



Scotland's Commissioner for Children and Young People

Child Protection Procedures

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1 Introduction

Scotland's Commissioner for Children & Young People is committed to the protection of children and regards the safeguarding and promoting the interests and well-being of children as a paramount concern. We are also committed to the protection of vulnerable children from exploitative relationships. Scotland's Commissioner for Children & Young People consider it the duty of all those employed or involved with the organisation, to prevent the physical, sexual or emotional abuse of all children with whom they come in to contact and to report any abuse discovered or suspected.

At Scotland's Commissioner for Children & Young People we do not investigate allegations of abuse of a child or young person. We follow national guidelines¹ which say that where a person/organisation is concerned that a child or young person is at risk from abuse, the concern must be passed on to the child protection agencies. By that we mean the relevant Social Work department and/or the Police.

1.1 Designated Person

Throughout this document reference is made to the Designated Person for Child Protection. This is the Head of Policy in the Commissioner's office. If the Designated Person is unavailable, staff members can approach any member of the Management Team to discuss any child protection concerns.

1.2 What is child abuse?

"Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, significant harm on the child. Children may be abused in a family or in an institutional setting, by those known to them or, more rarely, by a stranger." (National Child Protection Guidance, 2010).

The following definitions indicate how abuse may be experienced by a child but are not exhaustive, as the individual circumstances of the abuse will vary from child to child.

- Physical abuse
- Physical neglect
- Emotional abuse
- Sexual abuse
- Non-organic failure to thrive

For more detailed information see Appendix B.

¹ National Child Protection Guidance 2010 Scottish Government

1.2 What is child protection?

Child protection is when a child requires protection from “child abuse” or “child neglect”. For a child to require protection, it is not required that child abuse or neglect has taken place, but rather a risk assessment has identified a significant likelihood of risk or abuse or neglect.

1.3 How concerns about a child or young person could come to light in the context of Scotland’s Commissioner for Children & Young People

We may become aware of concerns about a child’s safety or well-being through –

- A child, young person or adult shares a concern about a child
- A child or young person tell us that they are at risk from abuse
- We observe a situation which indicates that a child could be at risk from abuse
- We receive a disclosure of historical abuse
- Phone calls or messages
- Letters, e-mails or text messages
- Anonymous communications

1.4 Confidentiality

If we believe a child or young person to be at risk of harm, this will always override any professional or Scotland’s Commissioner for Children & Young People requirement to keep information confidential. We all have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm. Children, young people and their parents will always be told this.

Children and young people sometimes ask us whether we can keep what they tell us confidential. We tell them that we will keep things as confidential as possible, but that we will need to do something if they tell us that they, or another person, could be at risk of harm. This means that we **will** pass on our concerns if we have reason to believe that a child or young person could be at risk from abuse, **even when** the child refuses to give his/her consent.

It is important that people who contact the office, are made aware of our policy on confidentiality, to enable them make an informed choice about information they may wish to share with any member of staff. This requires all staff to be vigilant in explaining our position as outlined above. The timing of this should be as close as possible to the beginning of the call,

although you may need to wait for the caller to explain the reason they are contacting us before doing so.

Where a child or young person draws back from telling us something, we tell them that it is important that they try to find someone to talk to if they are being harmed. We let them know that they can come back to Scotland's Commissioner for Children & Young People at any time to talk with us. We may also give them the ChildLine telephone number (0800 1111).

1.5 If someone shares a concern about a child or young person

If someone tells us that they want something kept confidential, we try to protect their identity unless -

- **a child or young person is in immediate danger** - We try to get the person telling us to agree to the information being passed on to someone who can help the child. If they will not agree, and the need for action is urgent, we will pass the information on without consent.
- **any other person is in immediate and serious danger** - Again, if we think that urgent action is needed, we will pass on the information without consent.
- **a child or young person is in danger that is not immediate but still considered to be serious** - We try to work with the person giving the information to us to get them to pass it on themselves (e.g. by providing the details of the local Social Work office). We will also make our own child protection referral (where there is sufficient information to enable us to do so). This will usually involve us contacting the child's local Social Work office. We will normally try to obtain the consent of the person contacting us to do that, but if the person does not agree, then we will pass on the information without their consent. We inform the person giving the confidential information that we are doing so, unless to do would place the child/young person at greater risk.

It is appropriate to disclose confidential information to a line manager or anyone else who 'needs to know' where this is in the 'public interest'. There is a 'public interest' in the protection of children. However, confidential information is not discussed with other staff or with anyone outside the Commissioner's office who does not have a relevant child protection role. Whilst the majority of child protection concerns are raised via the Enquiries Service, any member of staff may receive information that suggests a child or young person may be at risk. It is important that all staff are aware of the need to pass on concerns and how best to do so. If you receive information to suggest a child is at risk you should, in the first instance, talk to the Designated Person. In their absence, any member of

the Management Team will work with you to decide the best course of action. Where no senior manager is available, it is the individual staff member's responsibility to contact Social Work and/or the Police (as appropriate). If you make a referral to Social Work and/or the Police, you should inform the Designated Person (or any member of the Management Team) that you have done so.

2 What to do if you think a child or young person is at risk of abuse

2.1 A child, young person or adult shares a concern about a child

A child, young person or adult may express concern about another child or young person. Where this happens we listen carefully to what we are told and try to find out the following -

- the name of the child or young person who is the subject of the concern
- the child's age (date of birth would be best but may not always be known)
- the geographical area where the child or young person lives (so that we can make a referral to Social Work or the Police)
- the nature of the concern.

Where the information we receive suggests that the child or young person could be at risk from abuse, we make a referral to social work services.

2.2 A child or young person tells us that they are at risk from abuse

This can happen in a number of ways. Sometimes the information might be explicit. At other times, a child or young person might hint that they are at risk from abuse. Children and young people choose who to share their concerns with and it is not always the person in an organisation who has the child protection role.

If a child or young person tells us something significant, or if we think there is something they want to tell us, we

- listen very carefully to what we are told
- take seriously what we are told
- do not make value judgments about what we are told or about the people involved
- offer reassurance that sharing the concern was the right thing to do
- explain what we are going to do next (e.g. we may tell the child or young person that we are going to share what we have been told with the Designated Person)
- immediately pass the information on to the Designated Person or, in their absence, another member of the Management Team
- record as accurately as possible what the child/young person has told you using, as far as possible, the words used by the child/young person (this should be done as soon as possible to ensure accuracy) The notes should be signed by the worker,

counter signed by the Commissioner or Designated Person and dated.

We do not interrogate a child or trivialise or dismiss what a child or young person tells us. Also, we do not break our professional boundaries by offering to provide support and advice which is not within our remit or expertise. However, if we think it is helpful we may give the child or young person details of other services which do have this remit e.g. ChildLine and the Samaritans.

Childline – 0800 11 11

The Samaritans – 08457 90 90 90

Both numbers are available 24 hours a day.

2.3 We observe a situation which indicates that a child could be at risk from abuse

Through regular child protection training we make sure that staff are introduced to some of the possible signs and indicators of abuse which they may see in their different contexts of working with children and young people.

Staff who observe possible signs and indicators of abuse must report their concerns to the Designated Person (or another member of the Management Team). The Designated Person will discuss these concerns with the person who reported them. As with any child protection concern, the Designated Person will always consider the context within which the concern was raised and, where required, discuss it with the local Social Work department and/or the Police.

2.4 We receive a disclosure of 'historical abuse'

Children, young people and/or adults may disclose incidents of abuse which happened in the past and no longer occur. When a child, young person or adult alleges 'historical abuse' staff should treat this as a child protection concern which should be reported to the Designated Person via their line manager. All information should be accurately recorded.

2.5 Phone calls or messages

Phone calls or messages raising concerns are dealt with as described above, depending on whether they come from a third party or from the child concerned. All information should be accurately recorded. If the message is left on voice-mail or an answering machine, we do not erase it, but make sure it is preserved.

2.6 Letters, e-mails or text messages

We always pass on to Social Work and/or the Police any letters, emails or text messages which indicate that a child or young person could be at risk from abuse. When we receive a letter which raises concerns about a child, we will try to retain the envelope as this can sometimes give useful information, particularly when the letter is anonymous (e.g. the envelope will show where the letter was posted which can be very helpful). When we receive an e-mail or text which indicates that a child or young person could be at risk from abuse we will save it. All information should be accurately recorded.

2.7 Anonymous communications

The above procedures are followed even where information is received from an anonymous source. Other people and agencies will decide what to do about the fact that it is anonymous. The role for Scotland's Commissioner for Children & Young People staff is still to observe, record and report.

3 Action to be taken by the Commissioner or designated person

The Head of Policy is Scotland's Commissioner for Children & Young People Designated Person for child protection and decides how a child protection concern is to be managed and when to contact Social Work and/or the Police. Staff should report a concern to the Designated Person or, in their absence, to any member of the Management Team. The Designated Person may discuss the situation with relevant staff but in doing so will honour the principles of confidentiality as described above. Where a decision is taken not to pass on a concern (e.g. if there is insufficient information to allow us to do so), the information, and the reasons for not passing it on, will be held securely on the Enquiries Service database for future reference.

All cases of suspected or alleged abuse must be treated seriously and the relevant social work services office should be contacted immediately by phone. Please note that this is usually the Social Work office in the Local Authority where the child or young person lives.

The Designated Person will clearly state the concerns and the basis for them. When the local office is closed the appropriate emergency social work service should be alerted. All telephone calls should be followed up in writing within 24 hours using the standard referral form (Appendix A).

There may be some circumstances where it would be appropriate to contact the Police in addition to Social Work (e.g. if the child protection concern relates to the actions of a Social Worker). The Designated Person can help you decide if/when you should do this.

3.1 Liaising with a child's parents within the context of a child protection concern

Because of the context within which we work, Scotland's Commissioner for Children & Young People staff do not have sufficient knowledge about a child's needs and circumstances to be able to judge whether a child protection concern is low or high level and whether it should/should not be discussed with child's parent(s). For that reason, we do not become involved in alerting a parent to possible child protection concerns. Instead, we allow Social Work and/or the Police to do so.

4 Recording child protection concerns

When a child / young person tells you about something that may suggest that he/she is at risk of harm, you must record the information as soon as possible. The record should contain the following -

- context in which the discussion / information / concern arose
- the actual words the child used
- the record should contain the date and time you spoke to the child/young person, and it should be signed by you and a Management Team member.

Where a referral is made to the child protection agencies the record should also contain the name, agency and workplace of the worker who took the phone referral and should detail the outcome of the discussion. The phone referral should be **followed up in writing within 24 hours** using standard pro-forma (Appendix A)

Child protection information will often come to light via a third party contacting SCCYP's Enquiries Service. The Designated Person will work with the Enquiries Officer to establish whether a referral to child protection services may be necessary.

If a child protection concern is raised during an event organised by a third party, it will be the responsibility of the event organiser in discussion with the Designated Person to agree what action may be necessary. If the event organiser decides to take no action and the SCCYP Designated Person is still concerned that a child may be at risk, then the Designated Person should contact Social Work and/or the Police for further advice.

All child protection concerns should be recorded on the Child Protection Recording pro-forma which is at Appendix A of these guidelines.

5 What happens next?

It is the duty of Social Work and/or the Police to investigate matters of concern in relation to the protection of the child or young person. Where it is alleged a crime has been committed against a child, the matter is likely to be investigated jointly by Social Work and the Police.

The investigating social worker / police officer may require to speak to you as the person from whom the concerns originated. You should co-operate fully with any such enquiries.

5.1 Supporting children or young people who may become/ are the subject of a child protection investigation

The child or young person may continue to be involved with Scotland's Commissioner for Children & Young People following the reporting of the concern. Links should be maintained with the Social Work office involved in any investigation in order to ensure that the child or young person and their family is appropriately supported.

It is important if you are continuing to work with the child or young person that you act in a supportive manner.

You should :

- continue to listen with care
- reassure the child or young person he / she was right to tell

You should not:

- show disbelief
- be judgmental
- introduce personal or third party experiences of abuse
- display strong emotions
- question/interrogate the child or young person

6 What if it is someone within the office of Scotland's Commissioner for children and young people that you are concerned about?

At Scotland's Commissioner for Children & Young People we follow best practice in relation to the recruitment of staff and other adults who work directly with children and young people. However, we do recognise that concerns may arise about the conduct of one of our staff towards a child or young person. Where this happens, concerns should be immediately reported to the Designated Person. If the concern is about the Designated Person, then it should be reported to the Commissioner instead.

The Designated Person (or other Management Team member) will follow the same procedures as for concerns raised about anyone else's behaviour towards a child. The Designated Person (or other Management Team member) will contact Edinburgh City Council's Social Work office to report the concerns.

In order to ensure fairness and transparency, we do not investigate the allegations ourselves.

If you are accused of behaving inappropriately towards a child or young person, you are free to seek advice and support from your trade union or professional association in these circumstances.

It is the Commissioner who decides whether the person against whom the allegation is made should be suspended from work or assigned to different duties while the matter is under investigation. Such a decision is made in line with disciplinary procedures. The protection of children and young people is always our paramount concern. We are also conscious of the human rights and dignity of the person against whom an allegation is made.

Where the allegation or concern relates to the Commissioner, another member of the Management Team is required to contact the Chief Executive of the SPCB (Scottish Parliamentary Corporate Body) about the procedure to be followed.

7 Promoting everyday safe practice during events organised by the Commissioner's office

7.1 Safety during Scotland's Commissioner for Children & Young People events held outwith the Commissioner's Office

When we work with other organisations to plan Scotland's Commissioner for Children & Young People events we agree who is responsible for the safety of the children and young people – and the adults who work with them. The Commissioner's office will require third parties to confirm they have the appropriate child protection policies and procedures in place and that the organisers will be responsible for ensuring that all appropriate checks, parent/child consents etc are in place prior to the event. Third parties may be asked for copies of relevant child protection documentation.

7.2 Children & Young People Travelling to Scotland's Commissioner for Children & Young People Activities

Sometimes we ask a child or young person to come to a meeting, either in Edinburgh or somewhere else. If a child or young person is coming to help us, we normally pay travel expenses.

If a young person is aged 14 or over, we assume that they can travel alone, unless it is a long or dangerous journey or they need extra help. If we were not already aware that they needed help, we would expect the young person or their parent to tell us so we could arrange it.

If a young person is under 14, we assume that a parent will accompany them on the journey. We pay reasonable travel expenses for the person who accompanies them.

If a child or young person needs extra support, such as a carer, supporter, or interpreter, we will pay for that service.

Staff do not normally use their own cars to take children and young people to such activities. However, where a child or young person wishes to take part in an activity and has no alternative form of transport available to them (i.e. public transport is not available and his/her parents are not able to bring them to an activity), the Commissioner may consider making other arrangements. This may include providing a taxi or arranging for a member of staff to transport the child. These arrangements will always be discussed in advance with the young person, and where consent is required, with his/her parents.

Appendix A: Child Protection Report Pro-forma

Child Protection Pro-Forma to completed by the Designated Person and Forwarded to SW within 24 hours

Practice Guidance Note

When a member of staff has concerns about the safety and wellbeing of a child, they should immediately speak to their line manager who will discuss these concerns with the Designated Person.

When a decision has been taken to make a referral to the child protection agencies a telephone referral will be made to the appropriate locality office (social work, police). This telephone referral should be followed up within 24 hours in writing using this pro-forma recording all relevant information.

The Designated Person will have responsibility to ensure that the pro-forma is completed and forwarded to social work services. In completing the form, the worker who initially raised the concern may be requested to contribute to the completion of the pro-forma. It may not be possible to complete all sections of the document.

The Commissioner will be advised of all child protection referrals made to Social Work and/or the police.

A copy of this notification should be retained on file for future reference.

Scotland's Commissioner for Children & Young People

Child Protection Notification to Child Protection Agency

Name of child (if known)
Date of birth or age (if known)
Address and telephone number (if known)
Name of parents/carers (if known)
Names of other siblings (if known)
Special circumstances relating to the child (e.g. special needs, health and welfare issues)
Nature of the concern? (e.g. could be an allegation made by a child or a concern raised by a worker/third party).
Name of person the child spoke to, the location and time
Details of child protection concern (detail using child/young person's own words, details indicators of abuse etc)

Concerns raised by an adult (fully record concerns and state whether the concerns are those of the adult or another persons - detail the concerns)	
Name(s) of the person or persons implicated in the allegation/concern of abuse (record available information)	
This section should be completed by the Designated Person) following discussion with the external child protection agencies	
<i>Name of worker</i>	
<i>Workplace Address</i>	
<i>Telephone Number</i>	
<i>E-mail address</i>	
<i>Date referral made</i>	<i>Time</i>
Advice Given by social work services / police	
What advice was given about liaising with the child's parents/carers	

Signed (worker)

Date

Signed Designated Person

Date

This form must be kept in a confidential file. Information given in this form must only be disclosed to relevant persons on a need to know basis

Appendix B: Categories & Indicators of Abuse

The following definitions have been taken from the National Guidance for Child Protection in Scotland (2010)

<http://www.scotland.gov.uk/Resource/Doc/334290/0109279.pdf>

and Scottish Executive's Protecting Children and Young People: Framework for Standards (2004).

Child abuse and neglect can be defined as

“Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, significant harm on the child. Children may be abused in a family or in an institutional setting, by those known to them or, more likely, by a stranger.” (National Child Protection Guidance, 2010).

The following definitions indicate how abuse may be experienced by a child but are not exhaustive, as the individual circumstances of the abuse will vary from child to child.

Domestic abuse

Domestic abuse describes any behaviour that involves exerting control over a partner or ex-partner's life choices and that undermines their personal autonomy. It is an assault on their human rights. Although most victims are women, men can also suffer domestic abuse, and it can also occur in same-sex relationships. Children and young people living with domestic abuse are at increased risk of significant harm, both as a result of witnessing the abuse and being abused themselves. Children can also be affected by abuse even when they are not witnessing it or being subjected to abuse themselves. Domestic can profoundly disrupt a child's environment, undermining their stability and damaging their physical, mental and emotional health.

The impact of domestic abuse on a child will vary, depending on factors including the frequency, severity and length of exposure to the abuse and the ability of others in the household (particularly the non-abusive parent/carer) to provide parenting support under such adverse conditions. If the non-abusive parent/carer is not safe, it is unlikely that the children will be. Indeed, children frequently come to the attention of practitioners when the severity and length of exposure to abuse has compromised the non-abusing parent's/carer's ability to nurture and care for them.

The best way to keep both children and non-abusive parents/carers safe is to focus on early identification, assessment and intervention through skilled and attentive staff in universal services. Domestic abuse is widely under-reported to the police. Given the reticence of victims to come

forward, it is crucial that staff are aware of the signs of domestic abuse and routinely make appropriate enquiries.

When undertaking assessment or planning for any child affected by domestic abuse, it is crucial that practitioners recognise that domestic abuse involves both an adult and a child victim. The impact of domestic abuse on a child should be understood as a consequence of the perpetrator choosing to use violence rather than of the non-abusing parent's/carer's failure to protect. Every effort should be made to work with the non-abusing parent/carer to ensure adequate and appropriate support and protection is in place to enable them to make choices that are safe for both them and the child. At the same time, staff should be maintaining a focus on the perpetrator and monitoring any risk resulting from ongoing abuse. The ultimate aim should be to support the non-abusing parent/carer in re-establishing a stable and nurturing home for the child; in the meantime, protecting the child may mean them having to live apart from the non-abusing parent/carer for a time. In such circumstances, staff should work to ensure as much stability and continuity for the child as possible. Agencies should always work to ensure that they are addressing the protection of both the child and the non-abusing parent/carer.

Protection should be ongoing, and should not cease if and when the abuser and the non-abusing parent/carer separate. Indeed, separation may trigger an escalation of violence, increasing the risk to both the child and their non-abusing parent/carer. One area of critical concern is the child's contact with the perpetrator, which can provide a channel for continuing and even increasing the domestic abuse. Any decisions made in regard to contact by both social work services and/or the civil courts should be based on an assessment of risk to both the non-abusing parent/carer and the child.

Parental alcohol and drug misuse

Substance misuse can involve alcohol and/or drug misuse (including prescription as well as illegal drugs). The risks to and impacts on children of alcohol/drug-misusing parents and carers are known and well-researched. Alcohol and/or drug misuse during pregnancy can have significant health impacts on the unborn child. Parental alcohol and/or drug misuse can also result in sustained abuse, neglect, maltreatment, behavioural problems, disruption in primary caregiving, social isolation and stigma of children. Alcohol and/or drug-misusing parents/carers often lack the ability to provide structure or discipline in family life. Poor parenting can impede child development through poor attachment and the long-term effects of maltreatment can be complex. The capability of parents/carers to be consistent, warm and emotionally responsive to their children can be undermined.

Disability

Disabled children are not only vulnerable to the same types of abuse as their able-bodied peers, they are also more vulnerable to that abuse. Children who are deaf or hard of hearing, or with behavioural disorders, learning disabilities and/or sensory impairments are particularly at risk. Neglect is the most frequently reported form of abuse, followed by emotional abuse.

The definition of “disabled children” includes children and young people with a comprehensive range of physical, emotional, developmental, learning, communication and health care needs. Disabled children are defined as a child in need under section 93(4) of the Children (Scotland) Act 1995.

Abuse of disabled children is significantly under-reported. Local services need to ensure their systems for collecting information about disabled children are sufficiently robust. Where a child has a disability, the type and, if relevant, the severity of that disability should be recorded, along with the implications for the child’s support and communication needs.

Disabled children are more likely to be dependent on support for communication, mobility, manual handling, intimate care, feeding and/or invasive procedures. There may be increased parental stress, multiple carers and care in different settings (including residential); there may also be reluctance among adults, including practitioners, to believe that disabled children are abused. Disabled children are likely to be less able to protect themselves from abuse. Limited mobility can add to their vulnerability. In addition, the network of carers around the child is likely to be larger than for a non-disabled child, which can be a risk factor in itself. While the majority of parents/carers provide the highest standard of care for their child, it must be acknowledged that in some cases they themselves will be perpetrators of abuse.

Children looked after by parents/carers in the community can have complex health care needs which include life-threatening conditions. Caring responsibilities, which may involve complex clinical procedures, can lead to considerable pressure on families. Reliance on physical, mechanical and chemical interventions to manage health and behaviour can leave these children particularly vulnerable to harm. Disabled children’s dependence on medication may leave them exposed to further abuse, for example where medication is wrongly - or simply not administered - either deliberately or through lack of knowledge and understanding.

Disabled children are often highly dependent on their carers. They may be less resilient and failure to treat even minor ailments can have serious consequences. Practitioners may have an unrealistic view of parents/carers ability to cope. Parents/carers may be reluctant to admit that they can’t cope. To protect disabled children, assessments must cover

the ability and capacity of parents/carers to cope with the demands being placed on them.

Non-engaging families

Evidence shows that some adults will deliberately evade practitioner interventions aimed at protecting a child. In many cases of child abuse and neglect, this is a clear and deliberate strategy adopted by one or more of the adults with responsibility for the care of a child. It is also the case that the nature of child protection work can result in parents/carers behaving in a negative and hostile way towards practitioners.

The terms “non-engagement” and “non-compliance” are used to describe a range of deliberate behaviour and attitudes, such as:

- failure to enable necessary contact (for example missing appointments) or refusing to allow access to the child or to the home;
- active non-compliance with the actions set out in the Child’s Plan (or Child Protection Plan);
- disguised non-compliance, where the parent/carer appears to co-operate without actually carrying out actions or enabling them to be effective; and
- threats of violence or other intimidation towards practitioners.

Consideration needs to be given to determining which family member(s) is or are stopping engagement from taking place and why. For example, it may be the case that one partner is “silencing” the other and that domestic abuse is a factor.

Children and young people experiencing or affected by mental health problems

Two separate but not unconnected issues should be considered in identifying, assessing and managing the risks faced by children affected by mental health problems:

- children and young people who are experiencing mental health problems themselves; and
- children and young people whose lives are affected by the mental illness or mental health problems of a parent/carer.

These two issues are dealt with in turn:

Children and young people experiencing mental health problems

The emotional well-being of children and young people is just as important as their physical health. Most children grow up mentally healthy, but certain risk factors make some more likely to experience problems than others. Evidence also suggests that more children and young people have problems with their mental health today than 30 years ago. Traumatic events in themselves will not usually lead to mental health problems, but they may trigger problems in those children and young people whose mental health is not robust.

Changes, such as moving home or changing school, can act as triggers. Teenagers often experience emotional turmoil as their minds and bodies change and develop. Some find it hard to cope and turn to alcohol or drugs. Over the past 15 years, the incidence of self-harm and suicide among young people has increased.

For some young people, mental health problems will severely limit their capacity to participate actively in everyday life and will continue to affect them into adulthood. Some may go on to develop severe difficulties and display behaviour that challenges families and services, including personality disorders. A small number of children with mental health problems may pose risks to themselves and others. For some, their vulnerability, suggestibility and risk levels may be heightened as a result of their mental illness. For others, a need to control, coupled with lack of insight into, or regard for, others' feelings and needs may lead to them preying on the vulnerabilities of other children. It is imperative that services work closely together to address these issues and mitigate risks for these children and for others.

Separated children may be particularly vulnerable to mental health problems, particularly where they have experienced traumatic events. These can be compounded by feelings of alienation, loneliness, disorientation and "survivor's guilt". Many will have no awareness of the support available to them, making it difficult for them to access services.

Certain risk factors make some children and young people more likely to experience mental health problems than others. These include:

- having a long-term physical illness;
- having a parent or carer who has had mental health problems, problems with alcohol/drugs or a history of offending behaviour;
- experiencing the death of someone close to them;
- having parents who separate or divorce;
- having been severely bullied or physically or sexually abused;

- living in poverty or being homeless;
- having a learning disability;
- experiencing discrimination, perhaps because of their race, nationality, sexuality or religion;
- acting as a carer for a relative;
- having long-standing educational difficulties; and
- forming insecure attachments with their primary carer.

Children and young people can experience a range of mental health problems, from depression and anxiety through to psychosis. While most will recover, many are left with unresolved difficulties or undiagnosed illnesses that can follow them into adult life. Child protection is a crucial component of the service response to children and young people experiencing mental health problems. Local training and policies should reflect the need for awareness of these issues.

Children and young people experiencing such difficulties must have access to the right support and services, and know that their issues are being taken seriously. The same is true for parents and carers who may be bewildered or frightened by their child's behaviour or concerned that they are the cause of such behaviour.

Children and young people affected by parental mental health problems

It is not inevitable that living with a parent/carer with mental health issues will have a detrimental impact on a child's development and many adults who experience mental health problems can parent effectively. However, there is evidence to suggest that many families in this situation are more vulnerable.

A number of features can contribute to the risk experienced by a child or young person living with a parent or carer who has mental health problems. These include:

- the parent/carer being unable to anticipate the needs of the child or put the needs of the child before their own;
- the child becoming involved in the parent/carer's delusional system or obsessional compulsive behaviour;
- the child becoming the focus for parental aggression or rejection;
- the child witnessing disturbing behaviour arising from the mental illness (often with little or no explanation);

- the child being separated from a mentally ill parent, for example because the latter is hospitalised; and
- the child taking on caring responsibilities which are inappropriate for his/her age.
- There are also factors which may impact on parenting capacity including:
 - maladaptive coping strategies or misuse of alcohol and/or drugs;
 - lack of insight into the impact of the illness (on both the parent/carer and
 - child); and
 - poor engagement with services or non-compliance with treatment.

This list is not exhaustive. A number of other factors may need to be considered, including the attachment relationship and any instances of domestic abuse. Services involved with the parent/carer should consider the impact of these factors on the child's needs. Where concerns are identified, these should be shared with children's services.

The stigma associated with mental health problems means that many families are reluctant to access services because of a fear about what will happen next. Parents/carers may worry about being judged and that they will be deemed incapable of caring for their children. Many will therefore view asking for services or support as a high-risk strategy.

Children and young people who display harmful or problematic sexual behaviour

Harmful or problematic sexual behaviour in children and young people can be difficult to identify. It is not always easy to distinguish between what is abusive and/or inappropriate and what constitutes normal adolescent experimentation. Practitioners' ability to determine if a child's sexual behaviour is developmentally typical, inappropriate or abusive will be based on an understanding of what constitutes healthy sexual behaviour in childhood as well as issues of informed consent, power imbalance and exploitation.

In managing and reducing risk, the diversity of potential behaviour must be taken into account. Children and young people display a wide range of sexual behaviour in terms of: the nature of behaviour; degree of force; motivation; level of intent; level of sexual arousal; and age and gender of victims. Broader developmental issues must also be taken into account, including the age of the young person, their family and background, their intellectual capacities and stage of development. Young people with learning difficulties are a particularly vulnerable and often overlooked group who may need specific types of interventions.

Where abuse of a child or young person is alleged to have been carried out by another child or young person, such behaviour should always be treated seriously and be subject to a discussion between relevant agencies that covers both the victim and the perpetrator. In all cases where a child or young person displays problematic sexual behaviour, immediate consideration should be given to whether action needs to be taken under child protection procedures, either in order to protect the victim or to tackle concerns about what has caused the child/young person to behave in such a way.

Female genital mutilation

Female genital mutilation is a culture-specific abusive practice affecting some communities. It should always trigger child protection concerns. The legal definition of female genital mutilation is “to excise, infibulate or otherwise mutilate the whole or any part of the labia majora, labia minora, prepuce of the clitoris, clitoris or vagina.” It includes all procedures which involve the total or partial removal of the external female genital organs for non-medical reasons. There are four types of female genital mutilation ranging from a symbolic jab to the vagina to the partial or total removal of the external female genitalia. The Prohibition of Female Genital Mutilation (Scotland) Act 2005 makes it illegal to perform or arrange to have female genital mutilation carried out in Scotland or abroad. A sentence of 14 years imprisonment can be imposed.

The procedure is usually carried out on children aged between four and ten years. It is a deeply rooted cultural practice in certain African, Asian and Middle Eastern communities. Justifications for female genital mutilation may include:

- tradition;
- family honour;
- religion;
- increased male sexual pleasure;
- hygiene; and
- fear of exclusion from communities.

A range of health problems, both immediate and long-term, are associated with the procedure. Short-term effects can include haemorrhage and pain, shock and infection. Longer-term effects include bladder problems, menstrual and sexual difficulties and problems giving birth. The emotional effects of female genital mutilation may include flashbacks, insomnia, anger, difficulties in adolescence, panic attacks and anxiety. In Western cultures, the young person may also be disturbed by Western opinions of a practice which they perceive as an intrinsic part of being female.

Female genital mutilation is usually done for strong cultural reasons and this must always be kept in mind. Action should be taken in close collaboration with other agencies and should be proportionate and sensitive to the cultural norms and pressures on parents/carers and children. Where possible, workers with knowledge of the culture involved may be able to assist but the welfare of the child must always be paramount. Nevertheless, **female genital mutilation should always be seen as a cause of significant harm and normal child protection procedures should be invoked.** Some distinctive factors will need consideration:

- female genital mutilation is usually a single event of physical abuse (albeit with very severe physical and mental consequences);
- there is a risk that a child or young person is likely to be sent abroad to have the procedure performed;
- where a child or young person within a family has been subjected to female genital mutilation, consideration needs to be given to other female siblings or close relatives who may also be at risk;

Honour-based violence and forced marriage

Honour-based violence is a spectrum of criminal conduct with threats and abuse at one end and honour killing at the other. Such violence can occur when perpetrators believe that a relative/community member, who may be a child, has shamed the family and/or the community by breaking their honour code. The punishment may include assault, abduction, confinement, threats and murder. The type of incidents that constitute a transgression include:

- inappropriate make-up or dress;
- having a boyfriend/girlfriend;
- forming an inter-faith relationship;
- kissing or intimacy in a public place;
- pregnancy outside marriage; and
- rejecting a forced marriage.

A forced marriage is defined as a marriage conducted without the full and free consent of both parties and where duress is a factor. Duress can include physical, psychological, financial, sexual and emotional pressure. A clear distinction must be made between a forced marriage and an arranged marriage. An arranged marriage is one in which the families of both spouses are primarily responsible for choosing a marriage partner for their child or relative, but the final decision as to whether or not to accept

the arrangement lies with the potential spouses. Both spouses give their full and free consent. The tradition of arranged marriage has operated successfully within many communities for generations.

In Scotland, a couple cannot be legally married unless both parties are at least 16 on the day of the wedding and are capable of understanding the nature of a marriage ceremony and of consenting to the marriage. Parental consent is not required.

The consequences of forced marriage can be devastating to the whole family, but especially to the young people affected. They may become estranged from their families and wider communities, lose out on educational opportunities or suffer domestic abuse. Rates of suicide and self-harm are high. Some of the potential indicators of honour-based violence and forced marriage are listed below.

Education

- Absence and persistent absence from education.
- Request for extended leave of absence and failure to return from visits to country of origin.
- Decline in behaviour, engagement, performance or punctuality.
- Being withdrawn from school by those with parental responsibility.
- Being prevented from attending extra-curricular activities.
- Being prevented from going on to further/higher education.

Health

- Self-harm.
- Attempted suicide.
- Depression.
- Eating disorders.
- Accompanied to doctors or clinics and prevented from speaking to health practitioner in confidence.
- Female genital mutilation.

Police

- Reports of domestic abuse, harassment or breaches of the peace at the family home.

- Threats to kill and attempts to kill or harm.
- Truancy or persistent absence from school.

Cases of honour-based violence/forced marriage can involve complex and sensitive issues and care must be taken to make sure that interventions do not worsen the situation. For example, mediation and involving the family can increase the risks to a child or young person and should not be undertaken as a response to forced marriage or honour-based violence. Efforts should be made to ensure that families are not alerted to a concern that may result in them removing the child or young person from the country or placing them in further danger.

Concerns may be expressed by a child or young person themselves about going overseas. They may have been told that the purpose is to visit relatives or attend a wedding. On arrival, their documents, passports, money and mobile phones are often taken away from them. These concerns should be taken seriously, although practitioners must also be careful to avoid making assumptions. Such cases may initially be reported to the joint Home Office/Foreign and Commonwealth Office Forced Marriage Unit.

As with all cases of forced marriage, confidentiality and discretion are vitally important. It is not advisable to immediately contact an overseas organisation to make enquiries. If a family becomes aware that enquiries are being made, they may move the child or young person to another location or expedite the forced marriage.

When a child or young person has already been forced to marry, they will sometimes approach children's social work services or the police because they are concerned that they may need to act as a sponsor for their spouse's immigration to the UK. Practitioners should reassure the child or young person that they cannot be required to act as a sponsor until they are 21. Confronting the family may be extremely risky for the child or young person and result in their being put under increased pressure to support the visa application. These risks need to be discussed with the child or young person.

Cases of forced marriage may initially be reported to social work services as cases of domestic abuse. Spouses forced into marriage may suffer domestic abuse but feel unable to leave due to a lack of family support, economic pressures and other social circumstances. In some cases, they may fear having their own children taken away from them. In all cases, the social worker should discuss the range of options available to the child or young person and the possible consequences. A spouse who is the victim of a forced marriage can initiate nullity or divorce proceedings to end the marriage, but should be made aware that a religious divorce will not end the marriage under UK law.

Fabricated or induced illness

Fabricated or induced illness in children is not a common form of child abuse, but practitioners should nevertheless be able to understand its significance. Although it can affect children of any age, fabricated and induced illness is most commonly identified in younger children. Where concerns do exist about the fabrication or induction of illness in a child, practitioners must work together, considering all the available evidence, in order to reach an understanding of the reasons for the child's signs and symptoms of illnesses. A careful medical evaluation is always required to consider a range of possible diagnoses and a range of practitioners and disciplines will be required to assess and evaluate the child's needs and family history.

There are three main ways in which a parent/carer can fabricate or induce illness in a child. These are not mutually exclusive and include:

- fabrication of signs and symptoms, including fabricating the child's past medical history;
- fabrication of signs and symptoms and falsification of hospital charts, records and specimens of bodily fluids. This may also include falsification of letters and documents; and
- induction of illness by a variety of means.

For those children who are suffering, or at risk of suffering significant harm, joint working is essential both to protect the child and where necessary to take action, within the criminal justice and child protection systems, against the perpetrators of crimes against children. All agencies and practitioners should:

- be alert to potential indicators of illness being fabricated or induced in a child;
- be alert to the risk of harm that individual abusers, or potential abusers, may pose to children in whom illness is being fabricated or induced;
- share, and help to analyse, information so that an informed assessment can be made of the child's needs and circumstances;
- contribute to whatever actions (including the cessation of unnecessary medical tests and treatments) and services are required to safeguard and promote the child's welfare;
- regularly review the outcomes for the child against specific planned outcomes;
- work co-operatively with parents/carers unless to do so would place the child at increased risk of harm; and

- assist in providing relevant evidence in any criminal or civil proceedings, should this course of action be deemed necessary.

The majority of cases of fabricated or induced illness in children are confirmed in a hospital setting. The first task for the paediatrician is to find out whether a child's illness and individual symptoms and signs can be accounted for by natural causes. If not, the possibility that the illness has been fabricated or induced must be considered. CAMHS may be called in to look at the effects on the child and establish whether the parent/carer suffers from an underlying disorder. Police must investigate a possible crime. Social workers will co-ordinate the assessment of concerns about the child's welfare or the risk of harm and support to parents/carers during the assessment. Co-ordinated planning and assessment is essential in the investigation of fabricated or induced illness. Some methods, such as the use of covert video surveillance, should be discussed and agreed by all services involved before being implemented.

Physical Abuse

All children where there is physical injury and where -

“Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child whom they are looking after. This situation may be described as fabricated or induced illness by the carer”. In addition consideration needs to be given to –

a) It is known, admitted or reasonably suspected that the injury was inflicted by any person caring for the child or any person likely to be a member of the same household

or

b) anyone caring for the child knowingly failed to prevent the injury or acted without due regard for the safety of the child

or

c) the nature of the injury is inconsistent with the account of how it occurred.

Possible signs and indicators of physical injury

- Injuries, particularly if they are recurrent
- Improbable excuses given to explain injuries
- Refusal to explain and discuss injuries
- Admission of punishment which appears excessive
- Fear of medical help particularly on the part of the parent who may seem reluctant/make excuses for not taking a child to the GP
- Arms and legs kept covered in hot weather
- Withdrawal from physical contact
- Black eyes
- Bruising on the soft parts of the body – thighs, upper arms, buttocks
- Bruising around the neck area
- Physical aggression towards others
- Physical aggression towards self – hitting and telling self off for doing something wrong

Physical neglect

“Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs”.

This can also occur when an adult carer persistently pursues or allows a child/young person to follow a lifestyle inappropriate to the child/young person’s development needs or which jeopardises the child/young person’s health.

This may also occur when a child is left unattended or inadequately supervised, though careful judgment is required as to the appropriateness of any care arrangements.

Possible signs and indicators of physical neglect

- Constant hunger
- Compulsive stealing or scavenging
- Emaciation
- Constant tiredness
- Poor personal hygiene
- Poor state of clothing and/or child inappropriately clothed for the weather
- Untreated medical problems
- Frequent lateness or non-attendance at school

Emotional abuse

“Emotional abuse is where persistent emotional ill treatment of a child causes severe and persistent adverse effects on the child’s emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate or valued only in so far as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill treatment of a child, though it may occur independent of the other forms of abuse”.

Possible signs and indicators of emotional abuse

- Fear of parents being contacted
- Admission of punishment which appears excessive
- Physical, intellectual and emotional development lags
- Significant decline in concentration
- Sudden speech disorders
- Over-reaction to mistakes
- Continual self-deprecation
- Fear of new situations
- Inappropriate emotional responses to painful situations
- Neurotic behaviour
- Self harm
- Extremes of passivity or aggression
- Drug/solvent abuse
- Chronic running away
- Compulsive stealing/scavenging
- Indiscriminate friendliness
- Socio-emotional immaturity

Sexual abuse

“Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or in watching sexual activities, using sexual language towards a child or encouraging children to behave in sexually inappropriate ways.”

Possible signs and indicators of sexual abuse

Children under the age of five may -

- Become insecure or cling to parent in a fearful way
- Show extreme fear of a particular person
- Cry hysterically when their nappy is changed
- Become hysterical when clothing is removed particularly underclothes
- Have some physical signs in the genital or anal areas; smell of semen etc.
- Have soreness or bleeding in the throat, anal or genital area
- Regress to a much younger behavioural pattern
- Stare blankly, seem unhappy, confused, sad
- Become withdrawn, stop eating, have chronic nightmares, begin wetting again when previously dry
- Stop enjoying activities with other children, such as stories or games
- Seem to be bothered or worried
- Act in a sexually inappropriate way towards adults
- Behave in a sexually inappropriate way to their age, being obsessed with sexual matters as opposed to normal exploration
- Play out sexual acts in too knowledgeable a way with dolls or other children
- Produce drawings of sex organs such as erect penises
- Repeat obscene words or phrases
- Say repeatedly that they are bad, dirty or wicked

Children from the ages of five to twelve may -

- Hint about secrets they cannot tell
- Say that a friend has a problem
- Ask if you will keep a secret if they tell you something
- Seem to be keeping secret something which is worrying them
- Begin lying, stealing, blatantly cheating in the hope of being caught
- Have unexplained sources of money
- Exhibit sudden inexplicable changes in behaviour, such as becoming aggressive or withdrawn or regressing to younger behaviour patterns
- Stop enjoying previously liked activities such as music, sports, art, scouts, guides
- Be reluctant to undress for gym
- Have terrifying dreams
- Act in a sexual way, inappropriate to their age
- Draw sexually explicit pictures depicting some act of abuse
- Start wetting themselves
- Have urinary infection, bleeding or soreness in the genital or anal areas
- Have soreness or bleeding in the throat

Children from the age of twelve onwards may -

- Be fearful about certain people like relatives or friends
- Assume the role of parents in the house to such an extent that they are taking care of everyone's needs except their own
- Not be allowed to go out on dates or have friends round
- Find excuses not to go home or to a particular place
- Run away frequently
- Have unexplained sums of money
- Have recurring nightmares/be afraid of the dark
- Exhibit a sudden change in school/work habits, begin to truant
- Be fearful of undressing for games/gym
- Become withdrawn, isolated or excessively worried
- Have outbursts of anger or irritability
- Be chronically depressed
- Be suicidal
- Use drugs or drink to excess
- Self harm
- Develop eating disorders
- Exhibit inappropriate sexual/seductive behaviour
- Have recurrent genital/urinary/anal infections/bleeding
- Have chronic ailments such as stomach pains and headaches
- Become pregnant
- Have a friend who has a problem and then tell about the abuse of the friend
- Sexually abuse a child, sibling or friend

Non-organic failure to thrive

Failure to meet expected weight and growth norms or developmental milestones, which does not have a basis in a hereditary or medical condition, as medically diagnosed. In its extreme form children can be at serious risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long term effects such as greater susceptibility to serious childhood illnesses, reduction in potential stature and, with young children in particular, the results may be life threatening over a relatively short period.

Possible signs of non-organic failure to thrive

This condition is normally identified whilst the child is an infant. Signs which could indicate non-organic failure to thrive -

- Significant lack of growth
- Unexplained physical changes such as weight and/or hair loss
- Poor skin or muscle tone
- Circulatory disorders

Abuse by young people or children

Activities between children and young people of a sexual or physical nature where one or more of the following characteristics is present -

- Lack of true consent
- Inequalities in power (such as chronological age, developmental stage or size)
- Actual or threatened coercion

A distinction must be made between behaviour normally expected between young people and children and that which is clearly of a seriously abusive nature.

Appendix C: Document Control

Document Information

Prepared by:	Pauline McIntyre	
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Summary of Document Changes

Date	Version changed	New version no.	Brief description	Reason for change	Initials
22/08/2013	1	2	Edited title page, removing draft version details.		GM
13/12/2013	2	3	Added logo, formatted contents page and headings		GM