They go on to discuss the diverse patterns of behaviour at home and/or at school that may be associated with ADHD, and highlight the impact these can have on self-esteem and academic attainment. They argue that their findings suggest that a significant minority of disruptive pupils in schools may have ADHD, and that screening procedures could play an important role in establishing more focused assessment and intervention procedures.

In this paper, Wolfendale reflects upon the ways in which notions of ‘partnership with parents’ have become established within both special and mainstream education. She raises pertinent questions about the extent to which research with parents and families has typically been consistent with the principles of “partnership”. Using what she acknowledges is a highly selective review of research in order to present some illustrative examples, she draws attention to both methodological and ethical issues which require consideration if researchers are to follow a more genuinely participatory approach. She discusses four key elements of partnership, which will be familiar to those who know Wolfendale’s work, i.e., rights and entitlement; equal status; reciprocity; and empowerment; and outlines ways in which these might be applied to research with parents. The paper concludes with ‘a speculative Code of Conduct’ for cooperative research that incorporates these elements.

The importance of participatory research paradigms is becoming increasingly acknowledged with reference to people with disabilities and their families: this paper offers a useful contribution to our thinking about the involvement of parents, and could well also act as a starting point for extending the partnership to embrace both their children and other family members.


This short, engaging paper was the winner of the 1998 Stanley Segal Award (which is open to professionals whose work has not previously been published, and is given for the best article that informs the education of children or adults with special educational needs). It describes the use of the social story technique in a mainstream primary school with George, a child with autistic spectrum disorder. The technique was developed to help children recognise and understand the cues and actions involved in social situations that they find difficult. The social story, as used by Rowe, is a vehicle for very effective teamwork between George, his parents, school staff and specialist teacher, in which there is a sensitive emphasis on respect for George’s own ways of thinking and learning. The benefits of the approach for George are clearly and convincingly portrayed. Although there is an obvious need for caution in generalising from work undertaken with an individual child, the social story approach as described in this paper has evident potential for much wider use.

**Support for Learning (1999)**


Since its inception following the 1993 Education Act, the role of the Special Educational Needs Tribunal as an independent system for parents who disagree with LEA decisions regarding their children with special educational needs has become well-established. In this paper, Evans reports on an NFER study into its operation, focusing particularly on its impact on LEA policy.

Evans highlights two main reasons for parental appeals to the Tribunal: a fundamental factor lies in the lack of clarity between schools and LEAs about who is responsible for providing resources to meet children’s needs. A further factor results from the tension which almost inevitably exists between parents seeking the best possible provision for their own children and LEAs’ responsibilities for considering the full range of authority-wide needs. Evans argues that the Tribunal has had a very significant influence on LEAs. Positive aspects of this influence include: the identification of areas where provision
This article reflects work with adults with learning disabilities but the messages it contains are of relevance to those working with much younger students—a case for early intervention. There is an emphasis by the Government on individuals taking responsibility for monitoring and improving their own health. This approach to health provision creates challenges for both patients and doctors. For example, the system depends on patients seeking assistance when they need it and it cannot be taken for granted that people with learning difficulties are aware of this. Equally, doctors may be relatively unfamiliar with communicating with people with learning disabilities and this may form a barrier to accurate diagnosis.

Dodd and Brunker’s study chiefly involved GPs, keyworkers, psychologists, a community nurse and people with learning disabilities. After discussions with the GPs, a communication pack was designed. This took the form of computer-drawn pictures which could serve as communication aids covering the type of information doctors need during a consultation, concerning the site, type, severity and duration of pain. The pack was introduced to the participants as part of a training programme which also included work on what to do if you are not feeling well and what to expect at the doctors. At the end of the training, the GPs and the participants were each given a copy of the pack.

The impact of the training was evaluated at the end of the programme and six months later. All those who had taken part in the training programme benefited. Not surprisingly, the people with learning disabilities who had both cause and opportunity to use the communication pack in ‘real life’ contexts with their carers and doctors after the training programme finished made the greatest gains. The small sample size means that the results need to be treated with caution. However, it does appear that, contrary to what has been suggested by earlier findings, it is possible to teach people with learning disabilities both knowledge about their bodies and also the skills to be able to communicate about them more effectively.

There are clear implications for the personal, social and health education curriculum for younger students with learning disabilities, if we are to facilitate their active participation in matters of personal health.


Linked to increased knowledge about genetics and improved techniques for screening and diagnosis prior to birth, there has been an increase in genetic counselling. Genetic counselling is seen as a key strategy to reduce the incidence of learning and other disabilities and may be offered by the medical profession when risk factors have been identified or occasionally may be requested by the family.

This balanced article reflects on the mixed consequences of genetic counselling. It suggests that the wider issues related to providing this type of information need to be considered. One theme is the need for professionals to appreciate the impact that personal genetic information can have on the process of family adaptation to the presence of learning disabilities. A second theme concerns the impact of genetic counselling on wider family members. Barr notes that much available research evidence focuses on the perspectives of mothers and that there is a need to listen to other voices too.

Barr suggests three practical steps that would enhance the contribution of genetic counselling. These are that professionals recognise the extremely personal nature of the information involved and the impact that it may have on self-identity, self-esteem and self-concept; that both professionals and parents are better informed about the structure and nature of genetic counselling; and an attempt is made to identify and support those parents who either lack information or receive conflicting information. This article itself makes a useful contribution by raising the issues.
broken down into a number of subskills, which allowed detailed observational assessments to be made of individual pupils’ strengths and weaknesses with respect to their participation in the target-setting process. These in turn provided a basis for staff to plan strategies which would support pupils in developing their skills.

The authors are appropriately cautious about the extent to which the systems the school has developed so far will be fully successful in promoting pupils’ personal target setting. They highlight, for example, issues of involvement for those pupils with profound and multiple learning difficulties or other complex needs. Nevertheless, the results of their research offer a potentially valuable framework for other schools seeking to develop their work in this area.

CHILD ABUSE SELECTION
Compiled by Viki Simpson

Child Abuse and Neglect (1999)

The recent publication of the Waterhouse report has focused attention on the abuse of children in public care placed in children’s homes. In this timely study Hobbs et al. examine rates of abuse of children in care placed in foster homes as well as in residential homes, by comparison with the rates of abuse of children in the general population, with a view to determining whether such children are vulnerable to further abuse.

A sample of 133 children in foster care and 25 children in residential care who had been referred for paediatric assessment on the grounds of possible physical or sexual abuse between 1990 and 1995 were identified retrospectively from the medical reports written at the time of the original assessment. The sample consisted of 59 boys and 74 girls in foster care (mean age 6 years) and 17 boys and 8 girls in residential care (mean age 12 years). The reason for placement and the referral was identified as well as the context in which the abuse occurred, the perpetrators, the presentation of the abuse and any behavioural problems exhibited. The inter-agency response to the child was also examined.

In relation to the group in foster care, 157 instances of abuse occurred of which 41% took place in the foster home, with 28 children being physically abused and 22% sexually abused by the foster-carer. 23.8% of the incidents took place during contact with natural parents including 22 children who were sexually abused by their parents. 20% of the incidents involved another child as abuser of which over half were other foster children. In addition it was found that children were the perpetrators in 24 cases of sexual abuse. In terms of presentation, 43 children disclosed their abuse, 29 children were referred for behavioural difficulties and 42 presented with injuries and other physical symptoms, e.g. vaginal soreness, vaginal discharge. Analysis of the inter-agency response to the identification of further abuse found that in 43 cases it was not possible to ascertain the outcome from the records and in another 6 cases no further action appeared to have been taken. Three families were also found to be involved in more than one report including one family who were identified in three separate reports involving 7 children.

In respect of the residential sample, 34 incidents were identified in relation to 25 children. Eight children were physically abused by a staff member, four by another child in the home and 13 by another child outside the home.

Further analysis of the rates of abuse of children in foster care and residential care by comparison with the general population, found that a foster child was 7–8 times more likely, and a child in residential care 6 times more likely, to be assessed by a paediatrician for physical and sexual abuse.

The study also found a high incidence of emotional, behavioural and developmental problems among the children placed in foster care with sexually abused children in particular having significant problems. Few foster carers are adequately prepared for such difficulties. Thus the children become vulnerable to further abuse. Children in residential care however tend to be older and to be the most disturbed as this group is usually composed of those children thought to be too difficult to foster. Nevertheless it is known that fewer than 50% of residential staff are trained, a factor which can only exacerbate the children’s problems.

Findings of this research therefore support the view that children in care are vulnerable to further abuse and point to the need for a comprehensive evaluation of the foster and residential care system in order that the needs of both children and carers can be met more adequately. Hobbs et al. also suggest that a system should be in place to record incidents of concern in relation to each foster family particularly where more than one local authority and different agencies are involved.


In the course of any discussion about outcomes for children in care it is often stated that most children remain in care for periods of less than six months before being returned to their family. This may be true, but little is known about the extent to which children are discharged from care to be reunited with their families only to be re-abused and readmitted to care at a later date. This research therefore examines re-entry rates and the factors associated with re-entry rates in respect of children reunited with their original families after being placed in care because of abuse and/or neglect.

For the initial stages of the research a sample of 1,515 children known to have been reunited with their families were identified from the Child Protection Services (CPS) computer files in order to develop an estimate of re-entry and to identify the factors associated with that re-entry. Re-entry was defined as a substantial incident of abuse and neglect occurring after the child returned home or a return to foster care due to the failure of the placement. The data showed that 20% of the children were readmitted into care due to abuse or neglect. The time for re-entry ranged from a few weeks to 42 months after their return home, with the greatest risk of re-entry during the first 6 months.

For the second stage of the research, 59 cases from the original sample were subjected to an in-depth analysis, 40 of which were randomly selected with the addition of a further 19 cases that were known to have used community based strategies for intervention. Data extracted from the files included all those variables identified as relevant from the literature on child abuse and neglect, e.g. substance abuse, criminal history, social isolation, parental incompetence, family conflict and type of abuse. A qualitative analysis was also carried out in order to provide a more detailed picture of the situation of the children of families that re-enter the system.
It was found that risk of re-entry was associated with a number of characteristics. These included type of abuse, i.e., neglect, physical or sexual, with neglect cases being most at risk of re-entry. The presence of previous referrals to the CPS was also a strong indicator of risk, with 67% of the re-entry group having had previous referrals, thus supporting the view that the best predictor of future behaviour is past history. Substance abuse was another major indicator, cited in 50% of the re-entry cases. It was also noted that although much emphasis was given to ensuring that the prime caregiver had complied with the treatment plan, little attention was paid to their partner and in every case where a substance abuse partner/spouse remained in the household, re-entry occurred. In addition, insufficient time was allowed in terms of ensuring recovery from drugs or alcohol abuse with children being returned in as little as three months when a minimum period of two years is known to be required if relapse is to be prevented.

Parental competence was a further issue in 27% of the re-entry cases, with two main factors identified. One group of parents had low levels of intellectual functioning, while a second group was identified who refused to understand or accept that their life style was not appropriate or compatible with parenting. It was found that parents in both groups repeatedly agreed to change in order to get their children home but equally repeatedly failed to implement the agreed change. Social support and family conflict were also found to be significant indicators of risk.

In conclusion, the research raises serious concerns about current family reunification practices given that, in this sample, a significant percentage of the children re-united with their families were returned to care due to further abuse. There is a clear need for improved risk assessment measures and more extensive research relating to this issue should be seen as a matter of priority.


Although child neglect continues to be the most frequently reported type of maltreatment, little progress seems to have been made in developing effective intervention techniques. In this interesting study Ethier et al. evaluate the effects of the Personal Family and Community Help Programme (PFCHP). This programme, based on an ecological approach, attempts to reduce neglecting behaviours by improving the family environment using home visiting, group meetings for parents, educational activities for children and individual counselling. The impact of the programme was compared with that of the intervention provided by the Local Community Service Centre (LCSC), which adopts a psycho-social approach focused on the social worker-family relationship.

Fifteen mainly low income families were assigned to the PFCHP and a comparison group of 14 families matched for socio-demographic characteristics and risk factors were recruited for the LCSC programme. In both groups, there was an average of 7.6 risk factors per family. It was hypothesised that, by comparison with the LCSC group, families in the PFCHP would show a greater decrease in child neglect and child abuse potential, a greater improvement in their parenting in terms of parental stress and depression, increased social support networks and an improvement in family and social relationships.

A number of pre- and post-test measures were used, including the Social Report Questionnaire (Sarason et al., 1983), the Parental Stress Index (Abidin, 1983), the Beck Depression Inventory (Beck et al., 1961) and the Child Abuse Potential Inventory (Milner, 1980). The mothers were also interviewed individually at the time of the post-test procedure in order to obtain their views on the intervention.

Analysis of the data showed a similar decrease in parental stress, maternal depression and potential to abuse for both groups, following intervention. Increased satisfaction with their social support network was also reported by both groups although there was some indication that the LCSC mothers sought less support outside the family and seemed to be turning to their own children for support. On the qualitative measures, the PFCHP group showed greater involvement in their children’s activities, had better discipline and were more able to show affection to their children whilst the LCSC group developed more self-confidence in themselves as parents and were more aware of appropriate parenting practices. The PFCHP group demonstrated a greater improvement in their relationships with their partners and were also found to be able to recognise and discuss psychological violence. These mothers were also more likely to return to work or further education.

The results therefore do not fully support the hypothesis. They suggest that both types of intervention can lead to an improved family situation, although it should be noted that whilst parental stress and maternal depression decreased, the levels at post-test remained worryingly high. By comparison with the LCSC group, the mothers in the PFCHP group had the better relationship with their environment, became more active and demonstrated improved self-esteem. Ethier et al. conclude that, given the multi-factorial nature of child neglect, it is essential that intervention programmes consider the material, affective and social needs of the families involved and also ensure coordination of the services offered.

**Child Maltreatment (1999)**


The relationship between domestic violence and child abuse has received increasing attention in recent years and it is now accepted that for a large proportion of those families where child abuse is known to be a concern, domestic violence is also likely to be an issue. Little is known however about the factors which differentiate child abusing families from families where there is both domestic violence and child abuse. This research attempts to examine those family and child factors that are most likely to differentiate between non-abusive, spouse-abusive and spouse and child-abusive families.

Two hundred and sixty-seven children, aged from 5 to 14 years, and their mothers were recruited for the study. Ninety-three were classified as being from non-abusive families, 128 from spouse-abusive families and 46 from spouse and child-abusive families. Mothers were asked to complete a range of tests including: the Conflict Tactic Scale (CTS; Strauss, 1979) to ascertain the level of spouse abuse; the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) to identify maternal distress and psychopathology; the Life Events Questionnaire (Garmezy, Master, & Tellegen, 1984); the Child Behaviour Checklist...
The factors that best differentiated between violent and non-violent families were found to be neighbourhood violence, lower socio-economic status, maternal symptomatology, a high number of life stressors and father experiencing physical punishment as a child. Family stress, neighbourhood violence and father’s experience of physical punishment as a child were also found to discriminate between spouse abusive and spouse and child abusive families. Children exposed to violence were found to have more socio-emotional and behavioural problems and school difficulties than children from non-violent families, with exposed abused children having significantly more emotional problems than their peers.

The results therefore are further evidence that high levels of verbal conflict, environmental stressors and poor maternal mental health are risk factors for domestic violence and child abuse. The authors conclude that spouse and child abusive families experience the same type of problems when compared to spouse abusive families but the difference is one of degree rather than kind, i.e., they experience higher levels of neighbourhood violence, family stress and fathers have a history of more severe physical punishment. This suggests that clinical intervention needs to address the families’ broader social context as well as family dysfunction.


Intervention in child abuse cases is designed to ensure that the child or children concerned are protected from further maltreatment. However, the issue of re-referral and re-occurrence seems to have received scant attention. This useful and carefully thought out study by English et al. is therefore of considerable interest.

A sample of 12324 referrals accepted for investigation by the Washington State Child Protection Services were followed up over an 18-month period to determine which risk factors were most likely to be associated with re-referral and re-occurrence of child maltreatment. Out of the original sample families 3527 were referred within 18 months. These re-referrals involved either the same child or other children within the family. Of these cases, 10.6% were regarded as re-occurrence.

Cases were examined and data extracted in respect of a range of variables, including child characteristics and whether or not an emergency placement had taken place, caregiver characteristics, previous history of child abuse and neglect, socio-economic factors, type of referred, type of area (metropolitan, urban or rural) and type of abuse.

Overall, the principal risk factors associated with re-referral and re-occurrence were found to be a caregiver history of child abuse and neglect, a history of domestic violence, substance abuse and caregiver impairments. It was also found that anonymous referrals have the highest rate of re-referral, suggesting that such allegations should be taken seriously. Further, families where reunification had taken place, i.e. the child had recently been in foster care, were much more likely to be re-referred (39% in 18 months).

English et al. argue that more comprehensive assessments of maltreatment, as opposed to incident-specific investigations, are required. They conclude that the caregivers’ history of abuse, together with the effects of substance abuse and domestic violence need to be emphasised when assessing the likelihood of re-referral and re-occurrence of child maltreatment.