methodological issues. Whilst the data sets for the interviews with social workers and the interviews with parents/carers appear similar, and the data set of the ICS case files appears different, there are methodological similarities and differences between the two. The interviews with the social work practitioners are an extension of the information they wrote in the ICS case files and could therefore be considered together. The views of the parents/carers were not connected to these case files directly and therefore could not be considered as part of this overall *truth*. They concerned parents/carers talking about experiences with other LAs.

In his third edition of *Qualitative Research and Evaluation Methods* (2002) Michael Quinn Patton suggests that his 'truly Herculean task [was] deciding what to add', as when working with theoretical and methodological issues there are so many frames (p. xxi). When deciding what issues to consider in relation to a methodological discussion, researchers can also feel the weight of this 'Herculean task' – of what to include, what not include and how to engage in a debate of methodological issues, methods, epistemology and ontology, considering the vast subject area that presents itself. Cassell and Symon (2004) suggest that to understand research practice 'was to appreciate a variety of ontological and epistemological stances'. Patton goes on to suggest that this also applies to determining the current 'primary trends, patterns and themes' (2002, pp. xxii). He suggests that the longstanding debate between qualitative and quantitative methods has been 'largely resolved' and that there is no longer a need to establish the *value* of qualitative methods as opposed to quantitative methods.

Williams agrees, suggesting that a post-positivist position has now been embraced, i.e. that both a positivist *and* interpretivist position can be taken (Williams, 2003, p. 18). Patton suggests this as a pragmatic approach – some things can be counted and measured and some cannot. The example given is if you want to know how much someone weighs then weigh them and get a numeric response. But if you want to know what their weight *means* to them you have to ask them what they think, how it affects them, what they do about it – find out about their experiences and hear their stories, etc. (2002, p. 13). Instead, recent debates have focused more on qualitative researchers debating with each other, reflecting the large differences between different kinds of qualitative methods and how these reflect differing ontological and epistemological positions. It is clear from these authors that qualitative methods contribute to knowledge but there is no universal agreement in terms of what exactly constitutes this or how it can be achieved.

When talking of grounded theory Patton states this is a 'theory that is inductively generated from fieldwork, that is, theory that emerges from the research's observations and interviews out in the real world rather than in the laboratory or the academy' (2002, p. 11). The term 'real world' is used here by Patton suggesting that what happens within the laboratory or academy is *not real*. When engaging in any research it is important to establish the researcher's views on what the 'real world' is. Does a 'real world' exist? Whilst there are a vast array of debates on this subject, ultimately there is no single agreed (universal) answer and no 'central organising idea', so the ontological foundation of the research depends entirely on the view applied by researcher (Shaw and Gould, 2001, p. 8). In its purest sense, an objectivist ontological approach would suggest that there *is* a real world that exists, independent of the people in it, therefore suggesting that an organisation exists and is real (Bryman, 2008, p. 19). However, a constructivist view would suggest that 'social phenomena and their meanings are continually being accomplished by social actors' (Bryman, 2008, p. 19). Patton, however, suggests that it is possible to consider the 'real world' as existing when using qualitative methods. When considering whether it is possible for this world to be actually understood (epistemological) and how knowledge can be defended, Shaw and Gould (2001) suggest that qualitative methods have been viewed as a-theoretical, and lacking in rigour, but this differs from the slightly later methodological views of Patton (2002) and Williams (2003), suggesting that rigour and authority *is* possible.

Länsisalmi *et al.* (2004) suggest that grounded theory should be used when completing any kind of organisational research because 'it produces organizational reality, which are easily recognised by the members of the target organization' (p. 243). But this presumes that the audience of the research is the same as the participants. What about research that is intended for both the research participants as well as other potential stakeholders such as academic and policy research?

In order to understand human beings, hermeneutics as a discipline suggests that their life itself needs to be understood through actions and descriptions, and not through mathematical formula or equations (McAuley, 2004, p. 193). In this sense all understanding is subject to context – the meaning behind what is said or written or acted out. This takes a fully subjective view – that there is no reality, only context to each interaction. But does this absolutely mean that that is no 'real world' or 'reality' for people?

'[A]ll researchers seek to account for their practice and assumptions whatever they are' (Cassell and Symon, 2004, p. 2). Concerning:

> *Critical appraisal of methodological practices*
> *Acknowledgement and reflection on epistemological commitments. Are we seeking a truth or creating an account? How do we justify our claims as a result of our research? Do we access mathematical formulae or self-reflection?*
> *Recognizing the influence of our disciplinary background on the knowledge we produce. In this way what we do is fit the people we encounter into our view of the world.*

Cassell and Symon take this *post positivist* view further suggesting that such reflexive work should be used whatever methodological approach is applied (2004, p. 7).

There are difficulties when considering methodology and the profession of social work. Everett *et al.* (1992) found that social workers were not researching or implementing research findings or keeping up with research in general to aid their practice (p. 1). They described the knowledge base of social work as pragmatic, i.e. concerning only facts, and the facts they referred to were examples from previous practice that they had learned from

as well as conforming to policy guidance, the 'process of control and conformity' (Everett *et al.*, 1992, p. 2). Whilst this was written twenty years ago, the situation (according to the Munro reports and Becker *et al.*, 2012) is still the same. When considering the ontological and epistemological position of social work and social work practice it could be argued that there is no single agreed position, either in terms of policy provision or its application in practice. This has developed from the divergent paths of sociology (in terms of discipline development) and social policy (in terms of applied relevance) (Shaw and Gould, 2001, p. 5).

The research referred to in the literature review concerning children who display SHB has, in the main, been conducted as quantitative inquiries (Hummel *et al.*, 2000; Johnson and Doonan, 2005; Parks and Bard, 2006). The research has developed from North America, and is psychological in nature – looking at recidivism, typologies, behaviour, etc. (Chaffin *et al.*, 2002). This research study, however, is concerned with what are referred to as the *lived experiences* of parents/carers and social workers. This focus on *meaning* does not fit with a positivist/objectivist position. Alvesson and Deetz (2000) express the importance of 'reflexive understanding' when completing research that tries to understand everyday life experiences (p. 112). '[F]ollowing rigorous methodological rules does not prevent different researchers from arriving at the same results' (Alvesson and Deetz, 2000, p. 135). So the context needs to be set in terms of the researcher who completes the research. Oliver (2012), however, suggests a specific methodological approach for social work research: critical realist grounded theory (CRGT). It is this approach that will now be contextualised to demonstrate the justification for its use in this research.

5.3a Reality-orientated qualitative enquiry to critical realism

Patton suggests that policy makers in particular subscribe to the existence of a truth and reality – that there must exist one particular way to address a problem successfully (2004, p. 90). Therefore research conducted by policy makers for policy makers tends to be from a positivist perspective – research that tests theories and defines a particular truth. *Reality-orientated qualitative enquiry* has, according to Patton, developed to recognise the problems in the rigidity of positivism and the open ended nature of interpretivism. Campbell

suggests that 'discretionary judgement' is not avoidable in scientific study and that natural and social sciences are not in fact inherently differently as it had been argued (2004, p. 92).

There is recognition in the 21st century that pure positivism is *impossible* (Patton, 2002, p. 93). When considering the ontological view in this stance, then social reality exists not just in the objects but in the actors themselves. This view has further developed and taken on the description of 'critical realism' rather than 'positivism'. Critical realism has developed out of the debate between the strengths and weaknesses of positivism and constructivism. It can be argued that in the absence of universal agreement between these two stances, critical realism strives to take the strengths from both these perspectives. In this perspective, knowledge is acknowledged to be socially constructed, recognising that *meaning* is also a social construct, and that social reality exists in both the object and the mind of the actor (Patton, 2002, p. 95).

In the 1970s, British philosopher Roy Bhaskar developed this new focus for methodological philosophy which later became known as *critical realism* (Bhaskar, 1978). This was the middle-way between hermeneutics and positivism with a retro-inductive approach. He encouraged the use of mixed methods and second stage dialectical argument. This critical view suggests that social actors' interpretation must be regarded as not being open to correction by outside experts. The positivist search for evidence outside of human consciousness and all meaning is constructed. Actors are influenced by, but not determined by, the social structures around them. Reasons are therefore courses of actions that follow. Bhaskar is criticised, however, for his inaccessible language, and certainly suggesting the direct reading of his texts to front-line practitioners would not be an effective method (Oliver, 2012). However, the essence of his arguments was significant and developed by further thinkers such as Norman Blaikie who emphasised the importance in establishing 'what kind of connections are possible between ideas, social experiences and social reality' (Blaikie, 2007, p. 13).

However, the philosophy itself has come under criticism for not prioritising a particular method (Young, 1997). Bhaskar determined that there are three ontological domains of reality (Danemark, 2001): empirical – the experience/data; actual – events that happen

outside of our knowledge; finally, real – mechanisms of power/knowledge such as law/policy. In application to this area of research, *empirical* refers to the intervention from CSCS as experienced by the children, family members and other professionals; the *actual* being the act of SHB which happened outside of the knowledge of the practitioner; and *real* being the mechanisms of public policy and how they were applied by the practitioners. Blaikie (2007) emphasises that events can (and more often than not do) occur independently of them being experienced. That is that social work practitioners must assess an event without having witnessed it…

5.3b Grounded theory: Glaser and Strauss to Glaser versus *Strauss*

In 1967 Glaser and Strauss devised grounded theory, which was the systematic development of theory in order to push for qualitative methods to have a clear theoretical philosophy (Glaser and Strauss, 1967). However, once this was established they developed in opposing directions. Glaser suggested that to apply a grounded theory approach, this meant that the researcher had to engage in constant comparative analysis of all data, not just the qualitative data. Strauss, however, then worked with Corbin (2008) identifying the researcher as a detective searching for the research question to emerge from the data. They recommended a structured analysis to qualitative data using coding which can be achieved by the use of, for example, software programs such as NVIVO. Data is initially fragmented then becomes focused through axial coding which reassembles the data. This is the method that has been applied in this thesis – the structured analysis of qualitative data through coding. In this process it is important to recognise the knowledge of the researcher themselves in how the data is fragmented and then reassembled (Charmaz, 2006). It is not possible for the researcher – or the data itself – not to be influenced by this, and therefore the important aspect is to acknowledge this and be transparent. This researcher has positioned herself as a social work practitioner, which has influenced the way in which the data is coded. This is not to be seen as a negative; it is important that social work practitioners have a voice in research especially in relation to front line social work practice. In effect this is participant observation in the construction of knowledge through the data. Giddens highlights the importance of this in acknowledging the different culture of the researcher from the researched. Yet by acknowledging the position as a practitioner this

researcher draws attention to the culture that exists between herself and the researched. (Blaikie, 2007)

Taking this into account in a research study, Patton suggests, involves being concerned about the validity of the research whilst recognising that it cannot be value-free and that the researcher's value base may affect how they view the data, making any possible bias as explicit as possible. In reporting data this is done by presenting 'good, solid description and analysis', not personal perspectives. Geerts (1973) refers to this as 'thick description' whereby the beliefs and meaning of the participants are presented as they are observed. This is a significant concept in the presentation of qualitative data as it enables the researcher to 'understand and absorvb the context of the situation or behaviour [sic]' (Ponterotto, 2006, p. 539)

5.3c Critical realist grounded theory (CRGT) for social work research

Oliver (2012) has highlighted the nature of empirical relativism – that there are many ways of knowing. This resonates with social work practice as this is based on theoretical and practice relativism – there are many ways of understanding and intervening in service user's lives. Oliver (2012) suggests that in light of this, social work research should combine the pragmatic approach, such as Evidence Based Practice, with research approaches driven by the academic community. Interpretative Phenomenological Analysis (IPA) focuses on the stories people tell however taking a CRGT approach goes further and seeks to discover the theories and beliefs of the actor in how they understand their actions. For example understanding *why* a child acted the way that they did. This also includes understanding of the silences and hidden positions of actors such as *how* parents manage risk.

In applying this methodological perspective to this study, is to inform practice using the principle of PBR but with a methodological approach of CRGT (Oliver 2012). The benefits of being an active participant in the research are that the opinions of social workers and their theories and beliefs are valued; the research is local and specific; it integrates social work knowledge into the research; and it can potentially build relationships between social workers, policy makers and service providers to reinforce the theory. Most importantly for

the future status of social work research, it brings research and its methodological philosophy into social work practice. The data identified provides an important source of more current information but at the same time protects the participants by distancing them from the theory and findings as they are not just based on their words.

5.3d How these have been applied to the research study

Social work as a discipline encompasses a variety of other different disciplines such as: sociology, psychology, philosophy and social policy. Thompson suggests that ontologically, social work 'operates at the intersection of the personal and the social' and that it is a question of the 'individual in society' rather than the 'individual vs. society' (2000, p. 20). In social work these should not be seen as separate but as interlocking factors that make up the reality of social existence for people. Social work, according to Thompson, needs to be both systematic and reflective, i.e. clearly focused as well as being open to consideration and change. This ties in with a critical realist perspective, that social workers acknowledge the reality for the person in their mind as well as the reality of the objects around them. As already suggested earlier in this chapter, the methodological basis of any research can depend on the discipline of the researcher. As a practising social worker during the course of this research study, working in frontline child protection for a Local Authority, this influenced the way in which the study was founded and how it progressed.

Whilst research skills have been taught to student social workers as part of their degrees for a number of years now, an actual focus on *Practice Based Research* (PBR) is relatively new. PBR was developed by Irwin Epstein and published in his research article 'Or, Why can't a social worker be more like a researcher?' PBR is 'research conducted by practitioners for practice purposes' and 'takes into account the ethical priorities of the practitioner who initiates the study' (Dodd and Epstein, 2012, p. 5). In this sense the social work practitioner is guided by their own practice and experience in order to decide on the area of study to be researched, with the end focus being on understanding and/or improving their practice as well as their colleagues'. Orme and Shemmings (2010) highlight this, suggesting that the intervention conducted by social workers themselves generates important research questions, and in particular when undertaken by those 'involved in the situation' (p.17). This

PhD was developed in this way – based on the experiences of the researcher as a social worker in practice, and the concerns experienced about the way in which children who display SHB were responded to by social workers in CSCS. The purpose of such research is not just about improving knowledge but about justifying why social work practitioners practise in a certain way, in order to improve or change the way in which they practice – PBR begins with 'questions' and 'wisdom' and ends with 'application' (Dodd and Epstein, 2012, p. 20). Therefore PBR is outcome-focused and social work research occurs in 'real world settings' (Dodds and Epstein, 2002, p. 185).

Powell and Orme (2011) referred to there being a continuing conflict between the perceptions of social work educators and social science academics. Social work educators have been perceived as those who educate social workers to practice, rather than being involved in academic research, and therefore separate from the research community. This has not necessarily just been about a perception but possibly also to do with a lack of opportunity for those practising social work to actually complete research themselves. Dodd and Epstein (2012) go on to refer to a lack of self confidence in social workers which has been a barrier to them completing research themselves. However, the British Association of Social Workers refer to the duty social work practitioners have to '[f]acilitate and contribute to evaluation and research' (BASW, 2002, pp. 5–6). This was the origin of the research area for this study, to look into an area of social work practice experienced by the researcher as a social worker and consider it in the context as a social work researcher (as completed earlier in this chapter).

5.3e CRGT: A critical realist reality-orientated qualitative inquiry

To clarify, this research has been conducted from the assumption that reality does exist, both in the object itself as well as in the mind of the social actors. Therefore a variety of data sets have been prepared in order to present both these realities concerning how children who display SHB journey through CSCS. It could be argued that the objects are CSCS and ICS, and the social actors are social work practitioners and parents/carers.

Data set 1 concerns information entered by social workers into ICS, and presents both the object and the social actors. The information is analysed to present a real understanding of how children journey through CSCS. **Data set 2** concerns the interviews with social workers, demonstrating how they viewed this journey as well as a reflection of their practice. **Data set 3** concerns the interviews with parents/carers, demonstrating how they viewed the journey for the child they were caring for.

Gaining access to this one LA's ICS meant access to the recordings of social work practitioners not normally meant for public viewing. Atkinson and Coffey (2004) advised caution when accessing documents as the researcher must understand the context of the documents and the implied readership. For example, minutes that have been prepared from meetings are usually written with their readership in mind and are not necessarily a representation of the views, in their *crudest* sense, of the author. They further state that these documents have a particular ontological status because they exist in a different *reality*, that 'we cannot treat records... as firm evidence of what they report' and we cannot learn 'through written records alone how an organization actually operates day by day' (Atkinson and Coffey, 2004, p. 58). However, this is not necessarily the case for the documents accessed via ICS, as they could be considered a *reality* of the views of the social work practitioners involved in cases of SHB – they are written by social work practitioners (author) for social work practitioners (reader). Whilst their completion was a government requirement, they are not about social work practitioners' self-presentation or how they publicise themselves, but they show how they viewed a particular situation with a particular family. The documents read would normally be confidential to those accessing ICS, and their readership is only other social work practitioners, such as social workers and their team managers. They were not altered before access was given, so this is a level of access which adds weight to the information obtained, particularly regarding the activities and observation logs, as these contain much more information than is seen in reports (which are shared with other professionals).

Ethnographic Content Analysis fits with a CRGT approach where theory emerges from the interaction with and analysis of the data. It is a systematic approach in order to identify themes and meaning, thus meeting the criteria for grounded theory as recommended by

Strauss and Cobin (2008). Through this approach generative mechanisms are identified, i.e. sequences of events in order to guide further analysis for the generation of a theory (Hartwig, 2007). In this way, the 'what' are identified (generative mechanisms) in order to identify the 'why' (abstract theory) (Blaikie, 2007)

There are of course caveats in that the quality of the information contained in the records is dependent on the social work practitioner's ability to accurately record their work, and the information contained is from their perspective alone. However, this is why the analysis of these case files was combined with interviews with the social work practitioners themselves in order to understand whether the electronic recording was a reflection of the *reality* of the social work practitioner's perspectives and/or experiences. For example, this involved considering the language used by the social work practitioner about the alleged perpetrator as documented in the recordings, and then raising it with the social work practitioner during their interview. Therefore these documents *are* evidence of the reality of CSCS (through the views of social work practitioners) and how it records its response to SHB.

5.4 Conclusion

This chapter has set out the process of data collection through to a methodological debate in order to justify the validity of the research in this study. This research is based upon a critical realist perspective which, in its basic sense, means that meaning as well as reality is found both in the person and in the object. Therefore the organisation of CSCS exists outside of people's interpretation of it based on the policy and guidance and manifested through ICS. Also, to understand how this becomes a reality for the people involved this was combined with interviews with those who had actually experienced it, in order to know how they understood and interpreted it.

There are similarities in the information gathered from the 30 LA cases files in the journey section, and the information from the interview participants. For the journey the data is set out for each case individually, rather than drawing it together and generalising in the first instance. Patton (2002) argues that there are no set formulas for the analysis of qualitative data and the destination remains unique for each researcher. He also suggests that there is

value in presenting detailed and descriptive data as this can show the individual variation of each participant's experience. The challenge is in making sense of the vast amount of data. As previously suggested, the amount of data recorded in ICS for each of the children in the 30 LA cases was *vast*. Therefore key aspects have been drawn out from this data to demonstrate each child's journey through their involvement with CSCS. The richness of these findings is the access to and analysis of these 30 LA cases, which is something that has not been completed before, and therefore it is important for the integrity of the research to understand each case at the individual level before this is brought together and interpreted by the researcher. The circumstances of each case are presented in order to show their diversity as well as their similarities at the micro level so that it is possible to understand each child's journey through CSCS. To do this, some parts of these findings are presented as tables containing information about each case, referral information and extracts from recordings followed by an analysis of the extent, depth and range of the findings. These are not case studies, as the way in which they have been presented is to show the experiences of each of the 30 cases individually. For the interviews, these are set out as summaries and extracts of the interviews with the parents, carers and social work practitioners in order to demonstrate their reality of their experiences with CSCS. The main analysis and drawing together of this information takes place in the Discussion chapter. Patton argues that '[g]ood description takes the reader into the setting being described' (2002, p. 437). The intention of these findings is to do just that, to take the reader into the experiences of children who display SHB as documented in ICS, and to then take the reader to the experiences of the parents, carers and social work practitioners involved. In doing so it is possible to show a more complex picture of a human service organisation and how it interacts with service users, putting policy and procedures into practice. The intention is to 'open up this world' to the reader, a world that, because of the access to ICS, has not yet been experienced by the reader (Patton, 2002, p. 438).

6 Journey Through Children's Social Care Services

This chapter sets out the 30 LA case files in the first data set presenting the actual information about the 30 cases including some basic statistical data. Patton's (2002) version of the presenting of research findings has been followed, with both the Findings chapters focusing primarily on the description of the data and the Discussion chapter on its interpretation.

The findings in this chapter have been divided into five main sections:

1. How CSCS responds to referrals for children who display SHB.
2. What does SHB mean?
3. The realities of case management.
4. Naming the behaviour and views of the alleged perpetrator.
5. Training and support.
6. Did CSCS respond according to government guidelines?

These are based around the emergent themes from the analysis of the 30 LA cases. They demonstrate *what* was recorded and each child's journey through their involvement with CSCS. Grounded theory has been applied throughout the analysis of the data where analysis has been conducted 'inductively to generate theories strictly from the data' (O'Leary, 2004, p. 97).

6.1 30 LA cases demonstrating Children's Social Care Services (CSCS) response to children who display SHB

As set out in the Methodology, 30 LA cases were accessed which were 'referred' to the Local Authority in relation to children who displayed SHB, and each child's journey was followed through their involvement CSCS. (Only access to ICS was given – as all paper copies of files were added to ICS by the Local Authority.) A chronological approach has been applied to presenting the data beginning with the way in which data was entered and found in ICS,

through to whether there was data to show that government guidelines and procedures were followed.

6.1a How is SHB logged in ICS?

Details have already been given in the Methodology section (Chapter 5) as to how the database was updated at this Local Authority, so what follows are more specific details in relation to how incidents of SHB were recorded into ICS. In theory the way in which a referral was responded to should be the same, as this data was from just one Local Authority; however, this was not always the case and depended upon whether a child's case (either the alleged victim or alleged perpetrator) was already open to CSCS i.e. either of the children already had a social worker who was actively involved with the family at the time of the referral in relation to SHB. What follows shows the predominant response to open cases and to closed cases.

Table 6.1 Closed cases versus open cases

Closed cases	***Open cases (if the alleged perpetrator is known and is an open case)***
Referral is made to CSCS duty team by a member of the public/police/other professional.	Referral is made to CSCS long-term team by a member of the public/police/other professional.
Social worker enters information into ICS as a 'contact record' on the alleged victim's file.*	Social worker contacts referrer to ask for any more details.
Social worker contacts referrer to ask for any more details.	Allocated social worker enters information onto ICS as an activity and/or observation.
Social worker discusses the referral with their team manager to decide a plan of action – this is looked at to see if it meets thresholds for social work intervention.	Social worker discusses the referral with their team manager to decide a plan of action – this is looked at to see if it meets thresholds for social work intervention.
If no action is deemed necessary, a letter of support is sent to the alleged victim's family.	
If action is necessary this could be an Initial Assessment or Section 47 enquiry and Strategy Meeting (*Children Act*, 1989) if more serious.	

(Note: *During this process a file is not opened for the alleged perpetrator.)

This information shows a difference in how SHB is recorded. This was also different depending on whether the alleged perpetrator's name was known and whether their case was already open to CSCS. If the case was open then the referral was given to the long-term team so it could be dealt with by the allocated social worker who logged the information as an activity and/or observation. To put this in context (as previously described in the Methodology section, Chapter 5) it is a requirement that social workers at this Local Authority document every piece of work they do on every case on a daily basis onto ICS. For example, a phone call to a parent, or to a professional; sending out a letter; receiving information; completing reports; conducting home visits or meetings, etc. Every single one of these events whenever they occur was to be logged as a separate *activity* into ICS. When more detailed information needed to be logged, like a statutory visit to a child for example, this was logged as an *observation*. Therefore, presuming the social worker logged everything they did then information was being recorded into ICS every day. There were no *flags* in ICS to show if any of these activities or observations were particularly important and the details they contained could only be seen once the actual data was opened and read. Therefore for cases where SHB was referred to the Local Authority where the child's case was already open to CSCS, there were no indicators in ICS to flag these up. To find this information required that each activity and observation was opened and read.

There were other documents available on open cases such as conference reports and core assessments. However, whether information concerning the child's SHB was recorded in these documents depended on whether the social worker concerned identified this as relevant to the other issues for which they were involved with this child. It was observed that on occasions no further recording was made of the SHB in future reports about the child (as discussed later).

Where the name of the alleged perpetrator's name was not known and/or the alleged victim's case was not open to CSCS then the referral was given to the duty team and the social worker logged it as a contact record. No examples were found in the data set where the alleged victim was already an open case to CSCS. What became evident here was that if just the contact records concerning SHB were looked at then this was only half the story as they did *not* include cases where the alleged perpetrator was already open to CSCS

(discussed in detail later). This also meant that there was a discrepancy where some SHB was recorded on alleged victim's files and some on alleged perpetrator's files. The reason for this was because long-term social workers did not appear to view information they received as a *new referral*, but more information to include in their ongoing assessment/s. In some cases while information was added to assessments (although, as already indicated, this did not always happen) this did not always make its way to already-open child plans. For example, in the case of one child (Child7 as discussed later), the independent reviewing officer (IRO) requested that an up-to-date risk assessment be completed, but when the plan was reviewed at the next meeting this had not been added to the plan. Child Protection plans were not always updated because, when there was police involvement, if the police took no further action then social workers appeared to take this as a cue to end their own involvement in relation to the SHB – this is discussed in detail later. Also, while initial referrals to the duty team may not have included the alleged perpetrator's name at first, once this was discovered files were still not opened, as discussed in more detail later.

6.1b Information about the 30 LA cases

The following information shows statistical data about the cases and, where useful, these have been set this out as pie charts or bar charts for a clearer visual representation of the data.

6.1b(i) Gender of alleged perpetrator

The majority of the alleged perpetrators of SHB in this study were male (77%). Tying in with this, the majority of victims were female (64%). The alleged perpetrators in this study were all children below the age of 18, and not just adolescents. This correlates with the findings of previous research suggesting that the majority of children who display SHB are male (NCH, 1992; Hackett and Masson, 2003).

6.1b(ii) Ethnicity of alleged perpetrator

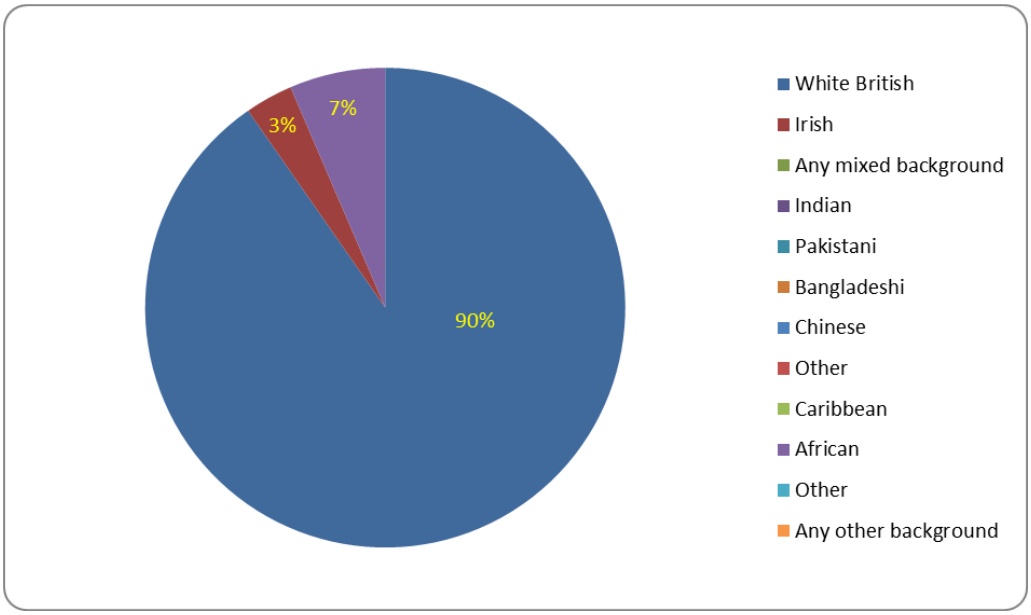

Figure 6.1 Ethnicity of alleged perpetrator

Information was available in ICS concerning the ethnicity of the alleged perpetrators as shown above. Figure 6.1 includes a broader range of ethnicity categories than are represented in the data itself. These have been left in to highlight the absence of ethnic diversity in the region where this research was completed. This geographic area is predominantly White British (93.1%) therefore these findings are relatable to that figure, where 90% of the alleged perpetrators were White British, 3% Irish and 6% African. This latter figure is slightly higher than the percentage of African families in this area, but

because of the small number of cases in this study the figure is disproportionately higher than would be expected in a large-scale study.

6.1b(iii) Disability of alleged perpetrator

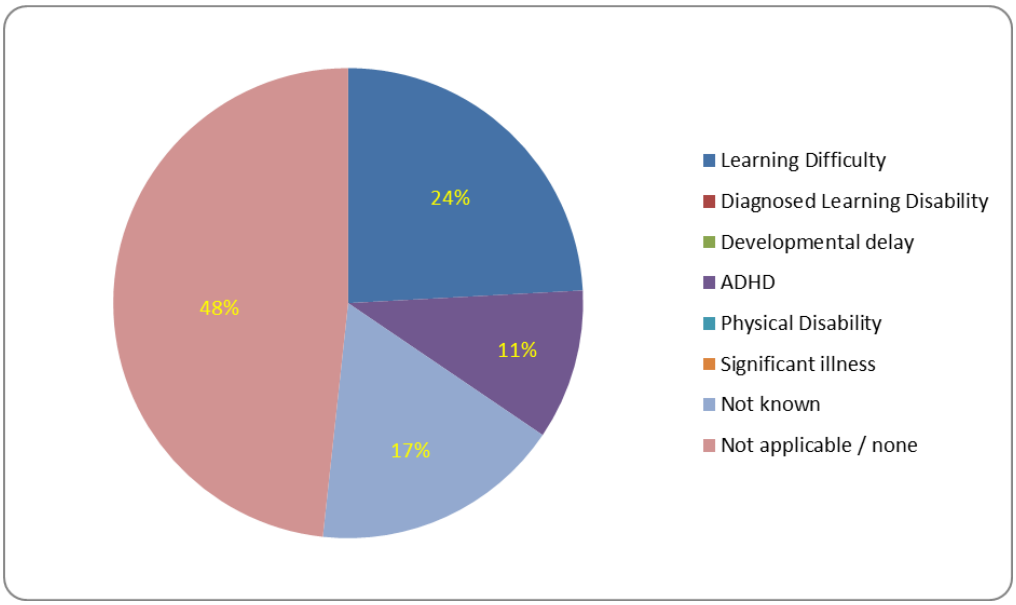

Figure 6.2 Disability of alleged perpetrator

Figure 6.2 shows that in 48% of cases the alleged perpetrator had no known disability, but that 24% were documented as having some form of learning disability. As with the ethnicity pie chart the full range of possible disabilities have been included that were looked for within the case files. However only a limited number of these disabilities are represented, and in the majority of cases there was no disability (or none was recorded).

6.1b(iv) Age of alleged perpetrator

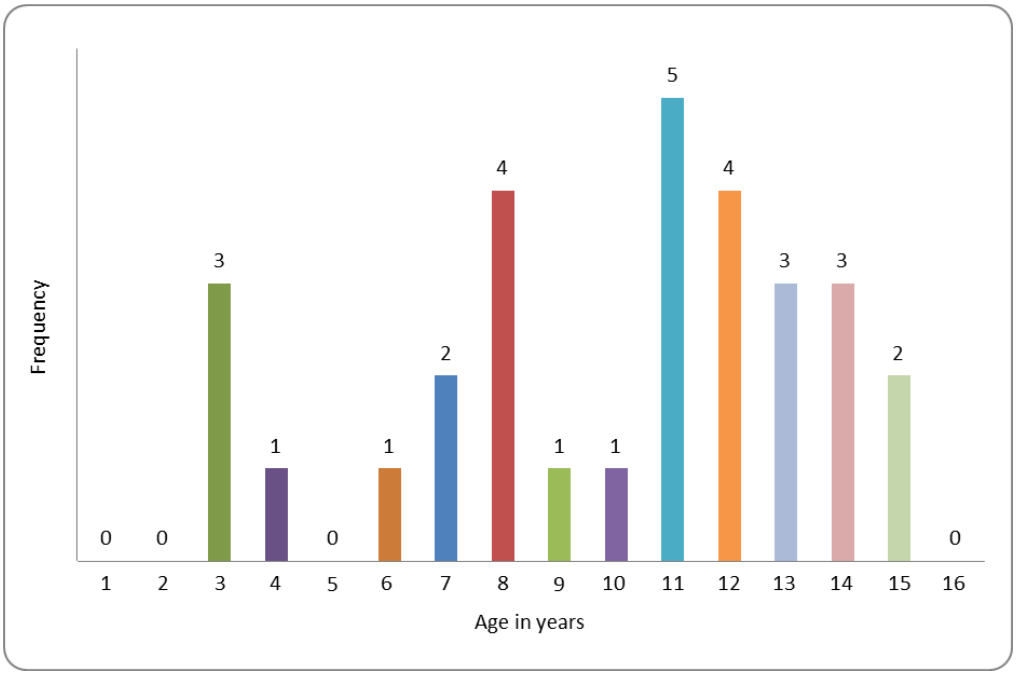

Figure 6.3 Age of alleged perpetrator

Figure 6.3 clearly shows that children aged 11 and 12 were more highly represented in this group, which would tie in with the onset of adolescence for most males – a time of increased risk in sexualised behaviour, as found by Zolondek *et al.* (2001). In their recent research study, Hackett *et al.* (2013) described the individual characteristics of '700 children and young people referred to nine UK services over a nine-year period… as a result of their' SHB (p. 1). In relation to age at referral, they found the mean age to be 14 years whereas the mean age in this thesis was 9 years. Whilst there are clearly differences in the sample sizes, there are also differences in the pool from which the data has been collected. This could reflect an older age group that are referred into therapeutic intervention – why this is case is difficult determine. Possible explanations could be that the behaviour is viewed different for older children or behaviour is not referred for therapeutic intervention until it has been repeated, which requires the passage of time.

6.1b(v) Alleged perpetrator already known to CSCS

In the majority of cases the alleged perpetrator was already know to CSCS. Other information indicated that in the majority of cases this was (in so far as far as it was possible to check in ICS) the first incident of SHB, meaning these children were known to CSCS in relation to a different matter. Fourteen families were found to have been known to CSCS because of domestic violence within the family. When drawing the information together there was also the issue of family bereavement present in six cases, five of which were out of the fourteen known for domestic violence. Although this is not necessarily a large number, in general families had different reasons for being involved with CSCS and were not a homogenous group. But these two issues, predominantly domestic violence however, were the largest common factors across the families. These categories developed through the application of grounded theory to develop the themes coming from the research itself (Altheide, 2004).

6.1b(vi) Further referral of SHB

In a significant number of cases (23%) there were further incidents of SHB referred in relation to the alleged perpetrator. Of those seven cases where there was a further incident of SHB, all but one had resulted in no further action (NFA) being taken by CSCS at the point of that first referral, and three of those cases did not have any assessments completed at that time. It was possible to find this information because of the cases referred by social workers, and so it was possible to access earlier information on the child's file and find the first referral in relation to SHB, which could have been anything up to five years before the study began. In the case of the referrals it was possible to access the cases six months after being given the information, so for some cases a further incident had occurred by then.

6.1b(vii) Number of social workers involved from referral to outcome (in relation to the SHB only)

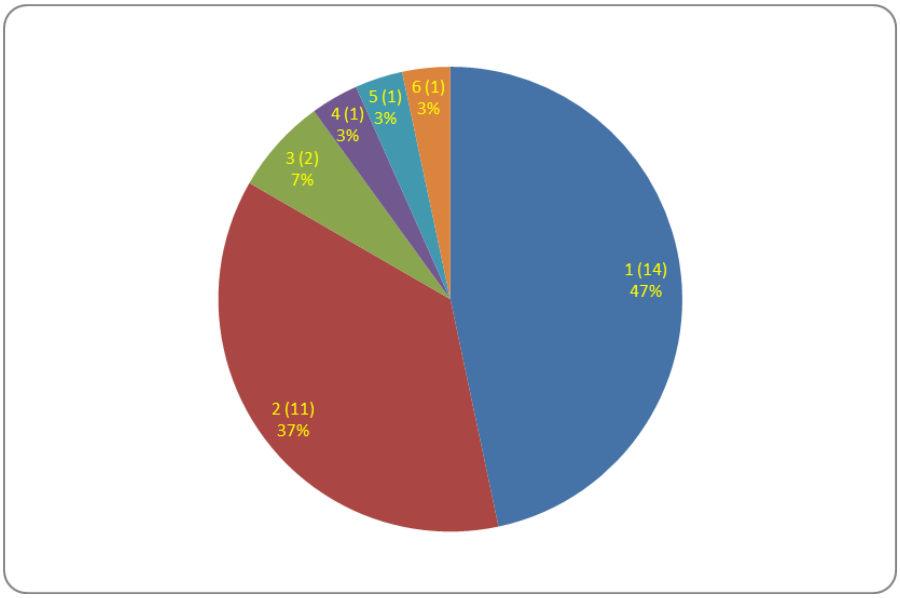

Figure 6.4 Number of social workers involved from referral to outcome (in relation to the SHB only)

Figure 6.4 shows that while 47% of cases involved only one social worker, 53% (therefore more than half of the cases) involved two or more. Considering the rather short length of time from referral to outcome in relation to the SHB (i.e. within weeks rather than months) this was surprising. It is also important to note that these figures do not include the number of other social work practitioners the children may have encountered, such as independent reviewing officers or team managers. It also important to note that in the cases where no further action was taken by the police, 50% of those cases involved two or more social workers, which was surprising due to the lack of assessment or intervention completed by the social workers while awaiting the police's decision. The CJJIR (2013) reported that families found it unhelpful when workers changed as this led to a lack of continuity for them.

6.2 Journey through CSCS – findings from referral to outcome

As already suggested grounded theory was applied to develop the research from the initial findings, which were, in a basic sense, that there was some 'response' by CSCS to SHB, even if that response was just to receive a referral and take no further action. A more focused exploration was then developed in trying to identify what these responses were before re-exploring these findings to prepare axial coding in which the data was sectioned into two main categories of response. These findings naturally developed into six main areas:

1. *How CSCS responds to referrals of children who display SHB.*
2. *What does SHB mean?*
3. *The realities of case management.*
4. *Issues of naming the behaviour and views of the AP*
5. *Training and support.*
6. *Did CSCS respond according to government guidelines?*

6.2a How CSCS responds to referrals for children who display SHB

As stated in the Literature Review, according to government guidelines, children who display SHB should be treated as children in need and assessed accordingly. Therefore in these 30 LA cases journey were plotted through CSCS to show each child's journey. These were separated the cases into two groups – those who had been treated as children in need (*CiN*) by receiving an assessment, and those who had not (*Other*). This developed from the research as it began to become clear that these children had not all followed the same route. To assist in viewing this information, those who received a CiN assessment are not shaded, and those who received an *Other response* are shaded. I have identified an *Other response* as one that did not appear consistent with other CiN responses and in which social work practitioners did not demonstrate that they had used assessment tools or frameworks for making decisions. However, the use of a *CiN response* does not necessarily mean the response was appropriately focused to the needs of the child, only that procedures were followed which meant that these children were, at least in appearances, considered as children in need. More specific definitions are as follows:

Other response – Assessment as children in need was not followed in relation to SHB. These include cases where CiN procedures were followed at the same time as the SHB referral, but where the assessments focused on another issue and did not assess the SHB itself. This information was evidenced through the absence of recording of guidelines being followed for example: no assessment was opened or completed; no s47 investigation documented; and no update in existing child plans. These also included cases where the initial referral information was then not the focus of the investigation, for example where the first alleged perpetrator was then viewed in a different way so not given a CiN assessment.

CiN response – Assessment as children in need procedures appear to have been followed for children who display SHB. Evidenced through the recording in ICS showing either s47 investigation, CiN assessment or updated child plans or existing assessments specifically referencing the SHB.

This information is set out in the table below in which each of the 30 LA cases have been individually addressed. This shows where there may be similarities in case information and perhaps different responses. Key decision-making times were found in the recordings that affected the way in which the children progressed through CSCS's intervention:

- What information was received concerning he behaviour
- Whether the child's case was already open to CSCS
- Who made the referral
- Whether the police were involved
- What action CSCS took – usually between one and three key action points
- What the police outcome was
- What CSCS outcome was
- The conclusion – whether the case remained opened or was closed

These responses were only in relation to the SHB rather than any other reason for involvement from the police or CSCS.

A variety of different ways were considered in which to present the following information, however all the options considered meant that information would be blended together in some way which lost the essence of the children's individual experiences at the outset. Summarising the data would in some ways begin to turn this information into a quantitative analysis which is the antithesis of the intentions of this study. The individual differences for each case were particularly important for this area of social work practice, so it was imperative that each child who was accused of SHB was seen as an individual first and foremost. What this table shows is how each child experienced CSCS and how CSCS responded to that child's circumstances. This can be categorised into the response of the police (if they were involved) and the series of actions (or lack thereof) taken by CSCS. In order to understand this, each child's experience must firstly be read in isolation before then considering it in the context of other referrals and how they also experienced CSCS and in doing so, this shows more clearly where there are similarities and where there are differences.

Table 6.2 30 LA cases from referral to outcome

Alleged behaviour	New/open case	Referral	Police actions	CSCS actions	CSCS actions	CSCS actions	Outcome – police	Outcome – CSCS	Conclusion
1 Male (12) sexually assaulted his seven-year-old male cousin	Open	Mother of victim calls police	Police refer to CSCS	CSCS initiate strategy meeting	CSCS complete s47 investigation	CSCS complete initial assessment	Police take NFA due to lack of evidence	CSCS take NFA	Closed
2 Male (13) raped his twelve-year-old sister	Open	Family friend of victim calls police	Police remove perpetrator from home and refer to CSCS	CSCS initiate strategy meeting	CSCS complete s47 investigation	CSCS have child protection conference	Police take NFA due to lack of evidence	CSCS take NFA	Open due to other issues
3 Female (12) exposing herself to friends in the street and from her bedroom window	Open	Grandmother talks to social worker	Police not involved in relation to this behaviour	CSCS talk to perpetrator and family members	Perpetrator already in foster care. CSCS refuse to allow her home as grandparents minimising their concerns	Allegations proven but no work completed with perpetrator		Perpetrator returns home	Closed

4 Male (11) 'sexually assaulted [his six-year-old sister] by touching' (Supervision record 10/2/10)	Open	Victim told social worker	Police not informed	No action taken.	No action	No action	Police were not informed until three months after the incident and then advised it was too late.	No action. Social worker did not inform people	Open
5 Male (10) sent a fellow pupil a love note and drawing on which he wrote 'let's have sex' and that later he 'aggressively pursued [a female pupil]'	Open	School talk to social worker	Police investigate and caution perpetrator	No action taken. Social worker does not talk to perpetrator or victim	No action	No action	Police caution perpetrator	No action. Social worker does not believe perpetrator was cautioned.	Open
6 Male (13) and friend sexually assaulted a fourteen-year-old girl (unknown to them) on the metro	New	Police called by victim	Police refer to YOT who contact CSCS	CSCS complete initial assessment			Perpetrator admits offence and is convicted of the offence	CSCS take NFA	Closed
7 Male (13) was accused by a twelve-year-old child in his foster placement of sexualised behaviour towards him	Open	Foster carer contacts social worker	Police not informed	CSCS initiate strategy meeting	CSCS complete s47 investigation	Allegations not proven	Police not involved	Both victim and perpetrator removed from foster placement and no further work completed with them	Open

8 Male (12) sexually abused his five-year-old niece	Open	Victim's mother contacts the police	Police refer to CSCS	CSCS initiate strategy meeting	CSCS complete s47 investigation	CSCS complete core assessment	Perpetrator is convicted of assault. Plea bargaining removes 'sexual' element from charges.	CSCS arrange therapeutic intervention	open
9 Male (9) accused of sexually assaulting his four-year-old female cousin	New	Victim's mother called CSCS in another LA, who called the police	Police refer to CSCS	CSCS initiate strategy meeting	CSCS complete s47 investigation	CSCS have child protection conference	Police take NFA because of lack of evidence	Perpetrator registered for sexual abuse (CSCS believe his behaviour was learned) Therapy recommended.	Open but transferred to another Local Authority.
10 Male (14) had sex with a twelve-year-old girl whom he had known for several years, she was under 13 therefore not legally able to give consent	New	Victim's mother called police	Police referred to YOT who referred to CSCS	Police did not believe it was in the public's interests to pursue the matter so referred him to YOT.	CSCS completed AIM assessment with YOT as perpetrator admitted the offence		Police NFA as not in public's interests	CSCS NFA as technically it was consensual	NFA

11 Male (11) sexually assaulted his seven-year-old sister	Open	Victim's adoptive mother called CSCS	Police were not informed as social workers made the decision not to refer to them	CSCS initiate strategy meeting	CSCS complete s47 investigation	At adoptive mother's request the perpetrator was removed from the home and returned to foster care.	Police were not informed	CSCS referred perpetrator for therapeutic intervention	Open
12 Male (14) was charged with possessing indecent images of children on his computer	Open	Police found evidence when looking at perpetrator's computer in relation to another matter.	Police referred to CSCS	CSCS initiate strategy meeting	CSCS complete s47 investigation	CSCS completed initial assessment	Perpetrator admitted offence and was bailed pending further investigations	CSCS tried to remove perpetrator from family home on five occasions due to their belief he was being sexually abused by his carer. They were successful on fifth occasion	Open
13 Male (4) sexual touching of other children at nursery	Open	Nursery called foster carer who called CSCS	Police not involved	Social worker spoke to perpetrator and advised his family			Police not informed	Social worker recommended NFA and that Nursery should monitor	Open

14a Female (3) 'Masturbation' in front of others	Open	Consultant Paediatrician observed the behaviour and advised CSCS	Police not involved	Perpetrator said 'daddy does it' so social worker investigates father for sexual abuse	Investigations only, no assessments		Police were not informed	NFA in relation to sexualised behaviour	Open
14b Male (7) Sexual touching of sister (5)	Open (brother of above)	Aunt contacted CSCS	Police not involved	No assessments completed but social worker refers perpetrator for therapeutic intervention	Investigations only, no assessments		Police were not informed	Attempts made to remove perpetrator from home and place in foster care while therapy takes place. Father refuses.	Open
15 Male (11) sexual assault of five-year-old male neighbour	New	Parents of victim contact NSPCC who contact CSCS	Police not involved	CSCS send 'letter of support' to victims parents			Police not involved	NFA	Closed
16 Female (8) was simulating sex with her seven-year-old sister, but said another eight-year-old child had shown her how to do it	New	Mother of one child contacted CSCS	Police not informed	CSCS initiate strategy meeting	CSCS complete s47 investigation	CSCS completed core assessment	Police not involved	CSCS's view was that this child was not the perpetrator	Closed

17 Female (6) went into the bushes with a six-year-old boy and kissed him and said 'if you touch my fairy and I touch your will we can have long sex'	New	School contacted CSCS	Police not informed	Social worker spoke to school and gave them advice on 'how to explore the issue'			Police not involved	CSCS's view was that it was 'experimentation'. NFA	Closed
18 Male (14) sexually assaulted his older sister (15) and eight-year-old cousin	New	Aunt contacted police	Police refer to CSCS	CSCS spoke to perpetrator and his father	No assessments completed		Police arrested perpetrator and interviewed him but NFA taken due to lack of evidence	NFA taken by CSCS	Closed
19 Female (3) rubbing her own genitals and her parents' and putting her hand down her 13 year old cousin's underwear in front of her parents	Open	Mother contacted GP who contacted CSCS	Police were contacted by CSCS. They transported mother and perpetrator to the medical and then expressed concern to CSCS about mother's sexualised language	CSCS arranged a medical of the perpetrator as the mother said she thought the behaviour was because she was sexually assaulted by her nephew	Strategy Meeting – but in relation to alleged sexual assault by nephew	Section 47 – but in relation to alleged sexual assault by nephew	Police take NFA because of lack of evidence. They express concerns about sexualised behaviour of the mother and father and its impact on perpetrator	NFA by CSCS after police decision. Further assessments make no mention of perpetrators sexualised behaviour.	Open

20 Male (11) videoed his eight-year-old niece pulling her trousers down, exposing her genital region, doing a short dance and waving her hand over her vagina	New	Mother of niece called police	Police referred to CSCS	CSCS did not take any action			Police interviewed perpetrator and victim but decided the video was not 'overtly sexual' so took NFA	NFA by CSCS	Closed
21 Female (3) found in nursery toilets with a male child of the same age – both were naked and the Female was on top of male	New	Nursery called CSCS	CSCS called police because they believed she had been sexually abused by mother's boyfriend	CSCS initiate strategy meeting because they believed she had been sexually abused by mother's boyfriend	CSCS complete s47 investigation because they believed she had been sexually abused by mother's boyfriend	CSCS complete initial assessment	Police interviewed child but in relation to possible sexual abuse of her by her mother's boyfriend. NFA no evidence	CSCS took NFA in relation to the sexualised behaviour except in relation to possible sexual abuse of her by her mother's boyfriend	Open
22 Male (15) was found in possession of child pornography on his mobile phone	New	Police investigating a case found child pornography on his phone	Police referred to CSCS	CSCS sent a letter of support to mother of victim	No action	No action	Police gave perpetrator a warning after he admitted receiving the image.	NFA by CSCS	Closed

23 Male (12) was watching his sister (14) undress and the school were concerned re him attempting to masturbate at school	New	Referral from school to CSCS after the victim tells them he has been watching her undress	Police not informed	CSCS completed an Initial Assessment			Police not involved	CSCS refer child for therapeutic support but this is not followed up and referral was delayed for four months	Closed
24 Male (8) is alleged to have touched another boy's (8) penis	Open	Victim told his social worker who referred to perpetrator's social worker	Police not informed	CSCS completed an initial assessment	No record on CSCS of the social worker talking to the perpetrator		Police not involved	NFA taken by CSCS	Closed
25 (Same incident as above, but separate referral received) Male (8) touched a female child (8) inappropriately and a male friend (7), child counter accuses the male friend of touching his private parts "loads of times"	Open	Parent of victim contacts school who contacts support worker	Police not informed	CSCS completes home visit, child makes counter accusations against victim			Police not involved	NFA by CSCS	Open

26 Male (15) raped a thirteen-year-old girl	New	Referral from school of an historic rape – unclear whether this was to the police or CSCS	Police involved	CSCS took no action	No action	No action	Police investigated but the victim refused to make a formal complaint therefore police took NFA	NFA by CSCS – they did not open a case for the perpetrator	Never opened
27 Male (7) has been 'sexually inappropriate' with a four-year-old neighbour and another child	New	Mother of perpetrator spoke to GP about what her neighbour told her about her son's behaviour. GP advised mother to contact police.	Perpetrator's mother contacted the police. The police contacted CSCS	CSCS visited perpetrator and his mother	CSCS completed initial assessment		System does not record response of police	CSCS recommended a core assessment which was still ongoing at the time of the research	Open
28 Female child (8) used sexual language towards another female child	New	School referred to CSCS that perpetrator asked another female pupil to have sex	Police not informed	CSCS completed Initial Assessment			Police not involved	NFA taken by CSCS in relation to SHB	Open

29 Male (7) 'inappropriately touched' a girl (9)	New	Victim told her mother, who told the school who contacted the police	Police contacted CSCS	CSCS spoke to the school and police			Police took NFA due to lack of evidence	CSCS advised school to complete a CAF	Closed
30 Male (11) sexually assaulted foster carer's six-year-old grandson	Open	Victim told grandmother who contacted her linkworker	Linkworker contacted the police and CSCS	CSCS found another placement for perpetrator as foster carer refused to allow him to stay	Strategy Meeting managed by another LA as foster carer in their area. This LA spoke to perpetrator who admitted behaviour but advised it was by mutual consent	CSCS updated core assessment and arranged therapeutic intervention in relation to good touch bad touch	Police NFA due to lack of evidence	CSCS arranged therapeutic intervention	Open

Table 6.2 shows the two major ways in which children who SHB were responded to by CSCS at this one Local Authority. Grant (2006) emphasises the importance of understanding the purpose of the assessment in order for it to work correctly, however these examples demonstrate that assessments were not always activated for referrals relating to SHB. In their study, Hackett and Masson (2003) reported that 31% of assessments were based on DoH 2000 rather than on a specialist model e.g. AIM. Of the 30 LA cases in this thesis, exactly half received a CiN assessment so 50% did not. Munro stresses the importance of assessments providing social workers 'with the information they need to make a judgement about helpful and safe next steps' (Munro, 2010b, p. 31). What is not clear is the decision making behind why half of these children were not viewed as requiring an assessment.

When looking at the cases there was a correlation between when the police were involved straight away and/or when it was the police that contacted CSCS. CSCS in the first instance responded and implemented the assessment process (although clearly this did not happen in every case) – usually this meant a strategy meeting and section 47 investigation. This implied that CSCS understood what response was required of them – that the alleged offence was serious enough to warrant police intervention. Although in the majority of cases this resulted in no further action (NFA) from the police due to lack of evidence. The *Other responses* appeared to occur more often when the referral came direct to CSCS and it was then their decision as to whether to involve the police. But this situation raised the question – did the individual social worker and team manager know and understand when the police should be informed of sexual behaviour? When does sexualised behaviour become a sexual offence? Even if the decision was made not to refer to the police, there was no consistent response from social workers to the behaviour. (This is addressed in more detail in the Discussion chapter.)

6.2b What does SHB mean?

There are potentially two explanations for why these cases were responded to differently: either that the social workers did not have a consistent understanding of what sexualised behaviour is problematic; or they did not know there were guidelines to follow in relation to these children and that they should be considered as a child in need. When the age and

gender of the perpetrator were considered in relation to the response of CSCS, CIN assessment procedures were generally followed for males between eleven and fourteen years old. This could be because they were over the age of criminal responsibility and consistently had police involvement as well. However, where procedures were not followed there were no similarities with age as they ranged across the board from three to fifteen. If we compare Case 2 and Case 26 they both involved an allegation of serious sexual assault and neither were charged by the police due to lack of evidence, but in Case 2 CSCS followed procedures and completed an investigation and assessment of their own whereas in case 26 they did not, including not opening a case file for the perpetrator. When referral information was received it was often very short and therefore lacking in a lot of detail, but based on the seriousness of the allegation it would seem that the threshold for an initial assessment had been met in order to clarify if the child was in need and were they being appropriately safeguarded (DfES, 2006)? As required by the Children Act 1989, Local Authorities must investigate referrals and be able to answer the following questions: is this child in need? Is it possible that this child is or is likely to suffer significant harm? Emphasis is made that whilst the information in referrals might not be proven this does not mean that the child may not be in need. This leads to the question – what was different about Case 26 that meant that a CSCS assessment was not warranted? In terms of the information in the electronic files it was difficult to determine what was different.

The table below shows the actual referral information copied from ICS, exactly as it was written but with identifying information removed. Case 26 indicates a serious allegation, but it is not clear from CSCS why no further action was taken by CSCS. (These are the contact records from ICS therefore do not include the cases where no contact record was completed as the cases were already open i.e. children 1– 14.)

Also, out of these 30 cases, information in the recordings suggested that one third of these situations were viewed by social workers as being the possible result of sexual abuse against the alleged perpetrator themselves. However, only in one of these cases was that confirmed by the alleged perpetrator.

Table 6.3 contains referral information extracts received regarding an incident of SHB involving children. It is important to note that these have been copied out *exactly* as they appeared in the contact record as recorded in ICS – including any spelling errors, punctuation and capitalisation. The only changes made are to remove the alleged victim's name (replaced with the word 'Victim') and the removal of any other indentifying information (replaced with 'XXX'). This table shows how individual social workers have recorded the information in the first instance.

Table 6.3 Referrals regarding SHB – exact reproduction

Child1–14	No referral information, as cases already open so no contact records completed, which identify information received as an *actual referral* in ICS.
Child 15	Victim (6) climbed into bed with Mum, XXX, on Monday morning and said he had a secret to tell her about a game he played with his friend Child15 (11) while at MGM house. The boys were left together playing on the computer in an upstairs bedroom and Child15 asked Victim if he could put his penis into Victim's mouth. Victim went along with this. Victim told Mum he feels like he has done something bad. Dad works away in the army came home last night and Mum told him what had happened. Dad said he is 'totally devastated' - crying on the telephone. Victim repeated what had happened to Dad and then asked if Dad was angry. Dad said after he composed himself (crying) he reassured Victim none of this was his fault. Dad and Mum went to speak to Child15's mum this morning - they are friends of the family live at XXX. Dad said he was surprised that Child15's Mum did not try to defend Child15 and hardly reacted to the information.
Child 16	Last night Victim's mother went into Victim s room where she witnessed Victim simulating sex with her sister. When questioned about this she stated that Child16 had shown her how to do this and also that she had rude pictures on her bedroom wall. Another child's mother has also been in touch with the school expressing concerns re Victim and her sexualised behaviour. Child16 has made counter allegations re Victim stating that there was an incident in the school toilets in which the childrens behaviour could be described as sexual. Parents to be advised - Written referral to follow.
Child 17	Child17 and another child (Victim) went into the bushes today to kiss. Child17 told Victim 'if you touch my fairy and I touch your willy we can have long sex'. At another point, Victim lay on top of Child17. Child17also told student sw XXX that her mummy hits her. She will speak to mum about this. XXX is going to speak to both sets of parents, and ask if they require advice or support.

Child 18	11:50: EDT contacted by XXX to say that lastt night her niece, Child18's slater Victim disclosed to her that Child18 had been touching her. Also that he had sexually abused their 8year old cousin 2nd Victim, 12:20: After checking ICS, CPR etc. I contacted XXX & informed that the incident concerning Victim possibly happened last year while they were on holday in Spain. Apparently Child18 was behaving badly and hence asked to share his grandparents bedroom at night. Victim there too. According to Victim this is when Child18 "touched" her. she was reluctant to discuss it any further however insisted that Child18had only "touched" her, 2nd Victim's mother present during this discussion between Victim end XXX. Hence she returned home to ask her daughter if Child18 had "done anything" to her. 2nd Victim apparently told her mother that Child18 had "put his willie" Into her but it did not hurt". 2nd Victim's mum now experiencing panick attacks.
Child 19	Parents have brought Victim to GP today stating that they are concerned she has been sexually abused by their thirteen-year-old nephew – Child19 who has been living with them over the last few weeks. Victim has been putting her hands down her parents trousers and rubbing their genitals, and up her mothers top and rubbing and kissing her breasts. Parents have also noted her putting her hands down nephew's boxers when he is lying on sofa. Nephew has spent time alone with Victim and behaviour has only started since he arrived. Parents have sent nephew back to home address. Victim has been examined by GP but no obvious abuse although behaviour is very concerning. GP feels child needs to be examined by comm paediatricain. Written referral to follow GP will organise medical on Victim and let us know when this is.
Child 20	Child20's HAS A NUMBER OF GROWN UP CHILDREN AS WELL AS AN 11YR OLD SON, Child20's. HER ADULT CHILDREN ARE XXX, XXX AND Victim's Mother. HER YOUNGEST IS Child20. Child20's sister's DAUGHTER IS Victim WHO IS 8. Child20 IS TECHNICALLY Victim'S UNCLE ALTHOUGH HE IS ONLY 3YRS OLDER. ON FRIDAY NIGHTS Victim GOES TO STAY WITH Grandmother [Child20's mother] AT XXX. Child20, XXX AND XXX ALL LIVE HERE TOO, AS DOES XXX'S GIRLFRIEND XXX. ON THESE VISITS Victim AND Child20 PLAY TOGETHER AND ARE VERY CLOSE. ON FRIDAY 5TH MARCH Child20 AND Victim WERE PLAYING WHEN Child20 MADE A VIDEO OF Victim PULLING HER TROUSERS DOWN ON HIS MOBILE PHONE. THIS IS LESS THAN 5 SECONDS LONG AND Victim DOES NOT APPEAR DISTRESSED, SHE LAUGHS THROUGHOUT. DURING THIS SHE EXPOSES HER GENITAL REGION AND DOES A SHORT DANCE AND BRIEFLY WAVES HER HAND OVER HER

	VAGINA. THIS VIDEO WAS DISCOVERED BY XXX WHO TOLD Victim's Mother WHO IN TURN CONTACTED POLICE
Child 21	Not a referral. Had a sexual abuse plan.
Child 22	Child22 HAS BEEN IN RECEIPT OF A CHILD SEX VIDEO WHICH HE HAS RECEIVED FROM A FRIEND VIA BLUETOOTH TO HIS MOBILE PHONE.THE FEMALE ON THE VIDEO IS 14YRS OF AGE.THE VIDEO WAS INITIALLY MADE BY AN ASSOCIATE OF Child22. Child22 WAS SPOKEN TO AT HIS HOME ADDRESS IN RELATION TO HIS INVOLVEMENT AND HAS BEEN WARNED IN RELATION TO THE POSSIBLE IMPLICATIONS OF POSESSION AND DISTRIBUTION OF CHILD PORN. Child22 IS AWARE AT THIS TIME THERE IS NO FURTHER POLICE ACTION BEING TAKEN BUT ANY FUTURE INCIDENTS MAY RESULT IN FURTHER ACTION. Mother WAS PRESENT WHISLT HER SON WAS SPOKEN TO AT HIS ADDRESS.
Child 23	The concerns for this family continue. Victim[sister] is currently self-harming, she says due to Child23's behaviour and that 'the whole family is sick of him.' Mum is apparently on holiday in Turkey at present therefore I am unable to discuss with her. This week Child23 has been speaking ina very sexually explicit manner. He has been caught attempting to masterbate and looking at pornographic material. He admits that he takes every opportunity to watch Victim[sister] undressing and she has equally admitted Child23 does try to watch her undress and it is part of what is causing her distress at present. She is very wary of giving too much away and says she is very wary of giving too much away and says she is worried that social services will 'take her away.' She does agree however that 'something needs to be done about Child23' and that the whole family are finding him difficult. I understand that Child23 is on a waiting list with CAMHS. Child23 is increasingly socially isolated***
Child 24	REFERRAL FROM SW XXX – Child25 B.071201 OF XXX THAT Child24 TOUCHED HIS PRIVATE PARTS LOADS OF TIMES. MOST RECENT INCIDENT OCCURRED SUN.310509. Child25 STATED THAT HE HAD HIS CLOTHES ON & Child24 TOUCHED HIM ON TOP OF HIS TROUSERS (BOTTOM OF STOMACH). Child24 SUFFERS FROM EPILESY & A LEARNING DISABILITY. INCIDENT ON SUNDAY ALSO INVOLVED Child25 TOUCHING Child24's sister ON TOP OF HER JEANS. Child25 ADVISED THAT WAS THE FIRST TIME.
Child 25	[Initially the referral relates to Child24 and is against him. However I went back into this child's files and found that actually the initial complaint was against Child25 and he made counter accusation against Child24.] REFERRAL FROM SW XXX – Child25 B.071201 OF XXX THAT Child24 TOUCHED HIS PRIVATE PARTS LOADS OF TIMES. MOST RECENT INCIDENT OCCURRED SUN.310509. Child25 STATED THAT HE HAD HIS

	CLOTHES ON & Child24 TOUCHED HIM ON TOP OF HIS TROUSERS (BOTTOM OF STOMACH). Child24 SUFFERS FROM EPILESY & A LEARNING DISABILITY. INCIDENT ON SUNDAY ALSO INVOLVED Child25 TOUCHING Child24's sister ON TOP OF HER JEANS. Child25 ADVISED THAT WAS THE FIRST TIME.
Child 26	Victim 180497 HAS REPORTED A HISTORIC RAPE (AUG 09) THE PERSON RESP HAS BEEN NAMED AS Child26 15YRS. Victim's friend HAS BEEN SEEN IN RELATION TO THIS AND SAYS SHE SAY THIS MALE DRAG Victim INTO THE BUSHES AND SHE TRIED TO STOP HIM BY PULLING Victim AWAY. SHE COULD NOT SEE WHAT WAS HAPPENING IN THE BUSHES SHE HEARD Victim SHOUTING "HELP Friend" SHE WAS HELD BACK BY ANOTHER MALE. WHEN Victim CAME OUT OF THE BUSHES HER TOP WAS INSIDE OUT. AS THE GIRLS WALKED AWAY FROM THE BOYS Victim SAID "I'VE BEEN RAPED". 030210 Victim's Friend WAS SENT HOME FROM SCHOOL AND THE HEAD TEACHER PHONED HER MAM CONCERNING RUMOURS CIRCULATING THE SCHOOL THAT She HAD BEEN RAPED 3 DAYS EARLIER BY Child26 AND THIS HAD BEEN WITNESSED BY Victim. THE SCHOOL STATE THIS ACCOUNT WAS CIRCULATED
Child 27	Mum has came into surgery today saying that one of the neighbours children who is four has accused her son Child27 of being sexually inappropriate with both herself and another neighbour who is three. It is difficult to get to the bottom of this, I know Child27's mum, she has contacted the police and police are in contact with you. Certainly the behaviour they are describing is sexual behaviour and is certainly inappropriate for the three, four or seven-year-old. It is not clear who initiated this sexual game but I have a concern that whoever has started the game has some inappropriate sexual experience at some stage and therefore I wonder whether you would please review the situation. [Info given to social services by GP.]
Child 28	On Tuesday May 5th 2009 Child28 was brought to the Headteacher by a teacher on playground duty. She had been in the school bushes and had pulled down her pants and the pants of a boy in her class. When questioned Child28 admitted doing this, stating 'I did it because of that dirty word starting with S'. Her mother was telephoned to come to school to discuss the incident. Throughout the conversation between the Headteacher and Mum Child28 stayed very calm and nonchalant. She repeated her admission & when asked about the word starting with S, said, 'The word is sex'. When asked how she knew about this word, at first she said, 'It just comes into my head' she then changed this to ' it's when I watch the television in your bedroom mum'. When asked what the word sex meant she said, 'It's to do with wu wu and fu fu. I didn't understand but mum did.

	Child28 meant willy and vagina and went on to say, 'It's when a boy puts his wu wu into a girls fu fu.
Child 29	Victim reported to police 260309 that a male friend Child29 D.O.B 27/02/2002 may have touched her inappropriately on the eve of 210309 Child29 lives at XXX and attends the same school as Victim. the school have been made aware of the incident by XXX's mother. the children were playing in a group when this is alleged to have occurred.
Child30	No contact record completed.

What is evident in this table is a high number of spelling and grammatical errors in the way information is recorded onto ICS, as well as information being confusing. It can take a few re-reads in order to try and understand what is being said and who did what to whom. Cooper (2012) reports in *Community Care* that social workers are still struggling with the existing IT systems like ICS. Social work practitioners are not held as accountable in the same way as researchers for how they present their data, except in court. However, this ICS information would not be presented in court so this suggests there may be a lack of concern as to how data is actually recorded. This does not show recognition of the importance of accuracy, any understanding that other professionals will need to read this information, or any consideration of whether it is set out clearly in order to aid communication.

When considering the cases that were referred to CSCS as well as those referred by the social work practitioners, axial coding was further employed by re-evaluating the findings as set out previously. The process was started with examining the gender of the alleged perpetrator and the alleged victim, being predominantly male and female respectively. From this different ages were considered and the data was examined to see if there were any relationships between these. Initially there was an almost equal gender mix found between those in the CIN category and those not. In terms of age, the majority of those in the *CiN response* were between four and eight, and in the *Other response* category there were two groupings – between eight and ten, and between thirteen and fifteen. Taking this further the age gap between the alleged victim and alleged perpetrator was considered in each of these categories: in the *CiN response* most cases were in the age difference between three and seven (with the alleged perpetrator being older than the alleged victim). Whereas in the *Other response* there was either no age difference or the alleged victim was slightly

older than the alleged perpetrator (nine out of thirteen cases). This was a significant finding in indicating one possible reason for why there may be a different response to the behaviours – because social workers may question whether the action is inappropriate as it was not against a younger child. In these findings this was the most significant grouping of information showing similarities in terms of the alleged victim, alleged perpetrator and response by CSCS – i.e. a lack of action taken, suggesting a different response based on size of age gap. As suggested in the Literature Review, Lovell (2002) reported on there being a lack of consensus as to how to define sexual exploitation or coercion of one child by another and in particular this becomes less clear as the age gap between the alleged perpetrator and alleged victim narrows. So, because they are the same age or older does this suggest that experimentation is the social worker's first thought? Or is it that because they are older they are seen as less of a victim? However they are all still classified as children, and require an investigation of the circumstances without assumptions being made that the situation was not abusive because there is little or no age gap between the alleged victim and alleged perpetrator. In the Literature Review it was set out that referrals relating to SHB should be considered in the same way within all Safeguarding Children. Therefore when making decisions the social worker should use their professional judgement to consider whether action should be taken. As Munro (2010a, b and 2011) suggests in her reports, it is important for social workers to be able to exercise professional judgement and Dominelli (2004) and more recently Wastell and White (2014) refer to a lack of professional autonomy in social work (2004); the latter specifically in relation to electronic recording. Therefore if social workers have not been able to apply professional judgement to these situations, on what have the decisions regarding NFA been made? Why is there a correlation between NFA and the age of the alleged victim and alleged perpetrator? Research suggests that there is agreement that children who display SHB are likely to have a background of some family dysfunction (Vizard, 2006) therefore taking this in context with the requirements of initial assessments regarding referrals, even if allegations are not proven the child may still be in need.

Another point of interest is technology in relation to SHB. Enemen *et al.* (2010) suggest that whilst the prevention of the sexual abuse of children is a *clear cut* issue there are difficulties in clarifying what constitutes abuse especially when considering the use of technology. So it

is not necessarily surprising that social work practitioners may be confused about whether certain sexualised behaviours involving technology are, or are not appropriate. It is likely that as technology is used more and more then these cases are will become more common in the future, and will be an issue that social work practitioners must understand in order to ensure a consistent response. This is confirmed by a recent special issue of the *Journal of Sexual Abuse* entitled 'Child Sexual Abuse and the Internet: Offenders, Victims and Managing the Risk'. Clearly, in the field of sexual abuse, technology is becoming more of an issue and as it filters down from adult sex offenders the issues will occur more and more with young people who display SHB. In this research study, Cases 12, 20 and 22 each involved the use of technology in SHB, which was a relatively new concept attracting more attention at the time of this study. CSCS took no action in relation to Cases 20 and 22, and in relation to Case 12 all the workers involved made it clear in their recordings that the alleged perpetrator had been groomed sexually by his male carer. This is not to suggest that these responses were not appropriate, only to highlight that this is an area where there is likely to be more and more inconsistent responses as it becomes more of a regular issue coming to the attention of CSCS.

6.2c The realities of case management

These cases show a correlation where the police took NFA, then CSCS tended to take NFA also (by NFA this means that no services or support were deemed necessary and therefore it was documented that there was 'no role for CSCS'). There were eleven cases where the police were informed but they then took no further action, and eight of these resulted in CSCS taking no further action also. But does this correlate? In their interviews, social work practitioners had negative views of police involvement and felt they operated from different expectations regarding the children, as well as working independently from CSCS (see Chapter 7 – Interview Findings). Conviction in itself is a spurious issue and does not determine the level of risk these children may pose or their responsiveness to treatment. The information in the recordings were written for example using the word 'therefore' by most of the social workers suggesting that because the police took NFA *therefore* there was no role for CSCS. According to the Oxford English dictionary therefore means 'for that reason; consequently' (Oxford Dictionary Website). However this does not fit with the

application of policy and legislation as suggested earlier that just because a referral is not proven does not mean that the child is not in need. The implication of the findings in relation these cases is that social workers believe that NFA by police suggests that they themselves do not have to do anything and can close the case. However if there was a police investigation then there must have been enough grounds for concern that an offence may have been committed. Even if this does not lead to criminal charges being made the burden of proof for this is different so even though there may not be enough evidence for prosecution there may still be question marks as to whether the incident did in fact take place. In these cases it would therefore be appropriate for CSCS to complete a CIN assessment anyway (as is required by policy and legislation) as had occurred in a number of cases.

Taking Case 1 as an example, this concerns a twelve year old boy who was accused of sexually assaulting his seven year old cousin. The case was already open as the mother of the alleged victim had requested support from CSCS, therefore there was no contact record containing referral information. The recording on ICS showed that a student social worker completed an initial assessment of the alleged perpetrator while her linkworker assessed the alleged victim. The alleged perpetrator experienced a clear route through CSCS from referral to investigation to assessment and then no further action. He was interviewed by the police and by CSCS. The recordings show that once a decision was made by the police that there was not enough evidence to confirm or deny the allegations, the question of SHB was dropped by the student social worker and her linkworker (the social worker responsible for supporting the student through cases while training). The recording stated 'NFA by police therefore no role for [Children's] services' – showing the use of the word 'therefore' suggesting that because the police took no action, consequently there was no role for CSCS. Whilst the student social worker did make comments about the sleeping arrangements in the child's household, and wrote of having concerns about the bad feeling between his parents and how this may impact on him, she did not connect these to the possibility that he could have displayed SHB or that he remained a child in need. Instead she made a referral to a community project in relation to other concerning issues about this child's behaviour, i.e. aggression and missing school, but this was not followed up and the organisation he was referred to were not advised of the SHB allegation. The majority of the

work completed with this child was done by the student social worker, and her assessment as to whether he displayed SHB was accepted by the linkworker. Obviously the police had not taken the matter any further but, as already indicated, the remit of the social worker is a different one to that of the police. The police's decision in this case that there was *not enough evidence* was accepted by CSCS as suggesting that SHB did not take place. There was nothing in the recordings to suggest to the reader that the student social worker's assessment showed concern that the child may be suffering significant harm if he had displayed the behaviour. No work was completed with him around good touch/bad touch and no specific assessment tool was used.

In relation to Case 18, this boy was accused of sexually assaulting his sister and cousin and NFA was taken by the police due to lack of evidence. At the time of this incident no assessments were completed by CSCS. When examining at later recordings, these showed further incidents of SHB by this boy towards other children. This suggests (in hindsight of course) that further intervention *was* warranted by CSCS at the time of the first referral even though the police took NFA, but because an assessment was not completed it was not possible to see why social workers decided not to conduct an assessment. In Case 26, while the victim refused to make a formal complaint to the police this does not mean CSCS should not have investigated for themselves and assessed the perpetrator's background i.e. completed an assessment.

6.2c(i) Risk management

It was difficult to assess how social workers managed risk especially when half of the cases did not involve an assessment being completed. However, there were some unusual examples of what social work practitioners viewed as an appropriate response to the risks of SHB rather than the completion of risk assessments and application of safety plans. In the case of Child4 the suggestion from the social worker (as recorded in ICS) was to place a beaded curtain over their daughter's door so they could hear if their son attempted to enter her room. In the case of Child3, her grandparents were told they were not protecting her from being sexually abused by her uncle in the house, but the recordings do not show whether they asked them to do anything, only that social work practitioners felt they could not protect her.

6.2c(ii) Connecting the dots...

As has been shown, difficulties were experienced in trying to access information about children who display SHB. When looking at the data and the recordings made by the social workers there was an absence of writing saying that there had been previous incidents of SHB suggesting they did not observe previous information in ICS about these alleged perpetrators. For example, in Case 20 there were no electronic recordings to confirm that the social worker spoke to either the alleged perpetrator or the alleged victim. In the electronic file there were a number of previous referrals to CSCS in relation to anti-social behaviour by the alleged perpetrator, but these were not referenced by the social worker in any other documentation suggesting that they either did not see them because they were not flagged in ICS or they did not view them as relevant.

When reading the ICS recordings for Case 25 previous allegations of a sexual nature were found that had been made by another family in another area against the brother of the alleged perpetrator in this instance. Nowhere in the relevant recordings did the social worker make any reference to these allegations when making decisions as to what action to take. The recordings of this social worker showed they believed that the family of the alleged victim were making it up in relation to this referral. Further referrals were made after this one, and again the social worker suggested they were not true. But had they accessed the background information and found information from another family about the brother, would they change that view?

In relation to Case 26 no actual electronic file was opened for the alleged perpetrator, all information accessed was on the alleged victim's file. This means that if an allegation was made against this same alleged perpetrator in future there would be no easily accessible record to show a previous allegation was made against him, as it would be likely that the victim would be different.

6.2c(iii) Assessment tools and research

When an assessment was completed no evidence was found of a particular assessment tool being used in relation to SHB, only those for general CIN assessments. Considering the

police were involved in some way with seventeen of the cases, it would be reasonable to expect to see more evidence of the AIM assessment framework being used in some way (Assessment Intervention Moving On Project – focusing on young people in the criminal justice system who have committed sexual offences), as referenced in the literature review (Morrison and Henniker, 2006). However, this was only referenced by social workers in three of the cases. While it can only be used directly if the alleged perpetrator admits to or is convicted of the offence, it could be useful for social workers to reference this especially when determining when sexualised behaviour becomes problematic. However these are social workers working within a generic social work service and not a specialist one as were the respondents in Butler and Elliott (2006), Erooga and Masson (2006), Hackett and Masson (2003) and Hackett *et al.* (2005). All 30 of these cases were checked for a reference to any other form of assessment tool in relation to SHB, but there were none. And out of 30 LA cases only one social worker made reference to recent research in their recording to back up their view (Child9). Her conference report (27 Sept 2007) stated that '[r]esearch shows that the younger the child displaying sexual abusive behaviour, the higher the likelihood of that child having been sexually abused or having lived in a sexualised environment'. The Department of Health (2000) recommend that assessments should be grounded in evidence – up to date knowledge, research and guidance; and unfortunately, this research was not interpreted correctly. This social worker talked of this being a young child displaying SHB, but he was actually an older child. If this was the first SHB incident then this was late onset, as he was almost an adolescent and was a month away from criminal responsibility.

The tendency was for social workers to give their own interpretation as to whether the SHB happened or, if it did, whether it was problematic. However, in their reports social workers did not back up their views with specific evidence as to why they had come to that conclusion. When considering the guidance from the DoH (2000) in relation to basing decisions on up to date knowledge, research and guidance it was difficult for this to be understood in the recordings on ICS. As suggested, there was only one case where recent research was reference and without this reference to research it was not possible to identify on what evidence social workers were basing their views.

6.2d Naming the behaviour and views of the alleged perpetrator

In ten out of 30 LA cases the word 'inappropriate' or 'inappropriately' was used to describe the sexualised behaviour. This often began with the information either direct from the referrer or from the social worker's recording of the referral information. In each of these cases they were not followed up with specific information as to what that behaviour was and why it was viewed as inappropriate. Sometimes information was only later clarified in an activity/observation or in a report. However, without any signposting within CSCS it was very difficult to find this without simply reading every single piece of recorded information. (See Chapter 7 – Interview Findings for the way in which people describe SHB.)

It was also found that social work practitioners appeared to have difficulty in focusing on these children as 'in need' because of their SHB, and especially when recordings were made onto an open alleged victim's file. Where the alleged perpetrators were seen as victims it was as victims of sexual abuse by another party (usually an adult male). Recordings in the files did not usually give justification as to why this view was taken except that the child's SHB was an indicator that they must have been sexually abused themselves. Only in the case of Child12 was information given as to why the social work practitioners felt he had been sexually abused by his carer. For example, information was given by the police that they found a recent video of Child12 on his carer's computer when he was in the bath with another boy and the carer was asking them to act up together. Generally, however, the social work practitioners did not write about the alleged perpetrators in a negative way. Information was not read to suggest they were being perceived as mini sex offenders, but this does not necessarily mean that they were viewed positively, for example Child1 was viewed as a *troublemaker*. In the minutes of the Strategy meeting the team manager for Child1's social worker wrote Child1 'gets into lots of trouble!' and 'He is a clever lad and has no learning issues, however he is disruptive in school and has no respect for others'. Only in the case of Child23 did the social worker talk of the child needing to address his 'demons'. It was much more common for behaviour to be dismissed either because the social work practitioner viewed it as experimentation or as a result of being sexually abused themselves, or because the police did not find enough evidence for criminal prosecution.

6.2e Training and support

The findings set out in this section show that there was very little evidence in CSCS of appropriate specialised training and support for these social workers during their involvement with these SHB cases. When considering that social workers were expected to exercise their professional judgment appropriate training is a key precursor to this. As previously suggested, Mir and Oakie (2007) found that 'training of social work practitioners is very important' but that they often receive 'very little and sometimes no formal training before commencing work' (p. 30). Out of the 30 LA cases only three of these had social workers who had completed the Local Authority's one-day training course before managing the case, and only two of these three had also completed the AIM assessment two-day training course. This is something that was raised with the social work practitioners during the interviews to see whether it was the case that training and support were, as they appeared here, inadequate (see Chapter 7 – Interview Findings). There were no records to suggest that in those three cases the social workers were given the cases because of their training, as the SHB occurred on open cases with issues that were not initially related to SHB. None of the social workers in this study referenced the guidance provided by the ACPC and there were no records from team managers indicating if they had recommended these, or the training courses, to their social workers.

It was also found that, out of the 30 LA cases, in sixteen of them there were no recordings from the social worker (or team manager) concerning case supervision. At this Local Authority formal supervision was supposed to take place between the social worker and their team manager every month. During this time the team manager would make a record of the discussion which was then typed up, signed by both and a copy kept by both. However, some social workers and team managers then recorded any relevant decisions on CSCS, but some did not. Therefore, just because there was no record of formal supervision on these cases does not necessarily mean that it did not happen, only that it was not recorded on ICS. However, it is highly likely that social workers would consult their team managers about their cases more than once a month and particularly if they have received new information about a case they were currently managing. Within this Local Authority's ICS there was another option for the social worker to record discussions they had with

colleagues or managers outside of formal supervision. This could be recorded as 'informal supervision with manager' or 'consultation with colleague'. In this way social workers were able to record when they discussed an issue with another professional. However this was not something social workers had utilised in the SHB cases. Again, however, the caveat here was not whether they did in fact consult colleagues but whether just did not record those consultations in the electronic system.

6.2f Did CSCS respond according to government guidelines?

For each case a summary has been given as to whether CSCS appeared to work effectively i.e. that government guidelines were followed in relation to children who display SHB. The criteria for this were that the alleged perpetrator was treated as a child in need, the social work practitioner's recordings showed clear and focused decision making, and there was a consistent response from CSCS as a whole – which is what government guidelines would suggest as an appropriate response to these children (see Literature Review). These have been set out for each child below, and this shows that there were a number of inconsistencies and a lack of clear information concerning the decision making of social work practitioners when deciding what action to take.

Child1 This child experienced a clear route through CSCS from referral to investigation to assessment and then no further action. He was interviewed by the police and by CSCS. Once a decision was made by the police that there was no evidence of SHB then no further action was taken in relation to this matter, either by them or by CSCS. A referral to a community project was made in relation to other concerning issues about his behaviour but this was not followed up. However the work completed with the alleged perpetrator was completed by a student social worker in relation to this child, and to her professional opinion was accepted when she had no experience and was even qualified.

Child2 This case did seem to work well but there were issues in having one social worker working with both the alleged perpetrator and alleged victim. This

raises the question of whether they can be entirely supportive of each child's needs. But if there were two separate social workers would this cause more confusion?

Child3 There are no records in this child's file to show that her concerning sexualised behaviour was passed on or acted on in any way.

Child4 Allegations made by Child4's sister were very serious and were happening at night while their parents were asleep. There are no records to show that any safeguarding work was completed with the family.

Child5 The actual allegations against Child5 did not appear to go through CSCS. The social worker appeared to dismiss these and focus instead on him being a victim of sexual abuse.

Child6 It was not clear in the records when the incident of SHB initially happened and why CSCS weren't involved straight away. The initial assessment completed was thorough and intimated that the mother needed support to manage the situation. However, no further action was taken and there is no information in the files to explain why no support was then given.

Child7 Decisions were made by the social worker but no explanations were given as to how they came to their conclusions.

Child8 This case appeared to work as it followed the assessment route through CSCS. However, the recordings were very much laid out like the recording of a police investigation.

Child9 This child appeared to be recognised as a child in need himself and a referral was made for therapeutic support.

Child10 Child was recognised as a child in need.

Child11 The assessment route was followed but the records show that his adoption placement broke down as adoptive mother was asking for respite while she came to terms with what had happened, but social workers advised against it. She then ended the placement the following week. This meant that Child11 was moved away from his new family and back into foster care hundreds of miles away. An example of how the reality of 24/7 supervision can be too much for parents/carers to handle.

Child12 The assessment route was followed and recordings indicate that social workers were right to be concerned that this child had been groomed sexually by his carer.

Child13 The issue of SHB only appeared in the records for a few days and was then never mentioned again in future records. In my view this is because it would not look good on adoption papers to prospective adopters.

Child14a Child14b For several months the records indicate that there were discussions about how to effectively manage the behaviour of Child14b. They suggest he should be placed elsewhere while SHB therapy was ongoing. However, this was dropped from the care plan without any details given. This coincided with an independent psychological report being completed (unfortunately a copy of this was not available to me, but this may explain why the therapeutic intervention was dropped).

Child15 This was the second referral relating to SHB for this child but it was not investigated and no assessments were completed.

Child16 An assessment route was followed and a decision made that some intervention was needed. However, this work was completed by a student

social worker who was not experienced or qualified.

Child17 The school gave information to CSCS on how they handled the situation and this was accepted as appropriate.

Child18 The social worker did not establish for themselves if anything may have happened or look into his background. An initial assessment was completed but it stated they needed to establish more information re family background. This does not appear to have been completed.

Child19 The social worker did not address the issue of the child's sexualised behaviour. He focused instead on the alleged sexual assault and, as this was stated to be unproven by the police, the child's sexualised behaviour was also dropped along with this.

Child20 Police took no further action so the matter was dropped by CSCS.

Child21 The social worker and team manager focused on their opinion that Child21 must have been sexually abused in order to display this behaviour. Therefore no work was completed with this child once the mother's boyfriend was kept away.

Child22 No work completed by CSCS.

Child23 This case appeared to work well and a referral was made to a therapeutic service, but this was not received and the social worker failed to follow it up, so the case was closed.

Child24 No further action was taken and no support provided.

Child25 The social worker did not give an independent assessment of the situation based on looking at history of child – this was ignored.

Child26 I am concerned that CSCS did not decide to look into this matter. If the allegation is true then he needs help and support. If he does something again, while the police records might connect him up CSCS will not necessarily do this because they did not open a file for him.

Child27 The child was thoroughly assessed and considered as a child in need. The child was protected while further investigations took place but not treated negatively.

Child28 The social worker provided very little information in the assessment of this child, although a referral was made to a therapeutic service.

Child29 Appropriate response to information received.

Child30 Child was spoken to and supported by professionals.

The key findings here, based on this information, is that it does not appear that CSCS operated consistently or efficiently with half of the cases not following government guidelines regarding the assessment of children who display SHB as CiN. This is evidenced in three areas:

(i) As already shown, where the police decided to take NFA then CSCS closed their cases and accepted the police's decision that nothing had happened (see Discussion).

(ii) Whether or not work appeared to have been completed also depended on the ability of the social worker to effectively document their work on ICS, showing the constraints that ICS can place on social workers as found by the Munro reports (2010a and b, 2011). For example, Child28 was referred for therapeutic support but there was very little information on ICS to explain why this was deemed appropriate.

(iii) There were also examples of information being dropped from ICS documents, and without a clear way of showing this then in future this could be missed completely.

6.3 Conclusion

The key issues found through the analysis of the 30 cases were as follows:

- Half of the 30 LA cases did not follow guidelines in treating children who display SHB as children in need.
- It is unlikely that any formal assessment tools were used.
- If there was police involvement which took no further action then CSCS took this as a cue to take no further action themselves.
- If the children were assessed at all it was likely to be as a victim of sexual abuse rather than understanding individual reasons for the SHB.
- Information was recorded inconsistently, sometimes on the alleged victim's files and sometimes on the alleged perpetrator's file, depending on whether they were already known to CSCS or not.
- The information that was recorded was not generally specific concerning the actual behaviour.
- Whether the information was recorded as a new referral depended on whether they were currently open to CSCS or not.
- These children were likely to experience approximately two or more different social workers during their involvement with CSCS.

These findings clearly show that there was a problem in recording and identifying SHB within ICS, and that there was a lack of consistency from professionals in how to respond to or deal with these cases. This is explored in more detail in the Discussion chapter.

7 Interview Findings

This chapter showing the interview findings has been divided into five main sections:

1. What does 'children with SHB' mean?
2. The realities of case management.
3. Issues of stigma.
4. The alleged perpetrator.
5. Training, support and reflection on practice.

These demonstrate the experiences of parents, carers and social work practitioners – how they make sense of their experiences of CSCS intervention. From the perspective of the social work practitioners this reflects their views on decision making.

In order to protect anonymity, the names of all the participants and anyone that they talked about have been removed. Pseudonyms have been used so that the participant's relationship to the child is evident i.e. mother, father, foster carer, adoptive mother social worker etc. Patton (2002) suggests that the first stage in analysis is to identify patterns which then develop into themes. The first *pattern* that emerged in the interview data set was that all except one of the parents/carers had not previously been involved with CSCS in relation to any safeguarding children issues prior to them becoming involved in relation their child's SHB. The two foster carers both had children of their own and had never had any CSCS involvement. Both adoptive mothers had been involved with CSCS but only in relation to the adoption of their child/ren. The only family with previous CSCS involvement was 7_Grandmother and 8_Step-Grandfather, but this was not in relation to their own children but when their grandchildren were still living with their mother. So, as carers, they had not had any involvement in relation to safeguarding children. When comparing this with the 30 LA cases only eight out of the 30 were not previously known to CSCS. This shows a significant difference between the 30 LA cases and those who were involved with a therapeutic service. It is difficult to suggest why this is the case, but it is significant that most of the interviews were with families who were accessing support via a therapeutic service

for children who display SHB. When this is considered with the findings of Allen (2006) those accessing private support for their children were often middle-class families and less likely to have other CSCS involvement, then this would seem to correlate. However, the therapeutic service in this study was accessed by these families via referrals from CSCS although 1_Mother said she often tried to access this support directly herself. It was also found that, again, all bar one of the families in this study were employed, with only 7_Grandmother and 8-Step-Grandfather claiming benefits, and only 9_Adoptive Mother was a single parent at the time of the incident of SHB – all the others were in long-term relationships.

The following sections present the key findings from birth or adoptive parents/carers and social work practitioners. Some sections are findings just from parents and carers, and some sections just from social work practitioners. These are based around the patterns and themes that emerged during the analysis of the data. After the interviews were transcribed verbatim these were compared with each other to consider any common patterns – Patton refers to these as 'a descriptive finding' such as '"[a]lmost all participants reported feeling..."' (2004, p. 453). The first stage of this was done with parents and carers views compared with each other, and the social work practitioners views considered separately.

The first patterns that emerged were:

- Parents/carers problems in understanding what *children who display sexually harmful behaviour* means.
- Parents struggled to talk explicitly about what their child had done.
- Social work practitioners talk of sexual abuse rather than SHB.
- Case reflections of social work practitioners.
- Social work practitioners' use of non-specific language to describe SHB.

These patterns showed similarities with each other, such as the difficulties in being explicit about sexualised behaviour by both parents/carers and social work practitioners. This is discussed in detail later in this chapter concerning the assumptions made about why this may be the case and why there may be different reasons for this happening.

Following the analysis of these patterns, specific themes were developed which Patton suggests are 'a more categorical or topical form' which develop from the patterns (2004, p. 453). In the final stage of axial coding these themes were developed and the views of parents, carers and social work practitioners were brought together around these themes:

- 7.1 What does 'children with SHB' mean?
- 7.2 The realities of case management
- 7.3 Issues of stigma
- 7.4 Views of the alleged perpetrator
- 7.5 Training, support and practitioner reflections

Thick description is used to present this data here as quotes from the participants during the interviews, as well as understanding of the context, these help to show the depth of emotion and thoughts regarding events of what was happening from the perspective of the participants (Patton, 2002). It is important that thick description is presented in this way so that the reader is able to understand what occurred before this is interpreted by the individual researcher. Therefore this findings section is focused on thick description with more in-depth interpretation and the main analysis taking place in the Discussion chapter which follows (Geertz 1973).

7.1 What does 'children with SHB' mean?

As previously stated, a narrative interviewing method was used when interviewing participants. This meant the interview took the form of a conversation in which they shared their stories, interpretations and beliefs. Each was begun by asking them the following:

> *If I say 'children who display sexually harmful behaviour' – can you tell me what this means to you in terms of your knowledge and experience of these children?*

Prior to the interview commencing, it was clarified that the interviewee had read the Information Sheet which had been provided (*see* Appendix 3). This clearly set out the interview topic in relation to children who display SHB. Whilst all the parents indicated that

they understood what this meant, the two foster carers and three social workers thought it meant children who had been sexually abused. This manifested in the participant talking about the sexual abuse by an adult towards a child therefore attempts were made to steer them towards SHB. However with both the foster carers explicit reference was made to the child they were caring for and why they were involved with a therapeutic service for children who display SHB. For example, 4_Foster Carer was asked:

> *Researcher: When you think back to your first experiences with children who display sexually harmful behaviour, can you tell me a bit about that? About what happened and how it occurred?*
> *4_Foster Carer: I did get a little bit of information from the social worker about the sexual behaviour as the little lad had said someone had touched him but at the time they had no proof....*

She then proceeded to talk about this child experiencing sexual abuse from a family member and did not talk of the SHB displayed by the child, and the alleged perpetrator of the abuse towards him was by an adult. Similarly 5_Foster Carer talked about a child in her care who had been sexually abused and ostracised from her family. She did start to talk about behaviour issues but none of those were sexually harmful. Even at the end of the interview when we were talking about children she had cared for I asked her again:

> *Researcher: I'm looking at children where either you knew they had sexual behaviour problems or it came out while they were here with you, can you talk about any of them?*
> *5_Foster Carer: Of course. The majority in some way have been touched, maybe not directly but indirectly by sexual abuse. The first boy I had his father had been in prison because he'd raped his sister and did something to his older brother...*

She continued to talk about children being sexually abused by adults, rather than children displaying sexual behaviour problems. It is possible that, as these two participants were foster carers that their experiences of caring for children who had been abused meant that had encountered children who had been sexually abused rather than those who displayed

SHB. However, while 4_Foster Carer confirmed that the boy in her care had been sexually abused by his father, as well as displaying SHB himself, 5_Foster Carer could not confirm whether the boy in her care had in fact been sexually abused himself.

This was simarilty found with three social work practitioners (Social workers 10, 11 and 13). 10_Social Worker was very clear in her view that Child5 had been sexually abused and that this was why he displayed sexualised behaviour. She felt this was the case because Child5 wrote notes saying 'let's have sex', which she indicated in her view meant that he had been sexually abused. She acknowledged that children probably did write notes like this but in his particular case she felt this was because he had been sexually abused. She later said 'When he was raped, well I mean he never used the word rape but we knew he had been'.

Three further social workers and one team manager although did explain what SHB meant, they justified that this behaviour occurred because the children had been sexually abused (social workers 12, 14 and 15 and 20_team manager). 20_Team Manager talked of how Child21 had said she had been sexually abused by her mother's boyfriend, although this information was not recorded on ICS. 15_Senior Social Worker's experience was that of working with teenage boys who had predominantly come through the criminal justice system and he said in his experience he had found that most had experienced sexual abuse themselves. He worked in a team where children were looked after by the Local Authority. However, he was clear of the difference between SHB and sexual abuse, but that his case experience showed a link between the two.

All of the team managers and 16_Independent Reviewing Officer, however, talked immediately about SHB and how the Local Authority responds to it with Team Managers 17, 18 and 19 gave explicit explanations such as:

> *[it covers] sexualised play... right through to children committing offences against other children or other people. Offences such as rape and there is a whole spectrum within that. And sexualised behaviour doesn't have to be towards other people it could be towards animals and there are a number of variations on that...*
>
> *18_Team Manager*

A possible explanation for these views was highlighted by 11_Social Worker who felt that professionals generally have a difficulty with this area as they still seem to understand that 'children who have been sexually abused go on to become abusers, which we know is not the case'. Generally her view was that 'as a society and as professionals we tend to overreact to what we perceive as sexualised behaviour in a way that did not used to happen' when she was a child and that we no longer accept that children can say things but it can be innocent. 11_Social Worker referred to writing a story when she was a very young child which included a planet which she named 'Hymen'. She felt that if that was presented to a school now there would be an overreaction and that questions would be being asked as whether she had been sexually abused. 17_Team Manager also talked of her concerns with the way sexual behaviour can be overreacted to. However, 19_Team Manager began talking of SHB and moved this immediately into talking about how she had experienced a lot of cases involving paedophilia and sex offenders.

7.1a What are the causes of SHB, in the views of participants?

It appeared that birth and adoptive parents found it more difficult to talk about causes of SHB as they were often directly considering the reason why their child had displayed SHB. Their views fell into two main areas: acceptance with some rationalisation; and denial with some rationalisation. (It is important to reiterate that only Child13 was not referred to a therapeutic service and therefore the allegations against her were not proven.)

7.1a(i) Acceptance with some rationalisation

6_Adoptive Mother, 7_Grandmother and 9_Adoptive Mother all accepted their child's SHB but tried to rationalise why they may have done it. 6_Adoptive Mother said she felt her son went into a 'time hole' and remembered what he had viewed when living with his birth mother and her boyfriend – seeing his birth mother raped – and that there was an opportunity, where he fell on top of his younger brother on the trampoline, and then went back into that time when he was younger which made him kiss and thrust against his younger brother. She was very pragmatic about this, and most concern that she displayed was to do with the professional response. She also said she no longer felt he was a risk a

year later, despite only just having started therapy after having waited nine months for it to start. She felt he was 'no longer in the same place'.

Similarly, 7_Grandmother was very matter-of-fact about her granddaughter's sexualised behaviour, i.e. exposing herself at her bedroom window, as she felt this was in response to the fact that she had been sexually abused as a younger child. However, she was adamant that her son had not sexually abused her granddaughter.

Most of the interview with 9_Adoptive Mother focused on why her son had committed the sexual abuse. There was no doubt from 9_Adoptive Mother that he had done it, but she gave a number of reasons as to why: being adopted, the divorce of his parents, the death of his girlfriend's father and the ending of the relationship with his girlfriend.

7.1a(ii) Denial with some rationalisation

2_Mother and 3_Father however did not accept that their son had displayed SHB against his cousin and rationalised why this could not have happened. 2_Mother referred to inaccuracies in what her niece was saying e.g. that the bedroom door was locked when there no locks on her bedroom door. 3_Father also talked about inaccuracies:

> *And we knew for a fact that my son was not there on some of the days when she alleged that things had happened. So she was saying things had happened at Christmas. Sorry, New Year and we were not there for New Year because we were at my brother's house. And she said she locked the bedroom door when she came to our house but there is no bedroom door because it is a loft, straight up to the bedroom so there is no door... I think it takes a weight off your mind because you know that you were not there and your son was not there and so he could not have done that and so you think then she must be making things up...'*

3_Father talked of feeling comforted by these inaccuracies as it meant that he could have trust in his stepson, 'I think it is wrong when parents say they haven't got doubts because I think they must have.' But the inaccuracies meant that, in his view, he could trust him. However, he also drew on his own experiences in the army of working with sixteen and

seventeen-year-old boys – 'their minds think particularly about sex'. He felt able to draw on this to help him understand his stepson's actions, so that he was not so surprised by them.

However, 2_Mother said she warned her husband to be careful not to just believe their son 100 per cent, as she said he is capable of lying. She had accepted he had done things before, but with this incident she was not sure. When I spoke to 3_Father about this, he did accept that his step-son had not done it:

> *I mean when I first heard about it then obviously the doubts are there, and you are thinking well has he or has not he done it? You know with his past experience and you are thinking well did he or didn't he? And then I asked him and said have you actually done this and he told me no, and so I said well I will stick by you 100%.*

3_Father felt it was important that parents did try to accept their child's behaviour otherwise this could act as a barrier in between them:

> *It has happened there is nothing that you can do about it. And I mean if we couldn't deal with it that would make it harder on our son wouldn't it. If we could not deal with it, it would create a barrier between us and our son. Which will just make it so much harder for our son. So much harder for him to be able to sort himself out.*

7.1b Social work practitioners views of SHB

Section 7.1 demonstrated how three social workers immediately talked of sexual abuse when talking of SHB and that a further three social workers and one team manager suggested sexual abuse as a cause of SHB. 10_Social Worker, 13_Social Worker and 14_Social Worker all had the view that these children would have been sexually abused and that's why they were displaying the behaviour. They did not make other suggestions for the behaviour in the children's backgrounds. 14_Social Worker however acknowledged that she felt inexperienced in relation to SHB, but said she would have to ask whether these children had been sexually abused themselves and whether they were internalising or mimicking that behaviour. 15_Senior Social Worker also referred to endemic sexual abuse within

families where boundaries had been blurred, which had been the experience he had with the cases he had managed. He acknowledged that those cases were ones that had often come down the criminal justice route therefore involving adolescents who had been subject to an AIM assessment.

16_Independent Reviewing Officer concluded, that in order to assess children who display SHB practitioners have to accept that they may have witnessed sexual abuse in some capacity, and so that should be their starting point. However, while the majority of social workers focused on child sexual abuse as a background reason to SHB, only one of the team managers did. 20_Team Manager's first response was 'what has happened to these children that they are displaying such behaviour? Have they seen it? Have they been sexually harmed?'

However apart from sexual abuse there was little agreement in the views of the social work practitioners. 10_Social Worker described SHB as 'risky behaviour to the child or to other people around the child – sexualised behaviour that is risk that could cause them harm'. 11_Social Worker's initial response to this question was very honest:

> *Why do children display sexually harmful behaviour? Well that's the big question isn't it? And I'm afraid I don't think I can answer that in this interview!*

Two social workers (11 and 12) both talked about 'adverse' issues in the child's background that could lead them to display SHB. In the view of 11_Social worker these families were living in deprivation and in crisis, substance misuse and neglect. 12_Social Worker referred to them having experiences abuse and clarified this as sexual, physical, emotional abuse and neglect and that SHB could be the response of the child to any of these circumstances. She also felt it was difficult because professionals often had differing viewpoints as to whether the behaviour was experimentation or is it harmful. (This ties in with the findings from the 30 cases where there appear to be different responses to similar referrals.)

18_Team Manager went on further to say she felt there could be a variety of reasons why children can display SHB and that this depends on the nature of the behaviour. '[T]he

behaviour to me is “abnormal” and indicates that they may have seen something they shouldn’t, or exposed to sexual abuse themselves – that would be the background that I would think of’. These views were based on her experiences of families she has worked with. When asked if she felt it was easy to determine what was ‘abnormal’ she replied ‘no, not at all’. She felt that context was important and in understanding the background and environment of the family.

This difficulty in determining whether sexual behaviour would be viewed as a problem or not, was also raised by 17_Team Manager, 18_Team Manager, 15_Senior Social Worker and 12_Social Worker. 17_Team Manager summed this up saying:

> *If it’s two four years olds is that OK? If it’s a four and a six-year-old is that OK? And I don’t think even as a social work team manager that we were very clear. I don’t think we’ve had enough training around sexual behaviour. I don’t remember doing any kind of training at [this Local Authority] around children’s sexualised behaviour. I’ve done my own research, but that’s it.*

18_Team Manager agreed that there was a difference between children and between young people, and that this affected what would be viewed as ‘appropriate’ behaviour depending on their age. The majority of the cases managed by 15_Senior Social Worker were teenagers, and those who were not sexually abused themselves he described as ‘exploratory’ which had gone too far. In these cases, he agreed with 12_Social Worker in that the children demonstrated ‘inappropriate behaviour and professionals have overreacted to it and once you tease it out it hasn’t been sexually harmful just exploratory’.

Each of the social work practitioners also talked about the actual cases they worked on in order to explain why they thought those children in particular displayed SHB. There were similar views when talking of the same children between social workers and team managers as to why the SHB had occurred. However, in different cases the social work practitioners each had different views for the causes, which were individual to each child. 10_Social Worker had suggested that a cause of SHB was a child having been sexually abused and she was clear in her belief that Child5 displayed sexualised behaviour himself because he had

been sexually abused by a foster child in his paternal grandmother's care. She said that she believed he had been sexually abused even though she acknowledged that he was 'vague' in the details he gave because he was frightened to go back to that house (in her view) and children don't lie about things like that. Similarly, 12_Social Worker referred to having a 'gut feeling' and to 'evidence' from her 'observations of [the] relationship' between Child12 and his carer which made her feel 'uncomfortable' which was why she believed Child12 had been sexually abused. She suggested that it was concerning that he had pursued a residence order for Child12 as, in her view, there was not a strong relationship in the past other than sporadic contact, and he was not a family member and had no relationship with the mother.

18_Team Manager who was involved in the case later also had this view after reading some of the letters written by Child12 to his carer (as previously stated). 19_Team Manager was managing 12_Social Worker on this case and she was very certain in her view that it was the carer who downloaded the images but that he had 'groomed [Child12] to say it was [Child12] because he was a juvenile and he would get a lesser sentence that what [his carer] would as an adult and this was our view'. However, the latter part of this sentence was not documented in CSCS or given verbally by 12_Social worker or 18_Team Manager, although 19_Team Manager was very clear that this was her view as to why Child12 admitted to the offence. She did not accept there was any possibility that Child12 could have downloaded any of the images himself.

Only one social worker (13_Social Worker) focused on the issues of domestic violence within the son's home environment and how she felt this had affected him and led him towards sexualised behaviour as, in her view, he had a derogatory view of women and instead focused on pleasing his dad, which he then transferred to his male foster carer. She did feel, however, that there was a possibility that he had been sexually abused by his father, as the son said he used to do these things with him. However, she said it was not possible to produce any other evidence to support this. She also mentioned that over a period of two years the two children had the impression that their father had murdered their mother with a knife when in actual fact she died of natural causes. She felt this would have impacted emotionally on them.

Prior to 13_Social Worker's involvement, 17_Team Manager was involved with this family initially in relation to the SHB displayed by Child14. 17_Team Manager's view was that Child14 was rubbing her vagina in front of people as a 'comfort thing and I don't think we know enough about why children touch themselves'. She felt that it's possible that people's views change when it is a little girl touching themselves. She felt it can be quite common for little boys to touch themselves and their parents stop them, but when little girls do it people seem to be concerned as to why. She felt we need to be trained as to what is normal behaviour for children to help us to make judgements. However, she did admit that perhaps she would be one of the people who would attempt to 'normalise' the behaviour and put it down to 'exploration'.

14_Social Worker said she found it very difficult to know who to believe. She talked of how the daughter was self-harming and she did wonder whether this was a cry for help, wanting the attention from someone to ask her what was wrong. But on the other hand she felt that she also told a lot of lies.

> *So you start to feel like the family don't you? You know, did it happen because she's lied in the past, or was it a cry for help? Was that her saying she wanted someone to ask her how's she feeling? But then the police interviews there were a lot of holes in them.*

She talked of how she would sway from one to the other. These views were also expressed by 18_Team Manager who felt it was very difficult to determine the truth and that they never really got to the bottom of it.

When 15_Senior Social Worker began working with Child8 he accessed historical files about his family and found that Child8's father was in prison for sexually abusing Child8's two older half-sisters. Child8's mother had a number of sexual partners and some of those men were flagged as a risk to children. There was also some information about his Uncle who 15_Senior Social Worker had worked with in the past where he had removed children from his care because of sexual abuse. So even though Child8 did not disclose any sexual abuse to him before the end of the court case, it was suspected that he may have at least been a

witness to sexual abuse which would have impacted on his own behaviour. 15_Senior Social Worker was also able to watch the interview of Child8's five-year-old niece and he felt the clarity of information given by her indicated to him that it had happened. Also, prior to the assault on his niece there were some concerns about Child8's sexual behaviour.

7.1c Summary

The views of birth and adoptive parents, carers and social work practitioners demonstrate that the term SHB, whilst used in research, conferences and journal articles, is not something that is fully understood by those who receive referrals, those who work directly with these children or those who are caring for these children. There was still limited agreement, as identified in the Literature Review, as to what constitutes SHB as Vosmer *et al.* (2009) found, there was a lack of consensus in terms of what constitutes 'normal' sexual behaviour. Only 19_Team Manager made reference to her own values and how this impacted on the decisions she may make and the way she may view things, i.e. being more likely to view sexual behaviour first as exploratory rather than concerning in the first instance. This was not something raised by the other social work practitioners – there were no stories relayed where they admitted to having a particular view about sexualised behaviour, only that they were doing their job and acting accordingly.

When considering why children displayed SHB the only agreement between social work practitioners was that the majority referred to these children as having been sexually abused or witnessed some kind of sexualised behaviour, as suggested by Hummel *et al.* (2000), Johnson and Doonan (2005) and Drach *et al.* (2001). However, Johnson and Doonan (2005) expressed concern that this opinion should not be encouraged in professionals as it could lead children to make an erroneous disclosure. This can be seen in the case of 10_Social Worker when referring to Child5, whom she acknowledged did not refer to being sexually abused himself, but she did. When considering other factors there was little agreement between social work practitioners, for example other forms of abuse were considered as well as domestic violence (as confirmed by Johnson and Donan, 2005; Pithers *et al.*, 1998; Friedrich *et al.*, 2005; Merrick *et al.*, 2008; and Boyd and Bromfield, 2006). As suggested by Pepler *et al.* (2000), children exposed to domestic violence are at risk of

developing behavioural problems, and Friedrich *et al.* (2005) suggest that this behaviour can be learned from their environment. However, as found only 13_Social Worker referred to domestic violence.

It is evident from these findings that it was difficult for parents to talk about their own children and it was difficult for them to explain why their child had displayed SHB. The CJJIR (2013) found that one of the most difficult issues parents reported was the emotional difficulty placed on them to actually accept the abuse had happened. In this thesis, when viewing their child's behaviour parents fell into one of two groups: acceptance with rationalisation; and denial with rationalisation. Whilst one adoptive mother suggested her son may have witnessed the rape of his birth mother, no other parent suggested sexual abuse as a possible reason for their child's behaviour. It is unlikely however that a parent would admit something that could be about themselves like this to a researcher, although it is possible that they could have looked to other people they knew or their child knew, but they did not. Therefore parents did not consider sexual abuse as a reason for their child's SHB. What is clear from these findings is that parents/carers of children who display SHB are going through a process of adjustment themselves in order to understand their child's behaviour and how to support them (Calder, 2000a). This therefore places greater emphasis on social work practitioners and their ability to engage with and support these parents/carers.

7.2 The realities of case management – how the response of professionals is viewed in relation to SHB

7.2a CSCS

Six of the parents demonstrated that they had negative views of CSCS in relation to their child's SHB. All the parents had not experienced CSCS before except in relation to this, and the Adoptive Mothers had only experienced CSCS prior to this to arrange the adoption. Both 1_Mother and 2_Mother felt that the response of CSCS was not helpful and was inconsistent. 2_Mother reported that:

> *Every time we have gone to get help and they have said well you are moving again soon, or you are moving next year, or you are moving in two years, we will not bother*

starting but wait until you get your next post. Then we'll do something then. And then you get to the next post and then they say well you are moving again so we will just wait. So it has been like that continuously...

The view of 7_Grandmother and 8_Step-Grandfather was that CSCS 'completely overreacted' to the note written by their granddaughter which resulted in them taking her into foster care. They were clear in their feelings and beliefs that the social workers had made up their minds what to do from the start and that they were not willing to listen to them at all. In relation to Child2, 14_Social Worker felt that it was the right decision for the alleged perpetrator to be removed from the family home while the police investigation was ongoing due to the severity of the allegation (rape). However, later the family decided that the daughter (alleged victim) should move out and the son (alleged perpetrator) could come back. She felt that if this had been the decision of CSCS then it would be wrong because 'why should supposedly the victim have to be removed from their home?' (although this was the case in relation to Child3).

9_Adoptive Mother was a health visitor and therefore had some knowledge of safeguarding children issues. She felt very upset that CSCS in her area did not follow the appropriate guidelines in dealing with her son referring to understanding later that a s47 enquiry should have been completed but was not.

The parents' experiences of inconsistency in the response of CSCS, was not surprising when considered with the views of the social workers in this study. Two social workers and one team manager also had negative views. 10_Social Worker said she was told what happened with Child5 by the school and her opinion was 'I was not in a position to do anything about [the sexualised behaviour] and I don't know even if I could have done anything'. This was confirmed by 11_Social Worker who said as an agency 'we struggle with children who display sexually harmful behaviour – we are really scratching our heads'. When asked what other options there are for the assessment of children who display SHB who have not admitted to or been convicted of the offence (as is required before an AIM assessment has been completed) 20_Team Manager's response was 'It is difficult because a lot of the agencies who would work with a child who has sexually harmed another child won't pick it

up because there has been no conviction or admission and they've said they can't work with a child who is in denial but I feel that's wrong...'. She felt it was important that therapeutic intervention began as soon as possible rather than 'going round in circles' about children being out of the home or in a settled placement first...

6_Adoptive Mother is herself a practising health visitor and had a lot of experience of dealing with CSCS in that capacity. Because of this she was able to influence CSCS response to her child. She acknowledged that the *normal* response to her son would have been police and social service intervention, however she was able to argue with social workers that this would not benefit her family, and she described how she 'made the active decision not to go down the child protection route Not only was she able to stop the police being involved but she was also able to decide what support her son should receive. 'We knew that [therapeutic service] was what he needed but they needed the evidence to prove it' which was difficult to produce after it was agreed that child protection would not be involved. This suggests that 10_Adoptive Mother was able to maintain more control over the situation due to her class status.

7.2b Police, the CPS and the courts

There were mixed views as to whether having the police involved was positive when their child displayed SHB. 3_Father and 16_Independent Reviewing Officer expressed positive views of police involvement. 3_Father felt pragmatic about the police involvement saying 'when things turned up they had to be involved'. 16_Independent Reviewing Officer was the only social work practitioner who had a positive view of police involvement in that it was 'reassuring as it's better when you know there's another process as long as it's joined up and you are communicating and you know what's happening... I find it's important'. Conversely most participants had negative views of police involvement. 9_Adoptive Mother felt that her son was treated like an 'adult sex offender' in the way that CSCS responded to him by involving the police straight away rather than going to CSCS first. Her view was that if CSCS were informed first then they would consider what was in both the victim and perpetrator's welfare and what was in the public interests before involving the police.

9_Adoptive Mother had initial involvement from the police due to her son's age at the time of the offence and she described this as being very 'traumatic':

> *So I picked up my son from school on the Thursday and took him to the police station and it was very, very traumatic. I'd not had any contact from social services whatsoever so I had no idea... you know, what to expect. So my son had to have his photograph taken, fingerprints, DNA sample.*

She felt she did not know enough about the procedures to know how things should go at that time. Although she said the policeman who conducted the interview was 'nice' she felt it was a very bad experience for her son, it was a 'two hour interview during which my son was very, very distressed and cried'. She described feeling like 'we were like lambs to the slaughter, we were just sent to the police without any support whatsoever'.

Social work practitioners also predominantly had negative views of police involvement. 12_Social Worker described how the police were the lead agency in the case of Child12 and that this caused delay in terms of them sharing information with CSCS. The police told her 'there was an image of [Child12] in the bath which they did not view as significant but we viewed that quite seriously and we said "no" we are quite concerned about this young person being at home'. She highlighted that these two professions have different thresholds when considering whether to pursue a case, what might not be criminally significant could still be significant in terms of the welfare of a child remaining at home. She felt that this was something the police did not consider when they decided what information to share and that 'because of [the police] investigation we felt [the police] were holding back a lot more information'. The difficulty was that if the police shared information that they felt this could impede their criminal investigation. However from the point of view of the social worker this meant the child remained at home a lot longer than they should have. This was because they did not have enough information/evidence for removal until that was shared by the police – meaning that he remained in what 12_Social Worker felt was an abusive environment for longer.

12_Social Worker said that 'the police work independently from social services, they do not work together'. This was also the view of the manager 19_Team Manager. She described the situation as 'confusing' and that she did not understand why the police did not share all the information immediately. 13_Social Worker, however, had not dealt with police involvement on a case in this way, but said she would find it quite challenging if there was still a police investigation going on when working with a family – 'knowing what to say... and what not to say more importantly'. 14_Social Worker also expressed concerns about police involvement but more in relation to families' expectations of an outcome.

CSCS had removed Child2 from the family home due to the ongoing criminal investigation to establish whether he had raped his sister as she alleged. After this process was completed she said a letter was received from the Crown Prosecution Service saying they were not going to take the matter any further due to lack of evidence. She said the family found this very difficult:

> *They really wanted a yes or no as to whether he had or hadn't raped [his sister] so that they could move on. That was the biggest thing for them that they were still left in limbo… that they didn't know who to believe or whether it did happen or not*

15_Senior Social Worker said he found that working alongside the criminal justice system could present difficulties for CSCS's remit in working with children. Once the case was completed with Child8 he began to talk to the social worker about what happened and why he did things, but he told 15_Senior Social Worker that he did not say anything to him before because he was told not to by his defence lawyer, 'so that closed him right down and he didn't know who he could trust and couldn't trust'. 15_Senior Social Worker felt that his remit was to work 'alongside' the criminal justice process but that he was unable to complete his work with Child8 at the time while proceedings were being completed. He described this as 'very frustrating' but necessary because of having to work within the legal context because he 'wouldn't want the criminal case to fall apart because of something I'd done'. 20_Team Manager was the manager on this case and she agreed:

> *It can be very difficult because as a social worker in the [...] team your focus is on his needs, on **his** needs, you're not focusing on the criminal side on the crime or the needs of the victim, you are focusing on **his** needs (original emphasis)*

She felt this was achieved by completing an AIM assessment and that there needs to be a balance when considering the alleged perpetrator's needs and comparing them to the safeguarding of other children (Morrison and Henniker, 2006, pp. 32–3). This assessment was similar to that of 12_Social worker and Child12, but she expressed concern that the police were not working with her and were not sharing information which meant she did not have the evidence to remove the child as soon as she felt was necessary.

Because it related to the case of Child14, 13_Social Worker talked of the frustration she felt when the courts were involved and how this impacted on her ability to provide support for Child14. She had wanted to provide specific therapeutic support in relation to the SHB of the son but was unable to because 'we weren't allowed to do any specific work around sexualised behaviour because the judge was always, there's no evidence of sexualised behaviour'. Once the Care Orders were granted she said the Judge ordered that they were still not allowed to do anything for the children, as the Judge said anyone doing work with the children would be 'biased in their analysis' against the father. Dealing with the courts and its impact on therapeutic support was also raised by 15_Senior Social Worker as he felt that the plea bargaining that occurred in relation to Child8 was not helpful, as he admitted to the offence of assault without any reference to the sexual nature and in 15_Senior Social Worker's view this meant that Child8 would not get the help he needed. He also confirmed that Child8's solicitor actually told him afterwards that, while he knew he had done the right thing legally for his client in getting the conviction reduced to assault, he was worried that by ignoring the sexual element this would mean Child8 would not get the therapeutic support that he needed.

7.2c Parents' and carers' views of social work practitioners and any support offered

All the parents (except 1_Mother) and carers were negative about their child's social workers and any support offered. 2_Mother talked of her son having had four social workers in the last year, and that 'as soon as they see 'social services' the barrier goes up'. Having some knowledge of the social work system did not appear to be an advantage to parents. 2_Mother felt that because she had more knowledge of CSCS that this worked against her and her sister during their involvement with CSCS. Their aunt is a senior social worker so was able to advise them of their rights and what CSCS could and could not do. 2_Mother talked of arguments she had with professionals around this issue because she raised more questions.

This was also the experience of 6_Adoptive Mother and 9_Adoptive Mother who are both health visitors and knew something of CSCS. While in some respects this knowledge could have worked in their favour they found that it did not as it simply meant they were arguing more but still not getting things done. They all talked of their exasperation at not getting support for their child quickly enough. In the case of 9_Adoptive Mother she was frustrated that he had not received a Child in Need Assessment, and that services were being suggested without him being properly assessed. 6_Adoptive Mother became 'frustrated' that there were cost issues, and arguments ensued between professionals as to who should cover the costs for therapeutic support. 9_Adoptive Mother also felt that there was 'a lot of collusion among all the professionals involved when they were aware that I had talked of complaining about CSCS'.

All parents had a negative view of CSCS's involvement prior to them actually becoming involved with their family. 3_Father described them as 'old nosey parkers' and that he was worried that when they became involved that they could take his stepson away. This view was echoed by 1_Mother and 2_Mother. The way in which parents coped with having CSCS involvement, depended on their view of the actual social worker. For example, 2_Mother suggested 'I think it also depends on your social worker as well and how they come and approach you.' This was similar to view of 6_Adoptive Mother who felt that personality was

a key issue in how you felt about a social worker as personality can make such a big difference in whether a parent feels they can work well with a professional. 2_Mother felt that an important personality trait was the ability to adapt working practice to suit the needs of the individual child. Yes, procedures must be followed but she said her son worked well with his new social worker (his fourth in a year) because she reduced the number of people needed at each meeting after sitting down with him and talking things through – establishing who was really needed and who was not.

5_Foster Carer also said the main thing was that 'these young people have a social worker for a decent length of time... sometimes they have one after the other and they don't know where they are. They need to have the time to form a relationship with them so they can talk to them when they need to'. 6_Adoptive Mother agreed that social workers should be able to adapt their practice when it was needed as her family already had an adoption social worker and a therapeutic social worker. However, when her son displayed sexual behaviour problems CSCS required another social worker to get involved to complete an assessment of her son as a child in need. Her view was that both social workers already involved knew the family well and both were experienced in safeguarding children (otherwise they would not have been able to apply for their current jobs) so why could CSCS not adapt to allow one of them to complete the assessment rather than having another person involved who did not know the family and would have to go through everything again?

All the parents and carers were asked what, in their view, made professionals not good and the parents all agreed that it was when they felt the worker was looking for some way to blame the parents for the child's behaviour, and also when they were hardly involved. For example, 2_Mother said 'well the second one, I didn't have a chance to get to know here as I only saw her twice'. She also expressed regret that it's the bad things you remember rather than the good ones:

> *I'll never forget. I won't forget someone coming in and pointing the finger at me and saying 'you've done wrong, you have not looked after this child' and I think you pick up on that more than you do the good.*

6_Adoptive Mother felt that the social worker should be someone you seek support from, but when she did this on one occasion she realised that she would be reluctant to do it again as this was used against her later. So rather than a focus on support her experiences were of social work as investigative and punitive.

This was also experienced by 4_Foster Carer as she felt at a Summer BBQ run by the foster agency that she was being observed rather than supported. She also talked of the difficulties she had to get some respite from caring from the boy in her care (see Risk management section) and also of how the financial support was removed from her because she was caring for a boy who could only be in a single placement yet she was set up for two. Financially this was something that she needed but the agency only paid her for 1.5 places, so she was losing money by keeping the boy with her. During our interview I observed that she was clearly torn about this issue as he had been with her for over a year and was settled, but financially she was finding the reduced income difficult.

She was generally very critical of agencies for being too focused on money rather than supporting their carers which is what she felt they were like in the beginning. This was also suggested by Langan (2006) where thresholds are in effect an excuse to save money and not provide support to all. 6_Adoptive Mother also raised concerns about how funding issues effect the provision of support. An application was made for her son to receive therapeutic support in the April and they did not get a response until the September and the actual therapy did not start until the following February.

5_Foster Carer also expressed concerns about the reality of support being offered:

> *I mean you have them twenty four seven so how much support do you want? How much support do you need? How much support do you ask for? In some cases I want someone there twenty four seven!*

7_Grandmother and 8_Step-Grandfather had a very negative view of CSCS when they became involved with their family. 8_Step-Grandfather felt he had just gone to a

professional for advice on what to do and it resulted in his granddaughter being taken into care rather than in receiving support.

The main issue they focused on was that they felt they were not being listened to, that the social workers had clearly made their mind up about what they wanted to do beforehand so just went through the motions of visiting the family before taking the granddaughter into foster care. 7_Grandmother and 8_Step-Grandfather clearly felt that they had not been asked about this and yet CSCS recording states that the granddaughter was removed with the grandparents' permission on a s20 (voluntary) accommodation. _Step Grandfather's response of 'social services to me are a waste of space' suggests that he did not feel listened to in this situation.

Only two Social work practitioners talked of the support they arranged for parents in relation to their child's SHB. 14_Social Worker said how the mother was struggling to cope with the question over whether her son raped his sister – who was telling the truth? The police investigation was unable to gather enough evidence and so the case was dropped which left the family without any definite answers. 14_Social Worker said she therefore arranged for therapy for the mother to help her to deal with her feelings about this. As well as this she arranged therapy for the daughter to help her deal with the feelings she had of not being believed by her mother.

When she was a social worker, 20_Team Manager said she researched the internet to find a counsellor who could speak Portuguese for the mother of Child21 to help her cope. She also discussed how she arranged family support for her and the family to help them cope with the difficulties that happened.

While parents had inconsistent responses for CSCS, most talked positively about their experiences with, and support from, the therapeutic service their child was involved with. 2_Mother gave particular reasons for this:

I actually think they are fantastic. From day one everything has been explained. Any time you have had questions about anything you don't understand it is just a case of, phone us. They have kept in constant contact.

1_Mother felt she was able to call them anytime she needed support and 3_Father said the way they talked to the family was more positive and considerate – less intrusive than CSCS. 9_Adoptive Mother was the only one who was really negative about the therapeutic support as she was not happy that a proper assessment had not been completed of her son and she therefore questioned how the therapeutic worker was able to address his needs when this has not been done.

7.2d Parents' and carers' experiences of meetings organised by CSCS

None of the parents or carers viewed the meetings organised by CSCS positively particularly with regard to their appearance of being disorganised. Parents agreed that they were often confused at the sheer number of professionals who attended meetings and did not know why they were there, especially when they had never met their child.

2_Mother remembered having professionals call her saying they were at the place of the meeting but it had been cancelled and they had not been told so they were calling her to find out what was happening. While her view was that the social worker was the professional who was supposed to organise things, if she needed to speak to someone she would speak to whoever she could get in touch with as she found that professionals were often so busy that it was difficult to get hold of them. She understood however that this meant that they needed to be considered when meeting times were arranged but she felt at first they did not apply the same consideration to her, as she has four children to manage so she had to bring her youngest to the meetings as she had no other childcare. At first she felt they were not understanding of this but ultimately she just had to tell them that it was either this or she would not be able to attend. This extends to when her son's social worker was changed and she was not informed why, 'it's a need to know basis and you're just a parent and you don't need to know. That's how it feels.'

3_Father similarly had concerns about the lack of communication around meeting attendance:

> *I was thinking well why are people missing? Well they should confirm it and make sure everybody is there. And if anybody is not going to be there then why not?*

Ultimately 3_Father felt this lack of professionalism raised concerns for him about how important his child was to them, 'I am coming here because it is my child and it is in my child's best interests but then the other people can't be bothered to turn up'. He also felt that them being organised was something he would have found reassuring, like they knew what they were doing.

The two foster carers also shared similar views to the parents. 5_Foster Carer described meetings with meetings as 'being led to the lion's den' because of how many people usually attend the meetings. 4_Foster Care worked for an Agency and therefore had experienced meetings with a number of different Local Authorities, and she described the meetings were organised 'as such'! By this she clarified that meetings ran differently depending on the social worker. 5_Foster Carer also found that sometimes the meetings were well organised, but this entirely depended on the personality of the social worker – 'some are very organised and some very scatty'. 4_Foster Carer suggested that she found reminder letters about meetings particularly helpful as well as arranging the next meeting when everyone was together. However, she was concerned about how information did not get passed on when children went to different areas and had different health and education authorities. She described this as 'who's going to do that 'cos I'm not 'cos it's not my job'! Similarly, 5_Foster Carer found the processes very confusing as 'there's this review, that review, core groups, care teams etc.'

While not organised by CSCS, 9_Adoptive Mother talked of how terrible a meeting was which was organised by her son's school:

> *I was so shocked because I went into this room and I expected to see the Headmistress and there was her, the deputy head, the woman from YOT, two people*

from the Education Authority, a young man from Connections and they'd had a case conference and I wasn't even told. It was like an ambush. I nearly fainted! It's been horrendous.

She was not given advance warning of the situation and it was in these circumstances that she found out her son had been excluded from school due to his conviction.

7.2e CSCS's preventative work

For the children of the parents interviewed there had usually been a prior incident of SHB so they talked about the work that was completed with their children in the early stages and what kind of preventative work was completed. A key theme was that some safety plans were set out for families but that these did not always work. 1_Mother talked of work initially being completed by a social worker concerning appropriate touch etc. After the further incident when the police became involved her son was referred to a therapeutic service where work was completed with him and a safety plan put in place. At our first meeting 1_Mother talked positively about this safety plan and that it was helping her son – she said 'I must admit that I cannot fault [therapeutic service] they have done a fantastic job'. However, at our second meeting, which took place several months later, a further incident had occurred and 1_Mother was no longer positive – instead she talked of it clearly having not worked, also that CSCS had not got in contact with her and she had been left unsupported and not knowing what was going to happen until her son had to answer bail conditions the following month.

6_Adoptive Mother advised that work was previously carried out with her son by a therapeutic worker in relation to aggressive and problematic behaviour, although not specifically sexual. This was in response to the aggressive behaviour he was primarily displaying and the few incidence of problematic sexual behaviour was also included in this. 7_Grandmother and 8_Step-Grandfather said no preventative work was completed with their granddaughter. This was something that 11_Social Worker agreed with (she became Child3's social worker after she went into foster care. 11_Social Worker was asked whether she thought, in light of her opinion that the response of CSCS was a proportionate one.

We didn't have evidence at all. I felt it was a bit heavy-handed to be honest. It was like the blue lights, get her out. I don't think it was the right approach... I think the way it was done was just too quick.

She also confirmed that at no point did Child3 make a disclosure of sexual abuse by her Uncle therefore while concerns arose while she was in foster care that focused on her sexualised behaviour and how this placed her at risk especially in the view of the social worker that her grandparents were minimising their concerns, but this was not the real reason for her being taken into care – that was the question over whether her uncle had sexually abused her.

For Child 2, 18_Team Manager said that when the allegation was made against him the response was to act as though the information was true in relation to prevention therefore safety plans were set up to ensure his sister was protected. She said it was clear from professionals' point of view that this did not mean they believed he had done it but it was necessary for the protection of other children while the police investigation was ongoing. However, she acknowledged that this was very difficult for his family to understand as it appeared CSCS had apportioned blame.

17_Team Manager felt it is clear that as an agency 'we do not know how to respond to sexually harmful behaviour'. She felt that safety planning as a preventative tool should be completed early on, e.g. at first referral stage to try and prevent problems occurring in the future. However, she was concerned that there are not may appropriate services to refer children to only therapeutic services but that that might be too much at an early stage. Generally she said 'I feel there is very little consistency across the authority'.

7.2f Summary

As suggested in the Literature Review, parents are concerned about their relationship with social work practitioners, not just in terms of their personality but in terms of the their actions (Holland, 2000;Spratt and Callan, 2004). With reference to *actions,* inconsistency

(when data suggested procedures were not followed) has been an issue throughout this study as raised in the 30 cases, and this has followed through the parents'/carers' experiences of social work practitioners. The view expressed by 6_Adoptive Mother was, however, that contrary to the findings of Holland (2000) and Spratt and Callan (2004), personality *was* a key issue in how she felt about a social worker, as personality can make such a big difference in whether a parent feels they can work well with a professional or not. They also perceived the relationship with practitioners as positive if the social worker listened and responded to them. 8_Step Grandfather's response of 'social services to me are a waste of space' certainly suggests that he did not feel listened to in this situation. Overall, parents reported feeling they were not treated with respect and as though they were a failure as a parent (resonating with the findings of Hackett, 2001).

The realities of case management from parents'/carers' perspectives therefore was largely viewed as negative in terms of the professionals involved and their views of CSCS's lack of support or preventative work, as well as the social workers involved. Hackett (2001) found that, amongst other issues, parents' expectations of practitioners were for them to keep them informed and provide clear information. This negative experience was further reflected in their views of the disorganisation, with meetings being cancelled and high numbers of other professionals being involved without them really understanding why. 3_Father's view, which represents the implications of this, was that this did not give parents confidence in CSCS or how they would treat their child. This was also found in the way 10_Adoptive Mother was able to maintain more control over the situation due to her class status (as also suggested by Allen, 2006).

Before the intervention they all admitted to having a negative view of CSCS and that this was then reflected in the lack of support they felt they received. Therefore parents' expectations of support from social work practitioners was not met (Hackett, 2001). Only two social workers made reference to any support that they were able to give parents in relation to their child's SHB. The limited focus on safety planning was summed up by 17_Team Manager when she said they just do not know how to respond. As suggested by Langan (1996), who identified there had been a shift towards the 'diligent pursuit' (p. xv) of the clues of abuse rather than supporting families in need; whilst welfare developments

have occurred since then, Frost and Parton (2009) confirm that this essential focus on the forensic punitive nature of child protection has remained. As suggested by Thorpe and Bilson (1998) if referrals are initially identified child protection then this can influence the way in which the work with families progressed. Child protection to this extent suggests a more punitive focus, which is backed up with what 11_Social Worker refers to as a 'blue light' approach.

7.3 Issues of stigma

7.3a Parents' and carers' difficulty in naming the behaviour of their child

Comment [MD1]: Removed 'experience' here

Foster carers and social work practitioners generally had experience with more than one child due to the professional nature of their involvement with children. However, all the parents' experiences were that of their own birth or adopted children (or grandchildren) and rather than thinking of sexual abuse when the issue of SHB was raised, they all appeared to struggle to want to actually talk about the behaviour. For example, this was shown in way in which participants deflected questions away from the behaviour. Each time the issue of the alleged behaviour was raised concerning 7_Gradmother and 8_Step Grandfather's granddaughter they returned to the issue of the accusation that their son (age 19) had sexually abused their granddaughter (age 13). Later in the interview they did talk about how prior to this incident she had been caught at school with a pornographic DVD which they say belonged to her brother. Also, 6_Adoptive Mother and 9_Adoptive Mother both circumvented questions about the SHB of their adoptive sons. Indeed 9_Adoptive Mother did not name the behaviour until towards the very end of the hour-long interview. When 6_Adoptive Mother was asked about it she gave the information very quickly and briefly before returning to her concerns about the conduct of professionals (discussed later).

7.3b Use of non-specific language and reluctance to ask for/give details

The issue of stigma was particularly prominent in all areas of this research– the 30 cases, the interviews with parents and carers, and the interviews with social work practitioners. 1_Mother talked of her son asking another boy 'to do things' and that he later 'touched' another boy and 'they were caught in the toilets'. With this mother it was not just a matter

of not naming the behaviour but also not actually knowing what it was, as later in the interview she admitted that she did not actually know herself what happened in the toilets, only that there was an 'incident'. Later in a meeting a school nurse asked if either of the boys had been 'checked for sexually transmitted diseases'. The mother felt the nurse was trying to imply something but did not give further details, and the mother's view was that nothing could have happened. When I asked whether she felt that someone should have told her exactly what was alleged to have happened she replied 'to tell you the truth I did not want to know'.

In the 30 cases analysed, the most common description of the behaviour was 'inappropriate sexualised behaviour'. This was used in recordings, reports and even in referrals. In most of these cases specific details were not given in the referral information recorded on CSCS. 4_Foster Carer had a similar difficulty in actually naming the behaviour andit was 30 minutes into the interview before she was comfortable enough to give more specific details. Likewise, it was not until towards the end of the interview before 9_Adoptive Mother was able to explain exactly what her son had been accused of, and admitted, to doing with the five-year-old neighbour. Parents also suggested it was not just an issue of not wanting to talk about details, but also about not wanting other people to know about the allegations against their child. 2_Mother, 3_Father and 6_Adoptive Mother all talked of not wanting to tell the other children in their family. They also felt it was important not to let them know that one of the children had a social worker in case this got out at school and the child was bullied because of it.

1_Mother did not tell her husband about what was happening with their son because he worked away and she felt it was not something you 'can easily talk about on the telephone or over a weekend when it is his only time at home for a month', 'he works away and it's not something you put in a phone call. And then when it's two–three weeks down the line when do you drop it into a conversation?' 2_Mother talked of how she told her other sons that the CSCS meetings were in relation to her oldest son's education as she did not feel happy mentioning the words 'social services' or 'social worker'. Although she did not talk about what she had discussed with her husband, 3_Father explained that 'Obviously I did not know everything until all of this came out and I found out more and more because my wife

had kept that to herself.' He did not express concern about this he just stated that this was the case. But he did express concern about support, 'I think it would be better if [people] could talk to someone. I mean it does not have to be a friend or a family member but surely there are loads of government bodies out there.'

For 2_Mother her main concern about talking to other parents was not the actual act of talking about things, but concern about whether other parents would be judgemental, not about herself but about her child:

> *2_Mother: I don't think I'd mind if they made suggestions about what I could have done better – that I could handle. But things being said about my child, that's totally different. I mean I can shout and scream at him and I can tell him off but his dad can't and the rest of the family can't but I can.*
> *Researcher: Yes, because you're his mum.*
> *Mum: Yes.*

Having not felt able to talk to anyone else, 1_Mother said the situation made her feel isolated 'You feel like you are the only one. You feel as if your son is the only one in this world that is doing it, it's hard'. Although in a different way, 4_Foster Carer also talked of feeling like that when she was due to attend a party for other foster carers and the children organised by the agency. In theory this should be a day when she could talk to other carers about issues, but instead she felt it was a day when she would be scrutinised – that workers would be assessing whether she managed to control the child in her care and whether she really was supervising him all the time. She found this very difficult to talk about and got upset and was crying due to how this made her feel. She also felt it was difficult to talk to other people about the child in her care as she was concerned about how their attitudes towards him would change. She also felt that people do gossip so she was concerned about information getting passed around the community, and what would happen if the child did do something to another child in her community.

If something happens it'll come back to my door and it'll never go away... If he were to touch anyone and people find out that you knew, it's such a thing to have on your shoulders. To be honest then we wouldn't be able to live here anymore...

Similarly, 7_Grandmother and 8_Step-Grandfather were very concerned about their friends knowing about their involvement with CSCS in relation to their granddaughter's SHB. They talked of how they meet their friends at a cafe to chat every week and they were angry when CSCS suggested they might want to have contact with their granddaughter there while she was in foster care. They felt this invaded their privacy and was unfair as it would mean a professional always being present in a situation that was supposed to be relaxing for them. 9_Adoptive Mother said that the biggest concern for her and her husband was the school being informed about their son. She was not specific in what she said, but there appears to be an understanding from parents that this information getting out is bad and will have negative consequences on the child and the family:

My ex-husband had said if this gets out we're in trouble. He was very much aware of the implications of everybody knowing about it.

None of the parents or carers were specific about what the 'implications' were as such, only that it would be a problem for their son and for their family of they did. 14_Social Worker, however, was more specific about the issue of stigma that could affect Child2. 'I felt sorry for him because if he hadn't done this, if he hadn't sexually abused her or raped her like he said, there was the stigma that goes with that, that people will always look at him and say "he was the one who... you know what I mean" it would not matter that he was not charged, it would always be with him.'

This issue of information getting out was something that was also raised by two social work practitioners. For example, when dealing with Child12, 12_Social worker talked of the complexities when a decision had to be made to tell other parents of potential abuse victims when it was not clear whether they had definitely been victims of abuse. This had to be weighed up as to whether this placed Child12 in danger, not just from his carer but also from the community once this information got out as it inevitably would. In Child8's case,

while 15_Senior Social worker acknowledged that everyone around him felt his assault on his niece was sexual, there were serious implications of this which was that his name could have been placed on the sex offenders register. So ultimately the solicitors on both sides agreed to a lesser conviction of assault. However, the sentence for this involved a secure unit and included therapy for SHB. 15_Senior Social Worker felt that because sexual abuse can occur within families this can bring up a lot of tension within families and within the community if information gets out. He had experience of families who have quoted human rights legislation about how much information gets out, and he felt that this was the professionals' 'responsibility about what gets shared and what gets out to the wider community'. He felt that could be quite a dilemma and difficult to deal with, and that it can have a knock-on effect if information gets out which is particularly an issue in the school environment.

As already suggested there was a reluctance to give details in the actual social work files, and this also carried on in the interviews with social work practitioners. 10_Social Worker did not give specific details about Child5's behaviour but simply described it as 'sexualised'. This embarrassment was further highlighted by 11_Social Worker when describing the specifics of Child3's sexualised behaviour – she verbally told herself off saying 'too much information!' because she was specific in her details talking about Child3 exposing herself at her bedroom window and showing her 'breasts' and 'pubic hair' to passers-by. Even the senior social worker used generic terms such as 'problematic behaviour' and touching a person in 'a sexual way', 'sexualised language', 'coercing another into engaging in sexual acts'. When 16_Independent Reviewing Officer talked about a referral he'd received to the duty team when he was a social worker there he said two young people 'had touched' another young person.

7.3c Feelings of blame/guilt

The feeling that they were somehow responsible for the child's behaviour was something talked of by all of the parents, and social work practitioners also talked of it from the point of view that they were looking to the parents for answers, making parents/carers feel like they've done something wrong. The reasons parents felt they had been made to feel they

had done something wrong, however, were different depending on the individual circumstances of each family. For example, in the case of 1_Mother, this was because her husband worked away.

In other circumstances the fact that her husband works away would not be raised as an issue, but 1_Mother indicated this was something picked up by professionals and she felt she was being criticised for this situation, as though this was the cause of her son's behaviour. She said how they 'have blamed me for what happened, but they cannot explain why they think I'm to blame'. This was similar to 2_Mother's experience, although the reasons for the blame were different which was that she had chosen to move her family from army-base to army-base in order to keep the whole family together. She referred to a social worker suggesting the situation was her fault because she 'could have had help if [she] had not moved around so much'.

6_Adoptive Mother, said she felt that professionals sometimes 'make you feel like you're doing a really bad job so you think well maybe you should take this child away because obviously I'm not doing it right'. And 7_Grandmother was defensive about CSCS implying that her granddaughter had been abused by her son in her home – 'If he went there [granddaughter's bedroom] I would hear him and I did not hear the doors open, because they creek.'

Foster carers also experienced feelings of blame and guilt in relation to the child in their care. 4_Foster Carer talked of the guilt she felt when the boy in her care was trying to tell her something but she did not understand by moving photos to face the wall which she later found out was because he had been made to engage in sexual acts with friends and was told that people should not see what was happening. She said she felt she should have known something was not right and not sent him back into that environment. Although this is different from parents it is the same general issue of there being signs but carers feeling they have not read them properly. 5_Foster Carer agreed with this, saying that you are always assessing your own practice and feeling like maybe you've missed something. She also felt that things could be more difficult because you are a foster carer, as you are expected to follow more rules where parents can get away with things.

These examples show that these parents/carers felt (that they were being blamed for their child's behaviour, with CSCS looking for whatever way that could be – 1_Mother because her husband worked away, giving the impression her son was from a broken home, and 2_Mother because she did not stay in one place and allow her husband to work away, but instead kept the family together when he had to move for work. Also, that foster carers felt responsible for the child's behaviour subsequent to them coming to live with them.

Whilst parents expressed concern about the way professionals sought to apportion blame to them for their child's behaviour, this was something that parents also did to themselves. 1_Mother said 'Why me and why him? Did I do something wrong when he was growing up?' 14_Social Worker described how Child2's mother always appeared to feel very guilty about whether the rape had actually happened. She said 'she told me she would look around the house for clues'. 9_Adoptive Mother talked of the responsibility she felt for her sixteen-year-old son sexually abusing a five-year-old girl. In her view she was responsible because of the breakdown of her marriage to his father.

She felt getting divorced was the right decision for her, as she had a brief affair and had not felt any regrets about the end of her marriage, but she did feel it was not right for her son. Later when she talked of the interview in the police station that her son had to go through, she wanted to take the blame on herself for effectively 'coercing' her son to talk:

> *I, along with the policeman coerced him to tell us what had happened. Now I wouldn't have used that word coerced at the time I was doing it because as far as I could see, as far as I was concerned, I just wanted to know what had happened and wanted my son to tell the truth.*

She came back to this issue on a number of occasions during the interview and while she did believe that her son was responsible for the offence she felt responsible herself for what she put him though in this situation instead of supporting him. She did not talk of professionals making her feel that way, but that this was how she felt as a mother.

7.3d Summary

The issues in actually talking about SHB for parents/carers suggests there were two levels of perceived stigma for families when dealing with SHB – one was the actual alleged behaviour of their child and the other the implication of that information getting out into public knowledge. If this happened, parents felt that their children would be viewed by the public as paedophiles, especially if their children were males and teenagers (as found by Parks and Bard, 2006). Parents talked of the complexity of feeling blamed by social work practitioners and other professionals, which they did not appreciate, while at the same time feeling responsible for their child's behaviour (as found by Hackett, 2001). There are examples in the findings indicating the isolation and stigma that this particular group of parents experience (Hackett, 2001; Allan, 2013), feeling as though they needed to hide information and keep away from social situations which could have a negative effect on them and their ability to support in the children in their care – something which social work practitioners need to be mindful of.

There are also concerns, as found by Mitchell *et al.* (2007), within the wider public as to how SHB should be talked about and how it should be reported. SHB is a complex issue and something which both families and social work practitioners appear to have difficulty in understanding, and all express concern about information becoming public knowledge due to perceived reactions by the wider community. Allan (2013) suggested there is a stigma associated with such behaviour referring to it is *delinquent* and *concerning* which can lead to an immediate negative reaction by social work practitioners and therefore can potentially impact on their views of these children and their parents. The difficulty this presents is that the labels applied to these children at the point of allegation can be potentially damaging and abusive (Goffman, 1968 cited in Allan, 2013). Parks and Bard (2006) suggest that this labelling presents them to the public as potentially untreatable and so once labelled as such they could carry this for the rest of their life – something the parents/carers were clearly concerned about.

7.4 Views of the alleged perpetrator

All except one of the parents and one of the foster carers expressed concern that their child was not viewed by professionals as vulnerable during CSCS's intervention. For example, 1_ Mother was concerned that the school were saying to her that girls at school were vulnerable because of the threat posed by her son but that they were not acknowledging that he was also vulnerable. 2_Mother felt that professionals were suggesting to her that her son had obviously abused his younger siblings as well. 7_Grandmother and 8_Step-Grandmother felt CSCS completely disregarded their granddaughter's feelings and needs by removing her from the family home and placing her in foster care, and that they twisted incidents to suggest she had been sexually abused by her uncle in the family home. They felt that their granddaughter was viewed as a victim of sexual abuse (by her uncle) rather than as a child who displayed SHB. (This connects to the findings that social workers assess children who display SHB as children who have been sexually abused. *See* Discussion.)

5_Foster Carer felt that because of his background social workers overreacted to acts of what she felt was *normal* behaviour for a teenage boy. Another boy was staying with her for respite (he was a year younger than her foster child) and her foster child assisted this boy with the software needed to download pornography from the Internet. She felt that had he not previously confessed to SHB social workers would not have reacted in such a negative way to this.

While all parents and carers had some concerns about the Local Authority services, only one parent was critical about the therapeutic service. 5_Adoptive Mother said she disagreed with the therapeutic service when they said they felt her oldest son '[created] the situation on the trampoline'. She felt this suggested her son was a predator and was manipulating situations, whereas she felt it was just an opportunist situation.

When all bar one of the social workers talked of children who displayed SHB, they specifically referred to their vulnerability if they had been (or were perceived to have been) victims of sexual abuse themselves. 10_Social Worker was very concerned that other professionals did not view Child5 as the victim of sexual abuse. She felt this meant his needs

were not considered by others. Child12 was also viewed 'as very vulnerable' by 12_Social Worker (confirmed also by 18_Team Manager and 19_Team Manager) because he was viewed to being 'groomed' by his carer. 14_Social Worker was the only social worker to express concern for the wellbeing of a child (Child2) where there was no suggestion that he had been sexually abused himself. She stated that she had concerns for his wellbeing and tried to ensure she was available for him to talk to, although she said he preferred not to. 16_Independent Reviewing Officer described how he did view Child6 as vulnerable, as during his assessment he 'tried to focus on the wider family dynamics and how they had not put the right boundaries in place, and how the family might be able to support him through that as well as minimising the risks in the future'. 15_Senior Social Worker expressed concern about social workers viewing children who display SHB as vulnerable victims, particularly with reference to Child8. He said that in not viewing him as a possible perpetrator of sexual abuse meant they did not address his behaviour earlier, which could possibly have prevented the escalation in his behaviour into the attack on his niece. This was also echoed by 16_Independent Reviewing Officer in relation to Child7:

> *I know we have the saying "innocent until proven guilty" but as a practising social worker I would say we have received some serious allegations here – is there any reason to disagree with what they're saying first of all?*

7.4a Social work practitioners' views of the alleged perpetrator's parents/carers

The words used to describe the parents/carers of children who displayed SHB in the electronic recordings were not always positive, so this view was raised with the social work practitioners during the interviews. Four social workers and two team managers referred to the child's parents negatively. 10_Social Worker's view of Child5's paternal grandmother was that 'she was more interested in her career than her grandson'.

11_Social Worker's views were also also clear in her recordings where she observed that they minimised Child3's sexualised behaviour. In the interview I asked how she came to that conclusion and she explained that:

They were very hostile and defensive towards myself so actually having an open conversation about what the concerns were tended to be dismissed. I was told that I was exaggerating.

11_Social Worker also expressed a negative view of Child5's paternal grandmother for allowing her grandson to share a bedroom over a weekend with a thirteen-year-old foster child in her care. She said she later found out that that child had been abused (implied 'sexually') so that means she should not have allowed them to share a room. 18_Team Manager was the manager of this social worker and she said she was aware that this was 11_Social Worker's view. She agreed with her based on the information that was given to her by this social worker in supervision, although she did not meet with the grandparents directly herself. 12_Social Worker, 18_Team Manager and 19_Team Manager all had experience of working with Child12. They were all interviewed separately without knowing the other was being interviewed, and were all in agreement that they believed Child12's carer was grooming him sexually. They all had concerns as to how this carer had been able to acquire a residence order for him. 18_Team Manager was very clear in her view that his carer 'sexually abused him for a number of years and probably passed him around'. She described the relationship they have as 'horrible' and how Child12 is now writing letters to this man who he calls 'dad' saying 'I love you so much and I miss you so much, you have to take care of yourself, don't do anything stupid and I'll be with you soon my darling'. During the interview she referred to him as Child12's 'dad' and then corrected herself and said 'no, I refuse to call him that' indicating her view that she believed he had been sexually abusing child12. 19_Team Manager described his carer as 'a bit of a cry baby who put a lot on [Child12]'. She also said 'we knew that [Child12's] mother used to associate with known sex offenders so we were starting to put a picture together'. However, the other two social work practitioners involved did not mention this and there is no record in CSCS to corroborate this view.

14_Social Worker's views were that the father of Child14 had clearly sexually abused her and her brother, and she could not really understand why the court did not agree with this view after the children had made disclosures. She had a further negative view of their father as she felt he was being obstructive saying that the children did not need therapy, which

meant they could not go ahead with this as the Local Authority did not have parental responsibility for the children. She advised that, even two weeks prior to our interview, the brother had displayed sexualised behaviour, although not towards another child but towards his male foster carer – sitting on his knee rocking backwards and forwards and saying 'isn't this nice'. So another referral was made on behalf of the foster carers to get support for them so they knew how to manage it. Further to this, she said after they tried a reunification plan with the father following a recommendation by the court, he changed his mind and said he couldn't cope with the children. She felt this delayed stability for the children and meant they did not know where they were. She felt the father was unrealistic as when asked what issues he would have in managing the children he could not think of anything. 19_Team Manager's views of Child23's parents were that they were not there for him because of their shift patterns at work. That their discipline of him was inappropriate – he had been naughty and told to sit in the corner for several hours and they had described him to her as 'a bad lad'.

There were only two social work practitioners who had more positive views of the alleged perpetrator's family. 14_Social Worker talked positively and sympathetically about the family she worked with. She said the situation was very difficult for the family because they 'were in limbo, they didn't know whether he had done it or hadn't done it, they didn't know whether to believe [sister]' (as the sister said her brother raped her and he said he had not). She described the mother as 'very distraught' and how the home conditions deteriorated after this point. She felt that the mother was unable to move on from that issue and continued to raise it over the subsequent months which led her to neglect the two boys still with her, ultimately leading to them being removed from her care. 14_Social Worker said she was disappointed that the therapeutic support she arranged for the mother did not help and so the boys are now in long-term foster care. When reading the case files for Child 6 I interpreted the way they were written, that 16_Independent Reviewing Officer's view of the family was sympathetic, which he agreed with when he was interviewed. He said:

> *There is an element in that case of the family just being presented with police intervention and very serious offence being alleged and there is a kind of shock factor*

to that for families in that situation. There wasn't an indicators beforehand about any sexualised behaviour or serious offending.

Also when 16_Independent Reviewing Officer was chairing the Looked-after Child (LAC) Reviews for Child7, in his view Child7's foster carers were not treated fairly. When their other foster child made allegations of sexual assault against Child7 the response of CSCS was to remove *both* children from their care.

7.4b Risk management

Four of the parents in their interviews said they felt that CSCS overreacted to the perceived risk their child posed, whereas social work practitioners felt parents or carers minimised the perceived risks. 6_Adoptive Mother felt frustrated at the requirements placed on her by CSCS about the safeguarding that was needed in relation to her oldest son. She felt that they were over-reacting to any perceived risk saying that there were doing 'twenty four hour supervision…round the clock…'.

She confirmed that they were keeping up this supervision because it was recommended, not because they agreed with it, and she said they were 'used to it' and it was 'manageable', not 'difficult' and that they did it 'more than we need to'. I asked her to explain what level of supervision she carried out.

Well we always know where the children are at any given time and we don't leave [the oldest son] with [the youngest son] or any other of the children alone unsupervised with them.

(In the context of this interview, and for the five minutes prior to it, the researcher observed the oldest and youngest sons together, alone and unsupervised, in the kitchen. The mother could not see this as she had a back to the door through which the children could be seen. Unobserved by their mother, they were participating in rough play with each other and the youngest boy was being carried around on the oldest boys' back.)

7_Grandmother and 8_Step-Grandfather talked of how their granddaughter was taken into foster care because CSCS decided after five days that they were not capable of managing the risk to their granddaughter posed by their son. As with 6_Adoptive Mother, they also felt that they were managing the risk but that they were not given a chance.

The foster carers did not question whether the risk was proportionate but did question how they were expected to manage it. 4_Foster Carer talked of how they have to prevent the boy in their care from having overnight stays with friends, he cannot play out, go to any clubs like scouts on his own with friends as he is too high risk. She talked of how they, as carers, have to try and fill these missing needs by taking him out and doing things. She talked of feeling like she was 'treating him like a five-year-old' as he cannot be unsupervised with any others – children because of the risk he poses to them, and adults because confidentiality means they cannot be told about his situation and therefore would be unable to appropriately safeguard him or the other children around him. Ultimately she said 'we just mange it ourselves'. Also that she was not told about just how high risk he was until he was already with her. She also expressed concern about the repercussions of SHB for her own life how she needed some respite as the risk management was relentless.
5_Foster carer described this situation as 'you do everything in your power to keep them safe but it just takes five minutes when they are out of your sight. You know you can't police them twenty four seven'. 9_Adoptive Mother also did not feel that her son presented a risk to other children as a psychologist 'did this psychological profile and recommended that he presented a low risk of reoffending'. However, while she felt he did not represent a risk to other children, other professionals did not agree, particularly his school.

> *I knew the circumstances around my son and I knew this was a little friend of his that he'd done this to and I knew that he got on really well with his friends at school and I had no worries about him being unsafe or a danger towards other children at school.*

Following his conviction, 9_Adoptive Mother was invited to attend a meeting at her son's school where she was told he was no longer allowed to attend due to the perceived risk he posed to other children.

There was complete agreement with all the social work practitioners that there were complexities in managing the risks children who display SHB pose. There could be further complicated when attempts to safeguard children could place the alleged perpetrator at risk themselves. This was the case for Child12 where 12_Social Worker had concerns that other children who had been to Child12's house may have been sexually abused themselves. This was described by 12_Social Worker as quite a 'grey area' and that they had to consult with the Legal Department on a number of occasions due to the complexity of it.

> *Decisions kept chopping and changing as to whether we should be informing parents, whether we should be opening them up on our system, whether assessments should be undertaken...*

Her concerns were that if information was given to these children's parents then Child12 was still in the home environment and this would increase the risk to him from his carer and from the community. However, it was also important that the parents of the other children knew so they too could be safeguarded. She confirmed that the decision was made in the end that the parents should be informed. 18_Team Manager felt that because of the environment in which Child12 had grown up 'his view of the world could be completely different' which would potentially make him a risk to other children.

In the view of 15_Senior Social Worker, managing the needs of the family against the risks to the wider community can be very difficult and he felt it was important for professionals to acknowledge that it is not possible for family members to supervise their children *all* of the time. 16_Independent Reviewing Officer expressed concern at the lack of risk assessment even completed in relation to Child7.

> *They had not done one, they just decided that both children should be moved to separate placements, which I listened to in disbelief. Why you would want to give the message to a possible victim of sexual abuse that they had to move placements because of their disclosures was absolutely unbelievable to me?*

It was also his understanding that no work was completed with the foster carers to reflect on what happened, and see how they could safeguard in future. Both children were simply removed from their care. He felt that this practice was 'dangerous', not informing carers of risk factors or what to be aware of, or how to be alert to the indicators of possible abuse. 18_Team Manager's view was that, when allegations were made, safeguarding had to be considered first and foremost. In relation to Child2, she talked of how they had to believe what the sister was saying so they set down requirements for her protection in terms of her and her brother not being allowed to be alone together. She said this was not about believing completely that Child6 had done it, but based on the allegations they had to set up risk management just in case it was true.

In the view of 11_Social Worker (as indicated in the section on perception of parents/carers), she felt that Child3's grandparents did not take on board the seriousness of their concerns regarding their granddaughter. Not necessarily in terms of the risk she posed to other children, but the risk she posed to herself in displaying sexualised behaviour. For example, she did not want any of Child3's brothers to be allowed in her bedroom. Her view was that she was met with 'a wall of denial' from the grandparents and that it was 'hostile, very defensive'. She appreciated that the situation was 'horrific' for them to come to terms with and felt that it was unlikely that the truth would ever be known about whether Child3's sexualised behaviour was in relation to possible sexual abuse by her uncle. This situation she described meant that, in her view, Child3 spent longer in foster care than was necessary because of the grandparents' hostility and unwillingness to acknowledge and respond to the concerns of CSCS.

20_Team Manager talked of a case she worked on where she questioned whether a risk assessment had been completed at all – a brother was convicted of anally raping his sister over a five year period and his 'sister had an anal passage that was described as cavernous', but he never admitted it ('but obviously the evidence was there') and never accessed any therapeutic support. When he came out of prison he went back to the family home to live there with his sister still there – 'CSCS didn't work, it didn't work for him and it certainly didn't work for his sister!' She advised that the justification from colleagues for him going

home was that 'she was older' so she could cope. But she felt that he was still a risk as he had not completed any therapeutic work.

7.4c Concern for the future

Concern for the child's future was something that was raised by all bar one of the parents and carers. 1_Mother was very concerned that another incident would occur and she would receive another phone call that her son had done something.

> *I do worry about things happening in the future. I worry constantly all the time. I go to work and I worry, am I going to get another phone call? I hate getting private numbers coming up on my phone. I answer them, but I hate them.*

In fact, between the interviews another incident *did* occur, and this time, due to her son's age (16) the police were immediately involved and she did not hear anything from CSCS. She described herself as feeling 'every day of the week I am dreading three o'clock. The only times I don't dread it are Saturday and Sunday because I know he's in the house.' 'When it comes to three o'clock I feel physically and violently sick every day.' She also felt that the professional response was that 'they have basically just shut the door'.

2_Mother was particularly concerned as her son was also now 16 years old and she feared losing her ability to intervene and stop him:

> *And the thing is you can't stop him as an adult. I panic so much about what is going to happen and what about when he has his own children. You know, what is it going to be like in the future? And it is hard to stop and think of it...*

1_Mother, 2_Mother and 3_Father all talked of being concerned for their child's future, either if they were to do something again, or how their past will affect their ability to get a good job (in the case of 3_Father).

Yes I do. He is due to leave school this year and go to college and I'm thinking will he get into college and what will happen when he gets to college? Will it start again in college? He will have more opportunities so I am constantly worrying all the time.

This concern was also felt by 9_Adoptive Mother as she said she was not worried about another incident occurring but because he had been excluded from school because of his sexual conviction and she worried how this would impact on his future. 4_Foster Carer said she was constantly worrying about the future for the boy in his care, whether it would be possible for him to learn that sexual behaviour towards other children was wrong. She said she worried saying 'it's just if he gets too friendly with someone you wonder...'. For 7_Grandmother and 8_Step-Grandfather, however, their main concern for the future was how to get over what happened. 7_Grandmother said 'I think it will take until the day I die to forget this, it really will' and 8_Step-Grandfather 'I feel it is hard to not think about it'. 7_Grandmother also talked of getting ovarian cancer and how she felt that this was brought on by the stress of dealing with this situation with CSCS.

As 15_Senior Social Worker worked with Child8 on a long-term basis while he was in long-term foster care it is understandable that he would raise concerns for this child's future. He felt that ultimately it was positive that Child8's name was not placed on the sex offenders register so this would not be carried with him for the rest of his life. He said that initially Child8 had not wanted to engage with therapy at the secure unit and he was surprised by Child8's reasons for this once he spoke of them – Child8 felt that if he engaged then they would release him sooner and he did not want to leave as being at the unit was the 'safest he'd felt in a very long time'. 15_Senior Social Worker was also very hopeful because Child8's foster carers continued to visit him at the unit showing that they were still committed to him. He said this was their personal choice and that Child8 knew this so it was having a positive impact on him. 18_Team Manager expressed concerns for the future of Child12 and it was her view that he would start to make disclosures about being sexually abused. She also felt that he would need therapeutic intervention which had so far been delayed because of the ongoing police investigation and AIM assessment, because he could have a 'completely different view of the world' caused by 'living in that environment' with his carer.

7.4d Summary

Similarly to the findings summary 7.2f, the views expressed by parents/carers were that of an over-reaction by CSCS and an investigative rather than welfare approach. The view of the alleged perpetrator and their parents/carers appeared to impact on the way in which the investigation/support would be conducted. Thorpe and Bilson (1998) in their longitudinal study found that the focus was linked to the way in which intervention took place. Considered with these findings, this suggests that when an investigative focus is taken this is at the expense of consideration of the welfare needs of the child and family.

As raised by Calder (2000a) social work practitioners 'need to acknowledge the centrality of parents in work … [and] do some work with parents first' (p. 35). Hackett's research (2001) identified that parents/carers wish to be treated with respect by social work practitioners. The findings above show that social work practitioners generally had negative views of parents/carers and in particular with regard to minimising the child's sexualised behaviour and the implications of this. Hackett (2001) found that parents can be in denial about what has happened with their child but that it is important for social work practitioners to work effectively with parents. Parents and carers however felt concern about the pressure to manage the perceived risk of their child and the lack of support they received in relation to this. (The observed example given earlier shows the reality of risk management for parents.) In these findings there appears to be concern from parents/carers that they are not supported by social work practitioners, and instead are pressurised.

7.5 Training, support and practitioner reflections

7.5a The training of professionals

Training was raised as a significant issue for both foster carers and social work practitioners. Parents also had their own views on whether they felt social work practitioners appeared to be appropriately trained. 4_Foster Carer said she had been given some training but in reality felt that 'nothing can really prepare you for dealing with these children'. Even when she had experience in dealing with them, she said the next time it can be completely different 'so you just have to keep learning as you are going'. Also that it can be difficult to deal with as

there is always a lack of information when children are initially placed in foster care, not necessarily because the social worker has not given it but because of the nature of the situation information does not come out from the child until later.

6_Adoptive Mother said she did not understand why CSCS could not adapt to allow workers who were already involved with her family and who were trained in safeguarding children to work with her family rather than bring in different people who did not know the family. Adoption workers have to have at least two years prior experience in a safeguarding children team so they would be qualified to complete an initial or core assessment in order to then apply for the appropriate funding for therapeutic intervention.

7_Grandmother and 8_Step-Grandfather were very negative about the attitude of the two social workers who came to remove their granddaughter. They observed them laughing while outside their house and felt this was directed at them. They felt this showed a lack of respect and professionalism considering the severity of the situation and did not take into consideration just how distressing the situation would be to this family.

Only two of the five social workers interviewed had received the Local Authority's training in dealing with children who display SHB. 10_Social Worker advised that even though she had to deal with a case that at no point during or after this had she been asked to complete the training. She felt it would have 'been useful' if this had been suggested to her to complete at the time of managing this case. This was also the case for 11_Social Worker and 14_Social Worker. Up to the date of the interview 14_Social Worker had been with the same Local Authority for three years and had never received any training in working with children with SHB, although she had dealt with a case in that area. She stated that it had never been to her suggested to her by any manager and her belief was that there was no training available in relation to that area at her Local Authority. She described how the training always seemed to be around domestic violence and substance abuse. Rather shockingly, 17_Team Manager said she had been with the Local Authority for over ten years and never received any training in relation to children's sexualised behaviour, and that the social workers in her team had not received any either.

11_Social Worker's view was that all social workers should be trained in order to complete work with children who display SHB, not just to assess them but also on a more therapeutic level so something can be tried before accessing more heavy therapy such as psychotherapy. She said she was 'afraid not' when I asked if she'd been offered any training. But she also felt that 'training is not a magic wand' and that as social workers 'we should be responsible for researching to expand our knowledge'. 18_Team Manager talked of the restrictions to this as, once they leave university, 'most social workers don't pick up a book again'! She expressed concern, however, that work at Local Authorities is not geared up to deal with new research and social workers keeping up with this. For example, the Local Authority she works for does not have a subscription to relevant journals so it can be difficult to access up-to-date research once out of university. She also felt that the current 'consolidation award' was not geared up to keep social workers up-to-date either and more specialist training in these areas was needed.

While 12_Social Worker had attended a one-day training course two years prior to this interview she described it as 'not particularly helpful'. She said this was about completing AIM assessments, but she had not experienced any specific training just relating to children who display SHB, and like 14_Social Worker did not think her Local Authority offered any training in this area.

> *I found that, because of the case I had this year, when I actually looked to see if there was any relevant training, that there was actually nothing if I'm being honest! And I felt that that would have helped a lot with this case. I felt that I had to go away and do a lot of reading myself about this specific area.*

She also talked of linking closely with the YOT (Youth Offending Team) to work together. She advised that her manager (19_Team Manager) did not suggest any training options to her at the time of her managing a complicated case of SHB. This was not surprising as 19_Team Manager's view was that, while she had completed AIM assessment training herself, most of her knowledge had been achieved through experience 'because when I was at [CSCS office] I always seemed to get the cases where there had been paedophilia, sex offenders, I worked closely with the police'.

Only 14_Social Worker and 15_Senior Social Worker had received training from the Local Authority which they felt was adequate for their development. 15_Senior Social Worker talked of another case he is working on now where it is documented that previously social workers seemed to recognise that an AIM assessment was needed but they had not been trained to do it, so did not go ahead with it. When he got the case 15_Senior Social Worker felt that if this had been completed things could have been different for the child concerned.

16_Independent Reviewing Officer had completed a one day training course prior to him dealing with any cases relating to SHB. However, he expressed concern that social workers in long-term teams are not trained to handle referrals regarding SHB as they often occur on cases that are already open to them, and that this causes problems for highlighting a pattern. Referrals are normally handled by a duty team so they are trained to some extent as to what to do, but social workers in long-term teams are not. He suggested what they do is log the information onto CSCS but do not actually action any work or assessment to be completed. This issue was also raised by 19_Team Manager – a concern that long-term social workers do not consider referral information about SHB as an independent referral and just log the information onto CSCS without doing anything about it.

While not actually having received any training herself, 17_Team Manager said she felt it was important to try and keep social workers up-to-date so on a number of occasions she gave social workers she was managing books by Simon Hackett or Martin Calder to help guide them when dealing with cases in relation to SHB. 18_Team Manager echoed these views and discussed how 'sexualised behaviour and sexual abuse is an area where there isn't enough training'. She felt she did not know why that was the case but that there is a lot of training on neglect and physical abuse but not on sexual or emotional. She felt this was concerning as it left the decision making as 'value-based' down to the professional concerned'. She felt this could lead to two children displaying the same behaviour being treated differently by the same Local Authority because of having a different social worker and team manager. 'This can depend as well on whether you get a measured reasoned response or a knee jerk response and a knee jerk response can be more harmful'.

20_Team Manager advised that recently she and another manager had compiled a training course list which consisted of training identified as 'mandatory' or 'expertise' (the latter being optional). SHB was, according to 20_Team Manager, mandatory so that 'eventually everyone will have had to do it'. In her view a lot of people have done it already, although this does not tie in with my findings. Also, AIM training was optional as these assessments are not commonly completed within the Local Authority (it is more likely that YOT workers would complete them as they concern young people who have either been convicted of or admitted to a sexual offence. Therefore the Local Authority ensured a minimum number of social work practitioners complete this training so they can advise other colleagues.

7.5b Social work practitioners' views on support they received from their colleagues/managers

All the social workers talked negatively of whether they felt supported by their colleagues and/or team managers. 10_Social Worker said she 'felt absolutely lost' about what to do in relation to Child5 and that while she had supervision of a 'reasonable standard' this was only once a month with informal supervision 'every now and then'. 11_Social Worker and said the support she received from her manager was 'very little, we were just scratching our heads' and 12_Social Worker also felt the supervision she received was not enough. 19_Team Manager felt it was very important that social workers receive good support and advice from their managers. However, she felt that social workers do not make regular use of informal supervision which should always be available but 'even experienced managers don't always get it right'.

13_Social Worker's experience was more extreme as she had 'a number of different managers' over a short period of time and because they all have different styles and ways of managing social work. In the space of three years she had had seven managers and her current manager was about to leave so she would have another soon. She did not move about herself it was just that the managers of the team she was in have left. She felt that her current manager has been supportive although she only came in just before the Final Hearing in relation to Child14 and she felt just her physical presence alone at that time was

very helpful. Prior to that, when she got the case, she felt her manager did not really understand the case and was not able to support her.

This lack of support was also raised by 16_Independent Reviewing Officer who said he could not remember the name of the team manager he had while working on Child6's case but 'what I can absolutely guarantee is that I would have been given the case, and I was a senior practitioner, and I would have went out and managed it and made decisions as I saw. I never felt that there was any input from the managers other than the authorisation of assessments.' His view was that he did not feel they would have been able to add to his knowledge. He also had a number of managers, some of whom left where he was but then he himself changed teams through his own choice to gain different experiences.

Only 12_Social Worker raised the issue of a high caseload as a detriment to her working with children who display SHB. She felt this meant she could not spend the appropriate an amount of time on what was, in her view, a complex case. However, she felt that she did not get enough supervision from her manager during the time she had this case.

7.5c Social work practitioners' views on the main issues concerning the cases they managed in relation to SHB

During each interview with the social work practitioners, they were given a short summary of the case/s they were involved with and asked to talk about how they felt about the cases on reflection in relation to the child's SHB (see Appendix 6, showing the cases managed by the social work practitioners). The social workers all focused on the issue that was prominent for them when dealing with the case and there were some similarities in the issues. 10_Social Worker was very firm in her belief that Child5 had been sexually abused and felt she was the only professional considering it, which she could not understand:

> *I referred him to a counsellor because I suspected he'd been sexually abused but no one else believed it, especially the people from the other Local Authority...nobody wanted to know because it was almost like they were trying to protect the paternal grandmother because she was a foster carer for the other Local Authority*

During the interview 10_Social Worker said he had definitely disclosed to her that he had been raped but later in the interview she said he'd actually been very vague. When asked what made her feel it was clear to her that he had been sexually abused she described how it was because he was frightened to go back to his paternal grandmother's and how at 'university you are taught that children do not lie about things like that'. This social worker was very clear that Child5 had been sexually abused and was convinced because 'children do not lie about things like that' even though by her own admission he was 'vague' and did not actually say he had been raped – that was her words. She also said he told another social worker this was recorded in ICS. 18_Team Manager however said it was important that social workers did not just presume children were telling the truth – she was the only social work practitioner to suggest that an allegation made by a child may not necessarily be true.

12_Social Worker described that when she first met Child12 and his carer she felt that 'something wasn't quite right' in their relationship. She could not put her 'finger on' what it was but explained that her 'instincts' suggested something was wrong. 18_Team Manager managed the case when it was transferred to another team and advised that evidence later came to light that some of the images were downloaded when Child4 was not at home so he could not have been solely responsible for them.

13_Social worker talked of the frustration she felt when she took over the case a year prior to this interview. A team had been approached to complete therapeutic work with the children, and in the son's case with regard to his SHB, but they had apparently advised CSCS that this should not begin until the court case was completed determining where the children would be living long-term. Therefore no therapeutic work was being completed at the time of this interview. She described this situation as 'treading water'.

14_Social worker raised the issue of whether the alleged perpetrator and alleged victim should have different social workers. (This was something that had been recorded on CSCS by this social worker and her manager, 18_Team Manager). However, it was felt this would provide complication due to possible manipulation of professionals by the mother, and

14_Social Worker felt she had reassured the family that her focus was on *all* the children equally in terms of their needs. She felt that having another social worker could provide conflict and mean more appointments and meetings for the family to cope with, and potentially have social workers being set off against each other. As her manager at the time, this was also raised by 18_Team Manager who said that in more offence-related cases where there has been long-running abuse then there *should* be separate social workers as 'the needs of the two children concerned are different'. She also raised the concern, however, about dealing with the mother in relation to Child2 as, in her view, 'she used to lie about everything'. 'So in an ideal world [the sister] should have had a separate social worker but I don't know with what I knew about mum I would advocate that...'. I asked whether it was easy for social workers to separate the needs out between the alleged victim and alleged perpetrator if they are within the same family.

> *I'm not sure all social workers could. I think [14_Social Worker] did. But then we work with families when [siblings] have different needs all the time. But then I suppose [the sister] was concerned about what she could say to [14_Social Worker] because she knew [14_Social Worker] was also talking to [child6 her brother, the alleged perpetrator]*

She described how this made her feel 'torn' as to whether it would be appropriate in this case for them to have separate social workers. However, she felt it can help the assessment for there to just be one social worker as they get the information from both sides which assists them in making an assessment. Therefore, in conclusion she felt that if the alleged victim and alleged perpetrator are from different families then they should 'absolutely' have a separate social worker, but not if they are from the same family.

The issue raised most by social work practitioners was *confusion*. 11_Social Worker talked of feeling confused about what to do about Child3's sexualised behaviour. In her view there were no other issues of sexualised behaviour and she did not know why it was happening. When she emailed to bring this case to my attention she said she was concerned that he may have been sexually abused but when asked her about this during the interview she was not confident about this and instead explained that she just had questions because Child3

'just seemed too knowledgeable' in terms of the sexualised language details he was using, for example 'suck my willy' which she said just felt 'less innocent' than just play. However, she did feel that there were issues for this child dating back to when her mother was alive who she described as a 'drug user who was emotionally unavailable to her children'.

This was also something raised by 15_Senior Social Worker who said he felt it was more clear when working with the adolescent cases he had managed but felt that the one or two cases he has had involving children were just exploratory and were an example of professionals overreacting to sexual behaviour.

18_Team Manager worked within a long-term environment so cases were taken over by her team and the way they were represented to her depended on the value-base of the worker who was handing over the case. She felt this could be difficult when dealing with very young children like Child13 and where there was a question as to whether behaviour is experimental. She raised the fact that if the previous worker felt it was not experimental then this was the view they presented when handing over the case, but it did does not necessarily mean that the new worker agreed with that assessment and she felt that it was important to question the interpretations given.

> *I feel my role is to question [the worker] to ensure they are appropriately assessing the situation to ensure the social worker can justify their decisions and not just take the anxiety from other professionals*

7.5c(i) Differences in social workers' recollections and CSCS recording

As part of the interviews questions were raised about information recorded in ICS for the social work practitioners' views. In some cases there turned out to be a discrepancy between information acquired from ICS and what the social work practitioners remembered about the cases themselves. In relation to Child5, ICS recorded that he had received a police caution for aggressively pursuing a female pupil at the school, whereas 10_Social Worker said he had *not* received a caution – but on ICS it was her recording that stated he did. Also, 20_Team Manager said that Child21 told her social worker that she had been sexually abused by her mother's boyfriend when he touched her 'in the vaginal area', but none of

the ICS information confirmed this – only that the social work practitioners suspected it. There were no recordings stating that this child confirmed the sexual abuse.

7.5d Social work practitioners' reflection on their practice in relation to SHB

When reflecting on their work all of the social work practitioners felt they had learned a lot but only one social worker felt they could have done some things differently, whereas all the team managers felt this. 10_Social Worker reflected on her practice and felt that sometimes priorities of professionals are not always right 'our motives are not always crystal clear, that we are not always doing things for the benefit of the child'. She also felt it was a 'steep learning curve' and how she learned 'a lot about sexual abuse during this time and how this abuse can manifest itself…'. She felt the good thing she did was in trying to fight Child5's corner in relation to her belief that he had been sexually abused.

12_Social Worker also felt she learned a lot during the 'complex' case of Child12 and that she struggled with it while she was also managing a number of other complex cases at the same time. 'I didn't feel I was able to give the time that this case really needed at that point.' She also felt that because there was a criminal investigation running alongside this meant that they weren't legally allowed to share as much information as normal with Child12's carer, and she felt this made her 'deceitful' and it 'went against our social work values'. In terms of her actual practice, however, she did feel that she, individually, had done all she could.

13_Social Worker, however, felt she should have fought more for the children to 'have therapy and I feel we were guided more by our barristers on what we could win and so things dragged and nothing moved'. She felt 'the adults in all this have been so demanding that it has been taken away from the children so hopefully now these children can get the support they need'.

14_Social Worker said she found the issue of no evidence a difficult issue to deal with and how she went backwards and forwards, although she felt it made no difference to her practice she felt it was important to remain focused. On the other hand, 11_Social Worker,

15_Senior Social worker and 16_Independent Reviewing Officer were positive about their actions and did not feel they would have done anything differently. 15_Senior Social worker' view was that this was because he had a lot of experience in this area so was not fazed by it. He had adapted his practice and did a form of 'life story work' with young people which he found worked in helping them to open up. He said he found the young people felt positive about this. 16_Independent Reviewing Officer felt that he was not judgemental about Child6 and that this meant he was able to work well with him, and that this was important for social workers to remember.

All of the team managers reflected on their practice and felt that they could have been better in some areas. 17_Team Manager felt that she did not have enough training in order to confidently oversee social workers with cases involving SHB. 18_Team Manager felt her knowledge in relation to Child2 was 'not as it should have been'. She felt this was because she had only just become a team manager at the time and her experience of 'working with sexualised behaviours was limited and so I wasn't able to give the support and understanding that I could now give'. She felt she could have had more support in relation to this as a new team manager. 19_Team Manager felt that as professionals we are still not good enough at sharing information so that professionals can make informed decisions. She also felt that social workers need to understand when information shared is potentially a criminal offence and when it should be shared with the police. 20_Team Manager said looking back she felt sometimes she wondered if Child21 was left at home along with her sister longer because of cultural issues. She explained there was an issue about the mother not understanding their concerns which for other mothers would mean workers may look to removing the children because they were not being safeguarded. But with this mother workers 'gave her the benefit of the doubt that she did not understand because of cultural issues'. 'Due to her distinct lack of understanding of the safety issues... so it was positive discrimination on mum's side'. However, she felt that in the current political climate this is not something that will easily change for fear of being seen as discriminating.

7.5e Summary

'Social care as a profession has always been eclectic in nature, perhaps uniquely so' (Frost and Parton, 2009, p. 182). Whilst this can be viewed positively it also presents a challenge to organisations and social work practitioners as to what they need to know in order to do their job effectively. In this research, social workers reported that they did not feel supported and did not feel appropriately trained in order to deal with children who display SHB. None of the social work practitioners made reference to government guidelines regarding how these children should be responded to, and none had accessed the LA's procedures relating to these children. Holland (2011) highlights the importance of social workers constantly consulting with colleagues to ensure their explanations are valid. However, as stated in the previous chapter, there was limited evidence in ICS regarding case supervision to back up what support social workers did receive. This may have been a lack of recording rather than lack of supervision; although social workers concerns regarding feeling unsupported in these interviews suggests that the supervision was not viewed as supportive by social workers.

As Munro (2010a, b and 2011) suggests in her reports, it is important for social workers to be able to exercise professional judgement, and Dominelli (2004), and more recently Wastell and White (2014), refer to a lack of professional autonomy in social work (2004); the latter specifically in relation to electronic recording. Defining *professional judgement* however is complex and contested. The social workers reported having *gut feelings* about certain situations and some were clear they felt they were right. How this fits with the evidence that presents itself is difficult to separate, as shown by some of the differences in the way social workers remembered the cases they worked on, and how information was recorded by them in ICS. As previously suggested, Munro (2011) found that when risk assessments were completed in general by practitioners, they were flawed in either over- or under-estimating the risks involved. She found that they were not realistic and often reflected public views rather than sound professional judgement. In the context of children who display SHB it is possible that public perception could play a role in how professionals make judgements about SHB.

Generally social work practitioners felt confused about what to do when confronted with cases concerning children displaying SHB. The generic assessment (DoH, 2000) does not specifically recognise the presenting issues of complexities of these particular children. Social work practitioners were also left unsure concerning how they could not only assess these children but also how to support them. Whilst team managers reflected on ways in which they could have improved their practice, only one of the social workers did this. Again, it is difficult to determine why this may be the case, perhaps they genuinely believed they had done all they could in the circumstances, but it could also be interpreted as a defensive reaction based on the negative way in which social workers are perceived by the public – as confirmed by the parents'/carers' views expressed in these findings.

7.6 Conclusion

The key issues reported through the analysis of the lived experiences of parents/carers and social work practitioners are as follows:

- Parents/carers experienced feelings of stigma and blame for different reasons.
- Parents/carers did not feel supported, found it difficult to name or discuss the behaviour, and felt at a loss to know what to do to support their child.
- If therapeutic support was recommended, this was either inappropriate, delayed or forgotten about altogether.
- Parents/carers had the view that social work practitioners overreacted to the risks of the behaviour; social work practitioners had the view that parents/carers minimised the risks.
- Social workers felt confused about how to deal with these children and did not feel supported by their colleagues/managers.

Where there was agreement between parents/carers and social work practitioners, was that there was a lack of training available and/or given to any professionals in this area, and that as a whole CSCS does not work for children who display SHB.

These findings and those of the previous chapter will now be analysed and discussed further in order to identify the generative mechanisms (the *what*) that impact on CSCS's response to children who display SHB.

8 Discussion

This discussion chapter is set out in order to answer the research questions raised at the beginning of this thesis. In answer to these I will set out the most significant findings and how these contribute to the construction of knowledge within the area of children who display SHB, and how this group of children encounter Children's Social Care Services (CSCS). Most of these findings are contained in answering the question of how CSCS deals with children who display SHB, as set out below.

1. How do CSCS deal with referrals of children who display SHB?
2. What are the reflections of social work practitioners on their practice in relation to working with these families?
3. What does a small group of users (parents and carers) say about how their cases were managed? How do parents/carers experience social work interventions?
4. What best practice recommendations can be developed to inform effective intervention by social work practitioners, and what appropriate training should be offered?

Further to this, having applied a grounded theory approach to the analysis of the data, generative mechanisms will be identified for further research and analysis.

8.1 Answering the research questions

8.1a How do CSCS deal with referrals of children who display SHB?

8.1a(i) CSCS – specific group of children

The focus of this research has been on CSCS and how they deal with referrals regarding children who display SHB. Most previous research completed (for example, Curtis and Ronan, 2004; Henggeler *et al.*, 1997; Johnson *et al.*, 2007; Hackett, 2004, 2007; Goulding and Calder, 2000) has focused their research on services that specialise in children who display SHB, such as therapeutic services, or on how they encounter the criminal justice

system. While this research is obviously useful in determining who these children are and what support is available to them, it does not look at *all* of these children at the very start of their relationship with professional services. Recently however the CJJIR (2013) was published following research of 24 YOTs. Many of the findings of this study reinforce those in this thesis, as will be discussed in this chapter. In this thesis, children have been identified who are referred to CSCS but who then receive no further intervention, all the way through to those who receive therapeutic intervention or who experience the criminal justice system. Therefore this thesis concerns the experiences of *all* children who are accused of displaying SHB where a referral is made to CSCS.

In terms of their interactions with CSCS, children displaying SHB are a small subset of those who are referred where the general focus is on all children who are in need or at risk of suffering significant harm (*Children Act*, 1989). As previously suggested, social work practitioners who represent the state in the interaction have a duty to safeguard children who display SHB. *Working Together to Safeguard Children* (2010) sets out clearly that these children should be considered as children *in need*, thereby suggesting their referral should be treated no differently than any other referral received by CSCS. Some important aspects are that:

- *the needs of children and young people who abuse others should be considered separately from the needs of their victims;*
- *a multi-agency assessment should be carried out in each case, appreciating that these children may have considerable unmet developmental needs, as well as specific needs arising from their behaviour.*

Department of Health, 2010, p. 303

Whilst these guidelines clearly show that these are children *in need*, the findings sections have shown that CSCS struggles to deal with this group because those needs are so specific, and are not easily met. Masson (2006) referred to these children as having a 'dual status' in that they are both *in need* or care and support as well as *in need* of some sort of control. Also, in order for assessments to work, its purpose must be understood (Grant, 2006). Yet, before this stage is even reached, the idea of these children as being both an alleged perpetrator *and* an alleged victim seems to cause confusion in practice as to how they

should be dealt with (this is covered further in the next section discussing the erratic response to them). The CJJIR (2013) found that that s47 (CA(1989)) enquiries were not initiated except in relation to possible reprisals against the alleged perpetrator, and that policies did not appear to have been adhered to (p. 23). They suggested that more specialist assessments such as AIM should be used in conjunction with standard assessments (which *should* be completed).

Social work practice has constantly changed over the years, and its current focus is on social work practitioners who can deal with a variety of issues rather than having a specialism. Whilst the government guidelines as to how children displaying SHB should be treated appear clear, there is no evidence that this guidance is feeding down to the front-line practice level where decisions about how to perceive these children are still being left to individual social workers. As set out in the findings section it is not clear why some referrals of SHB led to further action and some did not. The implication here is that it is down to the value-base of the particular social work practitioner – whether they viewed the behaviour as problematic or whether they had concerns about the alleged perpetrator (i.e. viewing them as a mini sex offender). As shown in the findings, where the age gap between alleged perpetrator and alleged victim narrowed so did the decision to proceed with an assessment, and therefore sexualised behaviour between children of the same or similar ages was being viewed possibly as more experimentation or just not relevant to social work intervention. As previously suggested Munro (2010a, b and 2011), Dominelli (2004) and Wastell and White (2014) refer to a lack of professional autonomy in social work. This thesis has identified areas where decision making can be left to individual practitioners. However in order for this to be viewed as *professional autonomy* rather than just *autonomy* requires practitioners to have the appropriate training and evidence base to inform their practice.

Whilst there are guidelines from the government regarding how these children should be responded to, this takes place within an abundance of legislation and both governmental and organisational policies that social work practitioners must adhere to continually throughout their practice. In essence, however, the decision whether or not to proceed with social work intervention should not lie so entirely with the individual social work practitioner as this is too open to interpretation and dependent on the individual. There

should be very clear, and most importantly, accessible guidelines about this group of children and how they should be treated at the very first point of referral – recognising their *dual status*. They must recognise the difficulties that already exist within CSCS when dealing with these cases, rather than just providing generic guidelines. These will be considered towards the end of this chapter, setting out what these should be. If these or similar guidelines are not implemented then these children will continue to be treated in a haphazard fashion, and some will continue to slip through the net.

8.1a(ii) An 'other' response

Recently I was approached by a Child Protection Nurse who wanted to set up a task force for children who display SHB to discuss current research and make recommendations for practice to ensure a consistent response within the local area. She advised me that the safeguarding manager she had approached had refused because she said her local area did not have a large number of children who display SHB who encountered CSCS – that the electronic records kept indicated that there were very few referrals in relation to children who display SHB. While this research involved a different Local Authority, these findings indicate several possible reasons why senior managers may not realise there is a problem in their area:

- some of these children have received an assessment and some have not;
- some behaviour has been viewed as problematic and some has not;
- some instances of SHB have been recorded on the alleged victim's file and some on the alleged perpetrator's file;
- some children have received intervention and some have not.

As Table 6.2 in the findings section shows (pp. 116–125), the responses to referrals can be erratic and inconsistent regardless of the referral information received, thus showing why the problem is not being seen. As found by the CJJIR (2013), practitioners appeared confused as to their remit and about what to do if behaviour was denied. This further highlights the need for more specific guidance and training of practitioners.

The term *other response* was used where there was no evidence of guidelines or assessment tools being used and where it was difficult to find evidence of the social worker's decision making. These responses tended to occur when a case was already open to a social worker in this Local Authority's long-term team. As they were not normally used to dealing with referrals they documented them as they would any other piece of information they received about the child they were dealing with. Many Local Authorities have separated their duty teams, i.e. those who take initial referrals, from their teams doing long-term work (such as managing those on child protection plans). By their very nature, duty teams would expect information they receive to be a referral, and long-term teams view this as additional information. As previously suggested, the Integrated Children's System was set up in 2007 to mirror the referral, assessment, planning and monitoring process for practitioners working with families (DoE, 2011, website). However, a review by Bell *et al.* in 2007 found serious flaws in the system. Practitioners and their managers found it too prescriptive, long, and repetitive, and focused on tick boxes. Whilst the system may have been attempting to mirror an existing way of working, what if there are already flaws in that? Where cases are already open to CSCS important information appears to get lost in this electronic system because the prescriptive process has already begun and electronic system appears to be unable to cope with this.

The findings by Bell *et al.* (2007) discussed in the literature review were similar to the findings in this study. They found inconsistency in the way information was recorded in ICS, and information (if not dates) was difficult to find. Whilst it may have been a grievance for the social workers in their research, it can manifest as dangerous practice where information is not easily found to show how children who display SHB are treated when referred to CSCS. Eileen Munro (2010b) also found that ICS made it difficult to 'see the child' because this electronic system was also used as a tool for reporting statistics to management (2010b, p. 59). Looking at the statistics within this Local Authority, there is a good reason for suggesting why children who display SHB may not be considered a significant issue – only 52 out of 512 (10%) referrals related to this issue, not as highly significant as perhaps other areas such as physical abuse or neglect. This figure is lower than the findings of Erooga and Masson (2006b) who stated that approximately between 'one-quarter and one-third of all alleged sexual abuse or sexual harm involves children and young

people' (p. 4). However, this figure must be considered in the context that none of the thirteen cases given by social workers were listed in the referrals, and only one of the cases was registered for sexual abuse. So almost half of the cases assessed did not go through the electronic referral system, and were therefore not included in this 10%. This is a key issue, indicating why so many children are being missed in relation to SHB. So whilst Munro (2010b) found that the recording for management purposes caused problems for social workers recording information about children and their families, this study found that the statistical information being reported to managers was not accurate either because of the prescriptive set up of ICS. This suggests that ICS is contributing to children who display SHB being invisible. In their longitudinal research over a sixteen year period, Harries et al. (2014) found evidence of missed opportunities for supporting families and that that 'filtering effect' led to families being re-referred back into the system. So it is significant that these children allegedly displaying SHB were not visible within this system.

It is not possible to say how many children who display SHB were missed, as this information was dependent on social workers referring the case to the research where there are no other triggers in CSCS to suggest that that particular case involved SHB. It is likely to be a higher figure because of the low response rate from social workers, as discussed in Chapter 5 – Methodology.

It is not unusual for researchers to encounter difficulties in accessing information from Local Authorities. In their research, Poursanidou *et al.* (2005) found that there were problems in the Local Authority's recording system for showing specific information. This made it difficult for them to gather information for their research into foster care. They suggested that 'most local authorities will have to modify the way they store and retrieve information' (2005, p. 3). While this research was in a different geographic area, the same legislation and government guidelines were being followed. It also involved the same principals of accessing information from the electronic recording system from a Local Authority, and found difficulties in this encounter. Obviously the electronic systems employed by Local Authorities are for the benefit of their own recording needs, but this thesis shows where the flaws lie, as effective service provision practitioners must ensure we are dealing

appropriately with service users, yet how can this be monitored when the majority of service users are invisible to CSCS?

8.1a(iii) Child in need response

In theory, the *child in need response* to children who display SHB was when social workers applied government guidelines and completed a Child in Need (s17) Assessment of the child displaying SHB, which occurred in half of the cases in this study. This did not necessarily stop the responses from being erratic following that assessment. In particular the findings showed that social workers recommended that no further action be taken when the police (if they were involved) decided to take no further action. This occurred in all relevant cases except for three. Obviously there are instances where that might be the most appropriate decision, for example in the case of Child10 where the police took no further action because they felt it was technically consensual. Having said that however, does this still really mean there is no role for CSCS? Should it not be the role of the social work practitioner to talk to Child10 about what is appropriate sexual behaviour for his age, especially when what happened ended up being reported to the police and he had to be interviewed? In their research in 1998, Thorpe and Bilson raised concern that when social work practitioners focused so much on the investigation process that this was detrimental to the issue of welfare. The Children Act, 1989, itself sets out clearly that Local Authorities must investigate referrals and be able to answer the following two questions: 'Is this child in need?' and 'Is it possible that this child is or is likely to suffer significant harm?' It could be argued that these not be applied to a child whose behaviour led to him being interviewed by the police? If Local Authorities are to act in a preventative, welfare-focused way then this kind of work would seem appropriate. But it is important that such a decision should not be left to individual social workers as this can lead to an inconsistent response. Early intervention and recognition of the behaviour could prevent a situation from spiralling out of control, and could provide a better outcome for the child – as in the case of Child14, where the social worker felt that earlier therapy could have helped him remain in the care of his aunt and uncle rather than ending up in foster care with the Local Authority.

Social workers did not appear to be looking at the whole picture for these children, but instead looked at what they viewed as isolated incidents (an investigative approach, Thorpe

and Bilson (1998)), which meant warning signs could be missed and this could lead to problems such as re-referrals and escalating behaviour. This was also found by the CJJIR (2013) – limited examples of holistic, shared assessments among professionals, with reasons or triggers for the sexualised behaviour not being fully explored in the assessment documentation suggesting that the focus for these children was not on their welfare.

This research has highlighted a real lack of preventative work being completed in this area. For example, no actual preventative work was completed with Child13, and the social worker's response to this case sums up the general response to SHB, which was to 'wait and see'. She could not determine why he displayed SHB so did not do *anything*, and then he did it again. These examples show how CSCS at this Local Authority was not working in a preventative way. In removing Child3 from her family home this did not prevent her displaying SHB as she then continued to display the behaviour in her foster placement. The SHB itself was not the focus for the social workers initially involved. Their view was that she had been sexually abused by her uncle and needed to be taken into care to keep her safe. But if they had factored in her SHB would this have changed their view? It is unlikely as, with the examples found in this research, it is more likely that they would have used it as further evidence that she had been sexually abused. However, although 14_Social Worker did try to work in a supportive and preventative way this was clearly limited because Child2 refused to participate. This highlights another issue in making sure work is completed with these children, as if they are not compelled to participate they can refuse. Of course, compelling them against their will would not help the therapeutic support work, but it is important that it is something that is at least offered to them, and to their families, to help work in a preventative way. Consistency needs to be applied in how these cases are approached so that, although outcomes may be different, social work practitioners are all guided by the same purpose.

These examples further show the flaws in CSCS in relation to SHB. The way information was recorded and viewed by others was not always the same as the thoughts of the social work practitioner concerned. If information was very important then it should be recorded *consistently* and *clearly* by all professionals so there can be no question later as to what actually happened or what was meant. As found by Bell *et al.* (2007), '[r]ecording practice

was variable as there were differences between social worker and work groups in the ways in which they entered the data' (p. 9). When cases were handed on, social work practitioners wrote a handover note – this research observed that these tended to cover current issues and would miss out information from the past that could in fact be crucial. They were backed up with a chronology of all events, but the length of chronologies for children known to CSCS for a long period of time can be considerable. As stated previously, recordings could show events from almost every day of a child's life, so over a number of years there could be pages and pages of recordings. In reality, anyone reading these could easily miss information that could be relevant to them as there was no consistency in the way it was recorded. This too is similar to the findings of Bell *et al.* (2007) who could not easily find a holistic view of a child and their family because of the way the system was separated into segments.

But even considering Bell *et al.*'s (2007) findings, clearly CSCS suffers from information overload and from not using appropriate flagging of information. But who determines what is important? The social workers tend to do this as they are the ones recording the information about what they have done. But this could make it difficult for someone else to take over a case and determine what the key issues were for this child. Obviously it is important that children are not permanently labelled by constantly having the past brought up as Chaffin argues, 'assumptions [are] drawn from adult pedophilia [sic]' (2008, p. 111), suggesting a particular view could be taken of these children connecting them to adult paedophiles. However it remains important that when sharing information with professionals they are also advised of key events, if for no other reason than acknowledging the turnover of staff and recognising that there are constantly new people who need to be brought up to speed. Professionals should be able to deal with this information without resorting to labelling these children. Whilst Munro (2010a) recognised the continuing importance of ICT, she emphasised that it should support and not obscure social work decision making. As the lead professionals in safeguarding children, social work practitioners should be able to provide information easily to others – after all, that is *working together*.

8.1a(iv) How can a perpetrator also be a victim?

Regardless of the practicality of how information was recorded, there was a more fundamental problem in the way this group of children were treated. Social work practitioners seemed genuinely not to know what to do about these children, as indicated by the *child in need response* above becoming more erratic even after assessments were completed. Social work practitioners appeared genuinely confused by the same child being both the alleged victim *and* the alleged perpetrator. It is as though social work practitioners, in seeing a child in these dual roles, were conflicted by two different processes operating at the same time, and this may indicate a reason for the inconsistency in their response. Whilst government guidelines (DoH, 2010) set out clearly that these children should be viewed as children in need, the child's other status as an alleged perpetrator appeared to cause confusion as to how to proceed. The response of social work practitioners appeared to be static at first – either intervention was required or it was not, or if the police did not take further action then CSCS did not either (again the investigative focus); but then it became more fluid after assessments were completed, fluctuating between viewing the child as a victim of their circumstances (sometimes as a possible victim of sexual abuse, as discussed later) or as a perpetrator. The ways in which social work practitioners were used to dealing with alleged victims and alleged perpetrators were usually very distinct, and it would usually be two different people. Alleged perpetrators were usually people who were assessed as to whether it was safe for them to be in the child's life, and recognising a child as this kind of person but also a possible victim of their own circumstances (what Masson (2006) refers to as 'dual status') was something that social work practitioners appeared to struggle to comprehend in practice (also found by the CJJIR (2013)). This again highlights the need for much more specific guidelines which recognise this conflict, so that there can be consistency in practice. That is not to suggest that social work practitioners become mere automatons in an inflexible system, but that they are given all the tools necessary in order to deal with this specialised group. Professional judgement (as identified by Munro 2011, Dominelli 2004 and Wastell and White 2014) is only possible if practitioners are appropriately trained with the transferable skills necessary to address different situations in social work practice. However as identified earlier in this thesis the only training given at this LA in relation to children who display SHB was a one day training course mainly focusing on the variety of values and

judgements across different professions. Whilst useful this did not address the required process for supporting these children or their dual status.

8.1a(v) When does sexualised behaviour become harmful?

The inconsistent response also followed through to the serious issue of how to determine whether sexualised behaviour was in fact harmful. Research has been completed in defining what SHB is (see Chapter 2 – Literature Review) but there is no one practice model for social work practitioners to use when assessing the behaviour. It is completely unrealistic to place this emphasis on individual social work practitioners themselves – firstly because, currently, their high caseloads mean they do not have the time, but also because this would lead to an inconsistent response as different social workers could use different models. Therefore it is the responsibility of the government to ensure they prepare practice models so that all social work practitioners are using the same – to my knowledge there is no current one model in use.

Throughout the 30 cases, and the interviews with all participants, the question of whether behaviour was harmful was very much determined by the individual. To give a few examples of how these differ:

- 1_Mother felt that the school was responsible for placing her son in the position of temptation with another child with similar sexualised behaviour problems.
- 3_Father felt that really boys will be boys and he was not surprised about some behaviour that his wife was.
- 6_AdoptiveMother felt the behaviour was not harmful because her eldest son went into a trance.
- 10_Social worker dismissed Child5's 'aggressive' pursuit of a girl in school.

Decision making by professionals was very much value based, down to the decisions of individual social workers and therefore potentially subject to social perceptions of this issue. As suggested by Beckett and Maynard (2013) that the values of social workers are not just personal but are greatly influenced by societal values, and it is the nature of social work that is 'prone to finding itself in difficult places where deeply held societal values collide'.

Sexually harmful behaviour (allegedly) committed by children towards other children is one such area. For a consistent response it is important that thresholds of behaviour are determined to guide these practitioners in their decisions so they are not solely guided by personal or societal values. This becomes even more essential when it is considered against multiple social workers managing each case from referral to outcome. It was found that on average a child would have two or more social workers from the point of referral to the outcome for that child. However, CSCS is also not adaptable, and cannot easily cope when confronted with the idea of having another social worker involved with a family. Why could the adoption worker not complete the assessment of 6_Adoptive mother's son? If she was trained appropriately then should she not be able to assess as well as any other social worker? If clear guidance was in place then this would seem a sensible course of action, but without that guidance, when there are already questions raised about consistency from case to case, this shows that there is likely to be further inconsistency within cases due to the potentially large number of social workers involved.

18_Team Manager raised the value-base as an issue as it can be difficult to understand when taking over a case if it is in conflict to your own values. This suggests the possibility of a focus changing because the social worker has changed. Casting a fresh set of eyes on a situation is not necessarily a bad thing, but if this social worker's views are completely opposite to the previous one then the entire focus for this child can change, and not necessarily for the better. If this is considered, along with these findings that only one social work practitioner made reference to recent research in the 30 cases, then it appears that all decision making by social work practitioners was value-based rather than research-based, which creates a worrying environment. It means that the response of CSCS was very fragmented and down to the perception and ability of the individual social workers not trained in understanding SHB. Yet there is emphasis in the DoH document (2000) on appropriate training being needed and on the need for staff not to dismiss concerning behaviour as just 'normal' (p. 302). On *Newsnight* (BBC website, 2010) Simon Hackett said that three thirteen-year-olds in different parts of the country, with the same presenting issues, are likely to be treated differently depending on the area in which they live. From this research, however, it is clear that these thirteen-year-olds could be treated differently even if they lived in the *same* area and were referred to the same Local Authority. When

you take into consideration how they first encounter CSCS, the situation for children who display SHB is even bleaker than that suggested by other academics.

8.1a(vi) What does SHB mean in the context of social work practice?

Throughout this study it has not been possible to develop a consensus as to what SHB actually means. Lack of consensus regarding what SHB is in relation to CSCS's response, when behaviour becomes problematic/harmful, reluctance to be specific in naming the behaviour, and being drawn to the presumption that SHB means the child has been sexually abused all contribute to this. The government recommends that children who display SHB should be subject to a Child In Need Assessment (DoH, 2010), but whether the behaviour is viewed as harmful is left to the perception of the individual social worker, and therefore a number of children in this research study were not given an assessment. But what is the difference between experimentation and abuse? If the child is over the age of criminal responsibility, and therefore has criminal justice system involvement, then this research suggests the behaviour will be viewed as abusive up until the justice system's decision is made. For example, if the police take no further action then social workers will close the case because of this, thus viewing the behaviour as not having been problematic. Outside of this social work practitioners appeared to find it difficult to assess behaviour and determine whether it was abusive. If, for example, Child3 was a boy, it is possible that the social worker would have been less confused and more certain that the behaviour towards the foster carer's grandson was abusive, due to perceptions regarding male perpetrators of abuse (Bromfield, 2006; Hackett, 2007; Chaffin, 2008). So there was uncertainty when assessing the behaviour of children (as opposed to adolescents) and females. The Brook Sexual Behaviours Traffic Light Tool (2012) gives guidelines for assessing sexualised behaviour, but it has not engaged with gender difference despite it being a significant factor.

Recognising the limits of acceptable behaviour was a problem, and particularly when considering the age gap, or lack thereof, between alleged perpetrator and alleged victim (NCH, 1992). This research found that social workers appeared to view behaviour as less problematic where there was little or no age difference between the alleged perpetrator and alleged victim. But does this really mean that the behaviour was not abusive? When considering the case of Child18 decisions were made on seemingly limited information

without any assessments being completed. Also, in the case talked of by 20_Team Manager the alleged perpetrator was allowed to return home because his sister was now older. This suggests that social work practitioners did not appear to understand that their remit was different from the police's remit. Social work practitioners do not have to prove the incident occurred, only that there was sufficient evidence to suggest it *may* have occurred, and that the alleged perpetrator could be at risk of significant harm because of their environment or because of their behaviour towards others (Children Act, 1989). Team managers, perhaps because they were more experienced, were more willing to actually name the behaviour in detail, and were not embarrassed to do so, whereas social workers and parents and carers found it difficult. While there is clearly a lot of debate within the academic community as to the appropriateness of labelling the behaviour (Friedrich *et al.*, 2005; Chaffin *et al.*, 2002), it is important, particularly for social workers, to overcome any issues they may have and name the behaviour in order that they might begin to understand it and determine appropriate action. Without giving the behaviour a name, this could continue to lead to inconsistencies in CSCS's response to it. It will also lead to inaccurate recording of information, as found with social workers being embarrassed to give specific information, for example. As professional workers this is something that must be overcome in order to be able to effectively deal with children who display SHB, and as professionals they should be able to do so without stigmatising the children further simply because they have to name their behaviour.

8.1a(vii) Children who display SHB must have been sexually abused themselves...

At the very beginning of the literature review it was suggested that there had been a tendency for parents/carers to be covertly, or even sometimes overtly, accused of sexually abusing their child. Vosmer *et al.* (2009) advised caution in presuming that any sexually inappropriate behaviour was the result of sexual abuse as there could be a number of variables that could be associated with such behaviour, and as can be seen from the literature review they are not alone in offering that advice. However, many social work practitioners in this research appear to operate from the viewpoint that if a child is displaying sexualised behaviour which they do view as concerning then this must have been learned behaviour and so learned from someone else who has sexually abused them. This information was important not just in relation to how parents/carers were treated but also

in relation to the viewpoint from which social work practitioners assess. In the 30 cases approximately one third were assessed from the point of view that the alleged perpetrator must have experienced sexual abuse themselves, but it was only confirmed in one of the cases. In relation to Child5, recordings in ICS by the social worker confirmed that she suspected he had been sexually abused by his grandmother's foster child and that his grandmother was covering for the foster child. During the interview she said 'when he was raped, well I mean he never used the word rape but we knew he had been'. This social worker appeared convinced that she was right despite no other professionals agreeing with her, and she acknowledged that he had never told her that, but she appeared to have almost convinced herself that he had. Because of this the issues of his SHB were not addressed. The recordings stated that he 'aggressively pursued' a young girl in his class so much so that her parents removed her from the school, but the social worker said she did not think it was within her remit to assess his behaviour and to suggest options for support. The recordings also stated that he received a police caution for the behaviour, but the social worker said he did not.

This example shows a social work practitioner so determined that they are right that they ignore other information that may be important because it is not in support of their own view, in this case that the child has been a victim of sexual abuse. This was a problem displayed not just by social workers but also by team managers. For example, in relation to Child21 the team manager interviewed, who had been a social worker on the case, was convinced that this child had admitted she had been sexually abused by her mother's boyfriend. However, on reading all of the recordings and having access to the paper files for this case there was no recording suggesting this had ever been confirmed. Records indicated that it was suspected by social workers because of her presenting SHB and because she told them she liked to play 'sexy games'.

These examples show how social work practitioners appear to become preoccupied with whether a child has been sexually abused and are not seeing them as possible perpetrators. Whilst government guidelines state that that alleged perpetrators must be viewed as children in need (DoH, 2010), it has a negative impact if they are immediately viewed as possible victims of sexual abuse rather than focusing on their behaviour and their overall

background, as it means that assessments are not being completed and services are not being provided. For example, for Child14a and Child14b the court ruled that the social work practitioners were stuck focusing on whether these children had been sexually abused by their father. If instead they had highlighted the SHB perhaps therapy would have been provided earlier and perhaps Child5 would be receiving therapeutic support; Child3 would have remained at home rather than being taken into care; Child8 may have received therapeutic support earlier which may have preventing him from assaulting his five-year-old niece... perhaps... The DoH (2000) states clearly that assessments should be grounded in evidence – up-to-date knowledge, research and guidance. What these examples do show, however, is that if social work practitioners become focused on one issue and convince themselves that it is true, without backing this up with evidence or research, then all the work they complete is focused around this to the detriment of any other issues. Whilst not relating to a child displaying SHB, Graham Badman who chaired the official enquiry into the death of 'Baby P' said that one of the downfalls was social work practitioners' 'willingness to believe' his mother (BBC, 2010). Social work practitioners became anchored to one viewpoint and were unable to look outside of this, despite other evidence.

But how should this information get across to social work practitioners? The advice has been out there for some time within the academic community and from government guidelines, but the reality is that, regardless of what happens in academia and how much of that information is passed on to governmental advisors to help influence policy decisions, the advice is not filtering down to the people actually doing the assessments. How are social workers continually kept up to date with changes in guidelines? Hackett and Masson (2003) found that training was a problem and, as raised by 18_Team Manager, some Local Authorities do not have subscriptions to any journals so it is not possible for social workers to access current research articles unless they happen to be attending a university as well. Emphasis must therefore be placed on the academic community and the government to ensure social work practitioners are directed to, or provided with, appropriate research guidance to follow (as discussed in more detail later).

8.1a(viii) How does CSCS deal with cases of children who display SHB?

Sections (i) to (vii) above have shown the ways in which CSCS deals with this group of children, but in essence the short answer to this question is 'erratically'. As an example, the case of Child4 shows a succession of issues that were encountered when trying to understand how CSCS responds to SHB. The extract below is taken from my field notes in the DCT when gathering information about this case, and in effect gives a summarised example of how CSCS works in practice. (Where quotes are used, this information was directly taken form electronic recordings by social work practitioners in CSCS.)

> *There was no referral for Child4 but there was a section 47 investigation (Children Act, 1989) completed and this is documented in his file. It is stated that the Emergency Duty Team (EDT) were contacted on 3 November 2009 by this child's sister's counsellor as she 'alleged sexual abuse from her elder brother in the guise of sexual touching and simulated sex. Parents made aware'. The information in the section 47 advises that this occurred on three different occasions and that Child4 denied this. The parents were described as 'very distressed'. However no recordings were made by the EDT worker on Child4's file. I was able to access information on his sister's record (the alleged victim). She was spoken to by the social worker on 6 November 09. She told her that he 'makes an "uh-uh" noise and rubs up and down on top of her', the sister described this as the same noise that 'mam and dad make when they are in bed together'. On several other occasions while her parents were asleep she reported these incidents: him pulling down her nightwear and underwear and forcing her legs apart; him doing this again but this time touching her vagina which hurt; him spitting on his hand and rubbing her vagina; and him saying 'I want to lick your fanny'. She told the social worker that she feels nice about him but also angry and sad but he always apologises. The social worker said child4 was there when she went to visit the sister and he denied doing anything. The social worker said she would meet him the next week but he cancelled as he had detention. She recorded that she would be see him the following week but there is no recording to show this was done. Also there is no recorded evidence that she put these specific allegations*

to him. The recordings stating that he denied it are chronologically after the parents were informed but before the social worker talked to the sister and got more specific details. The social worker's response was to refer him to Mosaic for children who have been sexually abused – why? He did not disclose sexual abuse according to the recordings. However, her recordings indicate that she believed she was referring him to a therapeutic service dealing with sexualised behaviour. The social worker also advised the parents to put something on the sister's door so it makes a noise so they can hear him if he attempts to get into his sister's bedroom again, e.g. a beaded curtain...

This case example highlights the practice of social work practitioners in relation to SHB: how information was recorded; whether the behaviour was viewed as problematic; and what action, if any, was taken. This case was then closed without ensuring appropriate support was provided.

8.1a(ix) Making good policy into good practice

As shown, just because policy guidelines are provided this does not necessarily translate into good practice. CSCS (and social work practitioners in practice) appear to have difficulty in understanding that their responsibility to these children is different to that of the criminal justice system. Hackett and Masson (2006) and the NCH Report (1992) both raised the issue of tensions between the safeguarding children system and the criminal justice system, and this research shows that this is still a problem. In practice, social work practitioners appeared to act differently when the police were involved, and as the interviews show there was a conflict even when they did know their different remit, as information was not always shared so that social work practitioners could protect the children from harm. This ties in with the findings of Hackett and Masson (2006) that concern remains about the practicalities of how to work across two different systems, one focusing on welfare and the other on justice. This goes some way to showing why social work practitioners may struggle with the perception of these children as both alleged victim and alleged perpetrator – that not only were they trying to merge their perception of the child into one but also merging two completely different systems. This research has found that, as yet, CSCS teams are still not working together. Social work practitioners are not registering that their remit is

different to the police and is not dependent on whatever action the police may or may not take.

Also, as shown in the literature review, the government have recommended that parents/carers should be helped to support their child's welfare. While the example of putting up a beaded curtain is just one example, it is representative of how good policy guidelines are not necessarily being implemented in practice. Social workers of cases already open tended not to update child plans to include any intervention in relation to SHB coinciding with when the police took NFA due to lack of evidence. While care must be taken not to subject children to intervention (e.g. therapy) that is not necessary, it is important to ensure that work is completed in a preventative way. Social workers (and all social work practitioners) first and foremost must to accept that their remit is different from that of the police. They do not have to prove something happened beyond reasonable doubt. Instead their remit is to assess for harm (Children Act, 1989). So although there may not be enough criminal evidence, is there evidence to suggest this child could be capable of acting out sexually, or are there any aspects to that child's background that mean they may be suffering or likely to suffer harm? Preventative work carried out by appropriately trained social work practitioners would be a benefit at the early stages of SHB to try and reach any children who may be acting inappropriately but where this cannot be proven.

Local authorities must also ensure they do not lose important information because of over recording, and should have more specific or searchable data systems. Munro (2010a) recognises the continuing need for technology in keeping records of work with families, but CSCS need to ensure all staff are appropriately trained, not just in relation to SHB (as discussed later) but generally in how to record properly and not inconsistently, as found by Bell *et al.* (2007). For example, when cross referencing, other children system IDs should be used rather than either nothing or just a first name. Using just names might make sense to the social worker at the time, but future workers may not know who they are referring to. Information must be logged onto the alleged perpetrator's file to ensure that if future referrals are received then these can be easily considered against past behaviour – repetition of behaviour, especially if preventative work has already been carried out, raises the risk that child poses to others. Social work practitioners need to be appropriately

educated about SHB and the thresholds for problematic behaviour. Rightly CSCS are victim-focused, but this can be at the expense of alleged perpetrators who are also in need of support, and this lack of recording shows an apparent lack of concern for their welfare and does not show a recognition of them as children in need. In their study Mir and Oakie (2007) said they contacted child protection units in Greater Manchester and reported that they 'failed to identify any relevant cases'. When considering this with the difficulties experienced by this researcher, with a working knowledge of ICS, then this suggests that perhaps the relevant cases *were* there but that the social worker practitioners could not find them!

8.1b What are the reflections of social work practitioners on their practice in relation to working with these families?

Throughout their training, social work practitioners are encouraged to be reflective of their practice – 'thinking things through' to consider what they did right and what they should change (Payne, 2002, p. 124). Therefore all the social work practitioners involved in this research were asked to reflect on the cases they dealt with in relation to children who display SHB. The findings showed that generally social work practitioners reflected positively on their own practice. There was some agreement that cases involving SHB were complex and that how they were dealt with by others depended on their value base. But a sense of defensiveness from social workers was felt, a sense of not really wanting to acknowledge that perhaps they could have done things differently or whether they may have made mistakes. Team managers, however, did feel that they could have done things better, for example 17_Team Manager, who felt she had not been appropriately trained in order to manage social workers dealing with cases of SHB.

8.1b(i) Lack of appropriate training

There was a general agreement that all social work practitioners need better training in this area. It became very clear that lack of training was a significant issue for all social work practitioners, and only a one-day training course is offered post-qualifying which, although apparently mandatory now, has not been mandatory before and so a lot of social work

practitioners have been dealing with cases of SHB without ever having received any training at all in the specific area, and continue to do so.

This highlights a concern about the quality of post-qualifying training for social work practitioners. NCH (1992), Hackett and Masson (2003), Mir and Oakie (2007) and DoH (2010) all emphasise the importance of appropriate training, but that there are problems with what is actually received by social work practitioners. Once social work practitioners leave university as qualified social workers they complete a certain number of hours of post-qualifying training as part of their continuous professional development. At the time of writing this research, in order to re-register as a practising social worker with the GSCC social work practitioners had to evidence that they had completed either 90 hours or 15 days of study, training, courses, seminars, reading or other activities which could reasonably be expected to advance professional development (GSCC, 2011, p. 2). As registration was for a three-year period this effectively means that social workers only need attend approximately 5 full days of training every year. But this is not about the quality of the training or how it contributes towards knowledge as a practitioner, only that they have completed enough hours. As professionals who deal with 'difficult places where deeply held societal values collide' it is appropriate for training programmes to be much more robust and recognise the importance of recent research and how this may impact on practice (Beckett and Maynard, 2013). For example, Harriet Ward and her research team at Loughborough have completed research showing that if parents are unable to effect and sustain change within a six-month period (usually following the birth of a child) then it is unlikely they will be able to sustain any change at all (Ward *et al.*, 2010). This information is useful for frontline practice where families are given chances time and time again, and where children remain in abusive situations. But this is not getting through to social work practitioners on the front lines. Information is out there in other guises, for example in television programmes like the Panorama investigation into the death of Baby P, and these provide useful information (Ward spoke about her research on this programme). It is important for the benefit of the children who come into contact with CSCS that such information is shared and integrated into each social worker's practice. This can only be done by overhauling the way in which social work practitioners are viewed and what their role is. Munro (2010a) expressed the importance of more robust training in social work.

Training and development must be incorporated into a regular working week so practitioners have the time and are able to develop a passion for learning and improving their knowledge.

8.1b(ii) Social work practitioners' views of CSCS

As well as having a negative view of the training (or lack thereof) offered, social work practitioners also had a very negative view about how CSCS deal with children who display SHB (although they were positive about their own practice, which they viewed differently to the overall response of CSCS). 11_Social Worker said that social work practitioners have a difficulty between responding to the behaviour and normalising it. There was a general agreement that sexual issues were still very much a taboo and could be difficult to talk about explicitly, which means that they were not easy cases to deal with. This was similar to Hackett's (2001) findings, where parents struggled to cope dealing with the knowledge of sexual abuse. However, this was parents, not professionally trained social work practitioners. It is clear from this that social work practitioners need better training (as discussed previously), especially as so much weight was seen to be given to individual social workers' value-based decision making. This could mean either that they placed higher value on it because it was too concerning to mention, or conversely that they placed less value on it because they did not want to talk about.

There was also agreement that delays in providing therapeutic intervention, once it was identified as a need, were not positive for the children. The social workers in particular felt constrained by police investigations and the intervention from courts. Most felt this impacted on their ability to assess and provide support for these children. 13_Social Worker summed this up by saying 'at the end it wasn't about them', meaning the children. 15_Senior Social Worker, who was the most experienced in relation to SHB (both through case experience and training), felt concerned that in his view some social workers did not intervene early enough because they viewed the alleged perpetrator (Child8) as a victim of sexual abuse rather than a perpetrator (as discussed previously). This is where the complexities of dealing with SHB lie – the *dual status* in ensuring social workers can view the alleged perpetrator as a possible perpetrator while also acknowledging them as a child in

need. As previously discussed, this is not an easy concept to grasp when social workers are used to dealing with children only as victims.

8.1b(iii) Invisible to CSCS – no appropriate assessment tools

There was a general sense of confusion from social workers as to the purpose of AIM assessments and how these should be applied in practice. This was a problem with the existing training offered, which did not really explain the circumstances in which social workers should use them, only how they should be used with adolescents. The term 'AIM assessments' (Morrison and Henniker, 2006) is something that appears to be common knowledge in general social work practice, but very few practitioners seem to know what they actually are or how they should actually be used. Also, no other tools were thought of in relation to how to deal with younger children who display SHB. This research has shown that a lack of consistent recording is one possible explanation for this because, as yet, the research community has not been fully able to view the way in which cases of SHB come to the attention of CSCS and how they are responded to. This was found by Mir and Oakie (2007) in not being able to access information from ICS.

Children who display SHB are slipping through the net and not coming fully to the attention of CSCS, so it is understandable (though not excusable) why there has been no focus on how to deal with this particular group, i.e. the children who are referred for displaying SHB. Most of the cases accessed as part of this research study may not otherwise be viewed by others (e.g. managers, as previously suggested) as there was no clear indication in CSCS of them actually existing. This also goes a long way towards understanding why social work practitioners do not appear to know what to do. There is a consistency in this, in that no-one interviewed really knew what to do in relation to children who display SHB – either how to record information or what assessments were appropriate.

8.1b(iv) Social work practitioners' reflections – a failing process

These examples show that CSCS are currently failing at all levels in relation to children who display SHB. CSCS are:

- failing in how to recognise behaviour as problematic and ensuring these children are visible to CSCS;

- failing in ensuring social work practitioners are appropriately trained; and
- failing to ensure social work practitioners have access to and understand the appropriate guidance and assessment tools they can use.

8.1c What does a small group of users (parents and carers) say about effective case management?

As suggested in answer to the previous two research questions, CSCS are not following guidelines (DoH, 2010) with a consistent and appropriate response, and the reflections of social work practitioners above indicate a process that is failing in relation to children who display SHB. The parents and carers of these children also agree that the CSCS response does not work.

8.1c(i) CSCS response does not work

In general parents and carers had quite different experiences in practice, but none were positive that social work intervention had had a beneficial effect on their family. 6_Adoptive Mother was able to stop the CSCS response to SHB in relation to her child, and this meant that she felt she knew what her child needed and was determined to ensure this is what he got – she could circumvent CSCS because she knew about it. The professionals involved allowed her to do this, but then this fell apart when they came to the next issue of actually providing support, which required evidence and this needed to be provided by the safeguarding children team. Allan (2006) found that in Australia middle-class parents were able to keep Safeguarding Children Services out of their lives, and this ties in with the experiences of 6_Adoptive Mother. However, 9_Adoptive Mother is also a health visitor and an articulate person, but she was not able to do the same. The police were involved with her son yet 6_Adoptive Mother was able to keep CSCS from involving the police. This is not a consistent response to SHB. This does not suggest that all middle-class parents should be treated the same, but that *all parents* no matter how articulate should be entitled to the same treatment. A family in other circumstances would not have been able to keep out the police or CSCS. In actual fact if they did try to stop them this would probably go against them. For example, 7_Grandmother and 8_Step-Grandfather were furious when CSCS decided to remove their granddaughter. In their view they were not given an opportunity to

convince professionals that they could safeguard her. Yet 6_AdoptiveMother was able to stop professionals from being involved and to articulate to them that she was able to protect her children. But could she really protect her children any better than these grandparents? During the interview, while she was talking of how she prevents her two sons from being alone together I observed on two occasions that they were alone together without her knowledge – in the kitchen and in the garage. This is not a criticism of this mother but a statement about the reality of 24/7 supervision – it is not possible. CSCS's response should not be open to manipulation and professionals being convinced by articulate parents that they can completely safeguard their children 24/7. CSCS is expected to follow legislation and guidelines consistently (DoH, 2010 and Children Act, 1989). If there was a consistent response and clear guidelines then this should not be able to happen.

All the parents/carers interviewed talked of a lack of organisation and cohesion from professionals, which also tied in with the experiences of social workers who did not feel they had clear guidelines from their agency on what to do in these circumstances. However, parents/carers generally had more positive views of the police. Most of the parents/carers found the police easy to deal with because things seemed clear to them about what their involvement was and what they were doing. Conversely, social work practitioners generally found dealing with the police and the legal system frustrating as it impacted on their ability to get involved and help the child – often delaying therapeutic work with the child which may have been necessary for them to be able to move on. This effectively left some children in a state of limbo.

8.1c(ii) Experience of social work practitioners

When considering interactions with social work practitioners, none of the parents/carers focused on their personality (as found by Holland (2000) and Spratt and Callan (2004)) but on their actions. All the parents/carers talked of feeling blamed for their child's behaviour. As set out in the findings, this could be very different depending on the family's individual circumstances but amounted to the same thing – that they felt social workers were looking to blame them for their child's behaviour (also found by Hackett (2001)). 1_Mother had a son similar in age to 2_Mother and 3_Father and they both displayed recurring behaviour. Ultimately they were both referred for therapeutic support but for 2_Mother and 3_Father

this was something they had to push for. They shared an experience of feeling as though they were being blamed for their son's behaviour but the reasons were different – 1_Mother because her husband worked away, and 2_Mother because she and the family followed her husband where his job took them. 4_TeamManager looked to the child's mother as being responsible for his behaviour and 10_Social Worker blamed the paternal grandmother for allowing Child5 to be in a vulnerable position where he was (in her view) sexually abused. Both 6_Adoptive Mother and 9_Adoptive Mother tried to use their own experience as health visitors to influence the response of CSCS to their sons. 6_Adoptive Mother was successful but 9_Adoptive Mother was not. 7_Grandmother and 8_Step-Grandfather were accused of minimising their grand-daughter's sexualised behaviour, but she was taken from their care not because of this but because they would not believe she had been sexually abused, which the next social worker then admitted probably had not happened. 2_Mother was ignored for years because she was concerned about her son's behaviour but she was told that because the family moved a lot there was no point in starting anything.

While research suggests it is appropriate to look into the child's environment for factors that could lead to their SHB (Hackett, 2004; Chaffin; 2008; Letourneau *et al.*, 2008), social work practitioners have to attempt to do this in a way that does not unnecessarily focus on the parents as being to blame. They need establish an open and honest working relationship with families, and if there are concerns within the family environment then these will need to be addressed. It is not about social workers becoming friends with these parents but simply treating all of them in a respectful manner. The parents talked about what it was that made the working relationship better, and that was being listened to. It did not necessarily mean that any of the circumstances changed but that they at least felt confident that they were being heard. For example, 7_Grandmother and 8_Step-Grandfather were very negative about the social workers involved except for the long-term social worker. She did not change in the view that she felt their granddaughter was at risk because she did not feel the grandparents were taking the concerns of CSCS seriously, but what she did appear to do was to listen to their point of view. Parents/carers also talked of feeling as though social workers should be someone that they felt supported by – someone they could talk to if they had concerns themselves. The issue parents and carers experienced was that when they

needed support they were worried about who to talk to for fear that things they said may be written down and used against them, as in the experience of 6_Adoptive Mother and 4_Foster Carer. 6_Adoptive Mother felt that when she tried to do this the experience was negative because she felt that the social worker would be documenting that she could not cope. There is a conflict here in that social workers within the safeguarding children arena are the social worker of the *child(ren)* but not the parents. But in trying to support the child what many social workers do not appear to put into practice is the notion that if you support the parents then you are indirectly supporting the child. As Johnson *et al.* suggest, '[r]ecognising the potential impacts for parents and involving them in the work is essential' (2007, p. 104). But in practice this is not something that is felt my parents.

8.1c(iii) Naming the behaviour

The actual naming of the behaviour was something that came up with parents and carers as something that was difficult to do. For parents to actually talk about the sexual activity of their child can be difficult, so to talk about it as possibly 'deviant' can be even more so. This led to the consideration, why is it so difficult to name acts of sexualised behaviour? Do people fear becoming deviant themselves by just talking about them? For parents, does it somehow make the situation more real if the acts are named and considered? Is it easier to continue to support and love their child if they do not look into too much detail about what they may have done? 1_Mother appeared to show a certain level of acceptance in that she accepted that her son had done something and had acted in a deviant way. However, in order to manage that fact she felt it was better not to know exactly what these acts were. It must be considered that it could be because as a researcher I was a stranger to these people that they were uncomfortable in sharing details, as with 4_Foster Carer who was able to share details later in the interview. However, regardless of my relationship to these participants it is something that people have difficulty in naming. This is a particular concern in relation to social work practitioners as specific details need to be given so it can be clear what happened and so others, for example their team managers, can confirm if they agree with the social worker's interpretation of the abuse. In the 30 cases and in the interviews with social work practitioners there was a reluctance to give specific details about the behaviour. The word 'inappropriate' was used a lot of the time, but what constitutes 'inappropriate' behaviour must be qualified, especially when the decision to take action is

value-based on the part of the social worker (and possibly their team manager). It is important that they overcome their embarrassment as specifics in CSCS recording are imperative to ensure consistent treatment. Perhaps this comes with experience, as suggested by the fact that the interviewed team managers were more comfortable in talking about the specifics of sexualised behaviour.

8.1c(iv) The realities of risk management

Parents and carers experienced difficulties in coping with the realities of risk management. 6_Adoptive Mother and 9_Adoptive Mother both felt their children were not the risk presented to them by social work practitioners, whereas 4_Foster Carer did not question the professionals about this but felt they did not consider the realities of what 24/7 supervision of the child in her care would mean and how this would impact on her own mental state. Power dynamics came into play where risk management was concerned. If social workers perceived a risk and determined what needed to be done to minimise this, this was not usually discussed with parents and carers. As Hackett (2001) found, parents often felt powerless when dealing with professionals. While social workers have a duty to ensure children are safeguarded from harm (Children Act, 1989) this research has shown there appears to be a lack of realism when it comes to how this can be maintained by families, and the power balance in favour of social workers means they can intervene and remove children at the first sign that 24/7 supervision is not being maintained, despite the fact that 24/7 supervision is not possible.

8.1d Best practice and training recommendations

I will set out specific practice recommendations in the Conclusion to follow (Chapter 9), showing how information should be recorded in CSCS and how these children should be treated in order to ensure a more consistent response. The following are my recommendations for more effective intervention.

8.1d(i) Training

A theme that has continually reoccurred throughout these research findings is the appropriate training of social work practitioners. As my both the findings sections showed,

only three of the social workers out of the 30 cases had actually completed the one-day training course run by the Local Authority. In the interviews the social workers talked of not being told about the training course, with one social worker suggesting that such training courses were not actually available with this Local Authority. Whether it is the social worker's or the team manager's responsibility to ensure appropriate training is completed, the social workers are not being trained (as discussed previously). Frontline practice and implementation of research knowledge should go hand in hand when dealing with any children who encounter CSCS, but this is not happening. There appears to be a separation between social work practitioners and academic social work researchers. Research informs government policy such as DoH, 2010, but as discussed throughout this research this has not filtered down to frontline practice level. As suggested by Cartney (2011) 'the fundamental idea is that professional knowledge incorporates both formal knowledge... and informal knowledge' (p. 15). That is, whilst social workers will use informal knowledge such as their practice experience they must also use formal knowledge such as theories and, of course, policy and legislation. Cartney refers to this having been misunderstood and debated almost since the beginning of the social work profession. Whilst some practising social work practitioners attend academic conferences they are often people who are specialists in a particular area rather than general frontline social work practitioners. What has been found in this research is there is still a long way to go before research and practice in social work are fully integrated and understood in frontline practice. Whilst there is continuing collaboration between universities and Local Authorities to ensure frontline professionals are trained, this training tends to focus on either specialist areas or social work students, and less priority appears to be given to post-qualifying social workers. It is also important that appropriate training should be given to foster carers to help them have at least some basic understanding of what to expect when caring for a child who has displayed SHB. They too had the same view of social work practitioners in presuming the child in their care must have been sexually abused (see Chapter 7 – Interview Findings). But they also need support and training in how to realistically manage these children. Social work practitioners must acknowledge that it is not physically possible for parents or carers to supervise their child 24 hours a day, seven days a week. Foster carers must not be made to feel at risk of losing work if they acknowledge that a situation is more difficult than expected and correctly ask for help and support. However, in times of austerity some Local

Authorities will be slower at prioritising training and reform, as suggested by Munro in a recent online debate with BASW (2013).

8.1d(ii) Assessment tools

Some social work practitioners that were interviewed were aware of AIM assessments but they had a lack of understanding as to whether they could usefully be used in practice. The main issue with the AIM assessment is that children actually have to admit to or be convicted of an offence in order for this assessment to happen (AIM website, 2011). However, this research shows that there are a large number of referrals where children do not admit to the allegation (of the 30 cases, only eight admitted to or were convicted of the offence). So if there is genuine evidence (although not enough for the criminal justice system) to suggest they may have done it, what tools do professionals have at their disposal to assess and support these children? Action for Children recently requested that children who display SHB be 'closely linked to CSCS' and that support should be provided with a prevention focus in mind. They emphasised the need for more consistent assessments, with supportive services provided that can reduce the risk of re-offending (Action for Children website, 2010). Also DoH (2010) states there should be 'a multi-agency assessment should be carried out in each case' (p. 303). At this Local Authority there did not appear to be any specific assessment tools used apart from the general Child In Need Assessment guidelines, but there was no evidence that the 2010 guidelines were being followed, and these do not resolve the threshold issue raised in this research. Whilst a multi-agency assessment is referred to, this needs to clearly address issues such as thresholds as well as guide social work practitioners through the process of assessment, appropriately geared towards children who display SHB.

8.2 Conclusion

Taking into account the lived experiences of parents and carers, these findings show that CSCS in this case has failed in the way it responded to children who display SHB. The response was inaccurately recorded, erratic and unfocused. Social work practitioners were not appropriately trained and not equipped with the appropriate assessment tools. Children who display SHB were either not seen at all or not dealt with consistently. If assessments did

take place they remained unfocused and erratic. If support was identified children could experience delays of up to and over a year, and in some cases (as with Child14) the therapeutic support was then not provided at all. Parents and carers still feel blamed, unsupported and threatened with their child (or the child in their care) being removed from them. So rather than providing support to help parents and carers deal with a very difficult situation, CSCS applied more pressure. While 30 cases and social worker interviews can from one Local Authority, the parents and carers interviewed had experiences of a variety of Local Authorities across the country where showing little difference in their experience across the UK.

So in summary, the CSCS response to children who display SHB in this country is inconsistent and inadequate. SHB is not visible to CSCS – there is no consistent response and no clear guidelines or thresholds for problematic sexualised behaviour in children being employed by social work practitioners. Considering the difficulties experienced in finding information for this research, it is not surprising that background information is being missed and social work practitioners do not appear to understand the complexities of SHB. What these cases show is that while it is a good policy decision to recommend a Child In Need Assessment for alleged perpetrators of SHB this is not being implemented consistently in practice. Good policy cannot account for the individual decisions of social workers as to whether to proceed, or as to whether they view behaviour in a particular way.

Taking a grounded theory approach to this thesis has led to the identification of generative mechanisms that inform the response to children who display SHB. These are:

- Societal norms – the influence of society's views on SHB on social work decision making. Connected to the actual (or fear of) labelling of young people as sex offenders/paedophiles: the construction of *normal* behaviour.
- Gender – the serious nature of SHB perpetrated by females, the threshold of what could be viewed as normal behaviour lowers. The general views of the male perpetrator and female victim.
- Age – SHB is not viewed as harmful as the age gap between the alleged perpetrator and alleged victim narrows of where the alleged victim is older.

- Class – the focus of social work intervention on single mothers on benefits and the ability of more educated parents to control aspects of the intervention.
- Professional judgement – the way in which ICS hinders/prescribes this and the lack of training so that decision-making is more value-based rather than professional judgement.
- Focus of child protection – the investigative focus at the expense of welfare-focused work.
- Bureaucracy – the way in which social work organisations work and their culture including tacit rules; the way in which NPM has changed the focus of welfare provision and support.

Each of these mechanisms requires further research in order to identify how much it influences the response to children who display SHB. Through this theory can be identified that can inform practice in this area (Harwig 2007 and Blakie 2007).

9 Conclusion: Beyond Erratic Practice

The findings of this research study have led to the conclusion that children who display SHB are, in many ways, invisible to Children's Social Care Services (CSCS). This is demonstrated through missing referral information in ICS, assessments not being completed, and appropriate support not being identified or followed up. Arriving at this conclusion has been a long and difficult process. Problems were encountered in terms of finding information about SHB in ICS and in accessing parents/carers to participate in the study. This chapter will therefore review some of those difficulties before making recommendations for changes to the current response to referrals and for future research.

9.1 Problems encountered and decisions made

The decision to focus so much on the recordings in ICS was not my first intention for this research. Initially, because of gaps in previous research (discussed in Literature Review), I wanted to gain insights into parents'/carers' experiences of social work interventions in the area of SHB in children. Whilst I was given access to ICS to identify relevant cases and for statistical information, the information I could find about SHB was initially relatively limited. However, the difficulties I encountered in doing this led to the realisation that this was a research finding in itself. Combining this with the difficulties encountered in accessing parents/carers (discussed below) led to the decision to focus on the ICS inconsistencies more in my research. This emphasises the importance of remaining open as a researcher to developing the research focus in response to challenges encountered in the field. It also shows how sometimes a problem encountered can actually lead to the formulation and basis of the research itself.

9.2 What could be done differently?

Engaging with parents/carers of children who display SHB is something that remains a challenge for practising social workers. The way in which they work with parents in child safeguarding is not always conducive to the development of practice in collaboration with

these parents/carers. Perhaps unsurprisingly, the parents/carers who were willing to talk about their experiences were those who were either no longer having contact with CSCS or those receiving specialist intervention and support for their children. It is important however to seek feedback from those encountering CSCS at the very start of their journey, even if that is also the end point, and this research would have benefited from being able to interview more of those parents/carers to understand their experiences in the context of their child's journey, particularly those who had experience of the Local Authority involved in this study. Calder (2000a) and Johnson (2007) both emphasised the need for the centrality of parents/carers in social work intervention, and I argue this is also central in research. However this was not easily achieved and the difficulties I experienced with finding parents willing to talk about their experiences were, in my view, in some ways influenced by my role at the beginning of this research as a practising social worker.

9.2a Reflections on being a practitioner researcher

My role as a practising social worker at the beginning of this study was often in conflict with my role as a researcher. At times, it was difficult to remain objective and not be influenced by my own experiences in social work practice. This presented me with a constant dilemma throughout the research and ultimately led me to the decision to leave practice and become a lecturer. Whilst this was a difficulty encountered, it is a conflict that needs to be addressed – how to encourage and support social work practitioners to become researchers, or at least be research minded. Practice Based Research is 'research conducted by practitioners for practice purposes' and 'takes into account the ethical priorities of the practitioner who initiates the study' (Dodd and Epstein, 2012, p. 5). Therefore research from this perspective is guided by social workers' own practice experiences. My own experiences had led me to question how a specific group of children are responded to – not those who receive specialist support, but those who a referred to generic social work practitioners. This is important, in terms of the research areas considered; that they are guided by those who *do* the frontline work in practice. However there is a need for caution, to consider the impact of the social worker role on the researcher role, and how this impacts on the willingness of potential participants to be part of the study.

9.3 Limitation of the study

The main limitation of this study is that it is based on data from just one Local Authority. My initial intention was to access more in order to conduct a comparative study, but the difficulties I encountered when accessing data in ICS led the research in a different direction. While I cannot make any claims to generalise to all CSCS departments, there are similarities between my findings and those of Bell *et al.* (2007), Mir and Oakie (2007) and the Criminal Justice Joint Inspection (2013) that lend confidence to the findings presented in this thesis.

Further to this, having applied a grounded theory approach, only the generative mechanisms have been identified at this stage rather than a grand theory regarding the experiences of this group of children. (Blaikie 2007)

9.4 Original contribution to knowledge

Whilst the Criminal Justice Inspection Report (2013) looked at how children are responded to by a youth offending team; and other research has been completed looking at children who have received specialist therapeutic support for SHB; the data presented in this thesis is from *generic* social work practice. This in itself is a significant contribution to knowledge, as research into SHB has not been approached in this way before, and so findings have not previously been presented in terms of how CSCS responds to children who display SHB. This is why, at this stage of research, it has only been possible to identify generative mechanisms in the response as each of these areas requires further research into their significance.

What the findings show however is that, by not assessing these children at all, CSCS practitioners are failing to act in a preventative way. Many of the cases in this research study, with the benefit of hindsight, indicate strongly that if an assessment had been completed then information is more likely to have come to light that could have prevented the child in question from committing further acts of SHB. The findings of the Criminal Justice Inspection Report (2013) concur with this. They took a retrospective look at children who encountered YOTs and identified instances where opportunities for early intervention were missed. This thesis has found the same, where social work practitioners appeared to miss opportunities for early intervention. If appropriate nationally guided assessments were

completed by social work practitioners, it is more likely that warning signs would be uncovered.

9.5 Recommendations for improving CSCS's response to children who display SHB

As suggested, children who display SHB remain largely invisible to CSCS. When they encounter it they are not receiving a consistent response from social work practitioners, and the Local Authority in this study is not accurately recording information so that cases can be properly cross-referenced and practice can be reviewed and followed up. Government guidelines need to be followed in practice so that *all* children who are alleged to have been displaying SHB, where information concerning this is shared with CSCS, should be subject to a section 17 Child in Need Assessment (*Children Act*, 1989; DoH, 2010). However, my research has shown that there is an essential stage prior to this – the Child in Need Assessment should be completed only *after* the behaviour itself has been assessed. But social work practitioners are not being trained to deal with the complexity of indicators for SHB and need more detailed guidelines so that children who display SHB can be ensured a more consistent response, or at least an informed response. How to understand when sexualised behaviour should be considered 'harmful', especially in young children, is very complicated and professionals need a national strategy for assessing this.

Based on the findings from this thesis, a two-step approach is recommended for the practice assessment of children who display SHB.

9.5a First step – assessment of the behaviour

First and foremost it is important that CSCS maintains a consistent approach to SHB and that the decision to proceed to the next step in an intervention is not left to the discretion of individual social work practitioners, an approach that this study shows can lead to inconsistent responses. The use of an appropriate, validated tool would improve the chances of assessing more accurately whether behaviour is abusive or experimental. This is particularly important when dealing with pre-pubertal children and situations where the alleged perpetrator and alleged victim are of a similar age, or where the alleged perpetrator

is older. As indicated in the literature review, what constitutes problematic sexualised behaviour is contested, so decisions regarding this should not be left to the judgement of individual social work practitioners alone. A recent report by Miccio-Fonseca and Rasmussen (2011) is one example of research into this, but direction is needed from policy makers as to what specific research and tools frontline social work practitioners should use. The introduction of guidelines on the identification of problematic sexualised behaviour in children would permit practitioners to develop their competence and confidence in this challenging area of work, so it is imperative that the government commissions more research to provide these guidelines. For example, the Brook Sexual Behaviours Traffic Light Tool (2012) gives guidance for professionals when faced with children displaying SHB. It is important that these guidelines are considered in light of the findings of this research however – in terms of different gendered-perceptions and age difference of the alleged perpetrator and the alleged victim. What also needs to be carefully considered is that this does not become another box ticking exercise, but gives practitioners a tool to use in *conjunction* with their professional judgement.

9.5b Second step – assessment of the alleged perpetrator as a child in need

If it is established that the nature of the alleged behaviour is sexually harmful then the alleged perpetrator (as well as the alleged victim) should be subject to a Child in Need Assessment (DoH, 2010). By doing this, CSCS would be acting in a preventative way to help avoid future referrals in relation to SHB. However, it is important that social work practitioners address the question 'why has this child acted in a sexually harmful way?' Are there any indicators in his/her own behaviour or in his/her environment that could be harmful to them? Social work practitioners must keep an open mind and not begin this process by asking (and attempting to answer) the question 'has this child been sexually abused themselves?' My findings suggest that if they do ask the question in this way and the answer is no, then they stop assessing the child. Social work practitioners must understand and be open to the fact that any and all aspects of this child's environment could impact on their behaviour. But in doing this they must ensure they do not alienate the parents, as by supporting the parents social workers are also supporting the child.

Once the assessments are completed appropriate support should be identified. This support may range from education by appropriately trained social work practitioners concerning good touch and bad touch, to referrals for specialist therapeutic intervention. It is essential that if the police are also involved, and decide to take no further action, social work practitioners do *not* interpret this to mean they need take no further action themselves. CSCS must always remember its focus – safeguarding and ensuring the welfare of children – and ensure its staff are aware and reminded of this. The role of CSCS is not about criminal justice.

9.6 Step-by-step process for responding to children who display SHB

In addition to this main two-step approach, further recommendations are set out below which are designed to guide all Local Authorities in developing clear standards and procedures for responding to all referrals involving SHB. These need to be considered in the context of the upcoming changes to ICS and the development of new electronic systems used by Local Authorities.

1. Each referral relating to SHB, whether an open, closed or new case, should be considered as new referral information and documented accordingly, so the referral information can be easily viewed at a later date.
2. Each referral should be subject to a preliminary sexual behaviour assessment in order to determine whether the behaviour should be considered as normal, harmful or problematic.
3. If the behaviour is viewed as harmful or problematic then the child should be treated as a child in need (as policy guidelines recommend) and subject to a section 17 Assessment in their own right (Children Act, 1989, DoH 2010).
4. Social work practitioners should be trained in working with children who display SHB specifically and should look at all aspects of the child's background (for possible causal factors and available support) and complete a risk assessment.
5. Social work practitioners must use specific and accurate descriptions of sexual behaviour rather than more general terms such as 'inappropriate' or 'sexualised' so it is clear exactly what behaviour the professional is saying is inappropriate.

6. All social work practitioners should complete a specialist training module *before* handling cases involving SHB. As referrals could come in on any open cases it is imperative that social work practitioners receive this training before having case responsibility for *any* children safeguarding issues.
7. Data should be recorded twice – on both the alleged perpetrator and alleged victim's files, as appropriate.

9.7 Recommendations for policy makers

This research (which was completed over a period of five years from 2007–2012) has involved an extensive literature research, the analysis of 30 referrals to a Local Authority and interviews with parents, carers and social work practitioners, using narrative interviewing and grounded theory to guide the research analysis. I have shown that there has been limited research concerning actual referrals to CSCS in relation to children who display SHB, and that the way in which they are responded to is erratic. In the current process children have no guarantee that they will be treated in the same way as other children encountering the same Local Authority. They are likely to experience two different social workers during the course of their intervention and they are not likely to be treated as children in need. Parents still experience feelings of stigma and blame and a lack of support as they encounter social work practitioners who consider whether the child concerned is in fact a victim of sexual abuse themselves, and the social work practitioner will not use any specific assessment tool to understand the behaviour or the child's background. If treatment is recommended this is likely to be with the incorrect agency (if it is financially possible at all), or it will be delayed for such a long time that it may even be forgotten about or never followed up. Social work practitioners feel ill-equipped to deal with children who display SHB and they will look to managers who also feel the same.

The following recommendations have been developed from the findings of this study and include recommendations for policy makers, practitioners and researchers.

1. *Training*. Social work practitioners and foster carers must be appropriately trained before encountering complex cases. Local authorities must acknowledge that SHB can

occur on open cases that are already allocated to social workers, and therefore if they are not trained before taking on any cases then how can an appropriate response be guaranteed? This training, ideally as part of initial social work training, should cover how to recognise SHB – understanding first what normal sexual development looks like (Staiger, 2005) followed by what SHB looks like. Following this, they need training in how they are expected to respond to referrals in relation to SHB – on a practical level in terms of electronic recording, as well as how to follow government guidelines. This is a complex area of social work practice and a one-day training course would not appear to be enough to ensure deep understanding of the issues in understanding SHB. It is also important that team managers are also appropriately trained in order to support the social worker effectively. To counter this, it is therefore recommended that specialist practitioners are considered as an effective tool. Because of the focus on generic social work practice, this ignores the complexity of certain children's lives. If specialist practitioners were more fully trained in LAs they could guide more generic practitioners in how to respond effectively.

2. *Appropriate assessment tool.* It is important to have access to a validated tool to assist social work practitioners in assessing whether sexualised behaviour is appropriate or problematic. This would move decisions away from the individual value-based decisions of social workers and/or team managers. This is not to suggest a return to more box ticking, but some guidance is an absolute necessity and it should be guided directly from the government (based on expert research) rather than being left to the decision of individual authorities.
3. *Recognising children who display SHB as children in need.* When sexualised behaviour has been assessed as harmful or problematic social work practitioners must treat the children as being children in need. They must not assume the child has been a victim of sexual abuse themselves, although this is not to suggest it is not possible for children who display SHB to have been victims of or exposed to sexual abuse, but that social work practitioners must assess *all* aspects of children's backgrounds in order to plan for appropriate intervention where needed.
4. *Appropriate recording system.* A simple measure to avoid problems of identification is to ensure long-term workers understand when information needs to be recorded as a 'referral' rather than just a 'day-to-day activity' (these are terms with specific meanings

in social work recording). There must also be a consistent standard in recording information onto both the alleged perpetrator's and alleged victim's files where it relates to them.

5. *Working with parent/carers.* If social work practitioners move away from the immediate view that they must look for sexual abuse in the child's family, this will create a more positive environment for parents/carers. Working with them to look at the child's environment and behaviour in an appropriately assessment-guided way would reassure parents that social work practitioners know what they are doing and are focusing on the needs of their child and, by extension, their family. Social work practitioners must ensure that parents and carers feel supported and that any risk management needed is realistic.

If these guidelines were implemented by Local Authorities this would help children who display SHB to become more visible, leading to a more consistent response and hopefully more positive outcomes for the children involved. I do not suggest that all difficulties will be resolved, but it would certainly be a step in the right direction, as greater consistency means all children would have the same opportunities for support.

9.8 Future research

Practising social workers need to be active researchers. Specialist practitioners are needed within general practice to keep up to date with current research and to advise colleagues. As Munro (2010a) suggested, the current career structure is based so much on a set development towards the manager role, but advancement to principal/senior social worker roles should be based on expertise. This is one area that could be looked into further to see if specialised, research-guided principal/senior social workers could assist in the sharing of knowledge, rather than every social worker having to understand about every area of practice in depth. It will also be important to understand whether the Munro reports have a positive effect on practice in this specialist area.

Further to this the identified generative mechanisms require further research in order to understand their significance in the response to children who display SHB.

9.9 Final thoughts...

When considering cases of neglect, I remember my team manager at the time asking 'but is it good enough?'. The children may be neglected but is it really so bad that we have to intervene and place them in foster care, or is it just 'good enough' even if it is not as good as we would like it to be? While this is a tactic consideration in practice, in order to ensure thresholds are met, it should not be applied when considering how good social workers should be at their job. It should not be about 'good enough' but about the best they can be so that they can confidently deal with complex situations and provide a high standard of consistent service to all service users and, in the case of this research, ensure that all children who display SHB can expect a consistent and professional service whichever Local Authority they encounter.

Appendices

Appendix 1: DCT pilot study

Case ID

DoB

Date info completed

First name

Last name

Gender

Ethnicity

Disability

Looked-after status

Accomodation status

Age at first contact with CSCS

Age at time of this form

Reasons for first contact

Involvement with other services

Education/Employment

Truancy history

Exclusion history

Age SHB began

Date of this SHB referral rec'd

Source of referral

Procedure by CSCS

Outcome of Referral

Tools used

Level of risk assessed

Supervision order?

Legal status at referral

Previous convictions

Sex Offender Registration

Relevant trauma issues suspected

Relevant trauma issues confirmed

Other behaviours displayed

Current living conditions

Environment experiences suspected

Environment experiences confirmed

Experience of abuse suspected

Experience of abuse confirmed

Assessment of sexual behaviour

Manner of behaviour

Location of behaviour

School awareness of behaviour

Intent

Nature of behaviour

Non-contact behaviour occasional

Non-contact behaviour frequent

Contact behaviour occasional

Contact behaviour frequent

Victim type

Number of incidents

Number of victims

Sex of victim

Age of victim

Appendix 2: DCT main study

Case ID

Initials (remove later)

Social worker to interview (remove later)

DoB

gender

ethnicity

disability

looked-after status

accomodation status

family background

Domestic Violence?

Bereavement?

Alleged perpetrator confirmed as being sexually abused

Alleged perpetrator suspected as being sexually abused

Family background summary

referral information (brief summary)

referral information on system

referral information on system additonal information and/or comments

further summary of incident taken from s47 assessment, core assessment or safeguarding children conference

source of referral

age of alleged perpetrator when this incident was reported

was this child already known to CSCS

if so, give reasons (brief summary)

is this the first reported incidence of sbp?

if not, please give details (brief summary)

if this was not the first incident, what age were they when sbp began(or were first reported)

where did the alleged incident take place (brief summary)

involvement from other services in relation to this incident (at time of referral)

number of alleged victims (based on this referral)

age of alleged victims (based on this referral)

gender of alleged victims (based on this referral)

first response by CSCS (as indicated in electronic files) (brief summary)

outcome of referral (pick one only - opportunity later to expand)

how quickly after the intial referral to CSCS was action taken by CSCS (in working days)

overall analysis of the way the child was viewed in the e-files

what background did the social worker refer to to explain this behaviour

what evidence did they give to back up these views

what evidence of analysis is used (research etc. Impressions?)

was the child interviewed by the social worker

if so, how many times

and if so, were they alone or was an appropriate adult present

is there evidence in the files of the perception of other professionals, if so, please describe

what was the overall outcome of the child to date

was the child's name placed on the sex offenders register?

flow chart to show this child's route through the system

how decisions made

decisions made in meetings/assessments

overall analysis of this case (brief summary)

how many social workers were involved in this case from referral to outcome concerning this incident?

did the social worker/s back up their opinions with evidence in the files (summary)

in the e-files what evidence is there of other professionals being involved, how many etc.

what evidence is there of supervision/advice from team managers during this process (summary)

did the system appear to operate effectiveley

give details

how did the alleged perpetrators family appear to be treated

was support offered to any other family members

give details

have there been any further incidents reported since this one?

if so, please describe

when interviewing the SW of this case - was the social worker appropriately trained at the time of their involvement

how long had they been practising

what was their job title at the time

any other analysis

issues to raise in any possible interviews with the social worker

general impressions (overall thoughts re management of case)

Documents used

Information from social worker when referring the case to me

Appendix 3: Information sheet

Research project

The system response to sexual behaviour problems/sexually harmful behaviour: family journey through the system.

Aim of research

- to analyse social work case files to develop a Journey of families' experiences of the system in response to their child's sexually harmful behaviour
- to understand the lived experience of parents/carers and professionals of the process;
- to use these shared experiences to identify needs and demonstrate how the professional system might better support parents;
- to identify appropriate training needs and support for social workers; and
- to set out key intervention guidelines and support options for professionals dealing with parents in these situations.

Research questions

1. How do CSCS deal with referrals of children who display SHB?
2. What are the reflections of social work practitioners on their practice in relation to working with these families?
3. What does a small group of users (parents and carers) say about how their cases were managed? How do parents/carers experience social work interventions?
4. What best practice recommendations can be developed to inform effective intervention by social work practitioners, and what appropriate training should be offered?

With your consent, I intend to record the interviews so I can type up the notes later. If you wish to receive a copy of these notes, please advise me. Once I have completed my research, I will destroy the printout and recordings of all the interviews.

Statement of confidentiality

I will ensure that your name is not used in my research and will not include any further identifying details.

Thank you.

Lesley Ann Deacon

Appendix 4: Why each parent or carer was involved with CSCS in relation to a child who displayed SHB

1_Mother

In September 2009 1_Mother's then fifteen-year-old son 'touched' another boy in what was viewed by professionals as a sexual way. This was not the first incident of sexualised behaviour from him as a previous incident occurred thirteen or fourteen months prior to this incident, where he was accused of taking another male child into the garage and asking him to do things with him. Because of the incident in September 2009 her son was involved with CSCS, the police and a therapeutic service for children who display SHB.

2_Mother and 3_Father

At the time of our meeting 2_Mother's sixteen-year-old son (and 3_Father's step-son, he is the father of the three younger sons) was involved with a therapeutic service for children who display SHB. 2-Mother reported that her son had sexual behaviour problems from around the age of three and received therapy on and off throughout the intervening years. When we met an incident had been reported by her thirteen-year-old niece (daughter of 3_Father's stepbrother) that her son had sexually assaulted her. 3_Father advised that the police were involved but that they took no further action due to lack of evidence. (Initially only 2_Mother agreed to participate but she spoke to her husband and he then agreed to participate as well. They were both interviewed entirely separately of each other.)

4_Foster Carer (female)

4_Foster Carer, at the time of the interview, had been a foster carer for approximately sixteen years and had two grown up sons of her own. She initially worked for a Local Authority, but for the last six years had been with an agency. She was currently caring for an eleven-year-old boy who was accessing a therapeutic service for children who display SHB, although he was in their care for a year before this began. She reported that the boy's father had made his three children (of which this boy was the youngest) engage in sexual acts with each other. The boy had an older brother and sister. All these siblings were split up and placed in separate placements, and are allowed supervised contact once a month.

5_Foster Carer (Female)

5_Foster Carer had been a foster carer for eleven years and was currently caring for a seventeen-year-old boy who was placed with her after his previous placement broke down (due to practice questions concerning the previous foster carer). Prior to this he came into care because he had sexual intercourse with his youngest brother approximately two years prior to our interview.

6_Adoptive Mother

6_Adoptive Mother adopted a sibling group of four, eight years prior to our interview. The youngest was 5.5 months (boy), 2.5 yrs (girl), 5.5 yrs (girl) and 6.6 yrs (boy). They came from a family with a history of neglect and physical abuse. The previous year the oldest boy was found on the trampoline with the youngest boy. He was on top of him, kissing him and simulating sex. The youngest boy was upset. The oldest boy was involved with a therapeutic service for children who display SHB. He did not have police involvement.

7_Grandmother and 8_Step-Grandfather

This family became involved in this research because there were concerns about their granddaughter displaying SHB while in foster care, towards her foster carer's five-year-old grandson. (Prior to this she lived with her grandmother, step-grandfather, uncle and siblings following the death of her mother.) However, she had come into foster care because three years ago the granddaughter showed a note to her brother which said 'I had a good sh*g on the field with ???'. The name she wrote was that of her uncle (her grandmother's youngest son who was only a few years older). This information was important to know as the grandmother believed these actions related to her granddaughter's sexualised behaviour, rather than her actually being abused.

9_Adoptive Mother

9_Adoptive mother adopted her son at sixteen months old. At the time of our interview he was involved with a therapeutic service for children who display SHB. This was because when he was sixteen years old he digitally penetrated a five-year-old female neighbour after going behind the bins together during a game of hide and seek. He also asked her to put her hand on his penis. The girl reported that this

happened twice. The son was convicted of sexual touching and given a Referral order for one year.

These show a wide range of incidents of children displaying SHB through from sexualised touching to full penetration. Taking these in the context of the research findings set out in the literature review, the children cared for the by 6_Adoptive Mother and 5_Foster Carer were older brothers accused of sexually assaulting and having penetrative sex (respectively) with their younger brothers. Whilst this is limited information on which assumptions can be made, it could be argued that these are examples of power and exploitation as found by Lovell (2002). Five out of the seven cases concerned an age difference between alleged victim and alleged perpetrator of at least two years or more (NCH, 1992).

Research by Gonsiorek *et al.* suggested that behaviours must be taken in the context of those participating and 'normal adolescence is often a stressful time in the development of sexuality' (1994, p. 117). Whilst 2_Mother reported that she had witnessed concerning sexualised behaviour from her son from the age of three, the other six cases all concerned children over the age of criminal responsibility. Only the case of 7_Grandmother and 8_Step-Grandfather was based on a case from the 30 LA cases. This case was not taken further in terms of therapeutic intervention for their granddaughter who was accused of sexualised behaviour towards the foster carer's grandson. The other cases were all from different Local Authorities in England and were cases where they were involved with therapeutic support for the child in the care.

Appendix 5: Social work practitioners involved

10_Social Worker (female)	This social worker had been working as a qualified social worker in a long-term team for one month when she had a case in which a child displayed SHB.
11_Social Worker (female)	This social worker was a qualified social worker when in a long-term team she managed two cases involving SHB.
12_Social Worker (female)	This social worker qualified as a social worker in 2007 and is currently based in a duty team when she managed several cases involving SHB.
13_Social Worker (female)	This social worker was a qualified social worker in a long-term team when she managed several cases involving SHB.
14_Social Worker (female)	This social worker is a qualified social worker in a long-term team and has managed one case involving SHB.
15_Senior Social Worker (male)	15_Senior Social Worker is a qualified senior social worker and has been for over ten years, and has been a practising social worker for twenty five years. He has managed a number of cases involving children who display SHB and has become the person in his team who gets those cases.

16_Independent Reviewing Officer (male)	16_Independent Reviewing Officer was a social worker for seven years before becoming a senior social worker for three years. He is now an independent reviewing officer. I spoke to him about two cases he worked on in relation to SHB – one when he was a senior social worker and one when he was an independent reviewing officer.
17_Team Manager (female)	17_Team Manager qualified as a social worker in 1999. She was a social worker for five year and then became a team manager for four years before taking up her current post as the manager of a team focusing on intervention.
18_Team Manager	18_Team Manager qualified as a social worker in 2004 before

(female)	being promoted to senior practitioner and has now been a team manager since 2007.
19_Team Manager (female)	19_Team Manager began as a social care assessment officer in different teams mainly with vulnerable adults and then in 2000 she began training as a social worker. She qualified in 2002 and was supposed to work with adults but the Local Authority needed social workers in CSCS so she was placed there. She became a team manager in 2005 initially in long-term work and then to duty work – three months prior to our interview she moved to be manager in a looked-after team.
20_Team Manager (female)	20_Team Manager qualified as a social worker in 1996 having previously worked in probation. She has worked in a variety of different teams within CSCS and became a team manager in 2008 with this Local Authority.

Appendix 6: Cases managed by the social work practitioners

Child	Social worker	Team manager (if applicable)
Child5	10_Social Worker	
Child3	11_Social Worker	18_Team Manager
Child13	11_Social Worker	18_Team Manager
Child12	12_Social Worker	19_Team Manager then 18_Team Manager
Child14	13_Social Worker	17_Team Manager
Child2	14_Social Worker	18_Team Manager
Child8	15_Senior Social Worker	20_Team Manager
Child23	19_Team Manager when she was a social worker	
Child21	20_Team Manager when she was a social worker	20_Team Manager is now the Team Manager of this case
Child6	16_Independent Reviewing Officer when he was a senior social worker	
Child7		16_Independent Reviewing Officer

Appendix 7: Interview discussion areas – parents and carers

I'd like to know about your experiences of the following, in relation to your child's SHB:

- Social work intervention – the process, the social worker and other professionals, including how you, your child and other family members were treated
- Your feelings towards your child who displayed SHB
- The support you, you child or other family members received
- Outcome for you, your child and other family members
- Suggestions for how the system could be improved
- Anything else you'd like to talk about not listed above

Appendix 8: Interview discussion areas for social work practitioners

Please give me a brief summary if your career history in CSCS

What do you understand by the expression 'sexually harmful behaviour'

What do you understand by 'children who display sexually harmful behaviour'

What is your practice experience of working with these children?

- Can you give details of any cases you have worked on?
- Have you attended any of the council's training courses in relation to this? If so, was this before or after you had to deal with a case in practice?

I have looked at the electronic recording of [one/two] cases that you have worked on where there has been an incident of SHB by a child involving another child. [Give names of cases] – can you tell me about your recollections of these cases?

- How and when CSCS became involved with the family?
- What happened to this family in relation to CSCS involvement?
- What was the outcome for them?
- When thinking about particular cases, what did you initially think when confronted with this issue?
- Which other professionals were involved in any of these cases? And in what way were they involved? Telephone calls? Meetings etc?
- What were your impressions about the child who was the alleged perpetrator?
- What were your impressions about his family and his family's background?
- When completing your assessments, did you access any research material about SHB? If so, please give details.
- Did you seek advice from colleagues? If so, whom and what was their experience?
- Did you discuss risk management with the family? If so, what form did that take and how did the family react to this?
- Did you feel confident in their ability to protect their children?

[Specific questions about the social worker's individual case that I have analysed – see below]

What the outcome was for the family? What support did they receive during and after the intervention?

Do you think the parents were treated fairly by the system? Please give examples either way.

What do you think you learned after dealing with these cases?

- How did you reflect on your practice and your interaction with these families?
- Did you find the process easy to follow – did you know what to do? Did you seek advice? Please give details.
- Did you feel supported by your manager during this process? Did you find it easy to access supervision? Please give details.
- Would you do anything different? If so, please give details.
- Was there anything you think you did particularly well? If so, please give details.
- Do you think there is anything that should be changed in the process? Can you give examples?

Is there anything else you'd like to add?

Case-specific questions (to clarify any issues from the analysis of the case – specific to each social worker and the case they managed).

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