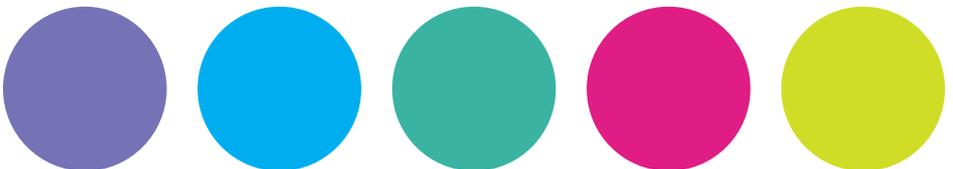


Child Protection and Welfare Practice Handbook **2**



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This handbook should be cited as:

Tusla (2018) *Child Protection and Welfare Practice Handbook 2*,
Dublin, Tusla.

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Acknowledgements

The content of the *Child Protection and Welfare Practice Handbook 2* has been compiled from submissions from numerous external and internal stakeholders and content experts. While there are too many to list individually, Tusla would like to acknowledge all of their contributions and assistance in the development of this handbook. Their observations and input have been crucial in producing a document that is evidence based and evidence informed; reflects a breadth of knowledge and experience; and should support best practice in child protection and welfare work.

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Additional support was provided by Mr Charney Weitzman, who contributed to the coordination and editing of the final version of the handbook.

We would also like to thank Ms Amelia Cox, HSE; Ms Deirdre Horan-Martin, Tusla; and Ms Daniela Jurj, New Communities Partnership, for their specific contributions. In addition, many others have made significant contributions. All individuals who have assisted in the development of the Practice Handbook deserve both the highest praise and considerable thanks.

Introduction

Welcome to the *Child Protection and Welfare Practice Handbook 2*. This handbook is for use of front-line social workers, their line managers and other professionals. It provides information on a number of circumstances that may make children more vulnerable to harm. Practice Handbook 2 is divided into four sections, following the categories identified in *Children First: National Guidance* (DCYA 2017: 11–12): Parent or Carer Factors, Child Factors, Community Factors, and Environmental Factors. Chapters are provided under each of these headings on factors identified in *Children First: National Guidance* as well as some additional areas.

While most chapters begin with a short **description** of the content area, followed by some key **messages from research** and conclude with a **practice note, not all chapter topics lent themselves to this format; a note is included in the relevant chapters**. The Practice Handbook 2 is intended to be a practical resource for professionals in assessing child protection or welfare concerns where there are additional vulnerability factors.

Principles of Child Protection and Welfare

The principles underpinning child protection in Tusla – Child and Family Agency are:

- The safety and welfare of children is everyone’s responsibility.
- The best interests of the child should be paramount.
- The overall aim in all dealings with children and their families is to intervene proportionately to support families to keep children safe from harm.
- Interventions by the State should build on existing strengths and protective factors in the family.
- Early intervention is key to getting better outcomes. Where it is necessary for the State to intervene to keep children safe, the minimum intervention necessary should be used.
- Children should only be separated from parents/guardians when alternative means of protecting them have been exhausted.
- Children have a right to be heard, listened to and taken seriously. Taking account of their age and understanding, they should be consulted and involved in all matters and decisions that may affect their lives.

- Parents/guardians have a right to respect, and should be consulted and involved in matters that concern their family.
- A proper balance must be struck between protecting children and respecting the rights and needs of parents/guardians and families. Where there is conflict, the child’s welfare must come first.
- Child protection is a multiagency, multidisciplinary activity. Agencies and professionals must work together in the interests of children (DCYA 2017).

Guidance on Working with Families

“Parents/guardians have a right to respect, and should be consulted and involved in matters that concern their family.”

“A proper balance must be struck between protecting children and respecting the rights and needs of parents/guardians and families. Where there is conflict, the child’s welfare must come first.”

*Children First: National Guidance 2017,
Key Principles*

“Parents often find the investigation and assessment process to be very difficult and intrusive. Social workers should try to form respectful and constructive relationships with families and their children” (Children First 2017: 47). All assessments should be carried out with rigor and grace.

When addressing child protection or welfare concerns, professionals are required to engage with parents about safety issues and to resolve child safety issues with parents wherever possible. Parents have the primary responsibility for resolving issues in their families. Professionals must find ways to engage with the family to address their needs in a manner that supports the family’s participation. For example, initial contact with the family in person, rather than by telephone or letter, may prove more effective. While each individual case may require a different approach, one-to-one personal discussions, where everything can be explained in an unhurried and respectful fashion, can give reassurances and support to families.

Developing a collaborative, professional and supportive working relationship

In developing a collaborative, professional and supportive working relationship with a family, the following points may assist you in practice:

- Get to know the children and family; build up a rapport if possible.
- Be punctual and responsive, for example, return telephone calls and attend appointments on time.
- Be honest about the concerns and issues, and ensure that they are understood by the family.
- Check the parents' understanding of what has been said to them. This is especially important where, for example, a parent may have an intellectual disability or not be a native speaker of English.
- Over time develop a partnership approach by empathising, listening to the family, clarifying everybody's expectations, and working at the pace of the family.
- Do not use jargon; use clear language in a respectful and sensitive manner.
- Be clear about what needs to change and what will be expected from the family.
- Be clear about what you will do after you have shared your concerns with them and be as clear as possible about what they can expect from you.
- Ensure that the family is aware if/how you will be sharing information with other professionals or agencies.
- If it is not possible to engage the parents/family in a meaningful discussion about the concerns/issues raised, discuss further appropriate action with your line manager/supervisor.

Challenges that professionals may experience in engaging parents and carers

Forming meaningful relationships with parents can be a significant challenge for professionals offering services to children and families. There are many possible reasons why it may be difficult to form a meaningful relationship with parents; understanding the underlying reasons can help in assessing the safety of the child. Some reasons for families not engaging fully are explored below.

Behaviours that can be displayed by parents and carers

The following types of behaviours can be displayed by parents and carers. This list of behaviours is not exhaustive and some parents/carers may display a range of these behaviours at the same time or at different periods of intervention.

- Ambivalence
- Avoidance
- Disguised compliance
- Confrontation
- Violence

Ambivalence

Behaviours may include always being late for appointments, repeatedly missing appointments and/or changing the conversations from uncomfortable topics. Ambivalence is a common reaction and may not amount to a lack of cooperation as everyone can be ambivalent at some stage. The ambivalence could be related to poor past experiences of involvement with professionals or where individuals are not clear about what we want.

Tips

- Acknowledge ambivalence and work through it.
- Use simple language so that the family member understands clearly what you are saying.
- Ask about past experiences of working with professionals. Use questions such as: “In your experience of having professionals involved in your life, what have you found most or least helpful?” or “What do you think I would need to do to be helpful to you?”

Avoidance

Behaviours may include avoiding appointments, missing meetings, blocking access to the children and/or cutting visits short. Some of the reasons for avoidance include trying to hide something, resentment of outside interference, and fear of the impact of talking about certain issues.

It is sometimes possible to overcome a parent/carer's avoidance. Where a parent/carer comes to understand that you are resolute in your intention, they may become more willing to engage, particularly if they perceive sincerity in your concern for them and your wish to help.

Tips

- Be clear with the family about your role.
- Persist in meeting and/or seeking meetings with the family.
- Let the family know that you have noticed 'avoidance behaviours' and let them know what your worries are about this. It is best if you give specific examples to the parent/carer.
- Acknowledge specific strengths within the family.
- Try to agree with the family on how you can work collaboratively. Seek agreed solutions to how they can convince you that they are going to work with you to keep the child safe.

Disguised compliance

There are many behaviours that parents/carers can use to distract and disguise compliance. These include the appearance of cooperating to avoid raising suspicions and to minimise Tusla intervention. Some families may deliberately sabotage efforts to bring about change, for example, regularly 'unintentionally' missing appointments. Parents may agree to referrals and then change their minds or they may start interventions, such as parenting programmes, and not complete them. Parents/carers may make unfounded complaints or unjustified requests for a change in worker. Behaviours such as these can distract professionals, leading to a failure to recognise the true areas of concern.

Tips

- In your work with the family, retain a clear focus on the safety of the child.
- Be clear with the family about what is expected.
- Be clear with the family about what the worries and the risks are.
- Do not be overly optimistic about changes that have not yet been sustained.

- Use curiosity, in these circumstances, to question the information being provided by families.
- Where possible, check the validity of information from the family with colleagues.
- Carry out an analysis of the chronology to help identify disguised compliance.
- Put clear contingency plans in place.

Confrontation

Confrontation can include parents challenging professionals. Provoking arguments can involve extreme avoidance and often indicates a deep-seated lack of trust leading to a ‘fight’ rather than ‘flight’ response to difficult situations. Parents may fear their children may be removed or they may be reacting to them having been removed. They may be suspicious of the motives of the professional and may find it difficult to accept that the professional is trying to help.

Tips

- Be clear about your role and the purpose of involvement.
- Be clear about what the worries and risks are and what would need to change so that people will know that the child is safe.
- Be genuinely interested in their lives and try to understand the family story.
- Gently challenge assumptions and let them know that you have to stay involved until you are sure that the child is safe.
- Be aware that the parent/carer may have difficulty in consistently seeing the professional’s good intent and may be suspicious of their motives.
- If there are numerous displays of confrontation and aggression, discuss it with your manager and/or call a multiagency meeting.
- Be clear about bottom lines.

Violence

Threatened or actual violence is the most difficult of uncooperative behaviours for the professional to engage with. Violence can include verbal intimidation and may reflect a deep and longstanding fear and hatred of authority figures. People may have experience of getting their way through intimidation and violent behaviour.

Tips

- Assess the capacity for change and be realistic about the child or parent's capacity for change in the context of an offer of help with the areas that need to be addressed.
- Provide clear risk of harm statements.
- Provide clear bottom lines and detail the actions that will be undertaken if the parent/carer does not cooperate. These should then be followed through.

1



Parent or Carer Factors

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1 Hidden Harm (Including Parental Drug and Alcohol Misuse)

Description

The experience of children living with and affected by problem parental alcohol and other drug use has become widely known as ‘hidden harm’ (Advisory Council on the Misuse of Drugs 2003). The term ‘hidden harm’ encapsulates the two key features of that experience: that children are often not known to services; and that they suffer harm in a number of ways through physical and emotional neglect, including exposure to harm and poor parenting (Russell 2006).

The concept of hidden harm can be further extended to children in families where there is:

- Parental problem alcohol and other drug use
- Domestic abuse
- Parental mental health problems (DFaHCSIA 2010)

These children can suffer in silence; their circumstances are often not known to services; they often do not know where to turn for help; and the impact of their parents’ problem alcohol and other drug use has a deep and long-lasting impact on their lives, which may not fully emerge until young adulthood and beyond.

The term ‘hidden harm’ is also used because it vividly describes the situation of many children and young people affected by parental problem alcohol and other drug use. Parental problem alcohol and other drug use can and does cause serious harm to children at every age from conception to adulthood. Children of parents who are misusing alcohol and other drugs experience an elevated risk of emotional and physical neglect; development of serious emotional and social problems later in life; and are vulnerable to the development of substance misuse problems themselves. This may add to potential intergenerational substance misuse.

However, not all parents who use alcohol and other drugs experience difficulties with parenting capacity. Equally, not all children exposed to parental problem alcohol and other drug use are affected adversely either in the short or longer term (Scottish Government 2013).

Hidden harm must, however, be considered as a central element of any child welfare or child protection assessment given its common association in the occurrence of child abuse and neglect. The impact of parental problem alcohol and other drug use often has a deep and lasting impact on young lives from conception onwards.



Messages from Research

- The *Children First: National Guidance* (DCYA 2017) identifies a child living with parental drug or alcohol misuse as a circumstance when a child may be more vulnerable to abuse.
- Parental alcohol misuse damages and disrupts the lives of children and families in all areas of society, spanning all social classes. It blights the lives of whole families and harms the development of children trapped by the effects of their parent's problematic drinking (Turning Point 2006).
- The National Study of Domestic Abuse (Watson and Parsons 2005) reported alcohol as a potential trigger for abusive behaviour in one-third of all cases and in one-quarter of the most severe. *Hidden Realities* (Alcohol Forum 2011) also estimated that 587,000 children nationally, over one-half of whom are less than 15 years of age, are exposed to risk from parental drinking. The report also found that one in every seven children placed in the care of the State was as a direct result of parental problem alcohol and other drug use. Data collated nationally by the HSE in 2011 (unpublished) showed alcohol abuse was present in one in every three cases referred to Child Protection services.
- The Report of the Independent Child Death Review Group 2000–2010, (Shannon and Gibbons 2012) outlined alcohol in the home as an issue in 37 of 112 cases reviewed, second only to neglect, and that alcohol misuse was more prevalent an issue than drugs. The report of the Roscommon Child Care Case Inquiry Team (Gibbons *et al.* 2010) found that the neglect and abuse of the family concerned was a direct effect of alcohol dependence.



Practice Note

Parental problem alcohol and other drug use can and does cause serious harm to children at every age from conception to adulthood. By working together, services can take many practical steps to protect and improve the health and wellbeing of affected children. Professionals need to recognise the complexity of the issues relating to hidden harm and understand that effective treatment of the parent can have major benefits for the child and the family.

In 2018, a National Practice Guide on Hidden Harm for staff working with children and families continues to be developed. The National Practice Guide will be used in the training of professionals and as the basis for the development of a National Protocol on Hidden Harm. This Practice Guide will complement *Children First: National Guidance* (DCYA 2017), bridging the gap between children and adult services by focusing on a whole-family approach.

As a consequence of parental problem alcohol or drug misuse, parents may become inconsistent, unpredictable and chaotic in their parenting style, which may result in the child experiencing neglect. Other negative parenting behaviours may include ambivalence or authoritarianism.

2 Parental Mental Health

Description

It is estimated that one in four or five people will experience some mental health problems in their lifetime. Mental health problems can range from a low or sad period to a more serious depression, with a small number of people going on to experience severe mental health problems. Most people with mental health problems can be treated by their general practitioner (GP), and are referred to the Health Service Executive (HSE) Mental Health Services when necessary. **It is important for professionals to consider the impact of the adult's mental health problems on children in their life.**



Messages from Research

- According to the Social Care Institute for Excellence in its report *Think Child, Think Parent, Think Family: A Guide to Parental Mental Health and Child Welfare* (SCIE, 2009), between one in four and one in five adults will experience a mental illness during their lifetime. At the time of their illness, at least one-quarter to one-half of these will be parents. Their children have an increased rate of mental health problems, indicating a strong link between adult and child mental health. Parental mental illness has an adverse effect on child mental health and development, while child psychological and psychiatric disorders and the stress of parenting impinge on adult mental health. Furthermore, the mental health of children is a strong predictor of their mental health in adulthood.
- The Royal College of Psychiatrists (2004) reports that only a very small number of children die or are seriously injured by a parent with a mental health problem. However, many more children suffer less obvious but still damaging effects since their own development or mental health may become compromised.
- According to Green and Goldwyn (2002), many of these children can remain 'hidden' from support because fear of consequences can result in problems not being shared with the services that may alleviate them. There is also the potentially hidden problem of those children who care for their parents (young carers) and who may miss out on many opportunities available to other children.

- In the United Kingdom (UK), Dearden and Becker (2000) estimated that the numbers of young carers nationwide vary between 10,000 and 40,000, of which about one-third care for a parent with a mental health problem. A National Society for the Prevention of Cruelty to Children (NSPCC) study showed that many of these children had significant experiences of loss, self-blame and stigma (Cooklin 2006).
- Abused women are at least three times more likely to experience depression or anxiety disorders than other women.
- Women who use mental health services are much more likely to have experienced domestic abuse than women in the general population.

Impact on children

- Children of parents with an uncontrolled mental illness face a high risk of physical neglect. Basic needs may not be met, such as having regular healthy meals and clean clothes (Cowling 2004).
- Parents may fail to attend to children's emotional needs, which can instil a sense of isolation and possible mistrust in children. There are risks of physical and psychological abuse by parents if symptoms of illness contribute to the parent being violent, reactive or punitive (Cowling 2004).
- Parental mental health problems can also increase the risk of perinatal complications due to possible side-effects of medications (e.g. antidepressants) during pregnancy and high stress levels in mothers (Cowling 2004; Huntsman 2008). Attachment difficulties may arise for babies and infants of mothers with maternal mental health problems, such as depression (Cowling 2004).
- Children of parents with mental health problems have also been found to be at risk of developing mental health problems of their own (Cowling 2004). Problems in a child's cognitive development may also arise due to the parent's inconsistent and neglectful behaviour (Cleaver *et al.* 1999).
- The recklessness associated with antisocial personality disorder, and the tendency of those suffering from it to minimise the harmful consequences of their actions, can put a child at risk of serious or chronic illness, injury and death. In addition, the promiscuity and poor relationship choices made by some adults with antisocial personality disorder may put a child at risk of abuse from others (Newman and Stevenson 2005).



Practice Note

How to talk to young people caring for parents with mental health problems

A group of young carers in Merseyside, UK came up with the following 10 messages as a simple checklist for professionals who come in contact with families where a parent has mental health problems:

1. Introduce yourself. Tell us what your job is and who you are.
2. Give us as much information as you can.
3. Tell us what is wrong with our mum or dad.
4. Tell us what is going to happen next.
5. Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens.
6. Ask us what we know and what we think. We live with our mum or dad. We know how they have been behaving.
7. Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
8. Please don't ignore us. Remember we are part of the family and we live here too!
9. Keep on talking to us and keeping us informed. We need to know what is happening.
10. Tell us if there is anyone we can talk to. **Maybe it could be you.**

Assessing parental mental health as a risk factor

Assessing professionals should consider the available supports that can be offered to the parent experiencing mental health difficulties to assist in their recovery and to mitigate the risks to the child and reduce the severity of the possible interventions. It also may be appropriate to liaise with HSE Adult Mental Health Services and other non-statutory services, such as GPs, support groups, etc.

The following questions are provided to assist professionals when considering the various areas in which parental mental health problems may be impacting on a child's health or welfare.

Attachment and relationship:

- Is the child's attachment damaged due to inconsistent parenting?
- Is there consistent emotional warmth from adult caregivers?
- Is there appropriate parental response in accordance with the child's age and stage?
- Is parental incapacity affecting the child taking on too much responsibility?
- Are the child's emotional needs consistently met (including security, stability and affection)?

Living conditions:

- Are the child's physical needs being consistently met?
- What are the child's living conditions like?
- Is the physical environment provided for the child good enough?

Financial circumstances:

- Is there enough money to allow for adequate parenting or the child's needs to be met?

Social and environmental circumstances:

- Does the parent's behaviour impact negatively on the child's treatment in the community (e.g. bullied, excluded, ostracised)?
- Is the child or young person and their family able to access resources in the community?
- Who looks after this child when the parent/carer is not able to care for them appropriately and/or in treatment or on medication?

Outcomes for the child:

- What is the long-term impact for each child of being exposed to parental mental health problems in the home?
- How does exposure to parental mental health problems impact on the child's overall wellbeing and all areas of child development?
- What is the evidence on which you base your assessment and analysis?

3 Parents with Learning or Intellectual Disabilities

Description

The National Disability Authority (2018) provides the following information on its website, www.nda.ie, “Different definitions of disability are used in different contexts – for example to set eligibility for particular services, or to outlaw discrimination on grounds of disability. There is no definitive list of conditions that constitute a disability. Any such list could leave out people with significant but rare conditions. There can also be a wide range of difference between how individuals with a particular condition are affected, ranging from mild to severe difficulties. A person’s environment, which includes the supports they have and the physical or social barriers they face, influences the scale of the challenges they face in everyday life.”

This chapter focuses primarily on information for professionals working with parents with learning or intellectual disability. Tusla recognises that the best interest of the child is always the paramount concern. However, when working with families where a parent has an intellectual or learning disability, it is essential that professionals also consider the rights of the parent with the intellectual or learning disability.



Messages from Research

- Parents with intellectual disabilities often need to overcome preconceived ideas among other people about their abilities to parent. For example, there is a willingness to attribute potential difficulties they may have parenting to their impairment rather than to disabling barriers or to other factors that affect the parenting of all parents. This has been described as the ‘presumption of incompetence’ (McConnell and Llewellyn 2002).
- Where a parent has an intellectual disability, it is important not to make assumptions about their parental capacity. Having an intellectual disability does not mean that a person cannot learn new skills. Intellectually disabled parents may need support to develop the understanding, resources, skills, experience and confidence to meet the needs of their children (Lamont and Bromfield 2009).

- Several factors have been demonstrated to have an adverse effect on parenting: these include low socioeconomic status, unemployment and social isolation or exclusion. All of these factors make parenting difficult. Parents with intellectual or learning disabilities are at greater risk of experiencing one or more of these disadvantages than other groups. Many parents with intellectual disabilities are unemployed, on low incomes and rely very heavily on benefits and statutory services; many are single mothers; and few have the same opportunities for ‘informal social learning’ from friends and extended family as non-disabled parents (Llewellyn and Hindmarsh 2015).
- Unless a parent with an intellectual disability has a comprehensive support network, it is likely they will need support from Tusla social work services and other agencies, including adult services. A study of children living with learning-disabled parents who had been referred to the local authority’s Children’s Social Work Services highlighted the need for collaborative working between children and adult services (Cleaver and Nicholson 2007).
- According to Coulter (2015: 42), “a substantial body of work demonstrates that parents with an intellectual disability can adequately care for their children given appropriate support and identifies the critical dimensions of effective support and training. The removal of children from intellectually-disabled parents has been the subject of an adverse ruling from the European Court of Human Rights, which found that no adequate supports were given to the parents and their children (Kuznter v Germany, [2002] 46544/99).”



Practice Note

Assessing parenting capacity where parental intellectual disability is a concern

In assessing the parenting capacity of intellectually disabled (also called learning-disabled) parents, Horwath (2007) and Stevenson (2007) identify the following key issues:

- Parent’s cognitive functioning
- Comorbidity, for example, diagnosis of mental illness and/or substance misuse

- Poor self-esteem
- Lack of positive role models
- Lack of support
- Adverse social conditions
- Parent's ability to anticipate risk to the child
- Managing diverse and complex situations
- Parent's thought processes may be rigid, thus making adaption to change (e.g. the child's needs or behaviour) difficult.

In circumstances where a parent/carer has a learning disability, it is likely that there are a number of professionals involved from different services. It is important that these professionals work together within enquiries and assessments to identify any links between the parent's learning disability, their parenting, and the impact on the child.

Any assessments should include an understanding of the needs of the family and individual children, and an identification of the services required to meet these needs.

It must be recognised that a learning disability is a lifelong condition. Assessments must therefore consider the implications for the child as they develop throughout childhood, as children may exceed their parent's intellectual and social functioning at a relatively young age.

A study by Buckley *et al.* (2006) outlines the following areas when considering the impact of having a disability on the parent/carer's parenting:

- Size of family
- Parent/carer's general physical health and mobility
- Parent/carer's cognitive ability, language and/or communication skills
- Parent/carer's relationships
- Extent of parent/carer's knowledge about healthcare, child development, safety, responding to emergencies, and discipline

- Expectation and responsibilities on child to play a caring role
- Financial situation
- Support systems available to and used by the parent/carer and their family
- Parent/carer's own experience of being parented and of receiving services as a child/young person.

Specific risks to children of parents with learning disability

- Poor pre-birth care because of late recognition of pregnancy and poor compliance with antenatal care.
- Impairment of their health and development through impaired parenting capacity.
- The child assuming a caring responsibility for the parent. The child being socially isolated and/or bullied.
- Men targeting a mother with learning disabilities to gain access to the child for the purpose of sexually abusing them.

Keep the focus on the child

It is important to have a very good understanding of the type and severity of the parent/carer's intellectual disability and how this impacts on the child on a daily basis.

- Does the child take on any roles and responsibilities within the home or in caring for a parent/carer that are inappropriate?
- Has the child been enabled to express their own views on what they want for themselves, taking into account their age, ability and level of maturity?
- How is the child coping with the parent's disability and what is their level of resilience?
- Is the child displaying emotional, psychological or behavioural symptoms that cause concern and, if so, what action has been taken to address this?

4 Domestic Abuse

Description

Domestic abuse occurs across society regardless of age, gender, race, sexuality, wealth and geography. Domestic abuse is generally underreported, but the 2005 study *Domestic Abuse of Women and Men in Ireland: Report on the National Study of Domestic Abuse* shows that 1 in 7 women and 1 in 17 men surveyed experienced severely abusive behaviour from an intimate partner at some time in their lives (National Crime Council and ESRI, 2005).

The HSE (2010b) *Policy on Domestic, Sexual and Gender Based Violence* (available on the Tusla hub), which has been adopted by Tusla, defines domestic abuse as:

“The use of physical or emotional force or the threat of physical force, including sexual violence in close adult relationships. It can also involve emotional abuse; the destruction of property, isolation from friends, family and other potential sources of support; threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone.”



Messages from Research

Even though men are also victims of domestic abuse, the majority of victims are women. A major study of police reports and crime surveys in the UK, United States of America (USA) and Canada found that between 90% and 97% of perpetrators of violence in intimate relationships are men. The *Women’s Aid Impact Report 2016* (Woman’s Aid 2017) recorded:

- 3,823 specific incidents of child abuse disclosed during contacts with direct services in 2016. These are incidents where the perpetrator was directly abusing the children of the relationship, as well as the mother.
- The kinds of abusive tactics used directly against children living in domestic abuse situations disclosed during contacts with direct services in 2016 include: the abuser smacking and hitting children (including with household items); the abuser

physically and sexually abusing children; the abuser constantly shouting in children's faces; and children witnessing verbal, physical, and sexual abuse against their mother.

- There were 15,952 calls responded to by the Women's Aid National Freephone Helpline. Some 550 callers identified themselves as migrant women, Traveller women and/or women with disabilities.
- 96% of callers to the 24-hour National Freephone Helpline were women, whereas 4% of callers were men.
- Women who experience domestic abuse have, on average, experienced it 35 times before they ask for help, and then make between 5 and 12 different contacts in an effort to end the violence.

Other research findings show:

- Prolonged and/or regular exposure to domestic abuse can have a serious impact on a child's development and emotional wellbeing, despite the efforts of the victim parent to protect the child (Cleaver *et al.* 1999).
- The most dangerous time for a victim of violence is when she is on the verge of leaving and for six months afterwards. Seventy-six per cent of homicides occur after separation.
- Women in minority communities may be more vulnerable due to the additional barrier of reporting and receiving help; for example, uncertain immigration status; no recourse to public funds; language/literacy barriers; housing issues; community/faith honour; cultural issues (e.g. female genital mutilation and forced marriage).
- Women experiencing violence may also respond to the trauma of violence in ways that damage their own health. These responses can include substance use, depression, anxiety and social withdrawal, and all can affect women's physical and mental wellbeing. This may impact on their ability to care safely for any children they may have.
- The majority of high risk victims have children. Some international studies into domestic abuse have found that one in four young people have witnessed violence against their mother or stepmother.
- During the vast majority of incidents of domestic abuse, children are in the same room or the next room.

- The link between child physical abuse cases and domestic abuse is high, with estimates ranging between 30% to 66% depending on the country in question.
- Studies show that adult partners who are violent toward each other are also at increased risk of abusing their children.
- Children who live with domestic abuse are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life.
- It is important to always consider the implications of any domestic abuse for unborn children since pregnancy and after the birth of a new baby are some of the highest risk periods for women.
- Pregnancy is a time of increased risk of domestic abuse since 30% of domestic abuse begins or escalates during pregnancy.

Margolin and Gordis (2000) in their study *The Effects of Family and Community Violence on Children* state: “Violence affects children’s views of the world and of themselves, their ideas about the meaning and purpose of life, their happiness and their moral development. This disrupts children’s progression through age-appropriate developmental tasks.”



Practice Note

The HSE policy (HSE 2010b), adopted by Tusla, makes reference to the three Rs to assist professionals:

- **Recognise:** Know the signs, indications and sequence of abuse.
- **Respond:** Know how to deal with the issue of abuse.
- **Refer:** Make a good, appropriate referral.

Points for professionals to consider:

- Are you familiar with the *HSE Policy on Domestic, Sexual and Gender Based Violence* (HSE 2010b), adopted by Tusla?
- Are you familiar with your local area’s policy and procedures on domestic abuse?
- Do you know the emergency contact information for domestic abuse victims?

- Do you know how to refer a domestic abuse victim for help?
- Do you know how to complete a safety plan with a domestic abuse victim?
- Professionals can be overoptimistic in their assessment of the situation, resulting in a minimising of the abuse/risks.
- A child who asks for help may be at increased risk because they may be ‘punished’ for calling in professional help.
- It is important never to ask a possible victim of domestic abuse any question about any possible violence in the home while other family members are present or where he or she can be overheard.
- **where English is not the first language consideration must be given to accessing an appropriate interpreter¹.** If accessing interpretive services, be aware that some minority and ethnic service users may not want an interpreter of the same culture present. There can be a fear that their story will be shared with the community. The question of whether an interpreter is needed should be addressed sensitively with the possible victim of domestic abuse.
- If an interpreter is booked, consideration should be given to the male-female dynamic in certain cultures; some female victims would find it very difficult to talk openly about domestic abuse in front of a male interpreter and vice versa. Some domestic violence support services are now using phone interpreting.
- The question of whether an interpreter is needed should be addressed sensitively with the child/adult.

Assessing domestic abuse as a risk factor: issues to consider

Always consider the child’s immediate safety first.

Communicating with the child:

- Keep the child in focus and do not look at domestic abuse as an ‘adult problem’ only.
- Be prepared if the child cannot express him or herself and/or talk about the violence.
- Be aware that a child who asks for help may be at increased risk because they may be ‘punished’ for calling in professional help.

(continued)

¹ See *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services* (HSE 2009) guidelines on the use of interpreters, (Policy adopted by Tusla and available on the Tusla hub and www.hse.ie)

- If possible, establish the child's understanding of the domestic abuse taking place.
- Be aware that the child may be experiencing feelings of divided loyalties between the perpetrator and the non-abusing parent/carer.
- Be aware of the possibility that the child may be being, or has been, physically and/or sexually abused.
- Consider that the child may have taken on inappropriate roles and responsibilities within the family because of the domestic abuse. For example, does the child try to protect the non-abusing parent/carer or has the child been made to watch violent acts against him/her? Roles that children may assume include caretaker, victim's confidant, abuser's confidant, abuser's assistant, perfect child, referee, and scapegoat (Cunningham and Baker 2004).
- When communicating with the child, be clear about your role. Obtain a detailed history of the child's experience of domestic abuse.
 - » When was the most recent incidence of violence?
 - » What are the nature, location, severity, frequency and duration of incidents that the child is exposed to?
 - » What is the child's involvement and how does he or she respond during these incidents, for example, witnessing, physically involved, trying to intervene?
 - » Is the child forced to participate in the abuse?
 - » Does the child demonstrate inappropriate behavioural responses as a result of witnessing domestic abuse?
 - » Does the child display emotional symptoms such as hypervigilance, attachment issues, 'clinginess', insomnia, nightmares, poor appetite, depression, not knowing how to play or relax as a result of an unpredictable and frightening parent?
 - » Does the child display behavioural issues and/or concentration deficits in school or the early years setting?
- Consider the impact on the non-abusing parent/carer's ability to parent and protect the child.
- Consider what is the non-abusing parent's ability to parent and protect the child or children.

- Be aware that the effects of violence (e.g. pain, distress, anger, irritability, fear, reduced mobility, hospitalisation) may affect parenting capacity, as may mental illness or substance misuse problems that emerge as a consequence of domestic abuse.
- Consider interlinking risk factors that may be affecting parenting capacity, for example, adult mental health issues, substance misuse, neglect issues, adult intellectual disability, social isolation, and child disability.
- Be aware that domestic abuse incidents are not necessarily individual occurrences, but rather part of a process within the context of the child's safety and welfare.
- Check with the non-abusing parent regarding what explanations have been given to the child about the domestic abuse and the perpetrator's behaviour.

Other important issues to consider during the assessment

- Are there any protective factors? What are they?
- Is the mother pregnant or had a baby in the last 18 months?
- Has there been involvement from the Gardaí? How often?
- Are there any legal issues to consider?
- Has the perpetrator breached protective court orders for either mother or child?
- Does the perpetrator have a criminal record?
- Is the family experiencing financial stress?
- Are the mother and child isolated, with limited support?
- Does the family have any pets? Check during home visits, as animal abuse is often an indicator of domestic abuse.

Risks to children who live with domestic abuse

There are many risks to children who live with domestic abuse, including:

- Direct physical or sexual abuse of the child or children.
- The child being abused as part of the abuse against the non-abusing parent.
- Being used as pawns or spies by the abusive partner in an attempt to control the non-abusive parent.
- Being forced to participate in the abuse and degradation by the abusive partner.

- Emotional abuse to the child from witnessing the abuse.
- Physical injury to the child by being present when the violence occurs.
- Hearing abusive verbal exchanges between adults in the household, including humiliation and threatened violence.
- Observing bruises and injuries sustained by their mother.
- Observing the abusive partner being removed and taken into Garda custody.
- Witnessing their parent/carer being taken to hospital by ambulance.
- Attempting to intervene in a violent assault.
- Being unable or unwilling to invite friends to the house.
- Frequent disruptions to social life and schooling because of moving house to flee violence or living in a refuge.
- Hospitalisation of the non-abusing parent/carer.

Perpetrator risk assessment

The main characteristic of domestic abuse is that the behaviour is intentional and is calculated to exercise power and control within a relationship.

Examples of these behaviours:

- **Psychological/emotional abuse:** Intimidation and threats, social isolation, verbal abuse, humiliation, constant criticism, enforced trivial routines, marked overintrusiveness.
- **Physical violence:** Slapping, pushing, kicking, stabbing, damage to property, attempted murder or murder, physical restriction of freedom, stalking, forced marriage.
- **Sexual violence:** Any non-consensual sexual activity, including rape, sexual assault, coercive sexual activity or refusing safer sex.
- **Financial abuse:** Stealing, depriving or taking control of money, running up debts, withholding benefit books or bank cards.

Professionals need to have the confidence and skills to ask about violent and abusive behaviour, as well as being able to refer to appropriate services for either intervention or practical assistance.

Teenage dating and relationship violence

The study by Burton *et al.* (1998), *Young People's Attitudes towards Violence, Sex and Relationships*, found that one in two boys and one in three girls think that there are circumstances when it is alright to hit a woman or force her to have sex, and that 36% of boys think they might personally hit a woman or force her to have sex.

The age where domestic abuse occurs in the highest numbers is in the 16–25-year-old age group, with pregnancy and teenage parenting adding additional vulnerability and risk (about 70% of teenage parents experience domestic abuse). Professionals need to be aware of the risk factors associated with teenage pregnancy and ensure that protective factors are in place to reduce the risks.

Child-to-adult violence

Child-to-adult violence is defined as “any harmful act by a teenage child intended to gain power and control over a parent. The abuse can be physical, psychological, or financial” (Cottrell 2003). In terms of prevalence, Lauster and Coogan (2015) state:

Figures vary but some argue 18% of two parent and 29% of one parent families (Walsh & Krienert 2009). [According to] Pagani et al. (2009), among 15/16 year olds, 12.3% of males and 9.5% of females were physically aggressive towards their fathers in the previous six months.

While child-to-adult violence is not necessarily a child protection concern, it can lead to a breakdown of family or alternative care placements. Professionals who encounter child-to-adult violence should discuss the matter with their managers and seek appropriate support. Additional resources are available on the Responding to Child to Parent Violence website: <http://www.rcpv.eu/resources>.

5 Adolescent Parents

Description

The Criminal Law (Sexual Offences) Act (2006) establishes the age of consent as 17 years of age for males and females. Underage sex is, by definition, non-consensual – the age of consent is a line below which the law does not recognise the minor’s capacity to consent.

When young people engage in underage sexual activity that leads to pregnancy, there is a need to ensure that the young person’s welfare is promoted and protected, and to ensure that the pregnancy did not result from sexual abuse. There is also a need to consider the welfare or protection needs of the unborn child.

Tusla has a specific responsibility in this regard. In partnership with An Garda Síochána there is a requirement to intervene, as appropriate, to ensure both the legal and welfare components associated with underage pregnancy are followed up.

The Children First Act 2015 details conditions that must be met to exempt the reporting of sexual activity between children. See section 14(3) of the Children First Act 2015 for more details.



Messages from Research

- Children in or leaving foster care or residential care are more likely to become pregnant as teenagers (Dworsky and Courtney 2010; Chase *et al.* 2006).
- Engaging in early sexual activity can have serious negative outcomes, including unplanned pregnancy and parenthood (Dworsky and Courtney 2010), exposure to HIV and other sexually transmitted infections (Morrison-Beedy *et al.* 2011), and an increased risk of poor medical outcomes for mothers and babies (Gaudie *et al.* 2010).
- Teenage mothers may experience poorer life chances (Layte *et al.* 2006), become dependent on welfare, and experience social exclusion and inequality (Gaudie *et al.* 2010).
- Research indicates that many factors influence and shape young people’s decisions on sex, relationships and parenthood. Such

factors may include place of residence, level and experience of education, ambitions for the future, family structure, and parental and peer attitudes and values to sex (Wight and Fullerton 2013; Gaudie *et al.* 2010; Chase *et al.* 2006).

- In one study, the absence of a biological parent during adolescence was associated with earlier sexual activity and/or increased numbers of sexual partners (Wight and Fullerton 2013).



Practice Note

Pregnancy arising from abusive activity

Where a young person has become pregnant as a result of sexual abuse or assault, the matter should immediately be referred to An Garda Síochána.

In cases where abuse is not suspected or alleged, social work staff may consult with An Garda Síochána to examine all aspects of the cases. Both agencies should acknowledge the sensitivity required in order to facilitate vulnerable young girls to avail of medical or therapeutic services, while at the same time satisfying relevant legal requirements.

Pregnancy as a welfare concern

Welfare concerns exist in all cases where the young person who is pregnant is under 15 years of age. In certain circumstances, there may be no need for further social work intervention following assessment. For example, where the young person (mother) is:

- Accepting of the situation
- Giving no indication of sexually abusive activity
- Is being fully supported and where there are no specific indicators of concern.

Such a decision should only be arrived at following assessment and should be recorded on the young person's case record. The assessing professionals should ensure that the young person is directed to appropriate support services.

6 Animal Abuse and Links to Child Abuse

Description

Animal abuse is defined as the intentional harm of animals, including wilful neglect; inflicting injury, pain or distress; or malicious killing of animals.

There is increasing research and clinical evidence which suggests that there are sometimes inter-relationships, commonly referred to as ‘links’, between the abuse of children, domestic abuse and abuse of animals. A greater awareness of these links can help professionals to better understand the risks and protect children and adults living in violent relationships.

The evidence linking animal abuse and risks to children and adults living in violent relationships has primarily been taken from studies in the USA but, recently, research in this area has also been produced in the UK.

In considering the links between child abuse and animal abuse, there are four facets that should be considered:

1. Animal abuse by adults to cause emotional harm to children.
2. Animal abuse by adults as an indicator of risk to children.
3. Animal abuse by children as an indicator of abuse.
4. Animal abuse by children as a possible indicator of future risk to other children.



Messages from Research

- **Animal abuse by adults to cause emotional harm to children:** Ascione (1993), Duffield *et al.* (1998) and Ascione and Arkow (1999) found that acts of animal abuse may in some circumstances be used by domestic abuse perpetrators to threaten, coerce, control, silence and intimidate women and children to remain in, or be silent about, their abusive situation.
- **Animal abuse by adults as an indicator of risk to children:** Becker and French (2004) observed:

Professionals ... can no longer afford to ignore the potential links between child abuse and animal cruelty. The two forms of abuse should not be seen as mutually exclusive; it needs to be recognised that they can coexist, or there may be associations between the two, and that there are consequently implications for policy and practice. (2004: 408)

- While not all perpetrators of cruelty to animals will harm children, or be violent towards adults, professionals should consider the possibility of risk to children where they encounter cruelty to animals by an adult.
- **Animal abuse by children as an indicator of abuse:** Research indicates that if a child is cruel to animals, this may be an indicator that serious neglect and abuse have been inflicted on the child (Tapia 1971; Friedrich *et al.* 1986).
- **Animal abuse by children as a possible indicator of future risk to other children:** Researchers have found that children who exhibit extreme aggressive or sexualised behaviour towards animals in some cases go on to abuse other children, unless the behaviour is recognised and treated (Duffield *et al.* 1998). Furthermore, sustained childhood cruelty to animals has been linked to an increased likelihood of violent offending behaviour against humans in adulthood (Merz-Perez *et al.* 2001).



Practice Note

It is recommended that professionals working with children should:

1. Be observant about the care and treatment of family pets while carrying out assessments.
2. Ensure that assessments consider the risk of harm and the needs of children, and animals, within the family.
3. Ensure that safety planning with victims of domestic abuse considers the safety of children. The safety of animals within the family should also be considered (London Safeguarding Children Board 2010).

Animal abuse can be a part of a constellation of family violence that can include child abuse. However, this does not imply that children who are cruel to animals necessarily go on to be violent adults or that adults who harm animals are necessarily also violent to their partners and/or children. Investigation and/or assessment are key to determining whether there are any links between these factors and the possible risks to the safety and welfare of children, adults, and animals (NSPCC 2001).²

It is important to explore issues of animal cruelty, in addition to other significant psychosocial risk factors, where a child displays aggressive or cruel behaviour towards animals. Professionals should aim to develop strategies that will focus on the young person's overall developmental needs, not just this element of their behaviour.

² See also information leaflet at <http://www.thelinksgroup.org.uk/wccms-resources/3/141bb3dc-e44c-11e4-9dd2-0050568626ea.pdf>

7 Fabricated or Induced Illness

Description

Fabricated or induced illness occurs when parents, usually the mother (according to current research and case experience), fabricate stories of illness about their child or cause physical signs of illness. Examples of fabricated or induced illness include where the parent secretly administers dangerous drugs or other poisonous substances to the child or smothers a child to make them appear unwell.

Symptoms that may raise concerns about the possibility of fabricated or induced illness include:

1. Symptoms that cannot be explained by any medical tests; symptoms never observed by anyone other than the parent/carer; symptoms reported to occur only at home or when a parent/carer visits a child in hospital.
 2. High level of demand for investigation of symptoms without any documented physical signs.
 3. Unexplained problems with medical treatment, such as drips coming out or lines being interfered with; presence of unprescribed medication or poisons in the blood or urine.
- Fabricated or induced illness is most commonly identified in younger children.
 - Fabricated or induced illness can be fatal. However, while many children do not die as a result of having their illness fabricated or induced, they do suffer significant long-term physical or psychological health consequences.
 - Fabrication of illness may not necessarily result in a child experiencing physical harm; there may be significant concerns about the child suffering emotional harm.
 - Child victims of fabricated or induced illness may suffer emotional harm as a result of an abnormal relationship with their parent/carer and/or disturbed family relationships.



Messages from Research

- According to Davis (2009: 498), fabricated illness or induced illness is when a child's illness has been “deliberately and consciously” fabricated by a parent or carer, causing suffering to the child or where they have been placed at risk of significant harm. Fabricated illness or induced illness is an uncommon form of child abuse. Similar to other types of abuse and neglect, it requires interprofessional and multiagency collaboration in diagnosis, management and treatment (Bass and Jones 2009). In most instances, it is perpetrated by the mother and detection usually includes a detailed assessment of information from various sources, including social work, child care services, police and medical professionals (Bass and Jones 2009).
- Research in the UK indicates that women presenting a child with fabricated or induced illness in clinical settings commonly have experienced social disadvantage, bereavement, and physical and sexual abuse in childhood. Many also use health services erratically. Behaviours such as regularly presenting a child at different accident and emergency wards or changing general practitioner are common (Bass and Jones 2009). Such behaviours result in a lack of continuity of care for the child and may mask abusive behaviour from medical professionals (Bass and Jones 2009).
- The fabricator's behaviour in most cases will have alerted health, social and child care services. Information gathered from various settings can be utilised in devising appropriate responses (Davis 2009).



Practice Note

In working with cases of suspected fabricated or induced illness, the focus must be on the child's long- and short-term physical and emotional health and welfare; consideration must be given to the likelihood of the child suffering significant harm. Suspected fabricated or induced illness requires full multidisciplinary and multiagency assessment. Bass and Jones (2009: 162) suggest that "effective management includes containment of the fabricator's long-term tendency to somatise or deceive, harnessing the strength of non-abusive carer or family members, and management of any parenting breakdown that has accompanied fabricated illness or induced illness behaviour."

8 Children Who Are Left Home Alone

Description

It is not specified in law at what age a child can lawfully be left unattended, however, parents can be prosecuted for wilful neglect if they leave a child unsupervised in a manner that places the child (or other children) at risk of harm. When considering the level of risk in relation to a child left alone, the following factors should be taken into account:

- The age of the child
- The needs and maturity of the child
- The length of time involved
- The frequency of such incidents
- The safety of the location
- Any other relevant factors, such as steps taken to reduce risk to the child

Following consideration of the above factors the key question is, was the child left at risk of significant harm?



Messages from Research

- Researchers have explored a variety of circumstances where children are left unsupervised, including: parental employment; parental incapacity, including physical or mental illness and/or substance misuse; and a child's increasing autonomy and maturity. Such research has generated diverse findings (Ruiz-Casares and Rousseau 2010). For example, Aizer (2004) found schoolgoing children left 'home alone' may be at a higher risk of becoming involved in antisocial behaviour, crime and other dangerous activities. Greene *et al.*'s research (2011) into children left to care for themselves suggests such children have an increased risk of poor performance at school, truancy, depression, and engaging in risky behaviour, including substance abuse. Moreover, lack of parental supervision and monitoring is linked to increased risk of early sexual activity and

underage pregnancy, according to Boislard and Poulin (2011). Research also suggests unsupervised children experience loneliness, fear, boredom and anxiety about schoolwork and the responsibility of caring for siblings (Ruiz-Casares and Rousseau 2010; Greene *et al.* 2011).

- Alternatively, as Zielewski *et al.* (2006) argue, self-care may help children develop independence and responsibility, when introduced at an appropriate time in a child’s development. Ruiz-Casares and Rousseau (2010) highlight positive effects of self-care for some young people and their families. Self-care may develop confidence and management and cognitive skills of young people, particularly when they are charged with household duties and/or the care of younger siblings. In addition, it may allow parents to avail of employment opportunities that increase income for the family (Ruiz-Casares and Rousseau 2010).
- However, Greene *et al.* (2011) note that ‘self-care’ can be considered child neglect when the children involved are too young or immature to care for themselves or others, or when it occurs over long periods of time. Ruiz-Casares and Rousseau (2010: 2572) believe that child protection agencies should consider “the risks and protective factors” in every family situation and surrounding context when investigating parental supervisory neglect. This includes taking into consideration the child’s perspective and any cultural aspects that may influence childcare.
- Research indicates that children of lone parents and employed parents are more likely to be home alone than children of two-parent families where a mother is not employed outside of the home (Greene *et al.* 2011; Casper and Smith 2004). However, being financially better off is not necessarily a predictor of parental care (Casper and Smith 2004), suggesting that parents decide childcare options taking account of a range of variables, including age and maturity of child(ren), local safety (e.g. crime rates), availability of extended family networks, and cost, quality and convenience of childcare (Greene *et al.* 2011; Casper and Smith 2004).



Practice Note

In responding to a situation where a child is found unsupervised, you must check:

- Is the child known to Tusla?
- Has such an event occurred before – is there a history or pattern?
- Has every effort been made to find the parents/carers?

Regardless of the above, an immediate response is required to ensure the protection and welfare of the children and An Garda Síochána may need to be involved.

Where it is not possible to locate or contact the parents, a Garda may choose to invoke section 12 of the Child Care Act 1991 to remove the child to a place of safety. If a Garda invokes section 12, information should be left for the parents at the child's normal place of residence outlining the action taken, the reasons why, and advising them of what to do.

If immediate protection is assessed as not necessary, professionals should:

- Establish the child's understanding of the whereabouts of the parent(s) or responsible person(s) and of the arrangements made.
- If the parent can be located, reunite parent and child and advise the parent of the dangers of leaving children alone.

9 Male Partners and Their History/ Association with the Family

Description

Professionals face the challenge posed by men involved in the lives of abused children. These men may be the natural or adopting father of the child; the foster father of the child; or the cohabitee or casual boyfriend of the mother of the child. Whoever the men might be, and whichever race or culture they are from, in the past they have often been ignored or avoided in child protection work.

The accelerating fragmentation of family life and dramatic increase in substitute father figures (e.g. boyfriends, male partners, stepfathers), many of whom have had little involvement or responsibility within the single-parent families they join, makes the involvement of unknown male partners critical.



Messages from Research

- Research by Thorpe (1994) revealed a high number of child abuse allegations made about single-parent mothers. In the authority for which the author worked, it was found that 274 child abuse referrals were made to six inner city teams in a single year; 77% (211) involved single-parent mothers. 47% (128) of these mothers, however, had associations with male partners who had been living with them for varying amounts of time.
- The non-involvement of men may occur during any one of the six principal phases of child protection work, namely: referral, investigation, intervention, case conference, care proceedings, or fostering. One might assume that it occurs more often during the investigation or intervention phase, but its roots may well be established long before, in what the professional thinks and does during the initial referral phase.
- Types of avoidance of men during the referral phase of children include when those taking the referral concentrate all their questioning on, or about, the mother; few if any questions are asked about the male partner, even though it may be obvious from the outset that the male partner is a significant factor in the alleged abuse.

- There are as many differing consequences of the avoidance of men as there are types of avoidance. There are three main categories: consequences for the mother; issues in the management of the case; and consequences for the child. By leaving men out of assessments and interventions, the assessment of need and risk is inadequate.



Practice Note

Assessing male partners

- Be clear as to who exactly lives in the household and their relationship and involvement with the mother and individual children.
- Insist on knowing the identity and carry out background checks accordingly.
- Involve and interview the new male partner as part of the assessment.
- Ensure that information on ‘new men’ accessing families is shared between agencies and assessments undertaken when necessary.
- Include appropriate checks with other agencies in the background information, and ensure the subject of the checks is interviewed by the allocated professional.
- Obtain information on other adults having substantial contact with the children, including occasional carers such as babysitters.

Case example: Baby Peter

There is demonstrable danger in the man that preys on vulnerable women who are unable to protect their children from him. One of the most dangerous of these situations is where an antisocial man who is unrelated to the children joins the household. The woman may not be able to stand up for her children and protect them because he is too intimidating. She may minimise his importance and involvement to others. It is essential that once

there is awareness of the existence of any unknown man in a child protection investigation, professionals in authority insist on knowing his identity and check out his background thoroughly. In the case review of Baby Peter, Haringey Local Safeguarding Children Board found there was a clear failure to establish the identity of Mr H, to interview him and conduct checks on his background (Jones 2010).

2



Child Factors

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10 Age of the Child

Description

In Ireland, a child is defined as anyone under the age of 18 years who is not and has not been married (Child Care Act 1991). There are a number of complicating factors associated with different age groups of children. It is important for professionals to take into account any additional complicating factors that may be present due to the age of a particular child they are working with.



Messages from Research

- Younger children are more likely to be neglected, while the risk for sexual abuse increases with age (Mraovick and Wilson 1999).
- The highest rates of fatal child abuse are found among children aged 0–4 years. The most common cause of death is head injury, followed by abdominal injuries and intentional suffocation. Global estimates of child homicide suggest that infants and very young children are at greatest risk, with rates for the 0–4-year-old age group more than double those of 5–14-year-olds (Runyan *et al.* 2002).



Practice Note

Risk factors and early years: the vulnerabilities of infants

- The majority of child deaths from abuse and neglect are of children under the age of four, when children are most vulnerable to physical attacks and to dangers created by lack of supervision and severe neglect, and are isolated from professionals, such as teachers, who might intervene to protect them.
- This age group is more at risk of being maltreated when they are growing up in families affected by parental substance misuse, domestic abuse and mental ill-health.

- Experiences of abuse and neglect can cause distress, emotional and physical pain, and overwhelming fear or terror in response to sudden separations, experiencing neglect, being assaulted, or witnessing violence.
- Exposure to trauma affects every dimension of an infant's psychological functioning (e.g. emotional regulation, behaviour, response to stress and interaction with others). Very young infants may be overwhelmed with intense negative emotions, manifesting in incessant crying, inability to be soothed, feeding problems, sleep disturbances, hyperarousal and hypervigilance, and intense distress during transitions. Toddlers may experience intense separation anxiety, wariness of strangers, social avoidance and withdrawal, and constricted affect and play. They are likely to have reduced tolerance of frustration and problems with emotional regulation, evident in intractable tantrums, non-compliance and negativism, aggression and controlling behaviour.

Risk factors and adolescents

Risks factors specific to adolescents and young people include:

- Adolescent mental health problems
- Self-harm and/or suicide
- Involvement with, or fear of, gang-related violence
- Sexual exploitation
- Teenage domestic abuse

The neglect of older children and adolescents is difficult to recognise and too often goes unnoticed.

11 Children with Disabilities

Description

The World Health Organization defines disability as “an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors)” (WHO 2001: 213).

In Ireland, the HSE provides and funds a range of services for people with intellectual, physical and sensory disabilities or autism and their carers. These services include basic health services as well as assessment, rehabilitation, income maintenance, community care and residential care respite, home care and day care.

Some services are provided directly by the HSE. Many of the community, residential and rehabilitative training services are provided by voluntary organisations with grant aid from the HSE.

Disabled children are children, first and foremost. They have the same rights to protection as any other child. People caring for and working with disabled children need to be alert to the signs and symptoms of abuse.

In working with or assessing a child protection concern for a child with a disability, it is essential to understand the nature of the child’s disability and to consider other services currently involved with the child who may be of assistance in understanding the nature of the child’s disability.



Messages from Research

- Disabled children are at greater risk of abuse and neglect than non-disabled children. Disabled children in a large-scale US study by Sullivan and Knutson (2000) were found to be 3.4 times more likely overall to be abused or neglected than non-disabled children. They were 3.8 times more likely to be neglected; 3.8 times more likely to be physically abused; 3.1 times more likely to be sexually abused; and 3.9 times more likely to be emotionally abused.

- A number of studies have found that different types of disabilities have differing degrees of risk for exposure to violence. For example, Sullivan (2003) reported that those with behaviour disorders face greater risk of physical abuse, whereas those with speech/language disorders are at risk of neglect.
- There are no differences in which form of child maltreatment occurs the most often between disabled and non-disabled children. For both groups, neglect is the most prevalent, followed by physical abuse, sexual abuse and emotional abuse (Sullivan and Knutson 2000).
- Disabled children are particularly vulnerable and at greater risk of all forms of abuse, including abuse while being cared for in institutions. The presence of multiple disabilities could increase the risk of both abuse and neglect.



Practice Note

Increased vulnerability of children who are disabled

In general, the causes of abuse and neglect of children with disabilities are the same as those for all children. However, several factors may increase the risk of abuse for children with disabilities:

- Many disabled children are at an increased likelihood of being socially isolated, with fewer outside contacts than non-disabled children.
- They receive intimate personal care often from a number of carers, which may increase the risk of exposure to abusive behaviour. It may be difficult for a child to distinguish between appropriate and non-appropriate touching and their right of choice about who carries out such care.
- They have an impaired capacity to recognise, resist or avoid abuse.
- They are especially vulnerable to bullying and intimidation.
- They may have speech, language and communication needs, which may make it difficult for them to tell others what is happening. They often do not have access to someone they can trust to disclose that they have been abused.

- They may be inhibited from complaining through a fear of losing services.
- Disabled children in care are not only vulnerable to the same factors that exist for all children living away from home, but they are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day-to-day physical care needs.
- In addition to the risk factors that exist for all children, disabled children are at risk of particular forms of abuse, for example, overmedication, poor feeding and toileting arrangements, lack of stimulation and issues around control of challenging behaviour, lack of information, lack of emotional support, etc.
- Disabled children are often seen as having no sexual identity and/or their sexual feelings are often not acknowledged. They may lack sex education and/or understanding, and this may increase their vulnerability. Sexualised and/or disturbed behaviour is frequently accepted as part of a child's disability without further thought or questioning.
- Disabled children are accustomed to being directed. They are rarely offered choices or provided with enough information to make a choice. This may mean they are less able to recognise abusive situations.
- There is a lack of recognition by many professionals and carers that disabled children are abused. Signs or symptoms of abuse may be 'explained away' as part of their normal behaviour. For example, bruising could be said to be caused by a child's tendency to fall, or sexualised behaviour may be put down to impairment. It is important to therefore check out all these explanations and not accept them at face value. It will be helpful to explore whether the child's behaviour is consistent with all carers.

Assessing child protection concerns in relation to a child with a disability

- Disabled children will usually display the same signs and symptoms of abuse as other children. However, these may be incorrectly attributed to the child's disability. All people who work with disabled children will need to be alert to the possibility of abuse and seek advice from appropriately trained professionals (e.g. paediatricians, social workers, nurses, specialist teachers) if

they are concerned that a child may be, or may have been, abused. When undertaking an assessment, professionals should take into account the nature of the child's disability and how this may affect the interpretation of indicators of possible abuse or neglect.

- Children with disabilities will often be involved with services and professionals in the statutory and voluntary sector. When assessing a concern, in particular where such a concern has been referred by disability services, it is important for there to be communication with professionals in these services who have knowledge and experience of the child and his/her specific needs and presentation. Such information is crucial when assessing any indicators of abuse in respect of a child with complex needs, who may have medical, communication and/or behavioural needs.
- If, after initial assessment, it is deemed appropriate for a case to be closed, the assessing professional should contact the professional who has made the referral to evaluate the information gathered during the assessment and to discuss its outcome before the case is closed.

Communicating with children who are disabled – keep the following in mind:

- When planning for children and young people with disabilities, anticipate various eventualities that should be considered at the planning stage of any assessment and/or interview.
- Always take account of the level of cognitive, social and emotional development and indicators of vulnerability of the child.
- Ensure, wherever possible, that the individual views, wishes and feelings of the child are taken into account.
- Be aware that some children may develop their own means of communication, the interpretation of which requires specialist knowledge of the child, and could therefore limit those from whom the child can seek assistance.
- Do not make assumptions about the inability of a child with disabilities to give credible evidence or to withstand the rigours of the court process.
- When planning an interview with a child with disabilities, take account of how a child communicates. It will often be appropriate to involve other professionals with skills, in particular modes of communication. The onus is on the interviewer to understand and use the child's own method or system of communication.

12 Mental Health Issues (Including Self-harm and Suicide)

Description

There is a wide range of mental health difficulties which children and young people may experience. These include hyperkinetic disorders such as ADHD; depressive disorders; anxiety disorders; eating disorders; psychotic disorders; and deliberate self-harm. The mental health services for children and young people are provided by the HSE through Primary Care and Mental Health Services. Tusla professionals regularly have involvement with these services, as mental health concerns in children and young people may involve a child welfare or protection issue that requires assessment and intervention.

Definitions and meanings

- **Suicide:** Self-harm, resulting in death.
- **Attempted suicide:** Self-harm with intent to take life, resulting in non-fatal injury.
- **Deliberate self-harm:** In its broadest sense, self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way that are damaging, such as cutting, burning, scalding, banging, hair pulling, and self-poisoning.

While suicide has a clear intent, the reasons for deliberate self-harm are varied. Rather than wanting to end life, the act may be carried out to feel more alive or to stop something more drastic from occurring. Some young people deliberately self-harm to release emotions and thereby experience a sense of relief, or to express their self-hatred through emotional punishment. Others self-harm to distract themselves from what seems like intolerable reality.

Services

Primary Care

GPs should be the first point of contact for parents or carers who are concerned about a child or young person's mental health; an appointment should be arranged without delay. The GP will conduct an assessment to determine if a referral to Child and Adolescent Mental Health Services is appropriate. In emergency situations, a child or young person should be seen by an out-of-hours GP or the local emergency department (ED).

Child and Adolescent Mental Health Services (CAMHS)

These are multidisciplinary teams that provide specialist mental health services to children and young people. Each locally based team is managed by a consultant child and adolescent psychiatrist. It is recommended that teams include junior medical staff, two psychologists, two social workers, two nurses, a speech and language therapist, an occupational therapist, and a social care worker.

Their function, as described in the CAMHS Annual Report 2011–2012 (HSE 2012) is:

- Assessment of emergency, urgent and routine referrals from primary care services
- Treatment of the more severe and complex mental health problems
- Outreach to identify severe or complex mental health needs, especially where families are reluctant to engage with mental health services
- Assessment of young people who require referral to inpatient or day services
- Provision of training and consultation to other professionals and services
- Participation in research, service evaluation and development

CAMHS has recently published a detailed standard operating procedure (SOP) (HSE 2015) which provides significant information on the operation of this service. The SOP applies to all staff engaged in delivering CAMHS in, or on behalf of, the HSE in both community and inpatient settings. The SOP is available to partner agencies, stakeholders, service users and their families.³

Children and the Mental Health Act 2001

Where examination, admission and/or treatment is being sought *under the Mental Health Act 2001*, parental consent (voluntary) or a court order (involuntary) is required. However, where examination, admission or treatment are being sought *outside the scope of the Mental Health Act 2001* (e.g. through CAMHS), legal advice should be sought.

³ The SOP is available at: http://www.hse.ie/eng/services/list/4/Mental_Health_Services/CAMHS/publications/

If a child is the subject of an interim care order or is in voluntary care, parental consent for examination, admission or treatment is required. For children on a full care order who require assessment, treatment or admission under section 25 of the Mental Health Act, an application is required through the District Court. Currently, this must be done through the chief officer of the HSE Community Health Organisation (see below).

In circumstances where a parent is not providing consent for what is deemed to be essential medical treatment, a referral will likely be made to Tusla as suspected neglect. This will require an initial assessment in accordance with the social work business processes. For children in the care of Tusla, Tusla may make an application to the District Court under section 47 of the Child Care Act 1991. Legal advice should be sought at an early stage.

Inpatient Care

Some children or young people will require inpatient care for accurate assessment of severe disorders and to implement specific and audited treatment programmes. The goal of inpatient care is the earliest possible discharge back to their family and care of the CAMHS team.

There are four HSE child and adolescent inpatient units, one for each region (see Table 12.1). According to the HSE, the number of child and adolescent inpatient HSE beds in 2013 was 60. However, there are still occasions when adolescents are admitted to adult psychiatric units. Ten per cent of these children were involuntarily detained in 2013. Mental health services are required to notify the Mental Health Commission in the event of a child being admitted to an adult approved centre. The HSE has set up a CAMHS Improvement Steering Group to oversee an improvement project to review inter alia, inpatient services; admissions to adult inpatient units; functioning of the CAMHS teams; waiting times and interaction between CAMHS and other agencies both inside and outside the HSE.

Table 12.1: HSE child and adolescent inpatient units

Region	Unit
HSE West	Merlin Park Hospital Inpatient Unit, Galway
HSE Dublin North East	St Joseph's Hospital, Fairview, Dublin
HSE Dublin Mid Leinster	Interim Linn Dara Unit, Palmerstown, Dublin
HSE South	Éist Linn, Bessborough, Cork

There are two private/independent providers of inpatient care, both in Dublin: St Patrick's University Hospital and St John of God Services.

Under the Mental Health Act 2001, the admission of a child requires a different process to the admission of an adult. The majority of children requiring inpatient treatment will be admitted voluntarily with the consent of a consenting adult. Consent is sought from the parents of the child, or either of them, or a person acting in *loco parentis* (i.e. Tusla). Under the 2001 Act, separate consent is needed for examination by a consultant psychiatrist, for admission and for treatment.

The Non-Fatal Offences Against the Person Act 1997 deems the age of consent for medical, surgical and dental treatment to be 16 years of age. These provisions do not extend to examination, admission and treatment under the Mental Health Act 2001.

Inpatient: Involuntary Admission

A minority of children will be admitted involuntarily for treatment for a mental illness or a mental disorder (as defined in section 3 of the Mental Health Act 2001). In such instances, the procedures outlined in section 25 of the Mental Health Act 2001 will apply; the HSE published a document to provide guidance for an application for examination, admission or treatment under the Mental Health Act (HSE 2010a). For children who require involuntary admission, an application to the District Court is required. Consultant psychiatrists, or their nominated deputies, require consent to interview or examine a child. At all times, the principle of the best interests of the child is paramount. Best practice dictates that decision-making regarding examination, admission and treatment should

actively include the child.⁴ Therefore, the child’s views and opinions should be clearly documented in the clinical file and in any reports made for the courts. Only the HSE can make an application to the District Court. The authority to make an application for a section 25 order rests with the chief officer of the HSE Community Health Organisation.

If the HSE identifies a child who requires assessment, admission or treatment under the Mental Health Act 2001 and, following reasonable enquiries, the parent(s) or person acting in loco parentis cannot be located, then Tulsa must be notified and involved in any further decisions relating to the child.



Messages from Research

- Suicidal behaviour covers a broad spectrum of behaviour ranging from feelings of hopelessness to passive death wishes, to suicidal ideation and planning, self-injury and self-harm, and behaviour that leads to untimely death. When an individual has few protective factors (such as resilience, connectedness, effective problem-solving skills) to draw on, and if there is a perception that escape or rescue from their predicament is unlikely, the option of suicidal behaviour may be pursued, particularly where there is access to means of self-harm (Joint Committee on Health and Children 2006).
- The number of deaths by suicide in Ireland is below the profile for most European Union (EU) countries. However, the figures for men aged 15–19 years and 44–64 years are particularly high by international comparison (Mental Health Reform 2015).
- Deliberate self-harm is a term used when a person injures or harms themselves on purpose. Examples include overdosing; cutting oneself, attempted suicide by drowning or hanging. It is a particular problem for young people. According to the National Suicide Research Foundation (2012), in 2011, the highest prevalence for self-harm was among those aged 15–19 years in females and 20–24 years in males.

(continued)

⁴ **Voice of the child:** “With regard to children aged 16 and 17 years ... irrespective of whether a 16 or 17 year old is capable, as a matter of law or fact, of providing an effective consent to treatment, his or her views as to their treatment should be sought as a matter of course. It will then be a matter for the treating health professional to judge the weight (if any) to be accorded to such views in all the circumstances” (Mental Health Commission 2006: 22).

- Of the under 18-year-olds who presented to ED in 2011 who had engaged in deliberate self-harm or a suicide attempt, 64% involved overdose of medication, while 32% involved self-cutting. Alcohol was involved in 15% of cases. Presentations to ED were most likely to occur in the evening time, between 6pm and 1am (HSE 2012).
- Deliberate self-harming behaviour is not necessarily an attempt at suicide, but can be a warning sign of suicidal ideation.



Practice Note

- Where a child or young person displays suicidal ideation or self-harm, this constitutes a child welfare concern, which may require assessment and support from Tusla. It may become a child protection concern if the child's parent(s) do not respond appropriately to the child's needs and fail to support the child adequately.
- When such a concern regarding a child or young person is reported to Tusla, parents should be advised to immediately bring the child to their GP or local ED for medical assessment. Advice should be offered to parents regarding appropriate levels of supervision; management of the environment (e.g. placing medication/alcohol in locked cabinets; removing sharp objects or weapons from the home) and details of support phone lines, such as Parentline, TeenLine and the Samaritans, should be provided.
- If a parent fails to act on the advice given, or if there is reason to believe that a parent will not act on the advice (due to history or other information being available), immediate intervention may be required by a professional to ensure that the child or young person receives the medical assessment they require, for example, a home visit or contact with the GP.
- Any child or young person who self-harms or expresses thoughts about self-harm or suicide has to be taken seriously and appropriate help and intervention offered immediately. Once a young person has given any indication that they may be feeling suicidal, prompt and specific action must be taken; possible indicators include self-harming, personal verbal reports of suicidal ideation, disclosure to a third party such as

a teacher, friend, etc. Professionals **must** provide a same-day response to these young people in order to ensure their safety. The young person should be assisted in seeking urgent medical attention through the GP, out-of-hours GP services, ED and/or HSE Department of Psychiatry.

- The young person's parents or guardians should be informed immediately, unless parental child protection issues are present and may increase the risk to the young person. Written information should be made available to parents or carers with regard to local support services.
- Once a medical consultation has been arranged, professionals should make arrangements for the young person to attend. This may involve arranging for a parent, teacher or member of the extended family to support the young person and bring him/her to the appointment.
- Professionals should provide the medical practitioner with background information regarding the young person's situation as this may assist in diagnosis and the development of a treatment plan. Professionals should ensure that all relevant medical details are recorded in the young person's file and are used to inform any future plans.
- In certain circumstances, these referrals can become a child protection matter. If the professional's view is that the parental response to the seeking of medical intervention has been to minimise the seriousness of the situation or to not act appropriately, this may constitute a child protection concern. As such, professionals may require supervision on the appropriateness of a legal solution to a parent or carer not acting on such a concern. A legal solution may be required to dispense with parental consent to ensure the young person gets prompt medical intervention.
- It is important for professionals to be aware that suicidal and/or self-harming behaviours may be linked solely to the medical needs of a young person. In these incidences, it is essential that child and adolescent mental health teams take lead management due to their expertise in the area.
- Assessments should take into account that suicidal and/or self-harming behaviour can be indicators of deep unhappiness within a young person's life.

- Poor mental health can be a significant factor in a parent's ability to provide adequate care and protection to a child or young person. The impact of parental mental health concerns needs to be assessed.
- If an immediate concern is reported that a parent is presenting as suicidal, a safety plan for the care of the child or young person needs to be put in place. Support should be provided to the parent in accessing the appropriate mental health service via their GP or local psychiatric hospital. Contact should be made, on behalf of the parent, with the relevant service, preferably with the parent's consent. However, professional judgement needs to be used and there may be occasions when it is appropriate to contact a medical professional regarding the concerns in the absence of consent. Liaison between the relevant professionals should continue to take place to identify if there are any specific risks to the child or young person based on the psychiatric assessment.

Deaths of a young person in care or known to Tusla

The death of a child by suicide who is either in the care of or is known⁵ to Tusla requires notification to the Health Information and Quality Authority (HIQA 2010). Similarly, deaths of young people by suicide who are under 21 years and who were in care until their 18th birthday need to be notified to HIQA. This should be done through the local area manager for Tusla.

⁵ A child is defined as 'known to Tusla' if they have a case open or a case has been closed in the previous two years (HIQA 2010: 2).

13 Children Involved in Prostitution

Description

Prostitution of children is a form of sexual exploitation. This sexual exploitation of children takes the form of exchange of sexual activities for commodities, such as money, alcohol and other drugs; shelter; protection; accommodation, etc. and is often perpetrated by an adult through violence or threats of violence. Children involved in prostitution and other forms of commercial sexual exploitation should be treated primarily as the victims of abuse; their needs require careful assessment. They are likely to be in need of welfare services and, in many cases, protection under the Child Care Act 1991. The arrangements for safeguarding and promoting the welfare of children involved in prostitution and for assessing their needs must be consistent with the approaches used for all children.



Messages from Research

- The commercial sexual exploitation of children describes a wide range of sexual abuse and crimes. It is a particularly serious form of sexual victimisation and can include children's involvement in prostitution, the production and distribution of child pornography, and the trafficking of children for sexual exploitation (Mitchell *et al.* 2011; Reid 2011). Apart from being sexually, and in some instances, violently abused, children may be treated by abusers as commodities to be exploited for economic benefit (Mitchell *et al.* 2011).
- Reid's (2011) research identifies the following categories of children as having a heightened risk of child sexual exploitation:
 - » Girls
 - » Children with a history of abuse or sexual victimisation (both sexes)
 - » Runaway or 'street' children
 - » Those involved in substance misuse
 - » Those having neglectful and/or dysfunctional family situations where domestic abuse and mental ill-health may be issues

- Prostitution has a devastating impact on both physical and mental wellbeing for those prostituted. It erodes self-esteem and self-confidence and it can cause depression and symptoms of post-traumatic stress disorder. Prostitution can result in infertility, unwanted pregnancies, sexually transmitted infections, fissures and many other physical consequences (Immigrant Council of Ireland 2009; Lawless and Wayne 2005).
- Risk factors identified that may lead to children's involvement in prostitution include:
 - » Living and growing up in poverty
 - » Living in urban areas with above average rates of crime, including adult prostitution
 - » Living where there is a high transient male population
 - » Being homeless (Reid 2011; Mitchell *et al.* 2010)
- Since the 2000s, increased sexual exploitation of children has been facilitated through the rapid expansion in internet use, creating new kinds of victims, clients, offences and offenders (Mitchell *et al.* 2011). In many instances, adolescents, predominantly girls, are 'marketed' alongside adult prostitutes on pornographic websites with established escort or massaging services (Mitchell *et al.* 2011).
- The vastness of the internet audience facilitates child abusers to network and share images of child abuse (euphemistically referred to as child pornography) (Mitchell *et al.* 2011). This is often achieved using encrypted file-sharing technologies that may make it difficult for authorities to trace the source of abusive material (Mitchell *et al.* 2011; Kierkegaard 2008).



Practice Note

- Parents, carers (including foster carers) and staff in children's homes must be alert to the following behaviours that may indicate a child's involvement (or 'grooming' for involvement) in prostitution:
 - Physical symptoms such as sexually transmitted diseases, or bruising consistent with physical or sexual assault.
 - Reports from reliable sources that a child has been seen soliciting or noticed in places where soliciting occurs.

- Being contacted by unknown adults/peers outside the child's usual range of social activities.
- Development of a relationship, usually with someone older, who encourages emotional dependence and controls the relationship by violence and threats.
- Persistent absconding or late returning with no plausible explanation (see also Chapter 28: Trafficking of Children).
- Returning after being missing, looking well cared for without a known place to stay.
- Being picked up by unauthorised adults in cars.
- Acquisition of money or possessions with no plausible explanation.
- An adult loitering outside the home to meet up with the child.
- Having keys to unknown premises.
- Self-harming behaviour.
- Substance, drug and alcohol abuse.

These behaviours are not conclusive signs in themselves. The most common predisposing factors associated with a child becoming involved in prostitution are low self-esteem and a history of being a victim of abuse.

Social work response

All referrals related to children suspected of being involved in prostitution must be notified between the social work department and An Garda Síochána. Such children should be regarded as at risk of significant harm, and a strategy meeting should be arranged. This strategy meeting will determine whether:

- The child is at risk of sexual exploitation and an assessment of their needs is required.
- The child is suspected of being at risk of significant harm.
- Immediate protective action is required.
- The above procedure represents the minimum response required. It may be appropriate that a child protection assessment be implemented in all cases.

The aims of intervention by Tusla and the Gardaí are to:

- Identify any child in the sex industry, including those involved in prostitution or the production or promotion of pornography.
- Help the child to understand the physical and emotional dangers of these activities.
- Identify and prosecute those adults involved in either coercing or abusing the child.
- Protect the child from further abuse and to support them out of prostitution or exploitation.

A child involved in prostitution and other forms of commercial sexual exploitation should be treated primarily as the victim of abuse, and as such her/his needs require careful assessment. All agencies should establish whether or not those who are known to pay for sex with children are themselves parents or carers of children. If this is the case, an assessment of the needs of those children should be considered, including whether they are at risk of, or are suffering, significant harm.

Minimum threshold for child protection assessment

The minimum threshold for child protection assessment is an immediate risk of significant harm. Examples which would meet this threshold include:

- Concern that prostitution or sexual exploitation is being actively encouraged by a parent/carer.
- Concern that prostitution or sexual exploitation is facilitated by the parent/carer, failing to protect the child.
- Concern that a related or unrelated adult, in a position of trust or responsibility to the child, is organising or encouraging prostitution.
- Concern about coercion by peers.

As with all referrals, child protection procedures should be initiated at any point where the threshold has been met. Where the threshold for child protection enquiries has been met, an initial assessment must be completed within **seven** days of the referral and a multiagency planning meeting held, including the referrer and all professionals relevant to the child and family, including An Garda Síochána.

14 Organised Child Sexual Exploitation

Description

Organised child sexual exploitation occurs when either one adult moves into an area or institution and systematically entraps children for abusive purposes (mainly sexually) or two or more adults conspire to similarly abuse children, using inducements.

Organised child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example, being persuaded to post sexual images on the internet or mobile phones.

In all cases, those exploiting the child or young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources.

Organised child sexual exploitation also involves exploitative situations, contexts and relationships, where young people receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) in exchange for either performing sexual activities and/or another or others performing sexual activities on them.

According to the UK Department for Children, Schools and Families: "Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability" (2009: 9).

Organised child sexual exploitation is a form of child sexual abuse that includes some combination of:

- **Pull factors:** Children exchanging sex for attention, accommodation, food, gifts or drugs.
- **Push factors:** Children escaping from situations where their needs are neglected and there is exposure to unsafe individuals.
- **Control:** Brainwashing, violence and threats of violence by those exploiting the child.

Sexually exploited children also suffer physical and emotional abuse and often neglect.



Messages from Research

- Mitchell *et al.* (2010) recommend that communities affected by organised child sexual exploitation should develop multidisciplinary, integrated responses at all levels. This includes educating young people, family members, as well as those working with children, about child prostitution and exploitation and who may be at risk.
- They advocate preventative actions such as including information concerning the reality of prostitution and organised child sexual exploitation, online or otherwise, in general sexual health and safety education, guidance and discussion (Mitchell *et al.* 2010).
- In addition, victims of organised child sexual exploitation may be difficult to identify as they may have been trafficked between countries and internally (McMahon-Howard and Reimers 2013). McMahon-Howard and Reimers (2013) highlight practitioner awareness of organised child sexual exploitation as vital; trafficked victims often come into contact with authorities through asylum and immigration services.



Practice Note

Organised child sexual exploitation comprises only a very small percentage of the child protection concerns that come to the attention of Tusla. Nevertheless, they are complex cases and require particularly careful handling. In cases of suspected organised child sexual exploitation, refer also to the *Joint Working Protocol for An Garda Síochána/Tusla – Child and Family Agency Liaison* (Tusla and AGS 2017).

Sexually exploited children commonly have low self-esteem and may exhibit some or all of the following characteristics:

- Going missing frequently and/or from a young age
- Bullying or being a victim of bullying in or out of school
- Experience of previous (and sometimes current) sexual abuse, neglect and physical abuse
- Exposure to domestic abuse within the family

- Family involvement in sexual exploitation, drugs and alcohol
- Drug and alcohol use
- Symptoms of emotional distress including eating disorders, mood swings and self-harm
- Involvement in theft and shoplifting

Boys and girls may be drawn into organised child sexual exploitation by peers who are already involved.

Girls, in particular, are frequently coerced into sexual exploitation by an older man who poses as (and is viewed by them as) their boyfriend. The girl is often physically and emotionally dependent upon this man, and the dependence may be reinforced by the use of alcohol and drugs. Over time, access to friends and family tends to become curtailed.

Sexually exploited children are rarely visible on the streets, and grooming of children for abuse via the internet has contributed to the invisibility of the organised child sexual exploitation of children.

15 Children and Young People Who Have Exhibited Sexually Harmful Behaviour

Description

Some sexual behaviour between children is recognised as part of normal childhood development. Different groups in the community may have different views about what is usual or acceptable. It is understood that children can have feelings which can manifest as sexual behaviour.

There is a need to distinguish between developmentally appropriate behaviour and sexually harmful behaviour displayed by a child or young person towards a younger child, a similar-aged peer, or an adult. In some instances, where a child has allegedly exhibited sexually harmful behaviour, the alleged victim may also be a child. There is a need to ensure that response and support is directed towards the child who has allegedly displayed the sexually harmful behaviour *and* the alleged victim. The child who exhibited the alleged sexually harmful behaviour is likely to be a child in need, and may, in addition, be suffering abuse, be at risk of significant harm, and may themselves be in need of protection.

The following sections explore this further by outlining issues that may arise in relation to young people and their sexual behaviour.

Sexually harmful behaviour perpetrated by children and/or young people should always be taken as seriously as abuse perpetrated by an adult. Whenever a child or young person may have harmed another child or young person, all agencies must be aware of their responsibilities to both parties; multiagency management of cases must reflect this. However, where a conflict exists, the interests of the identified victim must always be of paramount consideration. Professionals working with children or young people who have exhibited sexually harmful behaviour should also be alert to the fact that there may be a risk to children other than the current victim.

A significant proportion of sex offences are committed by teenagers. A small number of younger children also have exhibited sexually harmful behaviour. Professionals working with children, including carers of children living away from home, need clear guidance and

training to identify differences between consenting and abusive sexual behaviour, and between appropriate and exploitative peer relationships. Professionals should not dismiss sexual behaviour between young people as ‘normal’ and should not develop high thresholds before taking action; consideration must be given as to whether behaviour could be characterised as abusive or harmful. The fact that there is only a small age difference between two parties engaged in sexual behaviour does not necessarily mean that it is consensual; professionals should be cautious not to form judgements based on assumptions rather than facts.

Children and young people who have exhibited sexually harmful behaviour should be identified and responded to in a way that meets their needs while also protecting others.



Messages from Research

- Research recommends that professionals working with children who display sexually harmful behaviour should develop effective risk management frameworks that provide a systematic assessment of the risks such children pose to others (Findlater and Fyson 2007).
- Interagency communication and information sharing can provide clarity and help professionals to ensure all relevant factors are considered in assessing and managing cases of children who display sexually harmful behaviour. In addition, professionals should be aware that adolescent and preadolescent children who display sexually harmful behaviour have often themselves been subjected to abuse. These children require support and understanding if they are to change their abusive behaviours (Shaw *et al.* 2000; Findlater and Fyson 2007).
- Professionals face challenges in responding to children who display sexually harmful behaviour, particularly as most societies are uncomfortable in acknowledging adolescent sexuality. Indeed, most populations are unwilling to accept adolescent sexual activity’s existence until it becomes inescapable, for example, through teen pregnancy (Miccio-Fonseca and Rasmussen 2009).

- Research indicates a statistically significant prevalence of 'peer abuse'. It is essential that those working with children in child protection services be fully aware of the risk that some children may engage in sexually harmful activity (Findlater and Fyson 2007; McGee *et al.* 2002).
- Longitudinal research indicates that, in general, recidivism rates for young people are approximately 20%, while recidivism rates for young people who have received treatment are less than 9% (Worling and Curwen 2000; Worling *et al.* 2010).



Practice Note

Teenagers perpetrate a considerable proportion of child sexual abuse. It is important that different types of behaviour are clearly identified and that a distinction is made between sexually harmful behaviour and other types of behaviour. Younger children may also exhibit sexually harmful behaviour.

Abuse reactive behaviour: In this situation, one child who has been abused acts out the same behaviour on another child. This is serious behaviour and needs to be treated as such. In addition to responding to the needs of the abused child, the needs of the child who has exhibited the sexually harmful behaviour in this situation must also be addressed.

Sexually preoccupied behaviour: In this type of situation, the children may engage in sexually compulsive behaviour. An example of this would be excessive masturbation, which may well be meeting some other emotional need. Most children masturbate at some point in their lives. However, in families where care and attention is missing, they may have extreme comfort needs that are not being met and may move from masturbation to excessive interest or curiosity in sex, which takes on excessive or compulsive aspects. These children may not have been sexually abused, but they may be extremely needy and may require very specific help in addressing those needs.

Sexually harmful behaviour by children and young

people: Behaviour that is abusive will have elements of domination, coercion, bribery, manipulation and certainly secrecy. The fact that the behaviour is carried out by an adolescent, for example, does not in itself make it ‘experimentation’. However, if there is no age difference between the two children or no difference in status, power or intellect, then one could argue that this is indeed experimentation. On the other hand, if, for example, the adolescent is aged 13 and the child is aged three, this gap in itself creates an abusive quality that should be taken seriously.

Sexually active children

When encountering sexually active children, it is important to reflect on the circumstances and type of sexual activity being engaged in. Some of the common categories used for describing the sexual behaviour of children include:

- Normal sexual exploration by children
- Sexually active teenagers (consideration must be given to the age of consent)
- Organised child sexual exploitation⁶
- Sexual harmful behaviour by children and young people.

The Children First Act 2015 details conditions that must be met to exempt the reporting of sexual activity between children. See section 14(3) of the Children First Act 2015 for details.

Normal sexual exploration

Normal sexual exploration could consist of naive play between two children that involves the exploration of their sexuality and/ or bodies. This type of behaviour may be prompted by exchanges between children, such as “you show me yours and I’ll show you mine”. One of the key aspects of this behaviour is its tone; there should not be any coercive or dominating aspects to this behaviour. Usually there is no need for child protection intervention of any kind in this type of situation.

(continued)

⁶ See Chapter 14: Organised Child Sexual Exploitation.

The following gives information and examples of developmentally appropriate sexual behaviours. These are grouped by age of the child. This information provides a guide and should not be seen as definitive or exhaustive. In assessing possibly sexually harmful behaviour by a child, the individual and specific context of the child must be fully explored. The following information is taken from the National Child Traumatic Stress Network (2009) leaflet, *Sexual Development and Behaviour in Children: Information for Parents and Caregivers*.

Preschool children (less than 4 years)

Very young and preschool-aged children (4 years old or younger) are naturally immodest. Children in this age range may display open, and occasionally startling, curiosity about other people's bodies and bodily functions, such as touching women's breasts, or wanting to watch when grown-ups go to the bathroom. Wanting to be naked (even if others are not) and showing or touching private parts while in public are also common behaviours in young children. Young children are curious about their own bodies and may quickly discover that touching certain body parts feels nice. Examples include:

- Exploring and touching private parts, in public and in private
- Rubbing private parts (with hand or against objects)
- Showing private parts to others
- Trying to touch mother's or other women's breasts
- Removing clothes and wanting to be naked
- Attempting to see other people when they are naked or undressing (such as in the bathroom)
- Asking questions about their own and other people's bodies and bodily functions
- Talking to children their own age about bodily functions such as 'poop' and 'pee'

Young children (approx. 4–6 years)

As children age and interact more with other children (approx. ages 4–6 years old), they become more aware of the differences between boys and girls, and more social in their exploration. In addition to exploring their own bodies through touching or rubbing their private parts (masturbation), they may begin 'playing doctor'

and copying adult behaviours such as kissing and holding hands.

Examples include:

- Purposefully touching private parts (masturbation), occasionally in the presence of others
- Attempting to see other people when they are naked or undressing
- Mimicking dating behaviour (such as kissing or holding hands)
- Talking about private parts and using ‘naughty’ words, even when they don’t understand the meaning
- Exploring private parts with children their own age (such as ‘playing doctor’, ‘I’ll show you mine, if you show me yours’, etc.)

School-aged children (approx. 7–12 years)

As children become increasingly aware of the social rules governing sexual behaviour and language (such as the importance of modesty or which words are considered ‘naughty’), they may try to test these rules by using ‘naughty’ words. They may also ask more questions about sexual matters, such as where babies come from, and why boys and girls are physically different. Examples include:

- Purposefully touching private parts (masturbation), usually in private
- Playing games with children their own age that involve sexual behaviour (such as ‘truth or dare’, ‘playing family,’ or ‘boyfriend/ girlfriend’)
- Attempting to see other people naked or undressing
- Looking at pictures of naked or partially naked people
- Viewing/listening to sexual content in media (television, movies, games, the internet, music, etc.)
- Wanting more privacy (e.g. not wanting to undress in front of other people) and being reluctant to talk to adults about sexual issues
- Beginnings of sexual attraction to peers or interest in peers

Sexually active teenagers and the age of consent: research and legal aspects

Over one-quarter of 15–17-year-olds report that they have had sex, according to a survey of the health of Irish children (Health Promotion Research Centre 2012).

The survey also found that boys, and children from lower social class groups, are more likely to report having had sex. Some 93% of those children who reported having sex said they had used a condom the last time they had sex, while 59% said that they had used the birth control pill.

Under the Criminal Law (Sexual Offences) Act 2006, the legal age of consent is 17 years. While a sexual relationship where one or both parties is under 17 years of age is illegal, it might not be regarded as child sexual abuse. Investigations should be sensitive to the needs of the child.

In cases where abuse is not suspected or alleged but the boy or girl is underage, consultation must be held between Tusla and An Garda Síochána, and all aspects of the case will be examined. Both agencies must acknowledge the sensitivity required in order to help vulnerable young people avail of all necessary services, while at the same time satisfying relevant legal requirements.

The Children First Act 2015 details conditions that must be met to exempt the reporting of sexual activity between children. See section 14(3) of the Children First Act 2015 for details.

General guidance

Three key principles should guide work with children and young people who have displayed sexually harmful behaviour towards other children, similar-aged peers or adults:

1. There should be a coordinated multiagency approach. This should include, among others, youth justice (where appropriate), Tusla, education and health agencies along with An Garda Síochána.
2. The needs of the child or young person who has displayed sexually harmful behaviour should be considered separately from the needs of their victims.
3. A multiagency assessment should be carried out in each case. These children may have considerable unmet developmental needs, as well as specific needs arising from their sexually harmful behaviour.

Responding to Children and Young People Who Have Exhibited Sexually Harmful Behaviour

In assessing a child or young person who has displayed sexually harmful behaviour towards another child, relevant considerations include:

- The nature and extent of the sexually harmful behaviour. It is sometimes difficult for professionals to distinguish between sexually inappropriate or aggressive behaviour and normal childhood sexual development and experimentation. In this regard, it may be necessary to seek expert professional opinion in relation to case-specific assessment.
- Each child's presentation or affect.
- The child's age and developmental stage.
- The context of the sexually harmful behaviour.
- The child's family and social circumstances.
- Need for services, specifically focusing on the child's sexually harmful behaviour, as well as for any other identified needs.
- The risk to self and others, including other children in the household, extended family, school, peer group or wider social networks. Risk is likely to be present unless the opportunity for further sexually harmful behaviour is ended; the young person has acknowledged the sexually harmful behaviour and accepted responsibility; and there is agreement by the young person and his/her family to work with relevant agencies to address the problem.
- Any immediate risk to the child or young person who has exhibited sexually harmful behaviour (e.g. threats or harm by own family, victim's family, etc.).
- The need to draw up an initial safety plan.

Strategy meetings should be used to consider the following issues, among others:

- What plan of action should be put in place to address the needs of the young person, detailing the involvement of all relevant agencies.
- Review and monitoring of safety plans.
- Supervision requirements.
- Capacity of parents/carers to adequately supervise.
- The most appropriate course of action within the youth justice system, if the child is above the age of criminal responsibility.
- Whether there are additional child protection considerations which indicate that the young person who perpetrated the sexually harmful behaviour should be the subject of a child protection conference.
- Treatment/intervention regarding sexually harmful behaviour.
- Capacity of parents/carers to adequately support treatment/intervention.

16 Blood-Borne Viruses⁷

Description

A blood-borne virus is one that can be spread through contamination by blood and other body fluids. The most common examples are HIV, hepatitis B, and viral haemorrhagic fevers.

Transmission of blood-borne viruses “happens when the [contaminated] blood or fluids enter into the body of a susceptible person. The rate of viral transmission varies depending on how the person has been exposed to the virus (the route of transmission), the type of virus, how much of the virus the carrier has in their body and the immune status of the exposed person” (UK Health and Safety Executive 2016).

According to the UK Health and Safety Executive (2016), the more common routes of transmission include:

- Sexual intercourse (common for hepatitis B, HIV; inefficient for hepatitis C)
- Sharing injecting equipment
- Skin puncture by blood-contaminated sharp objects (e.g. needles, instruments or glass)
- Childbirth (i.e. the mother infects the child either before or during birth, or through breastfeeding)

A child exposed to blood-borne viruses can be at risk of significant harm. Child protection issues are likely to arise in relation to blood-borne viruses:

- When a mother who is known to be HIV positive refuses to accept treatment for herself in pregnancy and/or for the baby following delivery.
- When a mother who is known to be HIV positive insists on breastfeeding her baby against medical advice.
- Where a child is thought to have a blood-borne virus and his or her parents refuse to agree to medical testing and/or treatment.
- Where a child is on the appropriate treatment for a blood-borne virus but medication is given inconsistently or stopped altogether. There is a danger of the virus developing resistance to the treatment as well as risk of disease progression.

⁷ This chapter does not contain a section on Messages from Research as the content relates to a specifically medical topic.

- Where a child has been sexually abused and the abuser is thought to be infected with a blood-borne virus.
- Where a child has been exposed to contaminated needles and syringes.



Practice Note

Note that in these cases the lead practitioner will be a medical professional. They will refer cases to Tusla where the child or young person has an illness that, if untreated, is likely to result in significant harm being caused to the child. Similarly, where Tusla professionals becomes concerned that any of the scenarios described above may be present, they should liaise with the appropriate medical professionals.

17 Children from Abroad Needing Protection

Description

Children arrive into Ireland from overseas every day. Many of these children do so legally in the care of their parents or legal guardians and do not raise any concerns for statutory agencies. However, recent evidence indicates that a significant number of children are arriving into Ireland who are:

1. In the care of adults who, while they may be their carers, have no guardianship rights.
2. In the care of adults who have no documents to demonstrate a relationship with the child.
3. Alone.
4. In the care of 'agents'.

Status of children who arrive from abroad and legal duties towards them

- Children who arrive in Ireland alone, or who are left at a port of entry by an agent, invariably have no right of entry and are unlawfully present. They are likely to be in a position to claim asylum and this should be arranged as soon as possible, if appropriate. They are the responsibility of the Tusla team for Separated Children Seeking Asylum and should be supported under the Child Care Act 1991.
- Children who arrive in Ireland with or to be with carers without guardianship rights may have permission to enter the country or may be in Ireland unlawfully. If the child is assessed as being in need, Tusla can provide support for the child and the family.



Messages from Research⁸

- Kohli (2006 in Lundberg and Dahlquist 2012) found that young asylum-seekers' silence in interviews can result in scepticism and suspicion by social workers and other relevant authorities. Social workers contributing to his study recalled minors seeking asylum; many claiming to be younger than they looked; said little; and when they did speak their stories were similar to many others they had heard from other similar clients.

(continued)

⁸ See also the book *Child Migration Matters* (Mannion 2016).

- Child protection workers need the appropriate knowledge and skills to be able to move among a range of cultural and ethnic environments (Korbin 2007; Phillips 2007). Phillips (2007: 158) argues that there is much yet to be understood of “the role ethnicity plays in the child protection system” and highlights “ethnicity and culture do affect the referral, intervention and registration process”.
- Phillips (2007) suggests that, in the UK, a lack of trust may exist between child services and minority communities and their advocates. For example, the most deprived and socially excluded minority groups rarely access family and child support services (Phillips 2007). In addition, there is a general under-reporting of child abuse and neglect of children and families from these communities and from practitioners who may be professionally involved with families and minority communities.
- Pearce (2011: 1438) cautions that child protection needs may lurk behind silence and/or non-engagement and may go unnoticed by children’s services, especially if what she termed ‘a culture of disbelief’ has evolved. In addition, immigration procedures often can take precedence over child protection concerns and vulnerable children thus become invisible to children’s services (Pearce 2011). Kohli (2006 in Lundberg and Dahlquist 2012: 75) concluded that social workers who developed trusting relations with unaccompanied young people succeeded in making them feel safe. Social workers became “practical helpers, therapeutically minded listeners, and companionable people”, leading to ‘whole’ understandings of children’s circumstances and thereby appropriate responses.



Practice Note

• Children arriving from abroad who are unaccompanied, or accompanied by someone who does not have guardianship rights, should be assumed to be children-in-need unless assessment indicates otherwise.

(continued)

Consideration must be given to accessing an appropriate interpreter⁹ where English is not the first language of the child or the adult.

If accessing interpretive services, it is important to be aware that some minority and ethnic service users may not want an interpreter of the same culture present. There can be a fear that their story will be shared with the community.

The question of whether an interpreter is needed should be addressed sensitively with the child/adult.

First contact

The first contact with the child and carer(s) is crucial to the engagement with the family and the promotion of trust, which underpins the future support, advice and services.

Any unaccompanied child or child accompanied by someone not having guardianship rights should receive an initial assessment to determine whether they are a child in need of services, including the need for protection. Such children should be assessed as a matter of urgency as they may be quite geographically mobile and their vulnerability therefore greater. All agencies should enable the child to be quickly linked into universal services, which can begin to address their needs.

The assessment should address not only the barriers which arise from cultural, linguistic and religious differences, but also the particular sensitivities that come from the experiences of many such children and families. The needs of the child have to be considered, based on an account given by the child or family about a situation which the professional has neither witnessed nor experienced. In addition, the narrative is often presented in a language, and about a culture and way of life with which the professional is totally unfamiliar or has only basic knowledge.

(continued)

⁹ See *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services* (HSE 2009), policy adopted by Tusla and available on the Tusla hub and www.hse.ie.

It is vital that the services of an interpreter¹⁰ are employed in the child's first language and that care is taken to ensure that the interpreter knows the correct dialect. If that interpreter shares more than a common language, and is professionally trained, they can sometimes be a rich source of information about traditions, politics and history of the area from which the child has arrived. They may be able to advise on issues like the interpretation of body language and emotional expression.

Evidence shows that unaccompanied children, or those accompanied by someone who is not their parent, are particularly vulnerable. The children and many of their carers will need assistance to ensure that the child receives adequate care and accesses appropriate health and education services. A small number of these children may be exposed to the additional risk of commercial, sexual or domestic exploitation.

Particular sensitivities that may be present for the child

These sensitivities include:

- Anxiety raised by yet another professional asking similar questions to ones previously asked.
- Past trauma.
- Past regime/experiences can impact upon the child's mental and physical health. These experiences can make concerns from the authorities about minor injury or poor living conditions seem trivial; this mismatch may add to the fear and uncertainty.
- The journey itself, as well as the previous living situation, may have been a source of trauma.
- The shock of arrival in a foreign and alien culture. The alien culture, system and language can cause shock and uncertainty, and can affect the mood, behaviour and presentation of children.

Whenever any professional comes across a child who they believe has recently moved to Ireland as a separated child seeking asylum or not accompanied by a person with guardianship rights, the following basic information should be sought:

- Confirmation of the child's identity and immigration status
- Confirmation of the carer's relationship with the child and immigration status
- Confirmation of the child's health and education arrangements in Ireland

(continued)

¹⁰ See *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services* (HSE 2009), policy adopted by Tusla and available on the Tusla hub and www.hse.ie.

This should be done in a way that is non-threatening to the child and carer.

Age is central to assessment and affects the child's rights to services and the response by agencies. In addition, it is important to establish age so that services are age and developmentally appropriate. Citizens of EU countries will have a passport or identity card (usually both). Unaccompanied children very rarely have possession of any documents to confirm their identity or to substantiate their age; physical appearance may not necessarily reflect age.

The assessment of age is a complex task, which often relies on professional judgment and discretion. Issues of disability may compound such assessment. Moreover, many societies do not place a high level of importance upon age and it may be calculated in different ways. Some young people may genuinely not know their age and this can be misread as lack of cooperation. Levels of competence in some areas or tasks may exceed or fall short of expectations of a child of the same age in Ireland. The advice of a paediatrician or dentist with experience in considering age may be needed to assist in assessment of age.

There are some key principles underpinning practice within all agencies in relation to unaccompanied children from abroad or those accompanied by someone who does not hold guardianship rights. These are:

- Never lose sight of the fact that children from abroad are children first – this can often be forgotten in the face of legal and cultural complexities.
- Include in the assessment of need a separate discussion with the child in a setting where, as far as possible, they feel able to talk freely.
- Consider using an independent interpreter at every stage of the assessment process.
- Assessing the needs of these children is only possible if their legal status, background experiences and culture are understood, including the culture shock of arrival in Ireland.

- Be prepared to actively seek out information from other sources.
- Beware of ‘interrogating’ the child; assessment interviews should be a discussion not an interrogation.

Child’s developmental needs

Things to bear in mind when assessing developmental needs of the child:

- **Trauma and loss** can affect health, behaviour and social presentation. Famine and poverty can have an impact upon development.
- **Wider health needs** may need to be considered, including HIV, hepatitis B and C and tuberculosis. (This also applies to the parent or carer.)
- **Education:** What has school meant to this child?
- **Self-care skills:** Do not judge competence by comparing with a child of the same age in Ireland. This child may have had to be very competent in looking after themselves on the journey but unable to do other basic tasks. Some children will have been working or have been involved in armed conflict.
- **Loss of a parent** can enhance or deprive a child of certain skills. Having had to overcome extreme adversity can result in a child who is either deeply troubled or both resourceful and resilient.
- **Identity:** Who is this child? What is their sense of themselves, their family, community, tribe, race and history?
- **Physical appearance:** Life experience and trauma can affect physical appearance. Also, lack of nourishment may make the child present as younger or older. Perceptions of what constitutes disability are relative and attitudes towards disabled children may be very different.
- The **impact of racism** on the child’s self-image and the particular issues currently faced by asylum-seeking children and their families should also be considered.

Parenting capacity

Things to bear in mind when assessing parenting capacity:

- War, famine and persecution can make a family mobile.
- The family may have moved frequently in order to keep safe.

- The stability of the family unit might be more important to the child than stability of place.
- Judgements that mobility may equate with inability to provide secure parenting may be entirely wrong. In some countries, regular migration to deal with exhaustion of the land is part of the culture.
- The fact that a child seems to have been given up by a parent may not imply rejection, as the motive may have been to keep the child safe or seek better life chances for them.
- The corrosive impact on parenting capacity of racism against asylum-seekers should be considered.
- Talking about parents/family can be stressful and painful – in the same way as not being given the chance to do so regularly.
- The importance of the extended family/community rather than a Eurocentric view of family.
- Community, faith and religious leaders play an important role in family life in many cultures. These people can provide a source of support and guidance; they can also influence the decision-making of parents. It is important to explore, with the family, the support network they have in Ireland.
- Do not presume that you cannot contact a parent who is living abroad unless you have actively sought to do so.
- Lack of toys for a child may indicate poverty or different cultural norms rather than poor parenting capacity to provide stimulation.
- The additional issues of parenting a child conceived through rape – dealing with the negative response of the partner or with the stress of keeping it secret from him as well as the mother's own attitudes to the child.

Family and environmental factors

The importance of economic and social hardship is apparent. In addition, there may be other issues to consider, such as:

- Family history and functioning may include the loss of previous high status, as well as periods of destitution.
- Different concepts of who are or have been important family members and what responsibility is normally assumed by the whole community (e.g. who a child should reasonably be left with).
- Reluctance to divulge information, fear, confusion or memory loss can easily be mistaken for lack of cooperation, deliberate withholding of information or untruthfulness.

Many children/caregivers might not make basic distinctions between the role of a social worker, social care worker or social welfare officer. This is a key first step in building understanding and trust.

Open questions are most helpful, with a clear emphasis on reassurance and simple explanations of the role and reasons for assessment. If the 'engagement' with the family is good, there are more likely to be opportunities to expand on the initial contact, as trust is established. During the first contact with the child and carer(s), it is, however, vital not to presume that the child's views are the same as their carer(s), or that the views and needs of each child are the same. Seeing each child alone is crucial, particularly to check out the stated relationships with the person accompanying them (e.g. someone allegedly from the same place of origin should have a similar knowledge of the place).

The professional is going to be seen as 'in charge', as such a child may believe that they must 'get it right' when answering questions, even though they may not wholly understand the system or even the question. If the engagement is positive, there will be opportunities to expand on the initial contact. The ethnicity, culture, customs and identity of the child must be a focus, while keeping the child central to the assessment. The pace used in interviewing the child should be matched to that which the child is comfortable with, though the need to ensure the child's safety may necessitate flexibility in some circumstances.

Professionals should avoid using jargon during the assessment.

Parental responsibility

When considering who has parental responsibility, attention must be paid to the difference between 'parental responsibility' and 'guardianship rights'. While a professional may need to support those with parental responsibility, this must be done giving due regard to who has guardianship rights for the child.

The Child Care Act 1991 is built around the concept of 'parental responsibility'. In some cultures, child-rearing is a shared responsibility between relatives and members of the community.

Children brought to Ireland by adults may have been cared for by the adult for most of their lives but may be unrelated or ‘distantly’ related to the adult.

An adult whose own immigration status is unresolved cannot apply for a residence order to secure a child for whom they are caring.

Children whose parents’ whereabouts are unknown have no access to their parents for consent when making important choices about their life. While their parents still have parental responsibility, they have no means of exercising it. Children who do not have someone with guardianship rights caring for them can still attend school, and schools should be pragmatic in allowing the carer to make most decisions normally made by the parent. Such children are entitled to healthcare and have a right to be registered with a GP. Emergency life-saving treatment would be given if required; however, should the child need medical treatment, such as surgery or invasive treatment in a non-life-threatening situation, the need for consent would become an issue and legal advice may be required. Tusla has statutory duties if a child is deemed to be privately fostered, for example, where an arrangement has been entered into between the child’s parent(s) and the carer(s).

If a migrant child is in care, even if they have initially entered the country legally and accompanied by parents/guardians, special consideration should be given to securing the child’s immigration status before the child turns 18 years of age.

18 Young Carers

Description

A young carer is a child or young person under 18 years whose life is affected in a significant way by the need to provide care for a family or household member who has an illness, disability, addiction or other care requirement. This may include a child or young person who provides direct personal care or who takes on a supportive role for the main carer.

A young carer may carry out domestic tasks or may provide general, intimate or emotional care. These needs may arise on a regular or occasional basis. There is therefore a continuum of caring and, as a result, the service requirements of young carers will vary. It is important to differentiate between a level of caring that has largely positive consequences and a level of physical or emotional caring that impairs the child's health, development or welfare (Office of the Minister for Children and Youth Affairs 2010).



Messages from Research

According to the Central Statistics Office (2012: 109):

- 4,244 carers are aged between 15 and 19 years.
- 4,228 carers are aged under 15 years.
- 1,838 carers are aged under 10 years.

The National Carers' Strategy (Department of Health 2012) notes the following points:

- Children and young people under the age of 18 years with caring responsibilities generally provide care for members of their immediate family, such as parents, grandparents or siblings.
- The scale of caring responsibilities can range from helping around the house to providing personal care for a relative.
- Young carers have similar needs to carers of any age; for example, the need for a break and support for the person for whom they are caring. However, they may have additional needs, which include support in education, to help them achieve their full potential.
- Both the number of children and young people with caring responsibilities and the extent of the care provided by some, as evidenced by Census 2011, are a cause for concern.



Practice Note

While a child or a young person can learn valuable life skills through caring, in some cases they may be adversely affected by the extent of the responsibilities placed upon them. For example:

- They may have difficulties attending school or completing homework.
- They may have little or no time for recreational activities with peers.
- They may experience problems moving into adulthood, such as finding work.

The impact on emotional wellbeing and development can be profound.

Many of these carers can remain 'hidden' from health, social care and education support services. This may be because of embarrassment, worry that the authorities will remove the children, or because the children are not aware that their situation is unusual (Department of Health 2012). When carrying out an assessment where a child or young person may have a caring role, professionals must consider the impact on the child or young person's health, welfare or development.

19 Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Young People

Description

LGBTI young people are becoming aware of their identity and coming out at a younger age in comparison with previous generations in Ireland. According to the 2015 LGBTI Ireland Report (Higgins *et al.*), the average age for a young person to realise they are LGBTI is **12 years old**, and the most common age of sharing this with someone is **16 years old**. During this vulnerable interim period, young people can experience significant mental health challenges. According to research conducted in 2017 by LGBTI Ireland,¹¹ 70% of young LGBTI+ people do not feel safe at school.

List of terms and definitions

Biphobia is a dislike, fear or hatred of bisexual people.

Bisexual is a term used to describe someone who is sexually and romantically attracted to both males and females.

Bi-erasure is ignoring, removing, or re-explaining the evidence of bisexuality.

Cisgender is a term used to describe an individual's gender when their experiences of their gender correspond to the biological sex they were assigned at birth.

Coming out is a process that involves a lesbian, gay, bisexual or transgender person developing an awareness of an LGBTI identity, accepting their sexual orientation or gender identity, choosing to share the information with others and building a positive LGBTI identity (King and Smith, 2004). It not only involves coming out but staying out and dealing with the potential challenges that one might encounter as an LGBTI person.

Demi-girl is someone who only partially (not wholly) identifies as a girl or woman, whatever their assigned gender at birth.

¹¹ The Budding Burning Issues Survey was carried out as part of the annual GCN Magazine youth issue. The full article can be accessed from a link on this page: <https://gcn.ie/70-percent-of-lgbt-young-people-say-that-schools-in-ireland-are-not-safe-places/>.

Families of choice, or ‘friendship families’, refer to non-familial social networks which have been highlighted as playing a more significant role in the lives of LGBTI people when compared with heterosexual people.

Female-to-male (FTM) transgender refers to a person assigned ‘female’ at birth but who identifies as male.

Gay is a term traditionally used to describe a man who is sexually and romantically attracted to other men. While the term ‘lesbian’ is typically used to describe women who are attracted to other women, many women with same-sex attractions self-identify as ‘gay’.

Gender fluid refers to a person who does not feel confined by the binary division of male and female.

Gender identity refers to how a person identifies with a gender category. For example, a person may identify as either male or female, or in some cases as neither, both or something else.

Gender identity disorder is a controversial term. Within the medical world it refers to a formal medical diagnosis for the condition in which a person experiences persistent discomfort and disconnect with the biological sex with which they were born. It was included in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* in 1994 as a replacement for the term ‘transsexualism’.

Gender reassignment surgery refers to a variety of surgical procedures by which the physical appearance and function of existing sexual characteristics and/or genitalia are altered to resemble that of another sex.

Heteronormative, or the ‘heterosexual norm’, refers to the assumption that heterosexuality is the only sexual orientation. It is closely related to ‘heterosexism’ (see below) and can often cause other sexual orientations to be ignored or excluded.

Heterosexism is the assumption that being heterosexual is the typical and ‘normal’ sexual orientation, with an underlying assumption that it is the superior sexual orientation. This assumption often results in insensitivity, exclusion or discrimination towards other sexual orientations and identities, including LGBTI.

Heterosexual is a term used to describe someone who is sexually and romantically attracted to a person of the opposite sex.

Homophobia is a dislike, fear or hatred of lesbian and gay people.

Internalised homophobia is the homophobia of a lesbian, gay or bisexual person towards their own sexual orientation. It has been described as the conscious or unconscious incorporation of society's homophobia into the individual. It can be recognised or unrecognised by the individual but has been found to lead to struggle and tension, sometimes severe, for a person when dealing with their sexual orientation and identity.

Internalised stigma occurs when a person cognitively or emotionally absorbs stigmatising assumptions and stereotypes about mental illness and comes to believe and apply them to him or herself.

Intersex is an umbrella term used to describe a variety of conditions in which a person is born with anatomy or physiology that does not fit societal definitions of female or male (e.g. sexual or reproductive anatomy, chromosomes, and/or hormone production).

Lesbian is a term used to describe a woman who is sexually and romantically attracted to other women.

Male-to-female (MTF) transgender refers to a person assigned 'male' at birth but who identifies as female.

Minority stress is based on the premise that LGBTI people, like members of any minority group, are subject to chronic, psychological stress due to their group's stigmatised and marginalised status. While LGBTI people are not inherently any more prone to mental health problems than other groups in society, coping with the effects of minority stress can be detrimental to LGBTI people's mental health.

Pansexual is sexual attraction towards people of any sex or gender identity.

Self-harm refers to the act of harming oneself in a way that is deliberate but not intended as a means to suicide. Examples of self-harm include cutting, scratching, hitting, or ingesting substances to harm oneself.

Sexual identity refers to how a person identifies the gender of whom they are sexually and emotionally attracted to. It includes a wide range of identities, with the most typical being gay, lesbian, bisexual and heterosexual. A person's sexual identity may be different than his or her sexual behaviours and practices.

Sexual orientation refers to an enduring pattern of emotional, romantic or sexual attraction to men, women or both sexes. It includes a wide range of attractions and terms, the most common being gay, lesbian, bisexual and heterosexual. People who do not experience attraction to any sex may define themselves as asexual.

Transgender is an umbrella term referring to people whose gender identity and/or gender expression differs from conventional expectations based on the gender they were assigned at birth. This can include people who self-identify as transsexual, transvestite, cross-dressers, drag performers, genderqueer, and gender variant.

Transitioning is the process through which a person takes steps to live in their preferred gender. This can include changing appearance, mannerisms, name/pronouns, legal documentation, and other personal, social, and legal changes. This may also include undertaking hormone replacement therapy and/or gender reassignment surgery.

Transphobia is a dislike, fear or hatred of people who are transgender, transsexual, or people whose gender identity or gender expression differs from the traditional binary categories of ‘male’ and ‘female’.



Messages from Research

According to Higgins *et al.* (2016), LGBTI young people had significantly higher levels of risk than their heterosexual peers. Some key findings from their research into the lives of LGBTI people in Ireland include:

- LGBTI young people have twice the level of self-harm.
- LGBTI young people have three times the level of attempted suicide.
- 70% of LGBTI 14–18-year-olds had seriously thought of ending their own life (70% in the past year).
- LGBTI young people have four times the level of severe/extremely severe stress, anxiety and depression.
- Intersex, transgender and bisexual people were more likely to consider ending their own life than lesbian/gay females and gay males.

- Approximately 60% of transgender people have had someone use the wrong pronoun to refer to their gender (40% in past year).
- Only 40% of transgender people felt safe expressing their gender identity in public with 1 in 10 saying they would never do it.
- Only 20% of LGBTI students felt they belonged completely in their school.
- Only 44% of LGBTI students said they received positive affirmation of their identity.

LGBTI young people accessing mental health services

Key findings from research highlighted that ‘mental health professionals were not sufficiently aware and understanding of LGBTI identities and the appropriate language and terminology to use’ (Higgins *et al.* 2016: 184), which made LGBTI youth fearful of being misunderstood. Where a Tusla professional is involved with an LGBTI young person accessing mental health services, it is vitally important to check that the mental health service is LGBTI aware, friendly and safe.

The LGBTI Ireland Report (Higgins *et al.* 2016: 245) recommends that there is a need to “build the knowledge and skills of professionals and service providers” around LGBTI-specific mental health issues and the impact that homophobia/transphobia can have on a young person’s life.

The Mental Health Commission (2006: 14) noted in regard to consent for mental health treatment:

With regard to children aged 16 and 17 years, irrespective of whether a 16 or 17 year old is capable, as a matter of law or fact, of providing an effective consent to treatment, his or her views as to their treatment should be sought as a matter of course. It will then be a matter for the treating health professional to judge the weight (if any) to be accorded to such views in all the circumstances.



Practice Note

Vulnerability of LGBTI young people in care

While it is difficult to determine the exact number of LGBTI young people in the care system in Ireland, it is estimated that they comprise at least 5–10% of the total care population. Some common anxieties experienced by LGBTI young people in care include:

- Fear that being LGBTI might compromise their placements
- Risk of bullying, particularly in residential placements and from birth siblings
- Fear of negative feedback from care staff and other professionals
- Fear of rejection from foster carers

Youth and support services for LGBTI young people

It is vitally important for LGBTI young people to feel equal, safe and valued in all services they access. BeLonG To Youth Service is a national LGBTI youth service with 22 groups nationwide. Many local and regional mainstream youth services also have an LGBTI service. EPIC (Empowering People in Care) advocates for LGBTI young people in care.

Steps to take if a young person comes out to you

If a young person comes out to you, they will need:

- Someone to listen
- Someone to be positive
- Thank them for trusting you and having the courage to tell you.
- Focus on the young person and what they need.
- Acknowledge that it is a big deal for them to tell you.
- Do not tell them they are too young. Most LGBTI people know their sexual orientation or gender identity at an early age (the most common age is 12 years old).
- Do not rush the young person – let them say what they need to say.
- Ask the young person appropriate questions.
- If you do not understand anything, ask the young person to explain.

(continued)

- Treat the young person the same as everyone else.
- Let the young person know that you are there to talk at any time and will refer them to additional support if appropriate.
- Assure them of confidentiality. (In exceptional circumstances it may not be possible to guarantee confidentiality if you have grounds to believe the young person is at risk.)
- Have information and resources available to give to them, for example, on LBGTI groups. Support the young person so they can attend local groups.
- Each and every case is different and will require a different response. Use your professional discernment and skills to respond appropriately (EPIC and BeLong To 2015).

Parents/guardian/foster carer support

While coming out can be a high-risk time for an LBGTI young person, parents can also feel quite overwhelmed when a child comes out. Access to parental supports can be a key factor in supporting positive outcomes. Support for parents/guardians can be provided by professionals or peer support groups. Some useful organisations for parents include, Loving Our Out Kids (www.lovingouroutkids.org), BeLong To (www.belongto.org) and Transgender Equality Network Ireland (www.teni.ie).

If parental/foster capacity to support their LBGTI child becomes an issue, it is important that the rights of the child or young person are protected.

Ensure young people know their rights

You should ensure that the young person is aware of their rights under the United Nations Convention on the Rights of the Child, including:

- The right not to be discriminated against
- The right to have their voice heard (if in state care, they can obtain the support of an advocate from EPIC)
- The right to life, survival and development
- The right for their best interests to be taken into account when decisions are being made about them

LBGTI young people can lodge complaints regarding their rights to the Ombudsman for Children and/or the Equality Authority.

20 Fire Setting

Description

This section explores deliberate fire setting by a child or young person. There can be a number reasons for deliberate fire setting.

Curiosity

Children start fires for varying reasons. Although curiosity is a primary motivation for younger children, it should be noted that curiosity can also be a reason why older teens set fires.

A cry for help

Some children may have difficulties, either emotionally or developmentally, and can use deliberate fire setting as a method for seeking attention.

Family problems

Many young people who set fires have experienced family problems that could include poor parental judgement and parenting skills, chronic neglect and abuse, or parental alcohol and substance abuse.

Serious emotional disturbance

Serious emotional disturbance may be related to chronic abuse and neglect. One of the ways that a child or young person can express their serious emotional disturbance is through deliberate fire setting.



Messages from Research

- Children and adolescents engaging in deliberate fire setting is a significant and growing social problem. Intentional fire setting can result in significant trauma, injury or death as well as environmental damage and monetary losses (Lambie *et al.* 2012; Lambie and Randell 2011; Meara *et al.* 2012).
- Statistics in a number of countries consistently record children as being heavily involved in arson-related incidents. For example, 45% of those arrested for arson in the US in 2009 were juveniles. Likewise, in the UK, 40% of arson offences committed in 2000 were by children aged between 10 and 17 (Lambie and Randell 2011). It is commonly accepted that much fire setting by children goes unreported. Moreover, adults charged with arson often have histories of fire-setting behaviour as children (Lambie *et al.* 2012).

- Boys are two to three times more likely than girls to be involved in fire-setting behaviour (Lambie and Randell 2011).
- Boys who exhibit intentional fire-setting behaviour typically grow up in dysfunctional families characterised by behavioural and emotional disturbance (Lambie and Randell 2011). Lambie and Randell (2011) found high levels of parental stress, poor family and marital cohesion, domestic abuse, substance misuse, and paternal abuse of animals among families where there was a child or young person involved in intentional fire setting. They also found that children engaging in fire setting (and antisocial behaviour generally) may receive ‘negative parenting’, including limited and/or lax supervision and may experience neglect and, in some instances, abandonment or abuse (2011: 311).
- Research by Martin *et al.* (2004) found that boys engaging in fire setting are likely to have experienced physical and, to a lesser extent, sexual abuse. In severe cases, boys are likely to be engaged in a range of other antisocial behaviours (Lambie and Randell (2011). Lambie and Randell (2011: 326) recommend that professionals treating young people with behavioural problems be aware of “the role of fire setting and its particular importance as an indicator of particularly high risks in such individuals”.



Practice Note

Fire play and intentional fire-setting behaviour by a child must always be taken seriously. It can put a child, other people and the community at risk of significant harm. There is a very real risk of possible death and injury, as well as property damage.

Where intentional fire setting is suspected, a professional must assess the situation, giving consideration to the child or young person’s exposure to risk and factors contributing to the fire-setting behaviour. Issues for consideration in an assessment include:

- The child’s development needs
- Stressful environmental factors
- The degree of guidance and boundaries the child is receiving or is willing to accept
- The level of basic care and measures in place to ensure the child or young person’s safety

It is important to note:

- The size of a fire and the damage done are not necessarily indicators of the level of risk.
- Some young people who set fires start with small fires and then, as they become practised at setting fires, progress to larger ones.

If the child has set fires previously, it is important that the people caring for the child are familiar with the behaviours, triggers or stressors that surrounded the fire setting. Professionals can ascertain this information during the assessment and should share it with the carers.

Factors professionals should explore:

- Was the behaviour a response to some particular stressor, for example, a serious incident in the family or access with family?
- Is the child attracted to particular types of fires, for example, in bins or in bedrooms?
- Was the child on his/her own or part of a group?
- Was there alcohol or substance abuse/misuse involved?
- What was the child's affect prior to engaging in the incident?
- Does the child engage in particular behaviours prior to fire setting, for example, tearing up paper? (Fire setting can sometimes be part of a cycle of stressors and/or behaviours.)

If particular behaviours, triggers or stressors can be identified, de-escalating techniques such as diversion or distraction as well as increased supervision may prevent an incident. Referral for psychological or psychiatric help must be considered.

The Tusla assessment must consider if the child can be kept safe in their current environment. There is a danger that children labelled as 'fire setters' can be excluded from some services because of the risk posed by their behaviour. A young person who has a history of setting fires will need to be more vigilantly supervised than one who has not.

Most fires are started by lighters or matches. Ensure that as far as possible the young person does not have access to lighters or

matches or other combustible materials. Ensure that the persons caring for a young person with a history of fire setting is aware of the risks and takes steps to minimise the opportunity to set fires. Advise that they apply common-sense fire prevention strategies, such as:

- Store matches, lighters and combustible materials safely and securely, preferably in a locked cabinet.
- Never use lighters or matches as a source of amusement for children as children may imitate this behaviour.
- If a child expresses curiosity about fire or has been playing with fire, calmly but firmly explain that matches and lighters are tools for adults only.
- Use only lighters designed with child-resistant features. Remember child-resistant does not mean childproof.
- Teach young children and school-age children basic fire safety.
- Never leave matches or lighters in a bedroom or any place where children may go without supervision.

If you suspect a child is unduly fascinated with fire, consider referring them to psychology services.

3



Environmental Factors

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21 Poverty and Social Exclusion¹²

Description

Many of the families who seek help for their children, or about whom others raise concerns in respect of a child's welfare, are multiply disadvantaged.

These families may face chronic poverty, social isolation, racism and the problems associated with living in disadvantaged areas. These can include high crime rates; poor housing, childcare, transport and education services; and limited employment opportunities. Many of these families lack a wage earner.

Poverty may mean that children live in crowded or unsuitable accommodation, have poor diets, health problems or disability, are vulnerable to accidents, and lack ready access to good educational and leisure opportunities. When children themselves become parents, this exacerbates disadvantage and the potential for social exclusion. Racism and racial harassment are an additional source of stress for some families and children, as is violence in the communities in which they live. Social exclusion can also have an indirect effect on children through its association with parental substance misuse, depression, learning disability, and long-term physical health problems.



Messages from Research

Poverty

- The majority of people living in conditions of poverty and isolation do not maltreat their children. Children of middle- and high-income families are also at risk of neglect and maltreatment at the hands of their parents or carers. However, a disproportionate number of victims come from low-income families with multiple problems. Poverty, particularly when interacting with other risk factors such as depression, substance abuse and social isolation, can increase the likelihood of maltreatment.
- Poverty contributes to parents' inability to protect their children from exposure to harm and has systemic negative effects on children's health and development. This includes impaired school performance, possible delinquency, early childbearing and adult poverty.

(continued)

¹² This chapter does not contain a Practice Note because poverty and social exclusion are contributory factors which relate to many of the topics covered in this practice handbook.

- Homelessness can exacerbate the situation.
- Stevenson (2007) makes it clear that we must explore the financial position of families when assessing and understanding the impact of poverty on individual family members; consider particular difficulties in managing money; and consider including financial advice or assistance in any support plan.
- In the wider context of social isolation, it is important to ask the question as to where this family sits in the wider community and how they access support.

Single parents

- Lower income, the increased stress associated with the sole burden of family responsibilities, and fewer supports are thought to contribute to the risk of single parents maltreating their children.
- Coulter (2015) found that lone parents represented 74% of respondents in child care proceedings at District Court level. Many of these parents suffered from disabilities or addictions, and also often suffered from social isolation, and hence were particularly vulnerable.

Migrant communities¹³

Excluding Travellers, 26.5% of respondents in District Court child care cases included at least one parent from an ethnic minority; Irish Travellers accounted for 4.4% of respondents (Coulter 2015).

It has been recognised for many years in the UK that children from migrant communities are over-represented with children's specialist services. The studies suggest a number of reasons why this is the case, most commonly pointing to the following:

- There is a lack of access to appropriate preventative services.
- Children of migrant families are more likely to be resident in larger, poorer, more socially excluded households with higher rates of parental and child disability present within the household.
- Adult unemployment, often linked to uncertain immigration status, could be excessively high among these communities. Poverty rates are also linked to living in larger families.

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¹³ Visit <http://www.paveepoint.ie/resources/roma/> for additional information specific to Roma communities in Ireland.

- Families from migrant populations may be reluctant to engage with services for a variety of cultural reasons, including inappropriate or inaccessible services, or a disparity may exist in terms of professionals' treatment of migrant children and families with whom they engage.
- Some migrant communities may feel particularly reluctant to report concerns in relation to child protection for a combination of reasons. These include fear of stigma or belief that children's welfare and protection could best be met by accessing support from within the family. Alternatively, it could be argued that under-representation in welfare statistics is, in fact, reflective of the degree of levels of parenting support available to families.
- For migrant families living in an area where they are part of a very small community, or indeed households where residents are a minority group within a larger or different migrant population, greater risk of social isolation may exist.
- There is no systematic bias that exists in decision-making concerning migrant children, although professionals are often more hesitant and sometimes confused over how best to meet the needs of these children.
- Problems with receiving interpreting services have been regularly reported for families where English is not their first language. Inevitably, this impacts significantly on both comprehension of access to services and in engaging with child protection proceedings or working with service providers.

22 Begging

Description

Forced child begging is identified as a form of child exploitation and is associated with significant neglect of affected children. Forced child begging is when a child is forced to beg through psychological and physical coercion (Delap 2009).

An adult begging for money may seek to invoke public sympathy by having their own or someone else's child with them. A child may also beg alone or with adult support or coercion.

Since April 2013, An Garda Síochána have to establish a prima facie case that begging has taken place without legal authorisation (Street and House to House Collections Act 1962) in order to make a charge.



Messages from Research

Children may be forced to beg by parents or carers. Children may also be trafficked from poorer countries specifically to beg on the streets of wealthier nations by informal networks or organised criminal gangs (Delap 2009). The EU's Brussels Declaration on Preventing and Combating Trafficking in Human Beings (2002), states that children often are brought into EU member states or moved between member states for the purpose of exploitation through street begging or other criminal activities. Such exploitation has been labelled as 'serious violations' of the victim's human rights by the EU.

In the Dublin area, the Irish Society for the Prevention of Cruelty to Children (ISPCC) reported 182 sightings of child begging in 2013 (ISPCC 2013). According to the ISPCC (2008), the risks to children from street begging include:

- Being out in bad weather puts their health at risk.
- Exposure to many different public attitudes could have a negative impact on their emotional wellbeing,
- Very often they are being denied their right to education.
- They are at greater risk of substance misuse and of being sexually exploited.
- The likelihood of them becoming criminalised is high.



Practice Note

The presence of a child begging on the streets or on public transport raises concerns for their welfare and development. Begging is an offence that An Garda Síochána is responsible for prosecuting. In relation to good practice, anyone who observes children begging by themselves, with a parent, or another adult, should report the matter to An Garda Síochána, giving the whereabouts of the begging taking place and a description of the child. Once reported, An Garda Síochána will investigate the offence of begging and attempt to establish the identity and address of any child involved.

23 Transient Children

Description

A transient family is a family that moves often from one geographical area to another. The children within these families may include children already known to the child protection system. The family's movement from place to place may have a detrimental effect on the child's health and wellbeing.



Messages from Research

The frequent movement of families may, in some cases, be associated with a deliberate attempt to evade the authorities or an intention to impede child protection procedures. Such families require professionals to maintain close contact (Rotherham Doncaster and South Humber NHS Foundation Trust 2015).



Practice Note

Some families are readily identifiable as transient by their continual movement either across the country or within a particular locality, and this may be indicated in their health or educational records.

Other factors that may indicate transience within a family include:

- Failure to respond to professionals' enquiries and correspondence.
- Families where no single agency has a complete picture of the family's circumstances or about whom information is fragmented across agencies.
- Where a family only has temporary registration or has no registration with a general practitioner.
- History of missed significant health appointments and/or assessments.
- Constant change of health professionals within a team that is directly involved with the family.
- Families and children who have three changes of address or school within a 12-month period.

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If such families become known to the social work department, it has a responsibility to:

- Put an alert on the child's file that the family is transient.
- Check to see if a Child Protection Plan is in place.

Children and families who move more frequently between local authorities include homeless families, asylum-seekers and refugees, Traveller and Roma families, children in care, and families experiencing domestic abuse.

A parent's homelessness or placement in temporary accommodation, often at a distance from previous support networks, can result in or be associated with transient lifestyles. There is a risk the family will fall through the net and become disengaged from health, education and other support systems. There may also be a reduction in previously available family/community support.

Temporary accommodation, for example bed-and-breakfast accommodation or women's refuges, may present additional risks. For example, where other adults are also resident who may pose a risk to the child.

Families that move frequently can find it difficult to access the services they need. For those already socially excluded, moving frequently can worsen the effects of this exclusion and increase isolation.

Some families in which children are harmed move home frequently to avoid contact with concerned agencies, so that no single agency has a complete picture of the family.

The following circumstances, associated with some families with a transient lifestyle, are a cause for concern:

- Child/ren not consistently registered with a GP
- Child/ren attending hospital emergency departments frequently for treatment, rather than engaging with primary health services
- Child/ren missing from a school roll, or persistently not attending
- Information spread across a network of agencies with no single agency holding the whole picture of a family history

Unusual, extended non-school attendance, missed appointments, or abortive home visits may indicate that a family has moved out of the area. Local agencies and professionals, working with families where there are outstanding child welfare concerns, must bear this in mind.

24 Bullying

Description

A definition of bullying is supplied in the Children First: National Guidance (DCYA 2017: 12):

Bullying can be defined as repeated aggression – whether it is verbal, psychological or physical – that is conducted by an individual or group against others. It is behaviour that is intentionally aggravating and intimidating and occurs mainly among children in social environments such as schools. It includes behaviours such as physical aggression, cyberbullying, damage to property, intimidation, isolation/exclusion, name calling, malicious gossip and extortion. Bullying can also take the form of abuse based on gender identity, sexual preference, race, ethnicity and religious factors. With developments in modern technology, children can also be the victims of non-contact bullying, via mobile phones, the internet and other personal devices.

Bullying of children can also be perpetrated by adults, including adults who are not related to the child. Bullying behaviour when perpetrated by adults, rather than children, could be regarded as physical or emotional abuse. However, other major forms of child abuse, such as neglect and sexual abuse, are not normally comprehended by the term ‘bullying’.

Bullying can cause considerable distress to children, to the extent that it affects their health and development and, in extreme and severe cases, can be a source of significant harm, including self-harm and suicide. Bullying can include emotional and/or physical harm to such a degree that it constitutes significant harm. There is the potential for bullying wherever groups of children spend time together on a regular basis or live together.

Bullying can take many forms, such as:

- Hitting and/or punching (physical bullying)
- Teasing or name-calling (verbal bullying)
- Intimidation using gestures or social exclusion (non-verbal bullying or emotional bullying)
- Sending insulting messages by text, email or through social media (also known as cyberbullying – see cyberbullying section below)

Types of bullying perpetrators

The National Youth Council of Ireland, in its document *Let's Beat Bullying*, identifies six types of perpetrators of bullying (Keane and Murray 1998 in NYCI 2007):

1. **The reactive perpetrator:** These perpetrators may lash out at others because they are hurt and are crying out for help. This may be due to circumstances such as a family crisis or bereavement.
2. **The anxious perpetrator:** These perpetrators may have low self-esteem, emotional distress and insecurity. By bullying others, they are attempting to gain confidence and status.
3. **The sadistic perpetrator:** These perpetrators have little or no sympathy for their targets, are very aggressive, have high self-esteem and enjoy inflicting pain on their targets. The sadistic perpetrator rarely shows remorse or guilt towards their target.
4. **The homegrown perpetrator:** Here the perpetrator may come from a background where they were bullied and bullying is a learned behaviour. They see this type of behaviour as their only form of control.
5. **The underachieving perpetrator:** This perpetrator may be struggling academically/socially and seeks status by bullying others.
6. **The perpetrator/target:** This perpetrator may have been bullied and takes their frustration out on others who are perceived to be weaker, by bullying them.



Messages from Research

- Bullying has been identified as one of the most significant problems confronting children and adolescents in contemporary Western societies (Turner *et al.* 2013; Finkelhor *et al.* 2012). It generally takes a variety of forms, including persistent physical and/or verbal, emotional and relational (e.g. spreading rumours, isolating behaviour) harassment of an individual by another or others (Turner *et al.* 2013; Reijntjes *et al.* 2013).
- Bullying is harmful and repetitive and involves a power imbalance favouring perpetrator over victim (Bauman *et al.* 2013; Vacca and Kramer-Vida 2012). Research by Craig *et al.* (2009 in Sapouna and Wolke 2013) on the prevalence of bullying in 40 countries indicates over one-quarter of adolescents (26%) are involved in bullying: 13% as victims, 10% as perpetrators, and 3% as both.

- Bullying is associated with serious negative outcomes for victims including attempted suicide (Turner *et al.* 2013); suicide ideation and depression (Bauman *et al.* 2013; Sapouna and Wolke 2013); involvement in substance abuse and antisocial behaviour (Reijntjes *et al.* 2013; Mishna *et al.* 2012); eating disorders, low self-esteem, poor school performance and attendance (Vacca and Kramer-Vida 2012). Repeated and/or long-term bullying has resulted in victims' suicide (Turner *et al.* 2013).
- Foster children may suffer disproportionately from bullying, particularly if they have relocated to a new home/school environment where racial, religious, family structure, perceived sexual orientation, disabilities and poor self-esteem may set them apart from others (Vacca and Kramer-Vida 2012).



Practice Note

Many children, particularly boys and older children, do not tell their parents or other adults that they are being bullied, so it is important that adults are vigilant to possible signs of bullying. Here is a guide to recognising the signs of bullying and getting it to stop.

Possible warning signs that a child is being bullied include:

- Comes home with torn, damaged, or missing pieces of clothing, books, or other belongings
- Has unexplained cuts, bruises and scratches
- Has few, if any friends, with whom he or she spends time
- Seems afraid of going to school, walking to and from school, taking the school bus, or taking part in organised activities with peers (such as clubs)
- Takes a long, 'illogical' route when walking to or from school
- Has lost interest in schoolwork or suddenly begins to do poorly in school
- Appears sad, moody, teary, or depressed when he or she comes home
- Complains frequently of headaches, stomach aches, or other physical ailments
- Has trouble sleeping or has frequent bad dreams
- Experiences a loss of appetite
- Appears anxious and suffers from low self-esteem

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What to do if you suspect that the child you are working with is being bullied:

If a child shows any of the signs outlined above, this does not necessarily mean that he or she is being bullied, but it is a possibility worth exploring. Talk with the child and talk with staff at school or the club to learn more.

1. Talk with the child

Tell the child that you are concerned and that you would like to help. Here are some questions that can get the discussion going. It may be appropriate, depending on individual circumstances, for the parent(s) or carer(s) of the child to ask the questions if it is felt that the child may not discuss the issues with you.

Some direct questions:

- I'm worried about you. Are there any children or young people at school or your club/activity who may be picking on you or bullying you?
- Are there any children/young people at school or your club/activity who tease you in a mean way?
- Are there any children/young people who leave you out or exclude you on purpose?

Some indirect questions:

- Do you have any special friends at school or club/activity this year? Who are they? Who do you hang out with?
- Who do you sit with at lunch, in school and on the bus?
- Are there any children/young people at school/your club/activity who you really don't like? Why don't you like them? Do they ever pick on you or leave you out of things?

2. Talk with staff at the child's school, club/activity

If you feel the issue is at school, set up an appointment to talk with the child's teacher or year head, or advise their parent(s) or guardian(s) to do so. The class teacher or year head will probably be in the best position to understand the relationships between the child and their peers at school. Share your concerns about the child and ask the teacher such questions as:

- How does the child get along with other students in his or her class?
- With whom does he or she spend free time?
- Have you noticed or ever suspected that the child is being bullied by other students?

It can be useful to give examples of some ways that children can be bullied to ensure that the teacher is not focusing on only one kind of bullying (such as physical bullying).

Ask the teacher to talk with other adults who interact with the child at school (such as the music teacher, physical education teacher, or bus driver) to see whether they have observed students bullying the child.

Advise the parent that, if they are not satisfied with the conversation, to make an appointment to meet with the child's guidance counsellor or school principal to discuss the concerns.

If you feel that the issues are arising at a club or activity the child attends, make an appointment to see the club leader or activity organiser and relay your concerns as above.

If you obtain information from the child or from staff at the child's school or club/activity that supports your concern that he or she is being bullied, take action quickly. Remember that bullying can have serious effects on children.

Bullying behaviour can also serve functions for the bully that need to be acknowledged when attempting to understand and deal with bullying incidents. Such functions can include:

- Group recognition/status – demonstrating power
- Release of pent-up aggression – resulting in a sense of relief
- Sense of 'belonging' to a group

25 Social Media

Description

The *Merriam-Webster Dictionary* defines social media as “forms of electronic communication (such as websites for social networking and microblogging) through which users create online communities to share information, ideas, personal messages, and other content (such as videos)”. Any website that enables users to interact is considered a social media site, including social networking sites such as Facebook, Instagram and Twitter; gaming sites and virtual worlds such as Club Penguin, Moshi Monsters and The Sims; video-sharing sites such as YouTube; and blogging sites such as Tumblr.

An issue related to social media is sexting. Sexting involves sending sexually explicit images, videos or text messages via digital means. Primarily such ‘sexts’ are sent using mobile phones and/or chat apps, such as Snapchat, Viber or WhatsApp. Sexts can constitute child pornography.

What are the risks involved?

The risks young people may face when using social media include:

- Peer-to-peer risks (e.g. bullying)
- Exposure to inappropriate content and/or contact (e.g. pornography, exploitation)
- Lack of understanding of online privacy issues and the digital footprint (e.g. disclosing personally identifying information)
- Health risks (e.g. the addictive nature of social media can lead to eating disorders, obesity, heart problems, sleep disorders, and other related physical and mental health issues)
- ‘Facebook depression’ and ‘Facebook envy’, where the intensity of the online world is thought to play a role in triggering depressive symptoms (Krasnova *et al.* 2013). Those suffering from Facebook depression are at risk of social isolation and often seek ‘help’ from risky internet sites that may promote substance abuse, unsafe sexual practices, or aggressive or self-destructive behaviours
- Behavioural tendency to conform to what is popular without considering whether it is right or wrong (i.e. ‘Like pages’ as a means of cyberbullying)

- Exposure to inappropriate outside influence of third-party advertising groups
- Pictures posted may be distributed beyond intended recipients, either online or through mobile phones
- Increased risk to a young person of victimisation (i.e. cyberbullying)
- Development or exacerbation of mental health issues such as anxiety, depression and suicide ideation or thoughts
- Risk of criminal offences, under Irish law, depending on the age of the individual(s) depicted in ‘sexts’



Messages from Research

- The proliferation of mobile and gaming technology, digital media and increasing use of social networking (SN) sites on the internet has increased children’s risk of abuse and aggression (Baumgartner *et al.* 2012).
- A recent study (O’Neill *et al.* 2013) indicates 59% of European children aged between 9 and 16 and four in every five 12–17-year-olds in the US have SN profiles.
- O’Neill *et al.*’s (2013) study of online activity by children found those actively using SN sites were 46% more likely to have received sexual messages, 56% more likely to have seen graphic sexual images, and 114% more likely to have been bullied than peers not using SN sites.
- Sengupta and Chaudhuri’s (2011) analyses of survey data from 2006, concerning adolescent internet usage in the US, highlights that the way children interact with others on SN sites determines whether they are eventually subjected to online harassment or bullying.
- Posting unrestricted personal information, pictures and contact details, flirting online, visiting chatrooms, and unsupervised use of the internet were all found to increase SN site users’ likelihood of receiving unsolicited contact from strangers and cyberbullying (Sengupta and Chaudhuri 2011).



Practice Note

In some cases, the factors that increase young people's vulnerability online are often extrinsic to the social media sites themselves. It is therefore important to identify if a particular concern or issue is associated with technology (e.g. lack of understanding of privacy settings or appropriate norms for public communication online) or if the concern or issue would be better addressed through other non-technology-linked interventions (e.g. group work sessions on sex and sexuality, or supporting an individual young person to deal with specific issues around self-esteem, peer pressure or social isolation). Incorporating activities that help in developing young people's resilience, cognitive and emotional competencies, critical skills and self-esteem in real life will better equip young people to deal with the issues they face online.

In order to best protect young people online, it is essential to identify their specific needs. Conducting a survey can help identify current access to and engagement with social media, in addition to the skills and resources available to a particular individual/group. This will also help identify areas that may need to be addressed (e.g. lack of awareness of privacy issues, etc.), thus aiding professionals in providing relevant and timely safety guidance and support to young people and their families.

26 Cyberbullying

Description

Cyberbullying is defined as “any behavior performed through electronic or digital media by individuals or groups that repeatedly communicates hostile or aggressive messages intended to inflict harm or discomfort on others” (Tokunaga 2010: 278).

Cyberbullying, similar to more traditional forms of bullying, must meet three main criteria:

1. Intention to cause harm to the victim(s).
2. Repetition of abusive behaviour(s) over time.
3. Imbalance of power between victim(s) and bully/bullies (i.e. superior technological skills, anonymity).

Debate surrounds the use of the word *repeated* in the definition of cyberbullying. In some instances, one behavioural act can create an ongoing sense of intimidation for the victim (e.g. posting a humiliating photo/video that can be viewed by a large audience can have long-term effects).

Cyberbullying differs from more traditional forms of bullying in a number of ways:

- The audience is now larger.
- There are no time or location barriers; it can happen 24/7.
- The target’s reaction is often not seen, leading to a reduction in feelings of empathy or guilt for the perpetrator.

Forms of cyberbullying

Cyberbullying can be classified by the media through which the abuse occurs (e.g. mobile phones, instant messenger, chatrooms, social networking sites, video/photo-sharing sites/apps, gaming sites, etc.) and/or by the nature of the abuse itself (e.g. flaming, impersonation, harassment, etc.).

Willard (2007) has identified the following seven forms of cyberbullying:

1. **Flaming:** Online ‘fights’ using electronic messages with angry and vulgar language.
2. **Harassment:** Repeatedly sending nasty, mean and insulting messages.

3. **Denigration:** Intentionally setting out to damage a person’s reputation or friendships by sending or posting derogatory comments, cruel gossip, or rumours about the person; creating a webpage or website devoted to insulting another person.
4. **Impersonation:** Gaining access to someone’s account, posing as that person, and sending messages to make the person look bad, get that person in trouble or danger, or damage that person’s reputation or friendships. This behaviour is commonly referred to as ‘fraping’ when it occurs using Facebook.
5. **Outing and trickery:** Sharing someone’s personal or embarrassing information or images online or via mobile phone or other electronic media, or tricking someone into revealing secrets or embarrassing information, which is then shared online.
6. **Exclusion:** Intentionally excluding someone from an online group (i.e. a ‘friend list’, a gaming environment, or group chat). Within a gaming context, the term ‘*griefer*’ is often applied to a player who deliberately irritates and harasses other players within the game, using aspects of the game in unintended ways.
7. **Cyberstalking:** Repeatedly sending messages that include threats of harm or that are highly intimidating or engaging in other online activities that make a person afraid for his/her safety. Another definition of cyberstalking is using the internet or other electronic means as a way to harass, intimidate, threaten, monitor or make unwanted advances towards another. It can involve direct communications through emails, chatrooms, bulletin boards or social sites, such as Facebook, the surreptitious gathering of information regarding the target, or covert observation (MacKenzie *et al.* 2016).



Messages from Research

- Recently, cyberbullying (repeated harassment and aggression using technology, e.g. emails, text messaging, picture and videoclips, social media websites and internet forums), has become prevalent (Bauman *et al.* 2013; Slonje *et al.* 2013). According to Turner *et al.* (2013: 53), cyberbullying has “more far reaching effects” than traditional bullying because

harassment and attacks “can appear in multiple places online and endure over lengthy periods of time”. Young people spend more time interacting and communicating online (in chatrooms, social media outlets and through email, Twitter and Snapchat). As identities online can be withheld and/or altered or protected, more opportunities are now afforded for involvement in bullying (Mishna *et al.* 2012). In addition, as technology develops, new forms and methods of bullying emerge (Slonje *et al.* 2013).

- The quality of relationships with family and friends is important in determining adolescent resilience to bullying, including online harassment. Good family and peer relationships, in particular, protect adolescents, may reduce the impact of bullying, and help victims to better cope with harassment (Cassidy *et al.* 2009; Wang *et al.* 2009; Sapouna and Wolke 2013).
- Cyberbullying may occur within friendship groups and attention needs to be paid to peer interactions; routine teasing among peer groups can quickly lead to serious abuse and harassment (Cassidy *et al.* 2009; Mishna *et al.* 2012; Wang *et al.* 2009).
- The high risk of adverse mental health issues developing as an outcome of persistent cyberbullying highlights a need for targeted intervention efforts with victims, according to Turner *et al.* (2013).
- According to Turner *et al.* (2013), professionals working with bullied children and adolescents should consider the type of harassment experienced (e.g. physical, verbal, cyber) in order to devise and implement appropriate responses. Parents, professionals and teachers, among others, need to be aware of and knowledgeable about youth online communication and interaction as well as its role in children’s socialisation (Cassidy *et al.* 2009; Mishna *et al.* 2012; Davidson and Gottschalk 2011).



Practice Note¹⁴

Why does cyberbullying happen?

Cyberbullying can happen for a number of reasons. Willard (2007: 268–269) lists the following possible reasons for cyberbullying:

- A cyberbully may be a person whom the target knows or an online stranger. Or the cyberbully may be anonymous, so it is not always possible to tell. A cyberbully may solicit involvement of other people who do not know the target – cyberbullying by proxy.
- Cyberbullying and cyberthreats may be related to in-school bullying. Sometimes the student who is victimised at school is also being bullied online. But other times, the person who is victimised at school becomes a cyberbully and retaliates online. Still other times, the student who is victimised will share his/her anger or depression online as distressing material.
- Cyberbullying may involve relationships. If a relationship breaks up, one person may start to cyberbully the other person. Other times, teens may get into online fights about relationships.
- Cyberbullying may be based on hate or bias: bullying others because of race, religion, physical appearance (including obesity), or sexual orientation.
- Teens may think that cyberbullying is entertaining: a game to hurt other people.
- Teens may have no one to talk with about how bad they are feeling and how horrible their life is. Hence, they describe their feelings online. They might think that if they post this material online, they will meet someone who cares about them. Unfortunately, they may meet a dangerous stranger who will do them harm or hurt other teens, and who only reinforces their bad feelings.

(continued)

¹⁴ Professionals involved in cases of suspected cyberbullying may also wish to refer parents to Child Safeguarding: A Guide for Policy, Procedure and Practice, 'Appendix 8 – Technology, Internet and Social Media: SafeUse for Children and Young People', available at www.tusla.ie.

What are the signs/symptoms that someone is being cyberbullied?

Some signs or symptoms that may present when a child or young person is experiencing cyberbullying include:

1. More frequent health problems: headaches, stomach aches, frequent absenteeism, sleep problems, depression, or suicidal thoughts.
2. Behavioural and emotional changes: distressed, anxious, frustrated, fearful, angry.
3. School-related changes: inability to concentrate, drop in academic performance, reluctance to attend school.
4. Negative emotional expressions after use of social media: poor self-image, sadness, hopelessness, loneliness, suspicion of others.
5. Changes in online behaviour: more careful or cautious approaches to communicating online.
6. Being emotionally upset during or after using the internet or the phone.
7. Being very secretive or protective of their digital life.
8. Wanting to stop using the computer or mobile phone.
9. Being nervous or jumpy when getting an instant message, text or email.
10. Avoiding discussions about computer or mobile phone activities.
11. Physical symptoms such as self-harm, eating disorders and/or risky behaviours.

Actions to consider when a young person is the target of cyberbullying

- Confirm that you are dealing with bullying behaviour.
- Listen calmly and uncritically to the report the young person is making.
- Remind the young person that it is not their fault; it is the person who is doing the bullying that has the problem.
- Tell the young person not to respond to the bully as this can exacerbate the issue.
- Keep a copy of all correspondence between the young person and the bully.

- Encourage the young person to remove the cyberbully as a ‘friend’ online and block them from his/her phone.
- Report the issue to the website and/or mobile phone company as appropriate.
- Serious issues should be reported to An Garda Síochána: legal issues include making inappropriate sexual suggestions, racist remarks or persistent bullying that is seriously damaging to the young person’s wellbeing.
- Ireland currently has no specific cyberbullying legislation. However, a number of laws may have relevance to specific cyberbullying behaviours, such as:
 - » Criminal Damage Act 1991
 - » Non-Fatal Offences Against the Person Act 1997
 - » Post Office (Amendment) Act 1951
 - » European Communities (Electronics Communications Networks and Services) (Data Protection and Privacy) Regulations 2003 (SI No. 353 of 2003)
 - » Video Recordings Act 1989

Coping strategies for dealing with cyberbullying

In one of the few studies that asked young people directly how they coped with cyberbullying, Riebel *et al.* (2009) identified four major coping strategies:

1. Social coping (e.g. looking to others for help, getting advice from others, asking someone with authority to put a stop to the bullying).
2. Aggressive coping (e.g. ‘I threaten to beat him/her up’).
3. Helpless coping (e.g. ‘I don’t know what to do’).
4. Cognitive coping (e.g. attempting to reason with the bully or understand their motives).

Although this study did not assess which strategies were most successful, social and cognitive coping are commonly considered to be the most effective (O’Moore and Minton 2009). It is important that parents/carers of young people are made aware that aggressive and helpless coping strategies are ineffective and should not be encouraged. As each individual perceives and copes with cyberbullying in different ways, it is also important to connect the emotional impact of cyberbullying with the psychosocial contexts of the victims (Šleglová and Černá 2011).

27 Grooming

Description

Grooming refers specifically to the process of preparing a child for sexual abuse through the building of relationships and trust. Grooming is defined as “a process by which a person prepares a child, significant adults and the environment for the [sexual] abuse of [a] child” (Craven *et al.* 2006: 297). It can occur when an abuser builds attachment to a child through face-to-face and/or online interaction and communication (Whittle *et al.* 2013). Specific goals of an abuser include “gaining access to the child, gaining the child’s compliance and maintaining the child’s secrecy to avoid disclosure” (Craven *et al.* 2006: 297). Typically in the grooming process, an unhealthy attachment and bond of trust is formed, for example, through play and support, where a child’s inhibitions are reduced and desensitised and power and control are asserted, all involving the abuser’s manipulation of the child (Whittle *et al.* 2013).



Messages from Research

- Traditionally, offenders have accessed victims from within family, workplace, sporting and educational settings as well as children in residential care (Whittle *et al.* 2013; Craven *et al.* 2006).
- Grooming is a “well organised long-term process” where offenders integrate themselves into contexts where they will access children (Craven *et al.* 2006: 297).
- Offenders will often target vulnerable children and families (e.g. lone parent families and/or where child supervision is lax), offering support and seeking to build trust with the child and with adults significant in the child’s life (Craven *et al.* 2006).
- Gaining ‘insider status’ provides abuse opportunities and can protect offenders from accusations if a child discloses any abusive incidents (Craven *et al.* 2006: 293).



Practice Note

In recent times, the internet has provided offenders with new opportunities to groom children for sexual abuse. Utilising the internet, abusers can more easily access children through communicating and interacting in relatively anonymous and private virtual spaces. As children’s online presence increases, offenders are provided with opportunities to construct friendly and intimate relationships with children without having to come into contact with parents and other adults (Craven *et al.* 2006). In some cases, groomers are content to communicate and fantasise without ever actually meeting targeted children (Davidson and Gottschalk 2011).

While research into online grooming is at an early stage, certain risk factors have been identified by Whittle *et al.* (2013: 137) as heightening or reducing a child’s resilience to grooming. Table 27.1 lists risk factors and protective factors that relate to the individual child and to their family/community.

Table 27.1: Risk factors and protective factors

	Risk factors	Protective factors
Individual	<ul style="list-style-type: none"> • Female • Confusion about sexual orientation (both sexes) • Low self-esteem • Mental health problems • Social isolation or loneliness • Involved in risk-taking behaviour • Disability • Previous victimisation 	<ul style="list-style-type: none"> • Emotional stability • High self-esteem • Social support • Not involved in risk-taking behaviour
Family or community	<ul style="list-style-type: none"> • Poor family relationships • Lack of family cohesion • Substance abuse in the family • Lone parent or reconstituted families • Lax supervision • Poverty (a possible factor) 	<ul style="list-style-type: none"> • Supportive relationships • Internet supervision • High parent education • Support from peers

28 Trafficking of Children

Description

Under international law, child trafficking is a crime involving the movement of children for the purpose of their exploitation.¹⁵ Article 4(a) of the Council of Europe’s (2005) Convention on Action Against Trafficking in Human Beings defines the trafficking of children as the “recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation”.

Child trafficking is a form of child abuse and requires a child protection response. Children may be trafficked for many reasons, such as:

- Sexual exploitation
- Criminal activity, including cannabis cultivation and street crime
- Labour exploitation
- Informal care arrangements with related or unrelated adults for domestic servitude
- Benefit fraud or carrying out petty crimes
- Forced marriage
- Illegal adoption

This list is not exhaustive and children are often exploited in more than one way.

Child trafficking is a form of child abuse and requires a child protection response.



Messages from Research

- According to the UN, it is estimated that 1.2 million children are trafficked across the world each year and that 246,000 youngsters are thought to be involved in child labour (cited in BBC 2006), thus showing the possible extent of child trafficking.
- Child trafficking covers a broad range of crimes, some of which include initiation to prostitution, sexual exploitation, drug trafficking, illegal adoption, domestic service and forced labour (Somerset 2001; ECPAT UK 2007; Home Affairs Committee 2009).
- The NSPCC in the UK has found that traffickers use grooming techniques to gain the trust of a child, family or community. They may threaten families, but this is not always the case – in fact, the use of violence and threats to recruit victims has decreased (Europol 2011).

¹⁵ See also Chapter 14: Organised Child Sexual Exploitation.

- Traffickers may promise children education or persuade parents that their child can have a better future in another place. Sometimes families will be asked for payment towards the ‘service’ a trafficker is providing – for example, sorting out the child’s documentation prior to travel or organising transportation. Traffickers make a profit from the money a child earns through exploitation, forced labour or crime. Often this is explained as a way for a child to pay off a debt they or their family ‘owe’ to the traffickers. Although these are methods used by traffickers, coercion, violence or threats do not need to be proven in cases of child trafficking – to support a concern of child trafficking only requires evidence of movement and exploitation (NSPCC 2016).



Practice Note

The child rights-based approach to trafficking means placing the children at the centre of all trafficking related interventions. The child’s best interests need to be given primary consideration in all actions. These should be determined for each child, giving due consideration to his or her views. (UNICEF 2008: 39)

Identifying if a child has been trafficked is not easy. Trafficked children are often hidden; they may be scared or not realise they have been a victim of trafficking. Possible victims of trafficking may not be forthcoming with information and may tell their stories with obvious errors and inconsistencies. Some traffickers compose stories for victims to learn in case they are approached by the authorities, which can lead to stories with errors or a lack of reality.

Victims’ early accounts may also be affected by the impact of trauma. In particular, victims may experience post-traumatic stress disorder, which can result in symptoms of hostility, aggression, difficulty in recalling details or entire episodes, and difficulty concentrating (UNODC 2009).

Many victims may not speak English well or may have other communication difficulties. Qualified interpreter¹⁶ should be used to communicate with the child. Where possible, the interpreter should not come from the same country as the child, as the child's trafficking experiences may make them wary of adults from their home country. Family members, friends or members of the public should also not be used to interpret (NSPCC 2015).

Professionals should be alert to children who¹⁷:

- Have no access to their parents or guardians
- Look intimidated
- Have no friends of their own age
- Have no access to education
- Rarely leave their house, have no freedom of movement, and have no time for playing
- Live apart from other children and in substandard conditions
- Eat apart from other 'members' of the family
- Are given only leftovers to eat
- Spend a lot of time doing household chores
- Engaged in work not suitable for children
- Travel unaccompanied by adults
- Travel in groups with persons who are not relatives
- Are seen in inappropriate places, such as brothels or factories (or where the presence of toys or children's clothing in appropriate places such as factories or brothels is noted)
- Are unaccompanied and carry telephone numbers for calling taxis
- Are subjected to insults, abuse, threats or violence
- Are orphaned or living apart from their family or are living in an unregulated private fostering arrangement
- Are not known to any universal services, including education and health, or who might not be registered with a school or a GP practice
- Have been referred to social services following an arrest for illegal entry, use of false documents or cannabis cultivation

(continued)

¹⁶ See *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services* (HSE 2009), policy adopted by Tusla and available on the Tusla hub and www.hse.ie.

¹⁷ Adapted from NSPCC 2015.

- Live in substandard accommodation
- Are not sure which country, city or town they are in
- Are unable or reluctant to give details of accommodation or personal details
- Have no documents or have falsified documents
- Possess unaccounted for money or goods
- Are permanently deprived of a large part of their earnings, required to earn a minimum amount of money every day or pay off an exorbitant debt
- Have injuries from workplace accidents.

Other questions professionals should consider asking when assessing whether a child has been trafficked or not include:

- Does an adult, who cannot prove they are the next-of-kin, insist on interpreting for the child or refuse the child access to their social worker on their own?
- Does the child have a valid passport/visa (not applicable to EU nationals)?
- Is there a history of the child going missing (e.g. a possible indicator of re-trafficking or abduction)?
- Is the child known to youth offending services and are they a prolific offender?

Signs that an adult may be involved in child trafficking should also be considered by professionals trying to establish if a child has been trafficked. These include an adult:¹⁸

- Making multiple visa applications for different children
- Acting as a guarantor for multiple visa applications for children
- Travelling with different children whom they are not related to or responsible for
- Insisting on remaining with and speaking for a child whom they are not related to
- Living with unrelated or newly arrived children
- Abandoning a child or claiming not to know a child they were previously with.

Once a child has been identified as a victim of trafficking, they need to be appropriately protected and supported. This may include:

- Immediate emergency protection
- Assessment of their needs

(continued)

- Provision of a safe place to live
- Access to interpreters/
- Access to therapeutic services
- Provision of witness support so they can testify against the traffickers
- Access to advocacy
- Help with regularising their immigration status or returning to their home country
- Working towards reunification with their family
- Provision of education and assistance in developing self-protection skills.

What to do if you're concerned about a child being trafficked¹⁹

- Follow your child protection procedures if you are concerned about a child who may have been trafficked.
- Do not raise your trafficking concerns directly with an accompanying adult.
- Try to find out more about the child and speak with them on their own, with an interpreter if required.
- When speaking to the child, offer reassurance, explain what help you can offer, and what you will do.
- Record all details of the child and accompanying adults, as well as information including names and addresses of relatives overseas, in order to make necessary checks.
- Liaise with relevant agencies to establish who the adults are in the child's life, such as making checks with the Social Welfare Service to see who is claiming benefits for the child.
- As trafficking involves movement, be sure to link with agencies across borders and in other countries. This should include the child's country of origin and any other countries that you know they have passed through before coming to Ireland.
- Follow government guidance for child trafficking, sexual exploitation and children missing from Tusla care or Reception and Integration Agency accommodation.
- Put safeguards in place to try and prevent the child going missing.
- Make a thorough assessment of risk and safety, if considering returning the child to the adult claiming to be their parent/carer.

¹⁹ Adapted from NSPCC (2015), *Stop Child Trafficking and Slavery in its Tracks: Advice for Social Workers*.

29 School Non-Attendance²⁰

Description

The Education (Welfare) Act 2000 established the National Educational Welfare Board (now Tusla Educational Welfare Services), which is responsible for enforcement regarding school non-attendance. In January 2014, this responsibility was transferred to the board of Tusla under the Child and Family Agency Act 2013.

The Education (Welfare) Act 2000 requires school principals to register each child/student on the day the child first attends the school; the child is then deemed to be registered in that school.

The student's name cannot be removed from the register unless the child transfers to another school or the principal has received notification that the child is registered by Tusla Educational Welfare Services.

Arrangements for transfer of students

School principals must communicate any problems relating to school attendance and any other appropriate matters relating to the child's educational progress to the school to which a pupil is transferring.

Records of attendance

Under the Education (Welfare) Act 2000, the primary responsibility for school attendance rests with the child's parents. Parents are required, under the Act, to notify their child's school of reasons for any absences. Schools must keep a record of pupils' attendance and the reasons given for any absences.

Tusla Educational Welfare Services must be informed when:

- A student is suspended for a period in excess of six days.
- A student is absent in excess of 20 school days in a school year.
- A student's name is removed from the school's register.
- In the opinion of the principal, the student is not attending regularly.
- In the opinion of a principal, following school interventions, the attendance of a student continues to be of concern.

²⁰ This chapter does not contain a Practice Note as school non-attendance is a contributory factor which relates to many of the topics covered in this practice handbook.

When a report is received by Tusla Educational Welfare Services, it will make all reasonable efforts to ensure the continued education of the child and to consult with the pupil, teachers and parents/carers accordingly.

Failure to ensure a child attends school can lead to parents/carers being charged with an offence. This occurs when, following interventions from Tusla Educational Welfare Services, Tusla forms an opinion that parents are failing or neglecting their duties. Conviction may result in imprisonment or a fine being imposed.

Educational neglect

Parents/guardians have responsibilities under the Education (Welfare) Act 2000 to ensure their child attends school or otherwise receive a minimum education.

Types of educational neglect include:

- Permitting ongoing chronic absenteeism from school where the parent/guardian has been informed of the problem and fails to take reasonable action to resolve the issue.
- Following a conviction under the Education (Welfare) Act 2000, continued failure by the parent/guardian to ensure their child attends school.
- Failing to enrol a child of mandatory school age in a recognised school or to apply to register a child of mandatory school age under section 14 of the Education (Welfare) Act 2000.
- Refusing to seek appropriate educational services for a child.
- Neglecting to obtain or follow through with assessment and/or treatment for a child's learning difficulties or other special education need without reasonable cause.



Messages from Research

- Extended school non-attendance is associated with poor educational achievement, lower life chances and other more complex problems, including domestic abuse, serious psychiatric illness, substance misuse, crime and antisocial behaviour, early sexual activity and teen pregnancy (Pellegrini 2007). Young people with no qualifications were significantly more likely to be unemployed than young people with qualifications (Institute for Public Policy Research 2010). O'Donnell *et al.* (2008) report that over one-half of prisoners in Ireland have no formal education and only 10% of prisoners have completed the Leaving Certificate.
- Research has identified disturbed child–parent relations, parental mental health problems, parent conflict, and separated and lone parenting as factors in children's non-attendance at school (Thomas *et al.* 2011; Pellegrini 2007).
- Research suggests that children's risk of involvement in delinquent behaviour and dangerous activity is increased if they are left unsupervised for extended periods and/or have unstructured time with peers. School non-attendance is therefore perceived as leading to increased risk, according to Henry and Huizinga (2007).
- Patterns of attendance are established early in a child's school career. Children who miss a lot of school are more likely to come from families who do not value education and where parents themselves often missed school (Taylor 2012). Dos Santos (2012) outlines that early education is important and that ability deficits in early childhood cannot easily be modified in adolescence. Therefore, early intervention in a child's life in school is vital.

4



Community Factors

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30 Forced Marriage of a Child

Description

A forced marriage is where one or both spouses do not consent to the marriage or consent is extracted under duress. Duress includes both physical and emotional pressure. Forced marriage cannot be justified on religious grounds and every major faith condemns the practice.

It is very important that a forced marriage is not confused with an arranged marriage, a tradition that has operated successfully in many communities. An arranged marriage involves the families of both spouses taking a leading role in arranging the marriage, but where the choice of whether or not to accept the arrangement remains with the young people.

Key drivers for forced marriages

Perpetrators who force their children or other family members into marriage often try to justify their behaviour as protecting their children, building stronger families and preserving 'so-called' cultural or religious beliefs.



Messages from Research

Forced marriage is primarily, but not exclusively, an issue of violence against women. Most cases involve young women and girls aged between 13 and 30 years, although there is evidence to suggest that there are male victims as well.

While statistics on the incidence of forced marriage in Ireland are not available, it is known that forced marriage is a hidden practice that takes place in all jurisdictions and can be an issue for children as young as nine. The UK government has produced a number of resource and guidance documents which may be useful to professionals in Ireland²¹.

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²¹ These documents can be accessed at <https://www.gov.uk/guidance/forced-marriage#guidance-for-professionals>.

Often perpetrators are convinced that they are upholding the cultural traditions of their home country, when in fact these practices and values may have changed in their countries of origin. There are also others who are placed under significant pressure from their extended family to ensure their children or other family members are married. In some instances, an agreement may have even been made about marriage during their infancy.

Some of the key drivers for the imposition of forced marriages include:

- Being a victim of child sexual abuse and the associated perceived dishonour
- Controlling unwanted sexuality (including perceived promiscuity, or being lesbian, gay, bisexual or transgender) – particularly the behaviour and sexuality of women
- Controlling unwanted behaviour, for example, alcohol and drug use, wearing make-up or behaving in what is perceived to be a ‘westernised manner’
- Preventing ‘unsuitable’ relationships, for example, outside the ethnic, cultural, religious or caste group²²
- Protecting ‘family honour’, for example, ‘izzat’
- Responding to peer group or family pressure
- Attempting to strengthen family links
- Achieving financial gain
- Ensuring land, property and wealth remain within the family
- Protecting perceived cultural ideals
- Protecting perceived religious ideals, which are misguided
- Ensuring care for a child or adult with special needs when parents or existing carers are unable to fulfil that role
- Long-standing family commitments

²² Where English is not the first language of the child, consideration must be given to the use of an appropriate interpreter/translator. See *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services* (HSE 2009), (Policy adopted by Tusla and available on the Tusla hub and www.hse.ie.)



Practice Note

How is forced marriage a child protection issue?

Forced marriage involving anyone under 18 years constitutes a form of child abuse. A child who is forced into marriage is at risk of significant harm through physical, sexual or emotional abuse.

It is important to note that a child marriage is always a ‘forced marriage’, as children lack the capacity to make a fully informed and consensual decision to marry or not. The age at which a person may legally marry in the Republic of Ireland is 18 years of age (unless a court exemption order has been granted through the Circuit Family Court or the High Court).

It should also be noted that forced marriage is a denial of human rights and contravenes Article 3 (Best interests of the child), Article 19 (Protection from abuse and neglect) and Article 24 (Health and health services) of the UN Convention on the Rights of the Child.

Early warning signs for professionals

Figure 30.1, below, lists potential warning signs or indicators of forced marriage (HM Government 2014: 17).

A disclosure or allegation of forced marriage taking place or being planned warrants a social work assessment.

(continued)

Figure 30.1: Potential warning signs or indicators of forced marriage

Education

- Absence and persistent absence
- Request for extended leave of absence and failure to return from visits to country of origin
- Fear about forthcoming school holidays
- Surveillance by siblings or cousins at school
- Decline in behaviour engagement, performance or punctuality
- Poor exam results.
- Being withdrawn from school by those with parental responsibility
- Removal from a day centre of a person with a physical or learning disability
- Not allowed to attend extra-curricular activities
- Sudden announcement of engagement to a stranger
- Prevented from going on to further/higher education

Employment

- Poor performance
- Poor attendance
- Limited career choices
- Not allowed to work
- Unable to attend business trips or functions
- Subject to financial control e.g. confiscation of wages/income
- Leaving work accompanied
- Unable to be flexible in their working arrangements

Family history

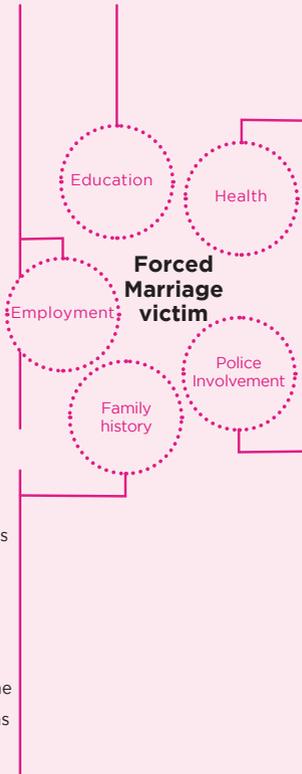
- Siblings forced to marry
- Early marriage of siblings
- Self-harm or suicide of siblings
- Death of a parent
- Family disputes
- Running away from home
- Unreasonable restrictions e.g. kept at home by parents

Health

- Accompanied to doctors or clinics
- Self-harm/attempted suicide
- Eating disorders
- Depression/Isolation
- Substance misuse
- Unwanted pregnancy
- Female genital mutilation

Police

- Victim or other siblings within the family reported missing
- Reports of domestic abuse, harassment or breaches of the peace at the family home
- Female genital mutilation
- The victim reported for offences e.g. shoplifting or substance misuse
- Threats to kill and attempts to kill or harm
- Reports of other offences such as rape or kidnap
- Acid attacks



Recommended response

- Be considerate and vigilant about decisions to discuss any concerns about forced marriage with the young person's family and community, as doing so may place the young person at further or heightened risk of harm. If there is evidence or disclosure regarding a forced marriage plan, the young person's family and community should **not** be alerted to professional knowledge of the concerns without a clear safety plan in place in respect of the child. To do so may trigger a denial of the concerns; the child could be moved to another location; travel arrangements could be expedited; or the marriage could be brought forward. Furthermore, there is a risk of further honour-based violence. This may have implications for the involvement of parents, family and community in the Tusla child protection and welfare processes. Consultation with line management and the Office of Legal Services is recommended.
- Complete an initial assessment if forced marriage is suspected, indicated or disclosed.
- See the young person/child immediately in a secure and private place where the conversation cannot be overheard by the young person's family or community. See the child/young person on their own, even if they attend with others.
- Consider the child/young person's cultural background.
- In cases of forced marriage, cultural mediation is not appropriate and is likely to increase risk to the child.
- In cases of forced marriage, family therapy or family group interventions are not appropriate and are likely to increase risk to the child.
- Consider whether or not the young person requires an interpreter. It is extremely challenging to identify an interpreter in Ireland who does not have some knowledge of the family or link to their community. It is very important to include a note here that when engaging an interpreter/translator that the family and young person are asked if they know him/her and that the interpreter/translator is asked if they know the family and/or are part of the same religious community. Confidentiality agreements or non-disclosure agreements are recommended.²³

(continued)

²³ See also *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services* (HSE 2009), policy adopted by Tusla and available on the Tusla hub and www.hse.ie.

- Consistently engage the young person in the assessment and interventions as they are likely to be experiencing a high level of fear and anxiety.
- Recognise and respect the child/young person's wishes.
- Where appropriate, consider the need for immediate protection for the young person. For example, is there a need for emergency legal interventions to protect the child/young person?
- Consider the therapeutic needs of the child/young person.
- In cases of forced marriage, interagency communication is critical and careful attention should be paid to the sharing and protecting of information, particularly regarding the multiagency management of information sharing with family. Regular interagency meetings or core group meetings are recommended with particular consideration of the dual role of Tusla and An Garda Síochána.
- The Garda Racial, Intercultural and Diversity Office can provide particular advice, practice guidance, and liaison regarding cases of forced marriage.

It is essential that a comprehensive assessment occurs in a timely manner to establish the level of risk to the child/young person and to plan for any protective measures necessary.

31 Female Genital Mutilation

Description

In 2006, following the United Nations’ hearing on Ireland’s second report on the implementation of the UN Convention on the Rights of the Child, the UN committee noted with concern that some immigrant communities continue to practise female genital mutilation (FGM) in Ireland (Committee on the Rights of the Child 2006). FGM should always be viewed as abuse and is a child protection issue. FGM is illegal in Ireland under the Criminal Justice (Female Genital Mutilation) Act 2012.

FGM involves removing all or part of a girl’s external genital organs, including the area around her vagina and her clitoris. FGM is done for cultural reasons and not medical ones.

In most cases, FGM is performed on girls between birth and 15 years of age but appears to be most frequently performed when the girl is aged between 4 and 10 years.



Messages from Research

- FGM (or circumcision, excision, cutting, sunna circumcision, infibulation) denotes all procedures involving the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO 2013). The practice is mainly performed in African countries and to a lesser extent in some Middle Eastern and Asian countries (Jones *et al.* 2004). However, according to Reyners (2004), increased migration from countries where FGM is common has provoked considerable medical, ethical and sociological dilemmas for social work/child welfare and health workers in Western countries as the practice migrates with the peoples.
- FGM is typically performed on children between the ages of 4 and 10 years but in some cases is carried out where local practices and cultural traditions dictate, in infancy or just before marriage (Braddy and Files 2007). The practice is strongly linked to the traditions of certain ethnic groups and

is fostered by deep-rooted cultural beliefs (Braddy and Files 2007). Jones *et al.* (2004) acknowledge that there are varied and diverse reasons why FGM is carried out but do, however, suggest that the practice is closely associated with rituals to enhance gender and ethnic identity. Research studies identify the enforcement of social and/or religious norms, marking of transitions in a child's development, and suppression of female sexuality as reasons for FGM (WHO 2013; Braddy and File 2007; Reyners 2004). In addition, pressure to conform can be substantial and forgoing genital cutting can lead to exclusion from one's community and ineligibility to marry among an ethnic group (Braddy and Files 2007). Uncircumcised girls may be damaging to family reputation; they may be seen by others in their ethnic group as out of control, prone to early sexual behaviour and unwanted pregnancies (Boyden 2012).

- It is important that interventions or treatments by social services and health professionals are based on an accurate understanding of a particular group's values, beliefs and customs, as well as forms of appropriate interaction (Braddy and Files 2007; Jones *et al.* 2004). Interventions should employ varied strategies focusing on and aiming to address the core issues, values and enforcement methods that underpin FGM (Jones *et al.* 2004). Jones *et al.* (2004) suggest involving 'at risk' adolescents in educational programmes that address such topics in a culturally sensitive manner. Jones *et al.* (2004) also argue for the use of education, and the creation and support of initiatives where social status can be expressed in safe alternatives to FGM. They highlight the need for a multisector approach (in communities where FGM is a risk), involving community and religious leaders, to support initiatives that empower women and their daughters to avail of such programmes.



Practice Note²⁴

Why is FGM performed?

Some of the reasons identified for FGM (O'Brien Green *et al* 2008) include:

- Cultural tradition
- Rite of passage into womanhood
- Religion (although no religion includes FGM as a requirement)
- Preservation of virginity until marriage
- Social acceptance, among peers as well as for marriage
- Cultural/aesthetic reasons

Who performs FGM?

Typically, FGM is performed by a traditional birth attendant or by an older woman in the community who has had no medical training. The use of anaesthetics and antiseptics is uncommon. Instruments used to perform FGM include razor blades, knives, pieces of glass, scissors and scalpels. In some instances, several girls will be cut using the same instrument, heightening the risk of infections, including HIV (O'Brien Green *et al* 2008).

Why does FGM continue?

The practice of FGM persists today for several reasons. In many instances, parents want their daughters to undergo FGM in order to avoid stigmatisation or social exclusion by the rest of the community. In practising communities, it is strongly believed that a girl is not marriageable if she has not undergone FGM. Therefore, she may become a social outcast.

The negative health complications associated with FGM are often poorly understood within practising communities. If the correlation between FGM and certain complications was more clearly realised among community members, particularly maternal morbidity/mortality and fistula formation, it is likely that FGM prevalence would decrease (RCSI 2008).

(continued)

²⁴ See also *Female Genital Mutilation: Information for Health-Care Professionals Working in Ireland* (Bansal *et al.* 2013).

Table 31.1, below, lists terms that are sometimes used in different countries²⁵ to refer to circumcision of both males and females. These terms are presented in their phonetic spelling (O'Brien Green *et al* 2008). If a professional hears these phrases being used in relation to a child they should be alert to the possibility of a concern.

Table 31.1: Terms used in different countries to refer to circumcision of both males and females

Term	Country
Khitan	Egypt
Mkhenshab	Eritrea
Absum	Ethiopia
Megerez	Ethiopia
Kutairi	Kenya
Ibi ugwu	Nigeria
Bondo	Sierra Leone
Gudniin	Somalia
Tahoor	Sudan

Are there long-term complications?

A number of long-term complications can arise from FGM (AkiDwA 2014). These include:

- Chronic urinary and menstrual problems
- Chronic pain
- Pelvic inflammatory disease
- Cysts
- Increased risk of HIV transmission
- Infertility
- Serious problems for mother and baby during childbirth

(continued)

²⁵ Where English is not the first language of the child, consider using an appropriate interpreter. See *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services* (HSE 2009), policy adopted by Tusla and available on the Tusla hub and www.hse.ie.

Some of the immediate health consequences of FGM include:

- Severe pain, shock and bleeding
- Difficulty passing urine
- Psychological trauma
- Infection
- Death (as a result of the above)

When a professional has concerns that a child has been the victim of FGM or is about to become a victim of FGM, the case should be assessed in accordance with the Tusla Social Work Standard Business Processes and an intervention plan developed. The welfare and safety of the child has to be the first and paramount concern. An Garda Síochána should be notified as a crime is suspected. A person is guilty of an offence under Irish law if the person does or attempts to do an act of FGM. It is also an offence to remove a person from the state if one of the reasons for removing her is to have an act of FGM done to her.

Factors to consider during the assessment:

- Whether FGM has happened or is proposed to happen to the child
- The length of time since FGM took place
- The age of the child
- The physical and the emotional wellbeing of the child
- The need for an immediate medical examination
- Other female children in the family who may be at risk
- Other female children in the community who may be at risk
- The risk that the child will be taken from the jurisdiction to facilitate the procedure
- Either or both parents' willingness to prevent a proposed FGM
- Protective factors which are in place to ensure that the child will not become a victim of FGM
- The child's story
- The parent/carer's story
- The parent/carer's awareness of the negative consequences of FGM

Where it is assessed that a child is at risk of FGM, consideration should be given as how to best ensure the child's safety. This may include application for an emergency care order.

32 So-Called Honour-Based Violence²⁶

Description

So-called honour-based violence, that is, crimes committed in the name of honour, have been defined in various ways. However, an ‘honour’ crime tends to be differentiated from other forms of domestic abuse or killing on the grounds that it involves a premeditated act to restore family honour, with some degree of approval and/or collusion from the family and/or community. Usually the person is being punished for actually or allegedly undermining what is believed to be the correct code of behaviour. By not conforming, it may be perceived that the person may have brought shame or dishonour to the family or community. Women are predominantly (but not exclusively) the victims of so-called honour-based violence.

So-called honour-based crimes could include:

- Attempted murder
- Manslaughter
- Procuring an abortion
- Encouraging or assisting suicide
- Conspiracy to murder
- Conspiracy to commit a variety of assaults

See also Chapter 30: Forced Marriage of a Child.

²⁶ This chapter does not contain a section on Messages from Research or a Practice Note. It should be read in conjunction with Chapter 4: Domestic Abuse; Chapter 17: Children from Abroad Needing Protection; and Chapter 30: Forced Marriage of a Child, among others.

33 Male Circumcision

Description

Male circumcision is the surgical removal of the foreskin of the penis. The procedure is usually requested for social, cultural or religious reasons (i.e. by families who practise Judaism or Islam). There are also parents who request circumcision for assumed medical benefits. Traditionally, religious leaders or respected elders may conduct this practice.

Male circumcision that is performed for any reason other than physical clinical need is termed non-therapeutic circumcision. The medical harm or benefits have not been unequivocally proven, except to the extent that there are clear risks of harm if the procedure is inexpertly done.



Messages from Research

The British Association of Paediatric Surgeons advises that there is rarely a clinical indication for circumcision (British Medical Association 2004). Doctors should be aware of this and reassure parents accordingly.



Practice Note

Where parents request circumcision for their son for assumed medical reasons, it is recommended that circumcision should be performed by or under the supervision of doctors trained in children's surgery in premises suitable for surgical procedures. Doctors and health professionals should ensure that any parents seeking circumcision for their son in the belief that it confers health benefits are fully informed that there is a lack of professional consensus as to current evidence demonstrating any benefits. The risks/benefits to the child must be fully explained to the parents and to the young boy himself.

Circumcision may constitute significant harm to a child if the procedure was undertaken in such a way that the child:

- Acquires an infection as a result of neglect or inexpert application of the procedure.
- Sustains physical, functional or cosmetic damage.

- Suffers emotional, physical or sexual harm from the way in which the procedure was carried out.
- Suffers emotional harm from not having been sufficiently informed and consulted, or not having his wishes taken into account; the age and developmental stage of the child will have to be considered.

In the case of non-therapeutic circumcision, consider the impact on the child and whether the non-therapeutic circumcision has resulted (or is likely to result if not yet carried out) in significant harm to the child. Harm in relation to non-therapeutic circumcision may stem from the fact that clinical practice was incompetent (including lack of anaesthesia) and/or that clinical equipment and facilities are inadequate, unhygienic, etc.

The professionals most likely to become aware that a boy is at risk of, or has already suffered, harm from non-therapeutic circumcision are health professionals (GPs, public health nurses, ED staff or family support workers involved in the home) and childminding, day care and teaching staff.

Professionals must ensure they are aware of the role that male circumcision plays in society and various cultures. They must also take care to consider how it can constitute abuse of a child in certain situations. Professionals should approach the issue in a multidisciplinary fashion and seek guidance from those who have an expert working knowledge of the associated issues: medical and sociological. The lead expert should be clinically trained in the area and is usually a consultant paediatric doctor.

34 Ritual Abuse

Description

The term ritual abuse is generally used to mean repeated, extreme, sadistic abuse, especially of children, within a group setting. Often this is associated with witchcraft or spirit possession.

Witchcraft can refer to the belief that supernatural or magical powers can be used to inflict harm upon a person or their property. It may also refer to benevolent purposes such as healing.

Spirit possession is the belief that spirits, gods or demons can take control of a human body. The belief in spirit possession exists in a number of world religions, including Islam, Christianity, Buddhism, Haitian Voodoo and Wicca, as well as in Southeast Asian, South American and African traditions.



Messages from Research

- Ritualistic abuse normally aims to create contexts where abusive men gain power and control over women and children by invoking metaphysical and quasi-religious overtones (Salter 2012). This is mainly done to enforce victims' compliance and submission to abuse (Salter 2012).
- Several studies report long-term and serious psychological harm to children and adults disclosing ritual abuse (Noblitt and Perskin 2000; Heckler 1988 in Salter 2012). Salter's (2012) research with 16 victims of childhood ritual abuse concluded that ceremonial-type abuse is used to 'legitimise' organised abuse of children.
- The research literature indicates that organised, ceremonial-type ritual abuse of children is uncommon (Salter 2012). However, cases of ritual abuse have been reported in many countries including the UK, Canada, the US, and the Netherlands (Jonker and Jonker-Bakker 1991).
- In some African countries, witchcraft may be used as a pretext or excuse to sexually and/or violently abuse children (Adinkrah 2011; Lalor 2004). According to Adinkrah (2011), across Africa children are regularly persecuted as witches and many have been killed, maimed and abandoned based on individual and village-level accusations of witchcraft.

- The majority of children abused are abused by family members, relatives or close neighbours. Abusers may seek to share and/or deflect responsibility and guilt by shifting the focus and blame for the abuse of children onto mystical or occultist explanations (Lalor 2004). For example, Lalor (2004: 842) reports “a widespread belief” in some African countries (Tanzania, Kenya) that traditional healers recommend that men have sex with children in order to cure HIV/AIDS.



Practice Note

Professionals should familiarise themselves with the characteristics of ritual abuse and be alert to its existence.

Children who are accused of witchcraft or spirit possession are at risk of abuse. Indeed, children are more likely to be accused of witchcraft and evil spirit possession than adults (Schnoebelen 2009). When ritual abuse does occur, it can be physical, sexual and emotional. Accusations of witchcraft can also result in neglect of the child. In some cases, it has resulted in death.

Motives for abusing children suspected of witchcraft are varied. In some cases, abuse can be motivated by a conscious wish to exploit or harm the child. In others, it can be motivated by beliefs that a child will benefit from punishment or deliverance. Although abuse usually takes place in the home, it may also occur in places of worship where alleged diagnoses and exorcisms take place. Evidence has shown that abusers can be family members, family friends, faith leaders, or other caregivers.

Children who experience ritual abuse or are accused of witchcraft or possession may also be abused in the following ways:

- **Physical abuse:** For example, beating, shaking, burning, cutting, stabbing, semi-strangulation, tying up the child, rubbing chilli peppers or other substances on the child’s genitals or eyes, etc.
- **Emotional abuse:** This can occur as isolation, for example, not allowing the child to eat or share a room with family members. Other examples include threatening to abandon the child or telling a child they are evil or possessed.

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An Ghníomhaireacht um
Leanaí agus an Teaghlach
Child and Family Agency