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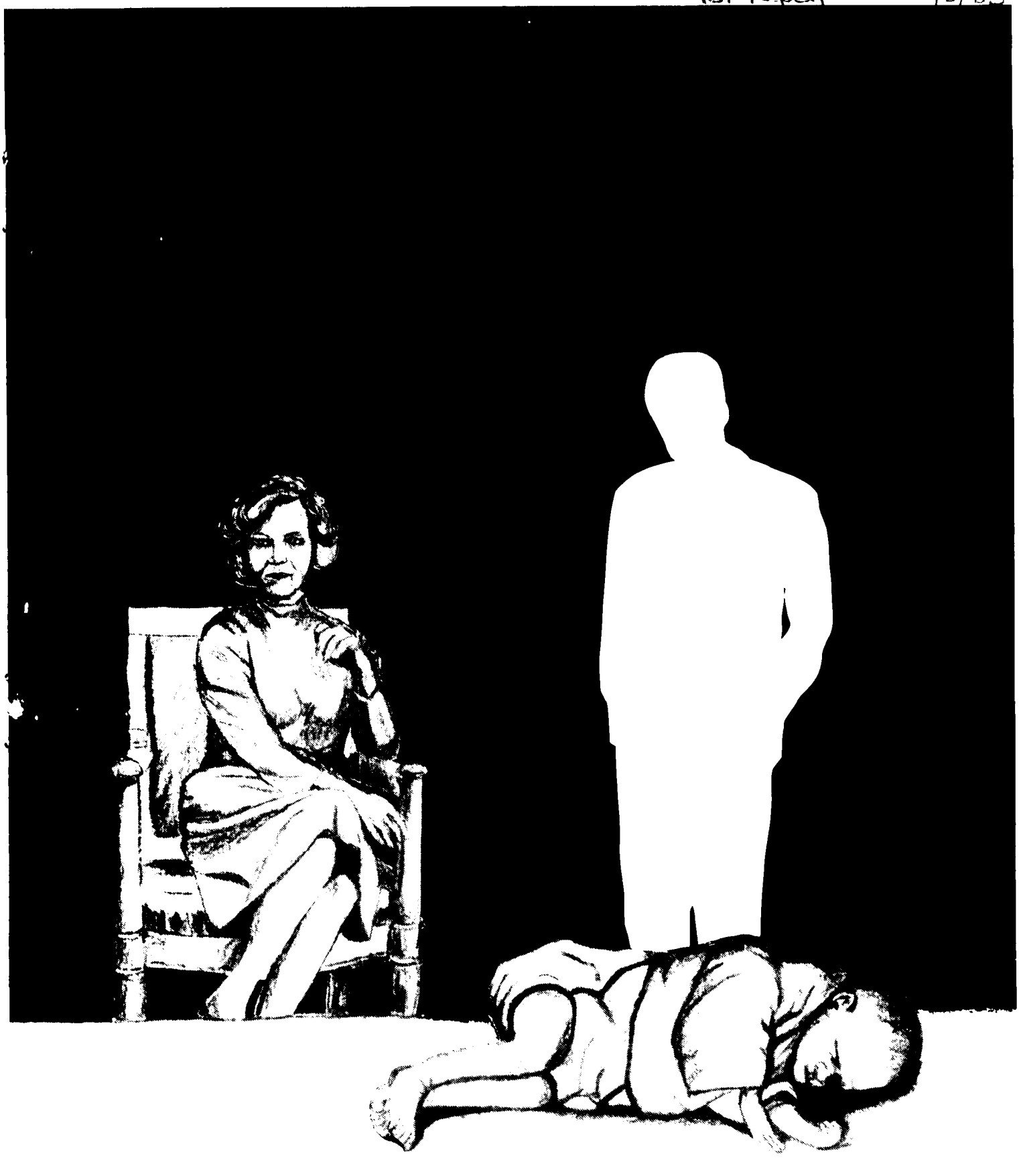

The Police Role in Child Protection in Queensland

Report prepared under a grant from Criminology Research Council and Queensland Police Department - Dr Sally Leivesley March 1984

QUEENSLAND POLICE DEPARTMENT

THE POLICE ROLE IN CHILD PROTECTION IN QUEENSLAND: AN EVALUATION OF THE JUVENILE AID BUREAU'S WORK IN CHILD PROTECTION 1980 - 1983

A REPORT PREPARED UNDER A GRANT FROM THE CRIMINOLOGY RESEARCH COUNCIL AND THE QUEENSLAND POLICE DEPARTMENT

DR SALLY LEIVESLEY.

MARCH 1984

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EVALUATION OF JUVENILE AID BUREAU INVOLVEMENT IN CHILD ABUSE 1980 - 1983

The evaluation of Juvenile Aid Bureau involvement in Child Abuse 1980-1983 is based on three Indicators. The methods used in developing these three Indicators are described in the Introduction. This section of the report summarises the findings under each Indicator. The main outcomes of the study are presented to provide an overview of the police role in child protection 1980-1983. Full recommendations appear in the last chapter. Chapters 1 to 3 discuss the findings from the Brisbane case study of 400 children, the literature on child abuse, and field work with the J.A.B. and other police officers throughout Queensland.

The three Indicators used to group the findings from data analysis and observations are:

INDICATOR 1 The degree of involvement in child abuse cases by police compared to the incidence of child abuse throughout the State.

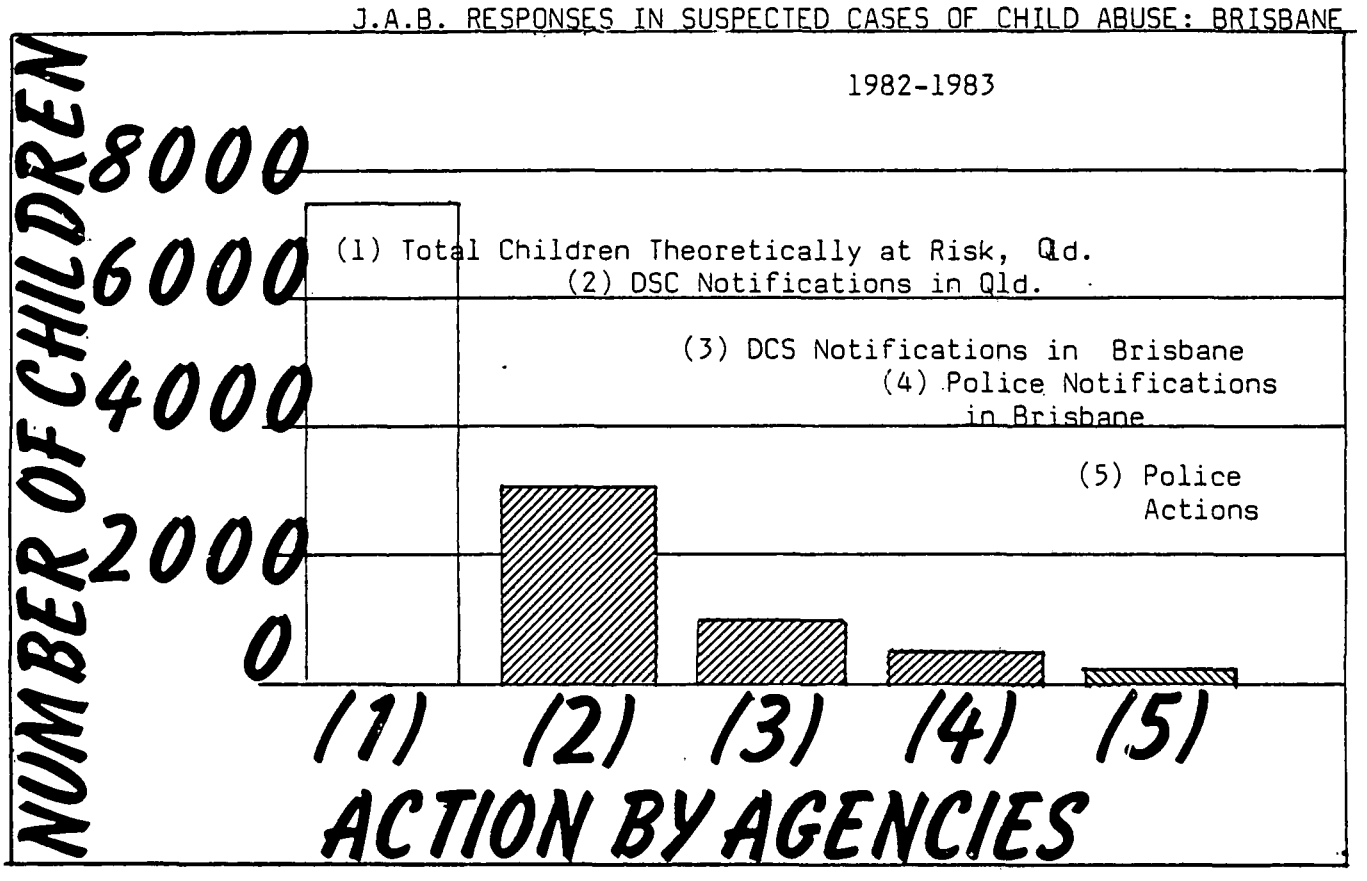
INDICATOR 2. The effectiveness of police action in protecting young children from abuse.

INDICATOR 3. The success of police involvement in the multidisciplinary team approach to child abuse and relations with the community.

INDICATOR 1. J.A.B. INVOLVEMENT IN CHILD ABUSE CASES COMPARED TO THE INCIDENCE OF CHILD ABUSE THROUGHOUT THE STATE

Figure 1 'J.A.B. Response in Suspected Cases of Child Abuse: Brisbane 1982 - 1983' shows the whole of State notifications to the Department of Children's Services of suspected cases of child abuse and neglect. These total 2,904. Nine hundred and seventy-five of the reports were in Brisbane. The total notifications of cases to the J.A.B. in this time was 404. Some cases came directly to the police from the public and were then discussed in SCAN meetings but the majority came to police notice by their attendance at SCAN meetings.

FIGURE 1



Police action was forthcoming in 57% of the 400 cases in Brisbane, i.e. 227 of the cases sampled. In 87 cases police action represented an investigation and / or liaison with other agencies for the care of the child or other involvement, and in 140 cases there was court action.

Active investigation in an estimated 227 cases represents police involvement in 23% of suspected child abuse cases in Brisbane for the year 1982-83 (See Figure 1). It may be assumed that the proportion of cases seen in Brisbane is higher than in the Regions as Brisbane has developed a specialised child abuse capacity. (In 1983 there was formal recognition of the Child Abuse Unit in the Brisbane J.A.B.). However, even the figure of 23% applied for the whole of State cases shows that the Juvenile Aid Bureau is only involved in a minority of the State's 2,904 reported cases.

An epidemilogical assessment of the real problem of child abuse on a whole of State basis is also shown in Figure 1. This figure is described in Chapter 1 as an estimate of 1 / 100 children at risk. In 1982 - 1983 there were 7,564 children in Queensland aged 0 - 17 who represent this proportion of children at risk. An optimistic assessment of J.A.B. involvement in 23% of

all cases would indicate that 5,824 children had not received any police action.

While it is not feasible to expect in any country that reporting rates will ever come close to the actual rate of child abuse there is a potential for increasing these rates by well directed public campaigns.

The evaluation of the present Juvenile Aid Bureau involvement in Queensland in child abuse cases leads to three major recommendations. (These are described in detail in Chapter 4).

RECOMMENDATION 1. The structuring of the J.A.B. as the central administrative unit for all State Police Regions in cases of child abuse.

The new role is to provide supervision, training and monitoring services. This recommendation includes the involvement of J.A.B. in ALL notified cases of child abuse in association with the Department of Children's Services, and a 24 hour response capacity in association with the Department of Children's Services to community reports of suspected cases.

RECOMMENDATION 2. The development of a central Police Information Bureau, Child Abuse Information file which is monitored by the central Abuse Unit and provides up to date information on the status of all cases that have come to police notice.

RECOMMENDATIONS 3 AND 4. Recommendations for combined investigations of suspected child abuse cases by J.A.B. Officers, and officers of the Department of Children's Services, and the medical officer (assisted by hospital social workers in hospital-based referrals).

This combined approach allows for the development of SCAN teams within the community. The police would work in close association with other professionals, notably: medical and nursing staff, teachers, principals and Regional Education Officers; and legal respresentatives from the community.

INDICATOR 2. THE EFFECTIVENESS OF J.A.B. ACTION TO PROTECT YOUNG CHILDREN FROM ABUSE.

FIGURE 2

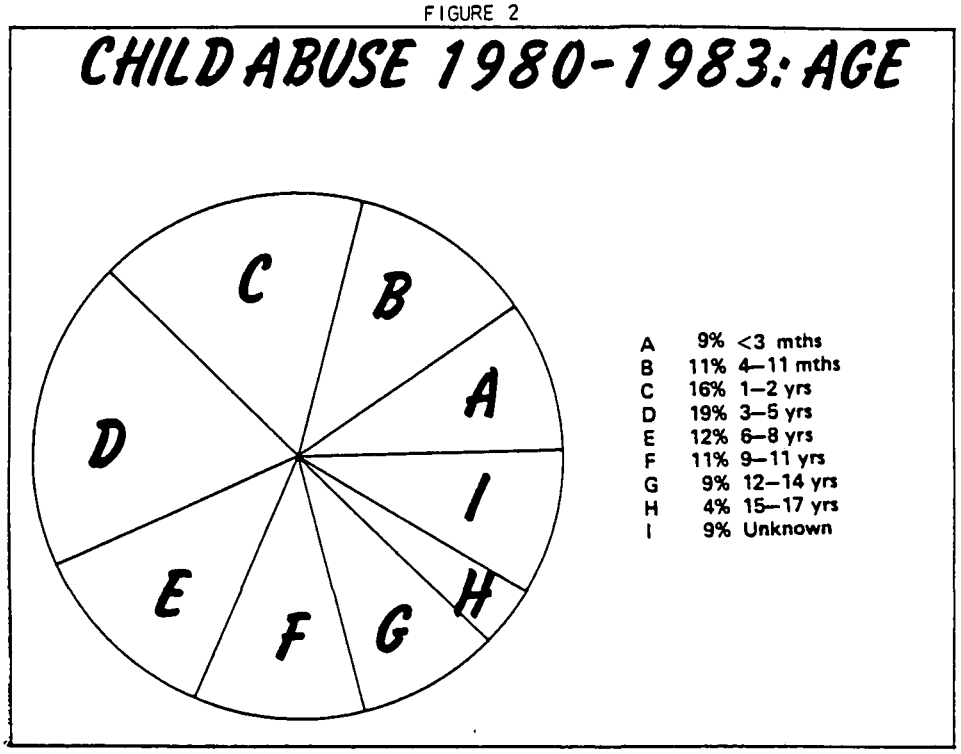


Figure 2. 'Child abuse 1980 - 1983: Age' shows that in the cases coming to police notice 55% are over the age of 3. Nineteen percent fall within the 3 - 5 age group. These figures suggest that where abuse has been chronic (in at least 85% of cases shown in Table 8) children are suffering a number of incidents of abuse or continual abuse over several years. The situation becomes so obvious in relation to the child's injuries or other forms of abuse that hospital authorities or neighbours or welfare workers make notifications which come to police notice.

Most analyses of child abuse cases confirm that it commences early in the infant's life. If police intervention gave emphasis to early detection and prevention of child abuse then Figure 2 could be expected to show a higher percentage of children under the age of 1 - 2 years and a lower percentage of older children coming to notice. The percentage should generally decline steadily for older age groups though some allowance should be made for female children in the 9 - 11 year group who would come to notice as sexual abuse cases.

FIGURE 3

CHILD ABUSE: POLICE ACTION BY AGE OF CHILD

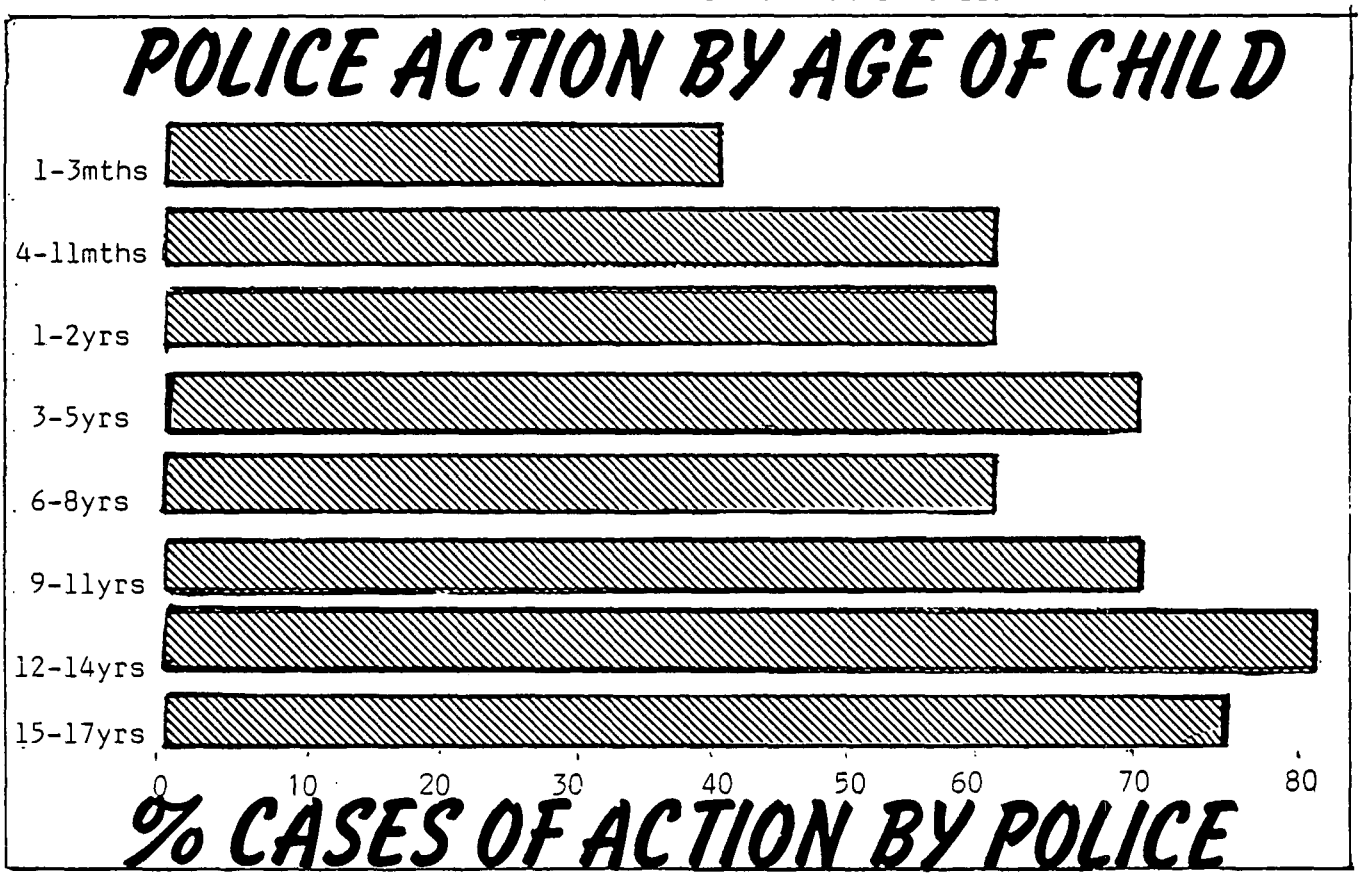


FIGURE 4

CHILD ABUSE: TYPE OF ABUSE BY ACTION BY POLICE

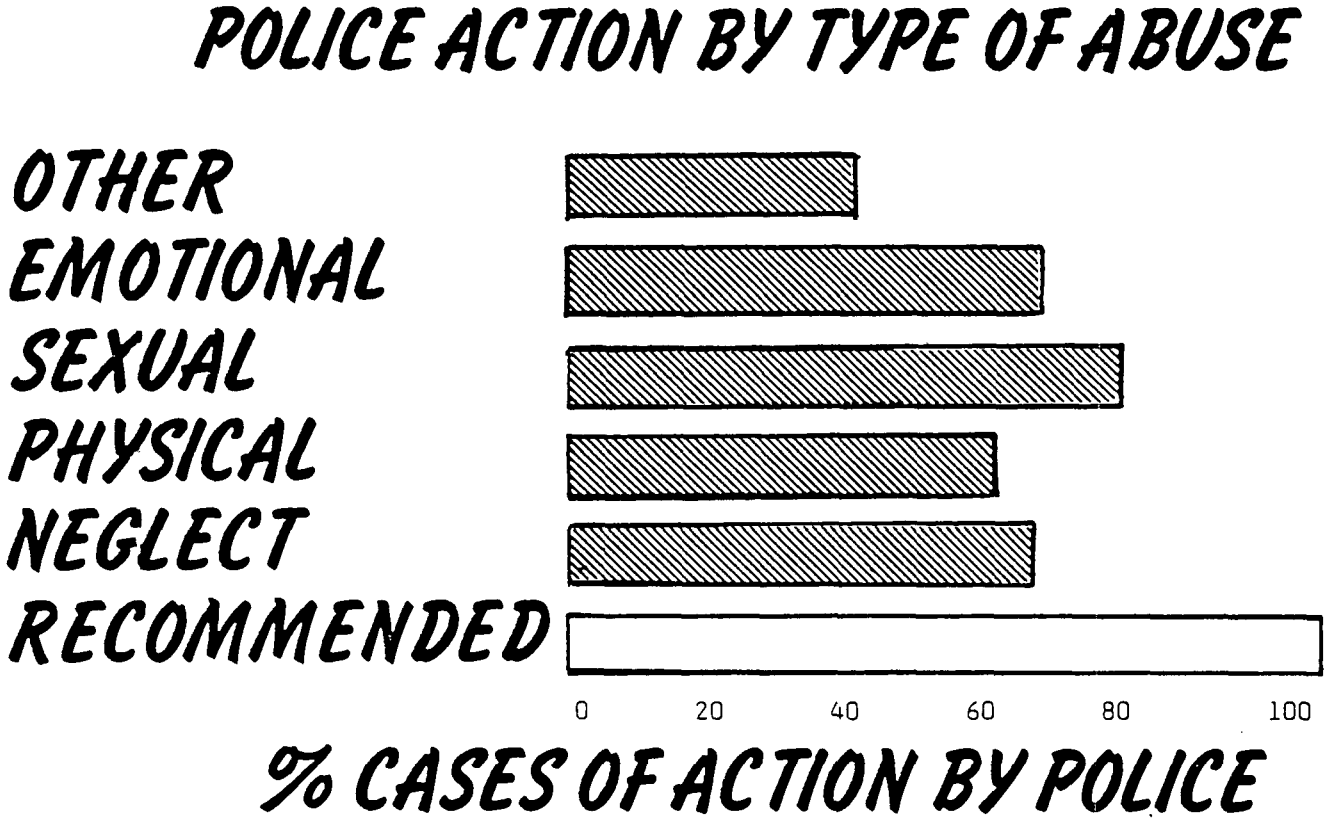


Figure 3, 'Child Abuse: Police Action by Age of Child' presents in a graphical form information describing the present problem of children, especially those aged 3 - 5 and older who are coming to police notice, being investigated and taken to court - 42% of 3 - 5 year olds. (See also Table 27, Chapter 3).

Figure 4, 'Child Abuse: Type of Abuse by Action of Police' shows that there were significant numbers of cases in all types of abuse that came to police notice through SCAN, where there was no police response. (See also Table 28, Chapter 3). The graph shows that 40% of neglect cases, 45% physical abuse, 27% sexual abuse, 38% emotional abuse and 62% of other cases (mainly at risk cases) had no police response. This demonstrates that the police were not involved in the investigation and protection of a large proportion of children who came to notice through SCAN.

The total picture of police non response was 43% of cases coming to notice (See Table 26, Chapter 3). These findings lead to the following recommendations discussed in Chapter 4:

RECOMMENDATION 1. The structure of the J.A.B. Child Abuse Unit be changed to allow for three supervisory positions to monitor and supervise all cases handled by J.A.B. (and uniformed branch officers where no J.A.B. officers are available) in Brisbane and all State Regions.

This will ensure that there are no gaps in cases which are to be followed through by police officers once notification is received.

RECOMMENDATION 2. The Child Abuse Information file to be created to allow for the effective supervision and monitoring of all cases. This file would also allow for continued monitoring where parents move within the State.

RECOMMENDATIONS 3 AND 4. Involvement of J.A.B. Officers in all cases of child abuse that are reported from hospital or community sources.

This includes targeting of schools as well as concerned neighbours to increase the reporting rates to police.

RECOMMENDATION 5. The development and use of an Operations Manual to ensure that procedures for identification of child abuse, planning of police action in each case, and information recording, are standardised and followed by all officers in each Region.

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RECOMMENDATION 6. The use of a planned course on child abuse within the existing J.A.B. training system, cadet training, and the introduction of in-service training to the Regional J.A.B. Officers.

This is to ensure that the quality of police involvement in child abuse cases is sufficient to allow cooperation in the multidisciplinary hospital and community teams (when the latter are formed), and to provide a capacity for detailed investigations of all cases throughout the State.

INDICATOR 3. EVALUATION OF THE SUCCESS OF POLICE INVOLVEMENT IN THE MULTIDISCIPLINARY SCAN TEAMS AND COMMUNITY RELATIONS.

FIGURE 5

CHILD ABUSE: ACTION BY POLICE

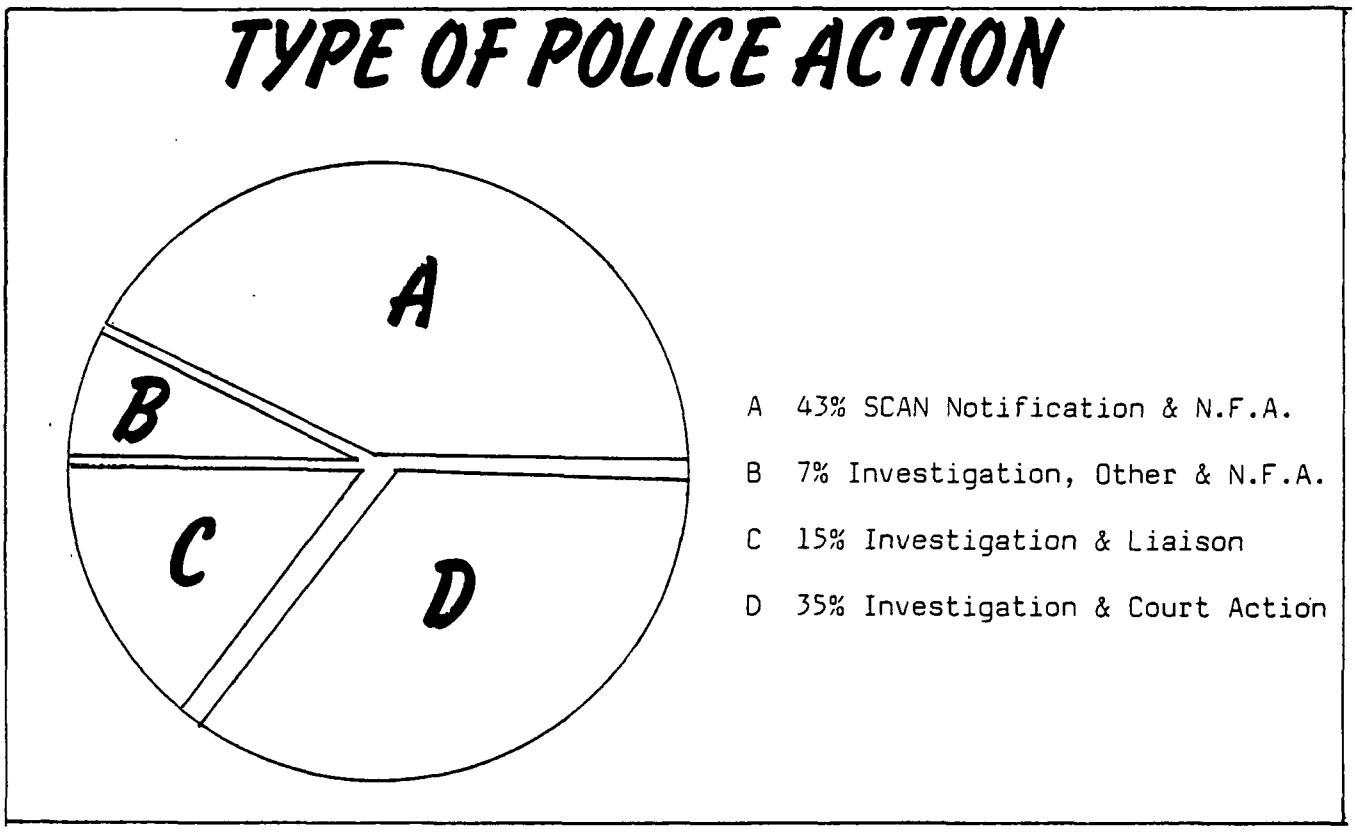

Figure 5 'Suspected Child Abuse: Action by Police' is a graph showing 43% group of cases where the police were attending SCAN but not involved in any action on the case. (See also Table 26, Chapter 3). This suggests a process of selective referral and casework through the multidisciplinary team where the police role has been to

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investigate the more serious cases. The weighting of 35% of police notifications becoming court cases further supports this bias in notifications.

This finding, along with the high proportion of children in older age groups, and histories of chronic abuse leads to the suggestion that intervention by police at the time of notification could lead to earlier identification of children. This could save children from suffering years of abuse before coming to notice. The police would also play a preventative role where early referrals were assisted and monitored by the continuing police involvement with the families. It is therefore essential that the J.A.B. become involved at the time of notification and in all notifications throughout the State.

FIGURE 6

SUSPECTED CHILD ABUSE: FIRST REPORTED TO POLICE BY

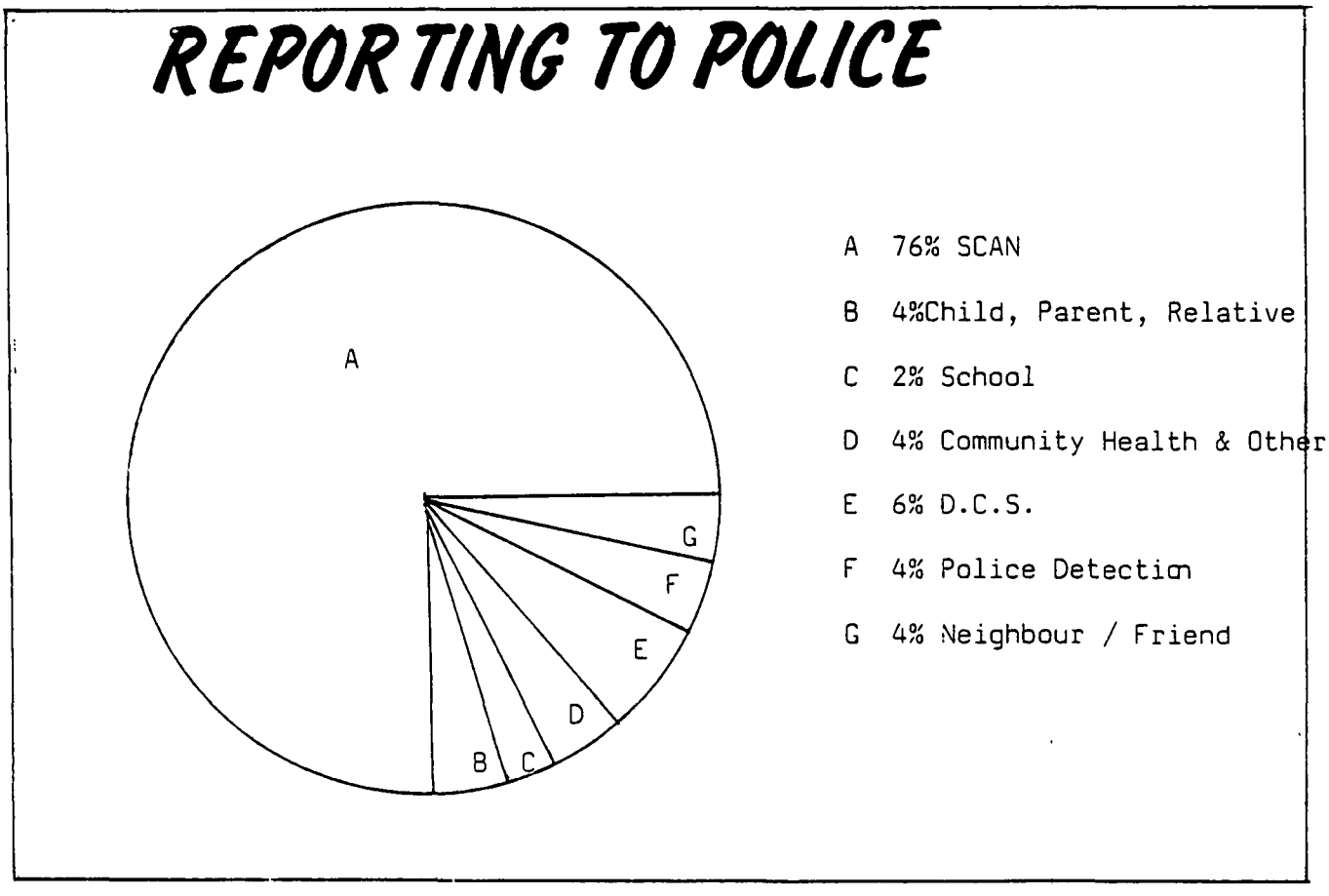

Figure 6, 'Suspected Child Abuse: First Reported to Police by..' is a graphical presentation that shows the pattern of police relations with the community from reported cases. (See also Table 25, Chapter 3) It does not present the pattern of contacts such as teachers in an informal effort to increase awareness. These contacts are generally made by police officers working out of hours in response to demands from the community for education. It can be assumed that the work in increasing community awareness does increase the potential in the community for reporting to the J.A.B. or to the Department of Children's Services.

Figure 6 shows that the bulk of cases come to police notice through SCAN and very few cases are reported directly to J.A.B. from the community: 4% from neighbours or friends of the family; 3% from other sources including general practitioners and Maternal and Child Welfare; 2% by parents of the child; 2% by school or pre-school; and 1% from Community Health. This pattern of reporting shows the gap in community relations that exists in present J.A.B. practice and directs attention in the recommendations towards using a 'community policing' approach by J.A.B. Officers which would allow them to spend time with potential reporting sources such as the schools and to use the media to encourage direct contact from the community with the J.A.B.

This evaluation leads to several recommendations in Chapter 4:

RECOMMENDATIONS 3 AND 4. The recommendations for police investigation with members of hospital and community SCAN teams (when the latter are formed) from the time of notification. It is further noted that the Child Abuse Unit in Brisbane and J.A.B. Officers in the Regions spend a proportion of their working time in contact with community agencies such as the Schools and Regional Education offices, and with the media with the aim of achieving earlier intervention in cases of child abuse throughout the State and increasing the reporting rate. The use of a community policing strategy is recommended to develop the role of the J.A.B. Officer as part of a team of community professionals involved in identification and treatment of child abuse within the community.

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RECOMMENDATION 6. The development of multidisciplinary training where the J.A.B. courses and in-service training within the Regions are opened to community agencies, in particular social workers within the Department of Children's Services who may work in close association with J.A.B. Officers in cases of child abuse, and teachers who are interested in identifying and understanding the multidisciplinary team approach to child abuse.

RECOMMENDATION 1. The recommendation of the structure of the Child Abuse Unit in Brisbane includes a role in preparing and implementing prevention programmes through planned community contacts. The development of a specialised Unit for Child Abuse and a centralised system of supervision for all Regions allows for preparation of specialised training material through this Unit to teach and update procedures used by SCAN teams throughout Queensland.

INTRODUCTION

HISTORY

The Juvenile Aid Bureau commenced on 14 May 1963 with two officers appointed as police juvenile liaison officers. The aims were for the police officers to concentrate on prevention and rehabilitation work with children aged 5 - 16 years.

Work with children included those children who needed care and protection from their natural parents. By the mid 1960's people in Brisbane, including the police were becoming aware of the prevalence of child cruelty. In 1966 the Police Commissioner (Mr F. Bischof) stated that in the 10 years January 1956 - December 1965 there had been 283 neglected children, and 29 cases of physical abuse. The police were finding that in many cases it was difficult to prove the child had been ill treated and not injured by accident. (Sunday Mail 6.3.66). By 1973 the Juvenile Aid Bureau (J.A.B.) was asking the public to contact J.A.B. or the Department of Children's Services on child abuse cases.

In 1978 the Juvenile Aid Bureau was liaising closely with the public hospitals in Brisbane and some regional centres (including Townsville) on cases of suspected child abuse or neglect. The Queensland Cabinet in late 1978 approved the establishment of the Co-ordinating Committee on Child Abuse and the formation of child abuse teams called Suspected Child Abuse and Neglect teams (SCAN).

The Co-ordinating Committee was constituted to advise the Minister for Health. The Director General of Health and Medical Services chairs the Committee and members are the Director of Children's Services, the Medical Superintendents of the Mater Children's and Royal Children's Hospitals, a representative of the AMA Qld. Branch, and the Assistant Commissioner of Police (Crime and Services).

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SCAN teams are now located in 33 centres throughout the State. The core members are a medical practitioner, a child care officer from the Department of Children's Services and a police officer. Greenaway (1982) says that there was no statutory basis for the establishment or operation of SCAN teams. The role of SCAN teams in response to both mandatory and voluntary notifications includes the provision of a comprehensive and continuing management plan with regular review, and to ensure that intervention is justified and coordinated.

Greenaway (1982) also comments that many cases of abuse come to the attention of other professionals, for example, Child Care Officers of the Department of Children's Services.

A comprehensive record system, the Central Register, has been set up within the Department of Children's Services to contain past instances of known abuse to ensure effective intervention and management.

Greenaway (1982) states that the Queensland notification system is a combination of legislation, inter-departmental and intra-departmental arrangements. Child protection services are provided by a wide range of services and it has proven difficult to provide a coordinated approach prior to government's decision in 1978. (The Central Coordinating Committee recommended mandatory notification by medical practitioners and the Health Act Amendment Act was made law in the same year).

THE POLICE ROLE IN SCAN

In 1980 the Police Department's view of child abuse was that the interests of the child were paramount. There was a need for flexibility and the police were to be part of a team acting in the best interests of the child. This role recognised the contribution each agency made to protect abused and neglected children. Duffy (1980:3) stated:

> "We as police do not have all the answers and an effective programme is not possible without team work as is envisaged by the proposed SCAN team".

Duffy (1980) said the role of the police officers in the SCAN teams was to use their developed investigatory skills. It was vital that the police become involved at the earliest possible moment.

Details of the police role in SCAN are identified by Purcell (1983) as follows: attendance at SCAN meetings to evaluate the degree of risk in each case; advise the team on the evidence; early involvement in cases; initiation of court proceedings; arrange assistance from police resources; assist in monitoring and supporting children and parents; and liaising with other police involved in SCAN cases.

The Juvenile Aid Bureau established a Child Abuse Unit to deal with all child abuse cases and to attend SCAN meetings. The Child Abuse Unit is responsible to the Inspector of J.A.B. The Unit has undergone rapid expansion with the increase in reporting of suspected cases through police involvement in SCAN. The present staff number is 16 officers.

EVALUATION OF J.A.B.

The present study commenced with a request by the Queensland Police Department to the Criminology Research Council for assistance with an evaluation of police work with juveniles and victims of child abuse. The Queensland Police Department and the Criminology Research Council agreed in November 1983 to jointly fund an evaluation of J.A.B. using an external consultant as evaluator.

The project was divided into two parts and the child abuse research commenced in December 1983. The hypothesis of the child abuse study is that the effectiveness of police work by the J.A.B. is dependent on three general Indicators. These incorporate information from statistical analysis and subjective observations and responses. The three Indicators are as follows:

. The degree of involvement in child abuse cases compared to the incidence of child abuse throughout the State

. The effectiveness of police action to protect young children from abuse.

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. The success of police involvement in the multi-disciplinary team approach to child abuse and relations with the community.

The aims of the evaluation by the J.A.B. Child Abuse study are:

1. To assess the work by police in J.A.B. with young victims of child abuse, the adult offenders and the families.

2. To identify the degree to which the police involvement in SCAN teams and community relations has assisted in the goal of protecting children from abuse.

3. To assess the effectiveness of the structure and administration of police work in relation to child abuse.

The methods for the study include:

a comprehensive review of the literature on child abuse,

a statistical study of a sample (400) of three years child abuse cases coming to police notice in Brisbane,

observation of police procedures in Brisbane and three other centres in Queensland; and

a brief questionnaire administered to a sample of J.A.B. staff and other police officers in the C.I.B. throughout Queensland who are required to do J.A.B. work.

There are a number of limitations to the study. The time frame for analysis of data was confined to four months which restricted the areas of information. The data from the 400 police files represents a retrospective study and therefore is limited as there can be no assumption on consistency of factual recording. The data was also compiled in part with the assistance of the J.A.B. officers responsible for the case so that material depended in some part on information that they remembered but did not record at the time on the file. The information from the 400 cases is therefore restricted and serves as a guide to general trends in child abuse for the police.

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Infant deaths have not been included in the study although this aspect is one of the significant Indicators of failure of early intervention. Forensic information and legal studies are two other areas which require detailed study and have not been included within this project. In addition, the particular needs of the Regions were not assessed beyond a brief visit to Townsville, Ayr and Charters Towers.

The use of an external consultant as evaluator has provided the Police Department with an evaluation which is not affected by internal bias. However, there is also the disadvantage of an external evaluator entering the Department for four months and being limited in experience of the long term work of the J.A.B. This problem has been overcome by the work of the Police Research Committee which was appointed for this study. The five members of the Committee included two Inspectors from the Police Academy (Inspector D. Braithwaite and Inspector F. Rynne) who had experience with the J.A.B., the Inspector of J.A.B. (Detective Inspector D.A.T. Reay) as Chairman, Detective Sergeant 1/c D. Macmillan from J.A.B. and Detective Sergeant 1/c D. Jefferies who is in charge of the Child Abuse Unit.

The Report is presented in four chapters. Chapter 1 describes the problem of child abuse in Queensland and analyses the growth of police cases of child abuse in relation to the total problem.

In Chapter 2 the results of the computer analysis of 400 cases of child abuse known to the police 1980 - 1983 are described and analysed in terms of the literature on child abuse. This analysis provides a list of Indicators of child abuse for police work.

Chapter 3 continues the analysis of the 400 cases and reports on the characteristics of abusing parents. The chapter is concluded by an analysis of police work in the multidisciplinary team.

Chapter 4 presents the recommendations on policy directions for the J.A.B. with four detailed recommendations focussing on centralisation of child abuse administration and information systems, a change in hospital and community SCAN team operations, an Operations Manual for general use throughout the police force, and a comprehensive training scheme.

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CHAPTER 1

CHILD ABUSE IN QUEENSLAND

The definition of child abuse from the Co-ordinating Committee (1980a) is:

> "A non accidentally injured or maltreated child is one who is less than 18 years of age whose parent or other person having care of the child has inflicted or allowed to be inflicted on the child physical injury or gross deprivation which has caused or created a substantial risk of such physical injury or gross deprivation to arise or exist. This definition includes sexual abuse or sexual exploitation".

Child abuse is any act of omission or comission that endangers or impairs a child's physical or emotional health and development.

Five types of child abuse have been identified:

(Co-ordinating Committee on Child Abuse 1980a)

1. Physical abuse and excessive punishment

2. Emotional abuse

3. Emotional deprivation

4. Physical neglect and / or inadequate supervision

5. Sexual abuse and exploitation

The Health Act Amendment Act 1980 provided for the notification of maltreatment by a medical practitioner within 24 hours to a person authorised by the Director General of Health. Temporary custody of children for 96 hours is possible where the child is presented at a hospital and the prescribed medical officer suspects

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maltreatment or neglect. (Co-ordinating Committee on Child Abuse 1980)

SCAN TEAMS IN QUEENSLAND

The Co-ordinating Committee on Child Abuse adopted an overall policy on central coordination and decentralisation of management. Local child abuse teams were therefore advocated and established in 15 major centres and 18 regional centres. The core members are Child Care Officer from the Department of Children's Services, medical practitioner and police officer who are empowered to co-opt other persons to join the team from statutory and voluntary agencies. There are a number of roles to be fulfilled by SCAN teams including: a response to each mandatory notification and direct non-mandatory referrals from the local community, provision of management plans for the child and family with regular reviews, to ensure intervention is justified and coordinated, and formulating community education programmes. (Co-ordinating Committee on Child Abuse 1980c)

Notification is viewed as the first step in the management of child abuse. The Department of Children's Services maintains a confidential central register of children at risk of abuse and of children known to have suffered abuse. The central register enables an authorised person of a SCAN team to obtain confidential information and access to any previously notified abuse suffered by the child. (Heyworth 1981)

Information is placed on the Central Register by two forms CP1 and CP2. The CP1 form details the voluntary complaint, referral or notification. The CP2 form records the outcome of the investigation and entry of the child onto the Register is determined by this form. (Carrick et.al. 1981)

The Department of Children's Services views the Child Care officer's role on the SCAN team as one of interpreting the Department's functions, particularly statutory applications for care and protection, either by voluntary process or through the Children's Court; placement of children; and assessing children and their families suspected of child abuse. (Carrick 1980)

The Child Care Officer places the family's strengths and weaknesses into perspective for the team, has access to local resources, knows the Departmental resources for Care orders, prepares the child for separation from the family, and may have ongoing contact with the child and family. (Carrick 1980)

The police officer on the team has the function of being part of the team and not acting unilaterally. The police role is to undertake efficient investigations with an emphasis on the manner and sensitivity used in responding to abuse cases. The police require detailed knowledge of the symptoms of child abuse, and the statutes, case law and how and where to obtain the required physical evidence. There are priorities of responsibility in child abuse cases of first protecting the child and secondly gathering evidence for possible prosecution. (Duffy 1980)

The philosophy of police involvement in child abuse through the multidisciplinary team is outlined by Duffy (1980:5) as follows:

> 'Police officers are by statute, charged with the responsibility of deciding when to prosecute. The police officer also has discretionary powers. The police officer should keep in mind the priorities of his responsibility. First, he must protect the child. Second, he gathers evidence for possible prosecution. When confronted with a case of obvious suspected child abuse, our officers will adhere to guidelines as presented in the procedure as set out for local management teams as set out in the booklet 'A Guide to Medical Practitioners'. Unilateral action without prior discussion will only take place in emergent circumstances. There is less immediate need to commence proceedings against the abusing parents'.

If decisions cannot be reached through the team the matter is referred to the Police Department representative on the Co-ordinating Committee who makes the final decision after consultation with other members of the Committee. (Duffy 1980)

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Officers on SCAN teams are retained for as long as possible to assist in team trust and cooperation. Training on child abuse at the Police Academy, for J.A.B. Officers, includes an input from other specialists in child abuse. (Duffy 1980)

STATE REPORTING OF CHILD ABUSE

Historically the Department of Children's Services has maintained information on complaints of suspected child abuse. Statistical information on reports was reorganised as the Central Register in 1980 to provide comprehensive information.

An early study of statistics on child abuse in Brisbane was made by Lange (1981) for the four years 1963 - 1966. Fifty-four cases were found in these four years (23 of which were in 1966) in a search of Department of Children's Services, two childrens hospitals, a Salvation Army Home, the RSPCC, and the Government Pathologist. Thirty-four percent of these cases were neglect and remainder physical abuse.

In the first six months of the Central Register in Children's Services 683 cases were reported. One hundred and sixteen of these reports came through the Child Protection Unit and 87 through Crisis Care. The highest number of community referrals were from neighbours (149), then relatives (76), and parents (69). (Carrick et.al. 1981)

An analysis of notifications in 1981 - 1982 shows that reporting of cases totalled 2,723. Forty-six percent of these notifications were reported to be unfounded and in a further 20% there was uncertainty. Thirty-four percent of notifications were confirmed. (Department of Children's Services)

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POLICE STATISTICS ON CHILD ABUSE

The J.A.B. in Brisbane has experienced a significant rise in reported cases through the SCAN teams at the Royal Children's Hospital and the Mater Children's Hospital. In 1980 - 81 99 cases came to notice at the Royal Childrens. This increased to 101 in 1981 - 1982 and 212 in 1982 - 1983. One aspect of the increased reporting at the Royal Children's Hospital was the increased reporting rates for sexual abuse. These numbered 4 in 1980 - 81, 9 in 1981 - 1982 and 65 in 1982 - 1983. The Mater Children's Hospital has shown a fairly stable reporting rate for the years 1981 - 1982 (167 cases), 1982 - 1983 (192 cases). In 1982 - 1983 the monthly average of cases that came to notice from both hospitals was 34 (8 new cases / week).

EPIDEMIOLOGY OF CHILD ABUSE

The epidemiology of child abuse in Australia cannot be calculated on the basis of State Statistics. Boss (1980) describes the provisions for reporting in the Australian States and Territories and quotes case figures which are widely variable:

In New South Wales between 1968 - 1977 there were 645 reports of child abuse. In 1977 - 1978 after provision for the Child Life Protection Unit in Sydney at Montrose (a Department of Community Welfare Service Office) the reports rose to 887. In Western Australia the reported cases were 140.

Price and Krupinski (1976) describe 316 cases found in a retrospective study in a single hospital in Victoria, the Royal Children's Hospital 1967 - 1973. Reports of incest are another example of variations in statistics - Macmillan and Jefferies (1981) comment on 13 incest cases reported in Queensland 1980 - 1981. An estimate for Victoria is 100 incest cases a year (Singer 1979).

The Community Welfare Advisory Committee (1976) surveyed 23 hospitals in South Australia in 1975 and found an incidence of 17 / 10,000 (0 - 15) child patients in a retrospective survey. There was a mortality rate of 5%. A prospective survey found a rate of 27 / 10,000

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cases of non accidental injury within child patients and a 10% mortality rate in this group.

Pearn (1981), refers to Anne Deveson's work for the Royal Commission on Human Relationships in 1977 which suggested 37 children a day were being injured. Pearn states that a study of violent child deaths in Brisbane shows the fatality rate is .57 / 100,000 for children 0 - 15 and 3.77 / 100,000 for children 0 - 5.

The present study has been limited in the investigation of infant deaths. However, it has been noted that the Juvenile Aid Bureau Child Abuse Unit is not involved in infant death investigations as these are undertaken by the C.I.B. Infant deaths from child abuse are the worst end of the spectrum of these cases and represents a failure by reporting sources to identify this group of children at risk. The present system also allows for the siblings of these cases to remain uninvestigated by the Child Abuse Unit.

Epidemiological studies from the United States and the United Kingdom provide a more practical basis for estimating the epidemiology of child abuse in Australia. Epidemiological studies from these countries still report scepticism about reporting rates in relation to real frequencies of child abuse but the reporting systems are more established than in Australia and there has been a consistent effort to collect statistical information. The rates of child abuse quoted from these countries represent the expected rate in Australia when reporting systems have developed more fully.

In the United Kingdom, The Select Committee (1977) reported that 1 / 1,000 children under four are seriously injured each year and of this group 10% die. The Select Committee stated 4 - 6 / 1,000 were injured less seriously but this group was not as easy to calculate.

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Creighton (1976) reports that .68 / 1,000 children 0 - 15 are registered with the NSPCC for physical abuse and of this group .5 / 1,000 were physically abused and the remainder at risk. The total estimate of children who suffer from any form of child abuse is 1 / 100 0 - 18. Oliver (1978) says that this represents the U.K. figure which was first calculated by Chesser in 1951. Similar figures have been quoted for the United States by Light in 1973.

In the United States estimates of the frequency of child abuse have changed as reporting systems developed. In 1967 Newberger and Hyde were quoting the total United States reports of child abuse at 7,000 and in 1974 this had increased to 200,000. In 1971 Kempe (Kempe 1972) was estimating 6 / 1,000 live births and 10 - 15% of all trauma cases of children under 3 and 25% of all trauma cases under 2. Larger studies of child rearing (Gelles 1979) have shown that in 1975 3% of parents were dangerously violent towards their children with incidents of kicking, punching, beating up, threatening or assaulting with a gun or knife. Seventy-three percent of parents reported one violent episode in raising a child.

The estimates in the United States vary from 1 / 10,000 to 4 / 100. Gil and Noble's study in 1969 reported an estimated upper limit of child abuse incidents between 13 - 21 / 1,000. However, the reporting rates are much lower than this with Gil quoting 37 / 1,000,000 (4 / 100,000) as the official statistics on abuse for 1968. (Fergusson 1972)

Carter (1974) has drawn attention to the differences in predictions caused by changes in definitions and Fergusson (1972) states that the recording shows regional variations in reporting and recording practices.

In Queensland the Co-ordinating Committee's definition of child abuse includes physical abuse, emotional abuse, emotional deprivation, neglect and inadequate supervision, and sexual abuse and exploitation.

The NSPCC records of abuse of .7 / 1,000 and the Select Committee reports of 1 / 1,000 seriously injured and 4 - 6 less seriously injured (i.e. 1 / 200 children)

shows that an estimate for all types of abuse of 1 / 100 0 - 17 could be accepted as the baseline rate for Queensland, with 1 / 1,000 as the rate for serious injury and 1 / 200 for less serious injury. The NSPCC figure of .7 / 1,000 shows the actual reported rate which is less than the frequency of abuse in the general population.

Oliver (1978:114) concludes a comprehensive world review of statistics on child abuse with the following statement:

> 'The '1 in 100' figures for child victims represent the proven apparent cases ... The '1 child in 10' usually just suffers, and his plight is only apparent to conscientious people who spend an appreciable part of the day with him ... he is the likely parent of the blatantly battered baby in the next generation'.

QUEENSLAND REPORTING RATES 1981 / 1982, 1982 / 1983

In 1981 - 1982, 2,723 voluntary notifications were made to the Department of Children's Services. Voluntary notifications are all notifications made by the community to the Department. This includes voluntary notifications from parents, children, siblings, neighbours, relatives, school, police, hospitals and government agencies. The figure excludes mandatory notifications which are made by medical practitioners separately to the voluntary reporting system. (Department of Children's Services)

The Annual Report of the Director of Children's Services for 1982 shows that in 1981 - 1982 21% of notifications were confirmed as abuse.

In 1982 - 1983 2,904 voluntary notifications were received by the Department of Children's Services. (Department of Children's Services). Population estimates for Queensland (Australian Bureau of Statistics) 1981 / 1982 / 1983 provide baseline data for calculation of mean populations of children aged 0 - 17. There were 740,010 children aged 0 - 17 in

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1981 / 1982 and 756,460 children in 1982 / 1983. Voluntary notifications totalled 2,723 in 1981 / 1982 giving an estimated reporting rate of 37 / 10,000. In 1982 / 1983 there were 2,904 notifications providing an estimated reporting rate of 38 / 10,000.

The theoretical proportion of children who may be at risk in the community is 100 / 10,000 children 0 - 17. Estimates on the population in 1982 / 1983 show that at least 7,564 children were at risk. Reports totalling 2,904 (38%) were made to the Department of Children's Services and this suggests that some increased reporting could follow any specialised campaigns particularly those targeted at neighbours and the schools.

The Brisbane reporting rates as estimated by the Department of Children's Services were 27.5% of all reports in 1981 / 1982 and 33.6% of reports in 1982 / 1983. This provides a total within Brisbane of 975 notifications in 1982 / 1983.

In 1981 / 1982 268 cases of child abuse within Brisbane came to notice of the Juvenile Aid Bureau and in 1982 / 1983 404 cases came to notice. In an estimated 42% of these cases the J.A.B. was not involved beyond attending the SCAN meeting where these cases were discussed.

CHAPTER 2

INDICATORS AND CHARACTERISTICS OF CHILD ABUSE

INTRODUCTION

This chapter reports the findings of the study of 400 cases of child abuse from the Brisbane Juvenile Aid Bureau Child Abuse Unit files. The 400 cases are a random sample of 1200 files held within the Child Abuse Unit of all cases of child abuse that came to notice of the Unit 1980 - 1983, a period of three years and eight months. These cases were subjected to computer analysis to ascertain frequencies of certain characteristics relating to the children, their families, the abusing adults, and police action by the Child Abuse Unit. In addition crosstabulations were made of significant variables to ascertain relationships that would concern the police in their investigations and to allow some formulation of hypothesis as to the significant characteristics of children and the abusing adult offenders. All percentages in the tables produced from the Brisbane case study have been rounded to reduce the decimal proportions.

In the interpretation of the data information is used from a comprehensive review of the literature from Australia and other western countries, and from the Department of Children's Services, medical sources, and interviews with J.A.B. and other police personnel.

The results are presented in five sections:

1. Characteristics of Abuse to Children including primary and secondary forms of abuse, the nature of injuries, and chronicity;

2. Characteristics of Abused Children including age and sex and type of abuse and associated abuse to siblings;

3. Abuse to Children within the Education System

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including characteristics of abused children aged 3 - 17 who fall within kindergarten, pre-school, primary and secondary school systems;

4. Consequences of Abuse for the child victims including homicide and the serious long term consequences of physical and psychological effects;

5. Indicators of Abuse In the Child which include those Indicators which are observed, identified by interview or medical or psychological investigation. These Indicators are analysed both within the context of general child abuse and specific forms of child abuse, to allow detailed investigation and assessments to be made by police officers.

1. CHARACTERISTICS OF ABUSE TO CHILDREN

TABLE 1

MAIN TYPE OF ABUSE

MAIN TYPE OF ABUSE	NO.	%
1. NEGLECT	85	21
2. PHYSICAL ABUSE	163	42
3. SEXUAL ABUSE	64	16
4. EMOTIONAL ABUSE	34	9
5. DRUG ABUSE	1	0
6. HOMICIDE	0	0
7. OTHER (INC. AT RISK)	47	12
TOTAL	400	100

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Table 1 'Main Type of Abuse', presents the main types of abuse to children in the Brisbane sample (N=400). Forty-two percent of children who came to police notice suffered physical abuse, 21% neglect, and 16% sexual abuse. A number of children came to notice as being 'at risk' were generally where mothers were considered mentally ill or otherwise unable to care for a new baby, or abuse to another child in the family placed the child 'at risk'.

The Department of Children's Services' analysis of all voluntary notifications in a one year period (1981 - 1982) gives a total of 2,723 notifications. Two hundred and nineteen cases could not be analysed through lack of information. Fifty-two percent of cases notified to the Department were presented with neglect, 27% physical abuse, 7% emotional abuse, and 5% sexual abuse. This shows a different pattern to those notified to the police where physical abuse was more prevalent than neglect. The Voluntary Notification to the Department of Children's Services presents the State-wide pattern of notifications whereas the Child Abuse Unit have been involved in a restricted number of cases.

Secondary abuse to the child in the sample of 400 was noted in 38% of cases. This means that in this percentage of cases a second type of abuse was 'known' and the real percentage could have been much higher. The signficant form of secondary abuse was emotional abuse which appeared in 44% of cases where secondary abuse was noted. Neglect appeared in 30% of cases and physical abuse in 16% of cases.

Table 2, 'Primary Abuse to the Child by Secondary Abuse', extends the analysis of abuse to the pattern of primary and secondary forms of abuse that appear together. The table shows that where the main type of abuse is physical, 45% of secondary abuse is emotional and 44% neglect.Where the main type of abuse is neglect the signficant secondary abuse is emotional (67%). In cases of sexual abuse both emotional and physical abuse may be found. The cases of sexual abuse are not large in this sample and therefore a conclusion is not possible. Where the primary abuse is emotional, physical abuse and neglect are similarly possible secondary forms of abuse.

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TABLE 2

PRIMARY ABUSE TO THE CHILD X SECONDARY ABUSE

	TYPE OF ABUSE					
SECONDARY ABUSE	NEGLECT	PHYSICAL	SEXUAL	EMOTIONAL	OTHER	TOTAL
NEGLECT	0	35	3	6	2	46
PHYSICAL	9	0	6	7	2	24
SEXUAL	1	6	0	3	2	12
EMOTIONAL	20	36	9	0	1	66
OTHER	0	3	0	0	0	3
TOTAL	30	80	18	16	7	151
PERCENT	20	53	12	10	5	100

The major finding from this analysis is that abuse to the child is not necessarily a single form of abuse but where one type of abuse is identified there is sufficient evidence from these cases to investigate for other forms of abuse. The pattern of child abuse from this study seems to be one where the normal safeguards for the child in the family have broken down and he becomes the subject of different types of abuse. A definition of abuse which recognises this component is used by Newberger and Hyde (1979). These authors describe child abuse as a family crisis which threatens the physical or emotional survival of the child. Abuse shows the family's incapacity to protect the child from the consequences of the parents' angry feelings or the hazards of the environment.

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There is a need for definitions of the above forms of abuse so that there is a clear understanding of the phenomena that are to be observed. Child abuse is best described as a 'Syndrome' or a pattern of signs that can be observed or symptoms that are described by the child or others. Together these form the specific type of abuse.

Bybee (1979) quotes a definition of physical abuse first used in 1973 by Gil (1973), describing it as the intentional or non-accidental use of physical force, or intentional non-accidental acts of omission on the part of the parent or caretaker interacting with a child in his care, aimed at hurting, injuring or destroying that child.

Physical abuse and neglect are frequently described together in the definitions of child abuse. Birrell and Birrell (1968) describe maltreatment as physical injury and or deprivation of nutrition, care and affection in circumstances indicating that such injury and / or deprivation are not accidental.

Incest is defined by Singer (1979) as sexual intercourse either continual or in a single instance between persons whose blood ties are too close to permit their lawful marriage. Singer says that violence is rarely found to accompany the incestuous act, possibly because seduction, passive compliance or sexual curiosity and exploration promote such relationships.

A broader definition of sexual abuse is any act of a sexual nature upon a child (Kinard 1979:83). Macmillan and Jefferies (1981) state that sexual abuse is exposure of a child to sexual stimulation inappropriate for the child's age, level of psychosocial development, and the role in the family. This includes cases where the child has been an active or passive participant.

Emotional abuse is injury to the psychological self. Kinard (1979) says that it is abuse with punitive intent and experienced as parental hostility or rejection in verbal criticism, harrassment or denigration.

Another form of abuse is institutional abuse and this is generally described as severe emotional abuse that

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results from a failure to provide the child with significant surrogate figures for emotional bonding. It may occur through constant changes of fostering parents or through life in an institution where staff shortages or personalities lead to a lack of personal care and attention to the child.

Details of the signs and symptoms that have been reported in the literature on each of the main types of abuse are listed as Indicators in the last section of this chapter.

The pervasive nature of child abuse in the family is also demonstrated in the findings from the sample of 400 of the chronic nature of the abuse. In cases where information was available 85% of abused children had suffered chronic abuse. This means that the incident that came to police notice was judged to be of a chronic nature and not necessarily a first time abuse.

FIGURE 7

BODILY LOCATION OF ABUSE

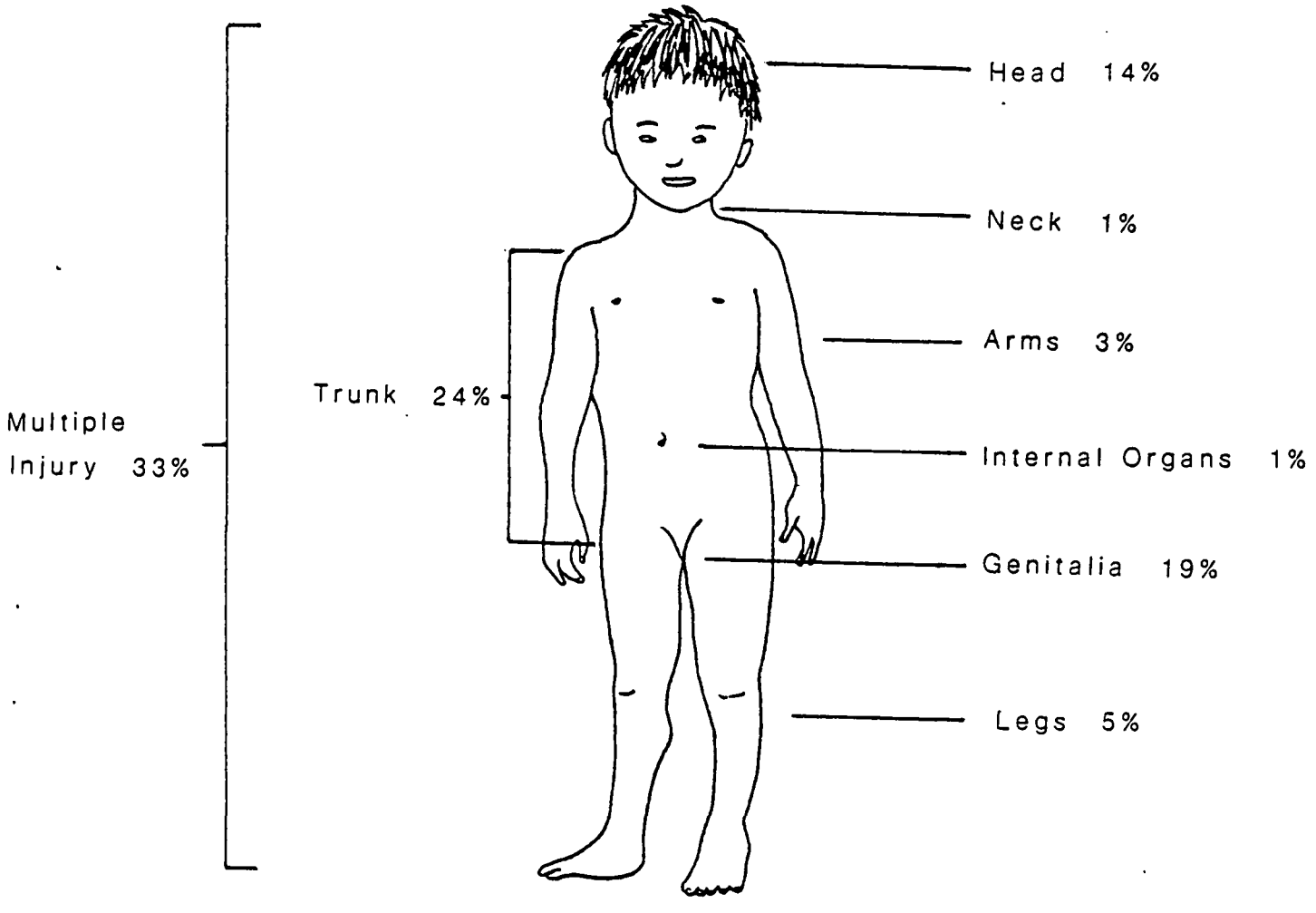

Figure 7, 'Bodily Location of Abuse' shows the percentage of the 400 cases where some physical part of the child was abused - 15 percent of cases involved head and neck injuries, 33% were multiple injuries, 24% involved the trunk, 19% the genitalia, 8% arms and legs, and 1% internal organs. A general but by no means absolute guide to severity of these injuries is that the serious and life threatening cases include those with head, neck or internal organ injuries or injuries to multiple parts of the body.

2. CHARACTERISTICS OF ABUSED CHILDREN

Figure 2, 'Child Abuse 1980 - 1983: Age' shows the age distribution of the 400 Brisbane cases. Thirty-eight percent of cases are under the age of two. The highest groups are those aged under 1 (23%) and 3 - 5 (19%). The age distribution shows an increasing number of children coming to notice up to the age of five and then gradually reducing to the age of 11 when there is a sharp reduction for the adolescent years.

The Department of Children's Services figures for age of children in voluntary notifications 1981 - 1982 also show a drop in cases after the age of 9 and a significant peak in the 3 - 4 year age group coming to notice (18%).

The sex of children coming to notice in the 400 case study showed a fairly equal relationship with 53% females and 46% males. The Department of Children's Services analysis of voluntary notifications 1981 - 1982 shows that 50.3% of notifications were males and 49.7% were females. Other studies in the literature suggest male children may be slightly more likely to be victims than female children - Gelles (1979) quotes 66% of sons of parents and 61% of daughters are at risk. Cooper (1978) quotes 58.8% male children in an English study and 41.2% female children. Smith (1976) quotes a study by Gil of slightly more boys than girls especially those suffering fatal injuries. Boys in this study outnumbered girls under the age of 12 but more teenage victims were female.

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TABLE 3

MALE AND FEMALE CHILDREN X TYPE OF ABUSE X AGE

TOTAL: MALES & FEMALES

TYPE OF ABUSE

AGE	NEGLECT	PHYSICAL	SEXUAL	EMOTIONAL	OTHER	TOTAL NO.	TOTAL %
1-3 MTHS	10	12	0	1	15	38	11
4-11 MTHS	11	26	1	2	4	44	12
1-2 YRS	17	32	2	7	8	66	18
3-5 YRS	20	31	13	6	6	76	21
6-8 YRS	8	20	11	6	2	47	13
9-11 YRS	6	18	14	5	1	44	12
12-14 YRS	8	11	10	3	2	34	9
15-17 YRS	1	4	7	2	1	15	4
TOTAL KNOWN	81	154	58	32	39	364	100
NOT KNOWN	4	15	6	2	9	36	-
TOTAL	85	169	64	34	48	400	-
PERCENT	21	42	16	9	12	-	-

The relationships of sex of children, type of abuse and age are presented in Table 3 'Male and Female Children by Type of Abuse by Age', Table 4 'Male Children by Type of Abuse by Age', and Table 5 'Female Children by Type of Abuse by Age'.

Table 3 shows the pattern of age and type of abuse for all children in the sample of 400 cases. Neglect

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occurred mostly in children up to the age of 5 years (72% of all neglect cases were under 5). Most physical abuse occurred to children below the age of 11 (90% of cases aged under 11) with the peak years 1 - 5 (41% of cases). Sexual abuse was highest in the 9 - 11 year age group (24% of sexual abuse cases). Sexual abuse starts to be significant in the 3 - 5 year age group, is highest in 9-11 year olds and starts to reduce after this time. Seventy-one percent of sexual abuse cases are aged under 11. Emotional abuse does not show a significant correlation with any age group and appears in all ages 0 - 17.

TABLE 4

MALE CHILDREN X TYPE OF ABUSE X AGE

MALES

TYPE OF ABUSE

AGE	NEGLECT	PHYSICAL	SEXUAL	EMOTIONAL	OTHER	TOTAL NO.	TOTAL %
1-3 MTHS	4	7	0	0	5	16	10
4-11 MTHS	5	17	0	0	1	23	13
1-2 YRS	11	13	0	5	4	33	20
3-5 YRS	15	19	3	3	5	45	27
6-8 YRS	5	11	1	4	2	23	14
9-11 YRS	2	8	0	2	1	13	6
12-14 YRS	3	3	1	2	1	10	6
15-17 YRS	0	2	0	1	0	3	2
TOTAL KNOWN	45	80	5	17	19	166	100
NOT KNOWN	2	10	0	1	5	18	-
TOTAL	47	90	5	18	24	184	-
PERCENT	25	49	3	10	13	-	-

TABLE 5

FEMALE CHILDREN X TYPE OF ABUSE X AGE

FEMALES

TYPE OF ABUSE

AGE	NEGLECT	PHYSICAL	SEXUAL	EMOTIONAL	OTHER	TOTAL NO.	TOTAL %
1-3 MTHS	6	5	0	1	8	20	10
4-11 MTHS	6	9	1	2	3	21	11
1-2 YRS	6	19	2	2	4	33	17
3-5 YRS	5	12	10	2	1	31	16
6-8 YRS	3	9	10	2	0	24	12
9-11 YRS	4	10	14	3	0	31	16
12-14 YRS	5	8	9	1	1	24	12
15-17 YRS	1	2	7	1	1	12	6
TOTAL KNOWN	36	74	53	15	18	196	100
NOT KNOWN	2	5	6	1	2	16	-
TOTAL	38	79	59	16	20	212	-
PERCENT	18	37	28	8	9	-	-

Tables 4 and 5 show the pattern of abuse to male and female children. Male children have low rates of sexual abuse (3% of abuse cases). Forty-nine percent of the male children sustained physical abuse and 25% sustained neglect.

Female children show a significant incidence of sexual abuse (28% of female abuse cases). Physical abuse is also the most frequent form of abuse, occurring in 37% of

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female abuse cases, with neglect in 18% of cases.

The significant difference in the pattern of abuse by age is that most male children who are abused are under the age of 5 (70%). Female children show a frequency of 54% under the age of 5 and a distribution after this age which peaks in the 9 - 11 age group because of the frequency of sexual abuse.

A study of patterns of child abuse notifications in New South Wales in 1981 to the Department of Youth and Community Services (Kraus 1983) shows that the signficiant age groups notified are children aged 0 - 3 (44%). The notifications show a reduction after the age of 6 with another small peak at the age of 9 and thereafter a reduction.

Other studies show varying age groups. Lewis (1982) in a study of 382 children found 18% were under 1, a total of 56% under 5, 42% aged 5 - 12 and 2% over the age of 12. Smith (1976) in a hospital study in England found 82% of 134 children were under 2. In a national survey in the United States Gil found 25% were under 2, 50% under the age of 6, and 20% teenagers (Smith 1976).

The pattern of notification and hospital admission of abused children shows that the significant age groups are young children. The percentages reported in the above studies also reflect the early or late identification of child abuse which is a function of the degree to which protection is offered by police, medical or welfare services.

The Brisbane study shows a high proportion of chronic cases and a peak notification to police at age 3 - 5. In the light of the above studies it could be hypothesised that earlier intervention would increase the proportion of children who come to notice UNDER the age of 2 and preferably UNDER the age of 1, rather than the 3 - 5 age group. The one exception is the increased frequency of 9 - 11 year olds who come to notice for sexual abuse where early reporting cannot be assumed. Physical abuse in particular appears to be significant in the 400 case study for ages 6 - 14 which suggests that children are suffering many years of abuse before intervention.

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In the Brisbane study, 38% (151) of the 400 cases contained no information on the number (if any) of siblings domiciled with the abused child. Where information was available 62% had juvenile siblings at home. Siblings were found to be abused in 74% of these cases.

TABLE 6

PERCENTAGE OF SIBLINGS ABUSED BY PRIMARY ABUSE TO THE CHILD

	TYPE OF ABUSE					
SIBLINGS	NEGLECT	PHYSICAL	SEXUAL	EMOTIONAL	OTHER	TOTAL
SIBLINGS ABUSED	58	63	28	17	18	184
SIBLINGS AT HOME	63	91	48	21	26	249
% SIBLINGS ABUSED	92	69	58	81	69	74

Table 6, 'Percentage of Siblings Abused by Primary Abuse to the Child' shows the pattern of sibling abuse. In cases where abused children had juvenile siblings at home 92% of these siblings were abused in primary neglect cases, 69% in primary physical abuse cases, 58% in primary sexual abuse cases (this is a low percentage which probably reflects a proportion of siblings at home being male), 81% of primary emotional abuse cases, and 69% of primary cases where the reason for notice was a child 'at risk' (this represents cases where the child at risk follows children in the family who have been abused).

In an English study by Oliver (1978) of 34 physically abused children who had 78 siblings, 63% of siblings had active physical abuse and it was suspected in a further 6%.

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The Department of Children's Services figures for 1981 - 1982 also show the pattern of sibling involvement in cases of abuse. A total of 2,723 children who came to notice were from 1390 families which shows an approximate ratio of 2 children notified as suspected abuse cases per family.

3. ABUSE TO CHILDREN WITHIN THE EDUCATION SYSTEM

This section presents a breakdown of figures from the Brisbane study to show the patterns of abuse in children aged 3 - 17 who fall within the education system through kindergarten, pre-school, primary or secondary school.

From Figure 2 the proportion of abused children within the 3 - 17 age group is 54%. This represents 19% within the kindergarten and pre-school ages, 23% in primary school, and 13% within secondary school age.

TABLE 7

TYPE OF ABUSE BY AGES 3 - 17

A G E

TYPE OF ABUSE	3-5 YR		6-8		9-11		12-14		15-17		TOT.	
	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
NEGLECT	20	26	8	17	6	14	8	24	1	7	43	20
PHYSICAL ABUSE	31	41	20	43	18	41	11	32	4	26	84	39
SEXUAL ABUSE	13	17	11	23	14	32	10	29	7	47	55	25
EMOTIONAL ABUSE	6	8	6	13	5	11	3	9	2	13	22	10
AT RISK & OTHER	6	8	2	4	1	2	2	6	1	7	12	6
TOTAL	77	36	47	22	44	20	34	16	15	6	216	100

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Table 7, 'Type of abuse by Ages 3 - 17' shows that the most frequent form of abuse was physical 39%, followed by sexual abuse at 25%, neglect at 20%, and emotional abuse at 10%. Physical abuse is high in ages 3 - 11, sexual abuse is highest in ages 6 - 14 with a peak in the 9 - 11 age group. Neglect and emotional abuse appear to spread over all the age groups. The percentages for the group of 15 - 17 year olds are artificially high and are excluded from this analysis becasue of the small absolute number involved.

Although the Brisbane case study figures show small numbers of adolescent children as abuse victims (13% of the sample) there is information in the literature from the United States on this form of abuse. Garbarino (1982) says that adolescents are victims in 1/3 of abuse cases referred to State Central Registries in the United States. These children, according to Garbarino, are seen as 'runaways', truants, offending by prostitution, drug abuse and vagrancy, assault, and theft, are suicides, failures in the schools, and patients with venereal diseases.

Libbey and Bybee (1979) say that the forms of abuse suffered by adolescents are less severe than younger children. It is provoked by the child starting to have a separate identity and associated with multiple family problems. Libbey and Bybee studied 25 cases and found that the abuse to the adolescents was immediately preceded by the child disobeying or arguing. The conflicts involved cleaning the room, closing doors, staying out late, leaving food around the house. Five of the cases had been chronic since early childhood. Seven cases involved injuries to the child's head. Ten of the cases came to notice by the adolescent telling a school nurse, counsellor or teacher.

Table 8 'Chronic Abuse by Ages 3 - 17' shows that in this group 74% of children suffered chronic abuse and 26% came to notice either as a first incident or the history of previous abuse was unknown.

The pattern of child abuse that is presented in the preceding sections suggests that the education system is one of the key areas for increasing reporting of child abuse. The chronic nature of abuse, abuse of siblings, and the prevalence of physical abuse and neglect which

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are more easily detectable than emotional and sexual abuse are all factors which indicate that the education system can identify and report cases which may not otherwise be detected.

TABLE 8

CHRONIC ABUSE BY AGES 3 - 17

A G E

TYPE OF ABUSE	3-5 YR		6-8		9-11		12-14		15-17		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
CHRONIC	58	76	32	68	35	80	23	68	11	73	159	74
UNKNOWN & *** FIRST INCIDENT	18	24	15	32	9	20	11	32	4	27	57	26
TOTAL	76	36	47	22	44	20	34	16	15	6	216	100

*** This group represents cases where information on past incidents has not been recorded and cases where abuse was judged to be the first incident. The Chronic abuse percentage is therefore a minimum figure.

4. CONSEQUENCES OF ABUSE FOR THE CHILD VICTIMS

A. Homicide

The Brisbane sample reported no homicides in the main types of abuse (Table 1) as infant deaths are investigated by the Homicide Division. A South Australian study of deaths in cases of non-accidental injury in

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hospitals reported between 5 - 10% fatality rates (Community Welfare Advisory Committee 1976). In Queensland the figure has been estimated at 2% (Pearn 1981).

In the United States a large study by Gil in 1970 found 3.4% of recorded cases of abuse were fatal (Noble 1978). Vesterdal (1972) reported on a series of 119 children in Sweden of whom 15 were killed.

An English study of non-accidental injury 1965 - 1971 in Newcastle reported a death rate of 10% in 136 children. Thirty percent of survivors had brain damage with combinations of mental retardation, cerebral palsy, blindness, deafness and epilepsy (Cooper 1978). Oliver (1974) comments on the offical statistics in the United Kingdom stating that the official death rates from violence are bare minimum figures. He estimates that in the United Kingdom 6 /100,000 children aged 0 - 3 are at risk of death. He also quotes German figures by Trube-Becker where 6% of deaths under 6 in Dusseldorf were the victims of abuse. Oliver surveys national studies of death rates and shows that these vary widely with examples of Australian published figures varying from 10 - 33% of abused children dying; 1 - 5% in the United Kingdom and 5 - 10% in the United States of America.

Smith's (1976) study suggests that children who died from physical abuse had more skull fractures, central nervous system, and internal injuries. A large proportion of these children also had another battered sibling.

Deaths appear to be more common in younger children as they are especially vulnerable to rough handling, particularly to shaking which causes subdural haematoma. Cooper (1978) found that nearly all children who are killed have previous minor injuries especially to the face.

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B. Physical Abuse

Oliver (1974) states that at least 25% of severely attacked young children are rendered intellectually damaged or subnormal.

Cooper (1978) says that when face and head are involved especially in very young children the injury is very serious because of the vulnerability of the brain. Reports of physical injury include descriptions of:

> fractures, bruises, burns, internal injuries, trauma to the central nervous system, delays in physical, neurological, intellectual, cognitive, language, and psychosocial development, problems in behaviour and personality, failures in bonding, and violent behaviour towards the self and others. (Bybee 1979)

> mental retardation, brain damage, perceptual motor immaturity, learning disabilities, developmental morbidity. In addition there are handicaps of neurodevelopmental delays and psychological problems of aggresssion, poor self-concept, lack of capacity to trust, deviant interpersonal relationships, and unusual attachment and detachment behaviour. (Martin 1982)

A number of studies have reported the substantial deficiences in emotional development that are the result of physical abuse to children. The battered child has a negative self-concept and may appear overly docile or aggressive. The physical scars can also contribute to a negative self-concept. Brain damage has an accompnaying psychological stress (Kinard 1979).

C. Neglect

Oates (1982) reports a 12 year follow up of 24 children who were failure to thrive admissions to hospital in Sydney. Six years later some of the children were below weight expectations and there had been admissions for physical abuse. There were educational, intellectual and behavioural problems and Oates concluded that non-organic failure to thrive children suffered serious

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consequences in language development, reading abilities, and behavioural disorders.

Drotar et.al. (1979) reports that children with growth failure have a higher than average incidence of emotional and cognitive deficits on long term follow up. These children suffer from varying degrees of nutritional and stimulation deficits.

In a study of the pathology of failure to thrive deaths, Winick and Rosso found that severe early malnutrition can result in curtailment of normal increase in brain celularity with increase in age. This links malnutrition to faulty brain growth and development. (Ayoub et.al. 1979).

D. Sexual Abuse

Kinard (1979) reports that sexual abuse leads to a negative view of the self, regressive infantile behaviour, and increased aggressive behaviour.

Johnston (1979) reports a detailed case study of ten children who were the victims of sexual abuse (nine girls and one boy aged 5 - 11). The sexual abuse ranged from exhibitionism to forcible rape. Manipulation of the child's genitals occurred in 7 out of 10 cases and was the most frequent form of abuse. Other reported acts included fellatio, cunnilingus, mutual masturbation, anal intercourse, and attempted intercourse. Projective tests revealed that the children had a preoccupation with oral deprivation and unmet dependency needs. These children longed for adequate parental care and attention. A similar theme was insecurity. Two of the children were very well defended, psychologically. There were disturbances in family roles in all but one case and the children displayed role reversal in 4 out of ten cases.

A wide variety of symptoms were reported in the children including sleep disturbances, school difficulties, depression, compulsive masturbation, phobias, extreme sexual curiosity, enuresis, hyperactivity, stomach complaints, headaches, and extreme interest in fire.

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Children who had been abused for several years were quiet, withdrawn, less spontaneous, and found it difficult to answer questions. They were overly compliant. (Johnston 1979)

Connan (1981) reports findings of an Adelaide study of 334 children who were sexual abuse cases referred to the Sexual Assault Referral Centre of the Queen Elizabeth Hospital. The cases included 40 boys and 294 girls aged to 17 years. Males were frequently anally assaulted and girls were almost all vaginally assaulted but there was a significant occurrence of oral assault. Handling of external genitalia accounted for a significant proportion of sexual assaults in young girls and on occasions foreign objects were used in older age groups. Both psycho-social and psycho-sexual problems were found in the victims. Numerous references are also made in the literature to the role reversal of female sexually abuse children who take on the mother's role.

E. Emotional Abuse

MacCarthy (1979) says that the emotionally deprived child suffers from a gradual impairment of health, growth and personality development. There can be a Syndrome of Dwarfism where the child's body proportions are infantile for its age. There is an expression of dejection, apathy, indifference and submission. The infant or young child who is rejected or emotionally deprived is found to be under eating because he is given too little and is too depressed, too passive to protest or is anorexic in association with his depression.

Toker et.al. (1981) describes studies of emotional abuse where children are emotionally abused in association with physical abuse, or subtly abused by terrorisation, berating and rejection. It may be primarily verbal and the child is continually told he is hated, ugly, stupid, an unwanted burden. He may be the family scapegoat. It can cause personality disturbances where conflicts are initiated with the child by double messages, the frustration of needs, and the denial of any development of adequate reality testing.

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F. Drug Abuse

Schlebaum (1981) says that chemical abuse has not been legally defined but is quite prevalent. It involves the excessive and / or inappropriate use of chemical substances. This form of abuse can commence in utero where the pregnant mother drinks heavily, takes drugs and smokes. There are perinatal problems from breast feeding mothers who smoke or drink. Adult addictions can lead to babies being born with addiction or withdrawal syndromes. This can lead to high infant death rates, prematurity and complications, and withdrawal symptoms.

Another form is the silencing of crying babies with drugs which can lead to suspicious cot deaths, to keep the child asleep while it is left alone, and to control the child's behaviour. Accidental problems arise in children following the over-administration of drugs and in addition there are malicious cases of chemical abuse. A further form of abuse is the withholding of drugs that are necessary to a child's health. (Schlebaum 1981)

5. INDICATORS OF ABUSE IN THE CHILD

Tables 9 - 13 present a survey of Indicators of abuse in the child. These Indicators are described by authors in 34 studies selected from three hundred studies on child abuse.

Table 9 'Indicators of Physical Abuse: The Child' lists 143 signs and symptoms that have been observed in physically abused children. These are listed alphabetically and appear in the way that information may come to the police from neighbours, the child, parents, social workers or medical practitioners. Specialised Indicators that describe technical findings on medical examination are a necessary part of the diagnosis as are colloquial terms used by non professionals when reporting for the police officers who are involved in decisions for the child's safety and possible court proceedings.

The majority of the Indicators provide information for the Officer at the Scene, or for the officer receiving a report to identify the risk to the child or continued abuse if intervention is not provided by the police, medical and welfare services.

TABLE 9

INDICATORS OF PHYSICAL ABUSE: THE CHILD

(PAGE 1)

. abdominal injuries
. adult bites and abrasions
. aggressive
. aggression to maternal rejection
. any bruising in immobile baby
. attend hospital 24 hours after injury
. avoidance and denial
. beaten up
. bilateral subdural haematoma
. bizarre skin marks
. black eye, 2 black eyes
. bleeding in or around brain
. bonding failure
. brain injury
. bruises
. bruises on lips
. bruises on gums
. bruise to forehead
. burns as splash marks
. cheek bruises
. cigarette burn moved along skin
. cigarette burns, single / crops
. colic and irritability
. comfort not sought from parent
. confined long time bed, playpen
. congenital abnormality
. cot death
. cries often
. damaged kidneys
. damaged bladder
. danger orientation to guardians
. deficient neurological status
. delayed medical care
. delayed motor development
. delayed physical development
. disinterest in toys
. disturbed identity formation
. drowning
. enlarged head from fractured skull
. epiphyseal dispacement
. exaggerated periosteal reaction
. eye injury
. failure to thrive
. feeding problem from fractured skull

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TABLE 9 (PAGE 2)

- feelings of worthlessness
- fingertip bruises, 3-4 and thumb
- fractures
- fractured skull
- fracture long bone
- funny turns
- generalised unhappiness
- generalised fear
- grabbed
- grazing from beating
- gun threat
- haematoma from abdominal injury
- haemorrhage/s on ear lobe
- harsh physical discipline
- high anxiety levels
- hit with object
- hysterical moods
- impaired capacity to trust
- impaired impulse control
- inappropriate food, drink, medicine
- inappropriate dress
- indifference to mother
- indiscriminate seeking attention and affection
- injuries on both sides of body
- irritable behaviour
- joint swellings
- kicked shins
- laceration from beating
- lethargy from fractured skull
- ligature marks
- metaphyseal injuries
- multiple injuries at various stages of healing
- multiple injuries
- multiple clear linear cuts
- outline of weapon on skin
- overactivity, demanding
- overall poor care
- overmature ego, compliance
- pain, dysfunction from abdominal injury
- passive behaviour
- periosteal new bone
- pin point haemorrhages
- poisoning
- poor intellectual function
- poor relationships peers, adults
- poor self-concept
- postural compliance 10 mths - 5 yrs
- premature baby
- preoccupation oral intake
- problems with feeding, crying
- projection, externalisation
- psychomotor retardation
- purple ear
- pushed
- repeated scanning people
- rib fractures
- role reversal
- ruptured intestines
- ruptured liver
- ruptured spleen
- scalds in mouth, top of legs, feet

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TABLE 9 (PAGE 3)

- scalds with high water mark
- scars, different ages
- scratches
- secondary infection of cigarette burns
- settles rapidly, foster home or hospital
- severe dehydration from abdominal injury
- shock from abdominal injury
- shoved
- sit motionless long time
- skull or facial bone fractures
- slapped
- small haemorrhage conjunctive
- small haemorrhage retina
- smothering with pillow
- smothering with plastic bags
- social skills mature
- spanked
- spanking young baby
- speech deficit
- spiral fractures
- subdural haematoma
- subcutaneous bruising - deep
- thickening of shaft
- threat or use of knife
- torn frenulum
- torn upper lip
- torn tongue
- undernourished
- unexplained fever from fractured skull
- unfulfilled dependency needs
- unrelated illness
- unrelated mental retardation
- unrelated physical handicap
- visual, auditory, hyperalertness
- vomiting from fractured skull
- vomiting from abdominal injury
- wildly overact and destructive
- withdrawn child

TABLE 10

INDICATORS OF NEGLECT: THE CHILD

(PAGE 1)

- abandonment
- abdomen retracted
- absence intraorbital fat
- afraid of parents
- aged face
- bronchopneumonia
- clothing caked with vermin, faeces
- cold hands and feet
- concavity of cheeks
- confined long time bed, playpen
- cries often
- deficit neurological status
- delayed physical development
- depression of eyes
- depression
- deprivation of food, fluids
- diarrhoea
- discipline poor
- dry, puckered, scaly skin
- eccyhmosis
- eczema from urine and ulcers
- excessively adapted
- extremely soiled clothing
- generalised unhappiness
- generalised fear
- heart disease
- hypothermia
- impaired capacity to trust
- impaired vision
- inappropriate dress
- inappropriate food, drink, medicine
- infestation by insects
- infrequent changing nappies
- insect bites extensive
- intense emaciation
- lack of subcutaneous fatty tissue
- lack of weight gain
- localised hypothermia
- long dirty fingernails
- maggot infestation
- marked respiratory rate reduction
- matted hair
- necrotising laryngitis
- otitis media advanced
- over familiar to strangers
- overall poor care
- poor intellectual functioning
- poor relationships peers, adults
- recurrent vomiting
- respond to calories and attention
- ribs prominent
- rickets
- sad and apathetic
- scarring from insect bites

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TABLE 10 (PAGE 2)

- secondary infection, nappy rash
- secondary infection, insect bites
- severe nappy rash
- skin hanging loosely on bones
- small underweight child
- speech development - delayed
- sucking fingers
- sunken eyes
- unresponsive child
- voracious appetite, hospital
- weeping nappy rashes

Table 10, 'Indicators of Neglect: The Child' lists 65 signs and symptoms. The literature concentrates on serious neglect cases and post mortem findings so there is probably a series of signs and symptoms relating to less serious neglect that are missing from this table. The Table, therefore, is a guide to serious risk cases where immediate action may be necessary to protect the child from death or long term physical consequences.

Table 11, 'Indicators of Sexual Abuse: The Child' lists 91 signs and symptoms including information given by the child on the history of the abuse. The secretive nature of this abuse means that investigating officers may need to rely on psychological signs to identify the nature of the abuse before careful interviewing of the child.

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TABLE 11

INDICATORS OF SEXUAL ABUSE: THE CHILD

(PAGE 1)

- afraid, especially in the dark
- ambivalence towards males
- anger and impulsive demands
- antipathy to same sex parent
- approached in bedroom
- approached while bathing
- ashamed and guilty
- behavioural problems
- bruises on body
- chronic depression
- clinging behaviour
- coitus
- conversion hysteria
- delayed cognitive development
- delayed disclosure
- denials of abuse
- depression
- describes taste of semen
- desire to talk of abuse
- developmental regression
- dominated by father
- drug abuse
- educational, cultural deprivation
- emotional deprivation
- fear status
- fears disapproval mother
- fears punishment mother
- fears retaliation father
- fears loss acceptance and home
- fears disclosure
- fondling of genitals
- genital irritation
- guilt over abuse
- handling external genitalia
- helpless and powerless
- history of frequent abuse / daily
- history of running away home
- histrionic behaviour
- inflamed throat
- insomnia
- isolation, secrecy and guilt
- lack of spontaneity
- lies immobile in fright
- loving, dependent relationship with father
- manipulative behaviour
- masturbation
- mothering role
- mutual masturbation
- night terrors
- oral assault
- plays 'possum' lying still
- poor school achievements
- poor communication skills
- poor socialisation skills
- poor personal image
- poor care of self

.../55.

TABLE 11 (PAGE 2)

- pregnancy unexplained
- premature domestic work
- pride in sexual proficiency
- promiscuity
- protective towards family
- provocative behaviour
- psychosomatic symptoms
- psychopathology
- rape
- redness, abrasion, purpura hymen
- redness, abrasion, purpura mouth
- redness, abrasion, purpura anus
- redness, abrasion, purpura genitals
- reversal of original story
- sabotages close relationships
- secrecy
- self-destructive
- serious rebellion against mother
- severe insecurity
- shoplifting
- sodomy
- sperm in vagina
- stains on body of blood, semen
- stains semen, blood underclothing
- sudden onset anxiety
- sudden school failure
- sudden massive weight loss / gain
- torn clothing
- truancy
- unable to communicate mother
- under-functioning at school
- unhappy or depressed
- use of foreign objects
- vaginal discharge
- vaginal tears
- venereal disease

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TABLE 12

INDICATORS OF EMOTIONAL ABUSE: THE CHILD

- aggression
- cravings for attention
- crying
- damaged self image
- delinquency
- difficulty with sleep
- disobedient
- dwarfism
- eczema
- encopresis
- enuresis
- frustration intolerance
- holding breath
- hypersensitive
- inability in close relationships
- insecurity
- locked in a room
- lying
- quarrelsomeness
- rebellious
- rebelliousness
- rejecting parents
- retarded psychological growth
- scapegoating
- seclusiveness
- shyness
- silence at school
- stealing
- temper tantrums
- terrorized, berated, rejected
- told is hated, unwanted, ugly
- truancy
- uncommunicative

Table 12, 'Indicators of Emotional Abuse: The Child' lists 33 signs and symptoms of emotional abuse. Emotional abuse is an area which is also neglected in the literature and is difficult to diagnose because of few physical manifestations, and the child's behavioural problems which may disguise the fact that the family's problem is not the presenting child, but parental rejection.

TABLE 13

INDICATORS OF DRUG ABUSE: THE CHILD

- bizarre symptoms
- blood abnormalities
- cancer
- congenital abnormalities
- congenital heart disease
- emotionally disturbed
- extrapyramidal effects in newborn
- feeding troubles
- fits
- Foetal Alcohol Syndrome
- foetal death
- foetal apnoea
- Hyperexcitability Syndrome
- irritability
- long term hypokinesis
- mental retardation
- metabolic abnormalities
- minimal cerebral dysfunction
- neonatal mortality
- reading impairment
- reproductive abnormalities
- respiratory difficulties
- retarded
- stunted growth
- sub-acute withdrawal (3-6mths)
- teratogenesis
- withdrawal syndromes
- withdrawal - temper outbursts
- withdrawal - irritability
- withdrawal - hyperactivity
- withholding medication

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Table 13, 'Indicators of Drug Abuse: The Child' presents 30 signs and symptoms of drug abuse. A number of these relate to the young child under 6 months of age and are more likely to come to the attention of hospital staff than to the police. However, these signs and symptoms are an essential part of an interview where drug abuse is suspected and information on the child's early history may assist in the diagnosis.

There are in total 370 signs and symptoms of abuse in the child presented in the above tables. These have been selected from special studies but merely present an open list that can be added to from the documentation of cases of abuse by the police, medical and welfare services. In addition, there are signs and symptoms of abusing parents that are also Indicators of abuse in the child. This information is discussed in the following chapter, in association with information on the multidisciplinary team approach to child abuse.

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CHAPTER 3

INDICATORS OF ABUSING PARENTS: THE POLICE AND MULTIDISCIPLINARY TEAM

This chapter presents in the first section Indicators of Abusing Parents from the Brisbane case study and Indicators from interviews and observations in the literature. This information together with Indicators of Abuse to the Child (described in the preceding chapter) provides an information base upon which the police officer can assess whether there is abuse.

The second section of the chapter presents the findings on Police Action in association with the multi-disciplinary team. These findings relate to the Brisbane study of 400 child abuse cases 1980 - 1983. The actions of the police are analysed from the data and recommendations from these findings are given in Chapter 4.

1. INDICATORS OF ABUSING PARENTS

Family Type

Table 14, 'Indicators of Abusing Parents: Family Type' shows that 37% of the 400 case sample were natural mothers and fathers. Thirty-two percent were natural mothers and 6% natural fathers. Twelve percent of families were natural mothers and de facto fathers. The unusually high number of single mother families is a similar finding to information on confirmed voluntary notifications to the Department of Children's Services 1981 - 1982. In confirmed notifications, 211 / 562 children (37%) were living with single mothers. The total number of single parent families (male and female) in confirmed notifications was 44%.

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Another feature of the high incidence of single mothers is the fact that single mothers are a significant proportion of those family types who are in contact with the Department of Children's Services and who are likely to use the public hospitals where SCAN teams are operating. However, these teams are involved with populations in receipt of welfare benefits and in public hospital patients, thus figures suggest that the single mother family is a high risk group.

TABLE 14

INDICATORS OF ABUSING PARENTS: FAMILY TYPE

FAMILY TYPE	NO.	%
1. NATURAL MOTHER & FATHER	148	37
2. ADOPTIVE MOTHER & FATHER	1	0
3. NATURAL MOTHER	126	32
4. NATURAL FATHER	22	6
5. ADOPTIVE MOTHER	0	0
6. ADOPTIVE FATHER	0	0
7. NATURAL MOTHER AND STEP-FATHER	14	4
8. NATURAL MOTHER AND DE FACTO FATHER	46	12
9. NATURAL FATHER AND STEP-MOTHER	7	2
10. NATURAL FATHER AND DE FACTO MOTHER	1	0
11. FOSTER MOTHER AND FOSTER FATHER	1	0
12. FOSTER MOTHER	1	0
13. FOSTER FATHER	1	0
14. OTHER (TEMP. CARE, GUARDIAN, ETC.)	6	2
15. NOT KNOWN	27	7
TOTAL	400	100

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Relationship to Child

TABLE 15

INDICATORS OF ABUSING PARENTS: RELATIONSHIP OF SUSPECTED OFFENDER TO THE CHILD

RELATIONSHIP OF SUSPECTED OFFENDER TO CHILD	NO.	%
1. NATURAL PARENT	322	81
2. ADOPTIVE PARENT	1	0
3. DE FACTO PARENT	18	5
4. STEP PARENT	9	2
5. FOSTER PARENT	1	0
6. AUNT OR UNCLE	2	0
7. GRANDPARENT	4	1
8. OTHER RELATIVE	2	0
9. SIBLING TO CHILD	2	0
10. FRIEND OF PARENTS	11	3
11. BABYSITTER	0	0
12. OTHER	2	0
13. NOT KNOWN	26	7
TOTAL:	400	100

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Table 15, 'Indicators of Abusing Parents: Relationship of Suspected Offender to the Child' shows that the natural parent is the suspected offender in 81% of cases of child abuse. De facto parents are involved in 5% of cases. This table suggests that the natural parent of the child is the most likely offender.

Sex of Offenders

The sex of suspected offenders in the 400 Brisbane case study (where the offender was identified) was female in 40% of cases of abuse and male in 60% of cases.

Sex and Age of Offenders and Type of Abuse:

Tables 16 and 17 show the analysis of the relationship between sex of the suspected offender, age of the offender, and the type of abuse suffered by the child.

Table 16 'Indicators of Abusing Parents: Male Perpetrators by Age by Type of Abuse' shows that 43% of male perpetrators were involved in physical abuse, and 39% in sexual abuse. This shows the pattern of male offenders in abuse to children. The age groups of the male perpetrators in this table also suggest a predominance of the age groups of 31 - 35 (37%), and 36 and over (33%). The table shows an increasing risk to children from males over the age of 31.

.../63.

TABLE 16

INDICATORS OF ABUSING PARENTS: MALE PERPETRATORS BY AGE BY TYPE OF ABUSE

MALE PERPETRATORS (1)

TYPE OF ABUSE

AGE	NEGLECT	PHYSICAL	SEXUAL	EMOTIONAL	OTHER	TOTAL NO.	TOTAL %
LESS THAN 15	0	0	0	0	0	0	0
16-20	0	2	2	0	0	4	5
21-25	0	8	0	0	0	8	11
26-30	2	5	2	5	1	10	14
31-35	0	12	13	1	1	27	37
36+	2	6	11	4	1	24	33
TOTAL KNOWN	4	33	28	5	3	73	100
NOT KNOWN	3	31	30	6	7	77	-
TOTAL	7	64	58	11	10	150	-
PERCENT	5	43	39	7	6	-	100

(1) SEX NOT KNOWN FOR 16 PERPETRATORS

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TABLE 17

INDICATORS OF ABUSING PARENTS: FEMALE PERPETRATORS

BY AGE BY TYPE OF ABUSE

FEMALE PERPETRATORS (1)

TYPE OF ABUSE

AGE	NEGLECT	PHYSICAL	SEXUAL	EMOTIONAL	OTHER	TOTAL NO.	TOTAL %
LESS THAN 15	1	0	0	0	1	2	1
16-20	7	9	0	0	4	20	15
21-25	15	23	1	9	8	56	41
26-30	11	5	0	5	6	27	20
31-35	6	7	0	1	1	15	11
36+	8	5	0	3	1	17	12
TOTAL KNOWN	48	49	1	18	21	137	100
NOT KNOWN	30	38	3	5	11	87	-
TOTAL	78	87	4	23	32	224	-
PERCENT	35	39	2	10	14	-	100

(1) SEX NOT KNOWN FOR 16 PERPETRATORS

Table 17 'Indicators of Abusing Parents: Female Perpetrators by Age by Type of Abuse' shows that 39% of female perpetrators are involved in physical abuse and 35% in neglect. The 14% of females in the 'other' category of abuse represents to some degree young mothers with new babies who are considered to be at risk. The pattern of age groups is significantly different in female perpetrators where 41% are aged 21 - 25. Another significant group is the young mothers aged 16 - 20 (15%). The risk to children from female parents over the age of

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30 appears to fall.

Previous Offences:

TABLE 18

INDICATORS OF ABUSING PARENTS: KNOWN PREVIOUS OFFENCES OF SUSPECT

KNOWN PREVIOUS OFFENCES OF SUSPECT	NO.	%
1. NO PRIOR OFFENCES	99	59
2. PRIOR CHILD ABUSE	5	3
3. ABDUCTION	0	0
4. AGGRAVATED ASSAULT	2	1
5. ASSAULT CAUSING BODILY HARM	5	3
6. MORE SERIOUS ASSAULT (INC. GBH, WOUNDING)	1	1
7. OTHER OFFENCES	46	27
8. CHILD ABUSE PLUS OTHER OFFENCES	10	6
TOTAL KNOWN	168	100
9. NOT KNOWN	229	-
10. NOT APPLICABLE	3	-
TOTAL:	400	-

Table 18, 'Indicators of Abusing Parents: Known Previous Offences of Suspect' shows that in the Brisbane case study the previous history of the parents was not known in 229 of the 400 cases. In the 168 cases where

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information was known, 59% of the suspected parents had no prior offences, and 41% had a previous history. The grouping of 'other offences' represents 27% of parents. Prior child abuse and assaults represent 14% of parents. These figures show a high proportion of previous offences and are therefore a significant Indicator of abuse. However, one fact in the interpretation of the figures is that the police cases where the history was known are generally the more serious cases of abuse and the figures could be lower when all cases of abuse are checked for previous history.

TABLE 19

INDICATORS OF ABUSING PARENTS: MALE PERPETRATORS BY TYPE OF ABUSE BY KNOWN PRIOR OFFENCES

MALES

KNOWN PRIOR OFFENCES	TYPE OF ABUSE: NEGLECT	PHYSICAL	SEXUAL	EMOTIONAL	OTHER	TOTAL NO.	TOTAL %
PRIOR CHILD ABUSE	2	0	1	0	0	3	8
ASSAULT	1	5	0	0	1	7	19
OTHER OFFENCE	2	7	8	2	3	22	59
CHILD ABUSE & OTHER OFFENCE	0	0	3	0	2	5	14
TOTAL (1) **	5	12	12	2	6	37	100
NO PRIOR OFFENCES	0	13	9	5	0	27	-
TOTAL KNOWN	5	25	21	7	6	64	-
PERCENT (TOTAL(1)/TOTAL)	8	19	19	3	9	58	-

** TOTAL PERPETRATORS WITH KNOWN PREVIOUS OFFENCES.

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Table 19, 'Indicators of Abusing Parents: Male Perpetrators by Type of Abuse by Known Prior Offences' shows a significant relationship between male perpetrators and a previous history - 58%. In this group 59% of offenders with a previous history fell within the category 'other offence' and 41% had a history of assault and / or child abuse. The relationship between the type of abuse to the child and previous offending is strongest in physical (19%) and sexual (19%) offences.

TABLE 20

INDICATORS OF ABUSING PARENTS: FEMALE PERPETRATORS

BY TYPE OF ABUSE BY KNOWN PRIOR OFFENCES

FEMALE PERPETRATORS X TYPE OF ABUSE X KNOWN PRIOR OFFENCES

FEMALES

TYPE OF ABUSE

KNOWN PRIOR OFFENCES	NEGLECT	PHYSICAL	SEXUAL	EMOTIONAL	OTHER	TOTAL NO.	TOTAL %
PRIOR CHILD ABUSE	0	2	0	0	0	2	6
ASSAULT	0	1	0	0	0	1	3
OTHER OFFENCE	11	1	0	7	5	24	75
CHILD ABUSE & OTHER OFFENCE	4	1	0	0	0	5	16
TOTAL (1) **	15	5	0	7	5	32	100
NO PRIOR OFFENCES	22	29	0	8	12	71	98
TOTAL KNOWN	37	34	0	15	17	103	-
PERCENT (TOTAL(1)/TOTAL)	9	3	0	4	3	19	-

** TOTAL PERPETRATORS WITH KNOWN PREVIOUS OFFENCES.

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Table 20, 'Indicators of Abusing Parents: Female Perpetrators by Type of Abuse by Known Prior Offences' does not show the same relationship as male perpetrators with a previous history. Nineteen percent of females had a previous history, mainly in the category of 'other offences'.

Physical Abuse:

Tables 21 - 24 present Indicators of physical abuse, neglect, sexual abuse, and emotional abuse drawn from 20 selected studies in the literature. These Indicators provide some guidance for police officers when interviewing parents, observing family relationships and when reading specialist reports. The tables present a total of 270 Indicators.

TABLE 21

INDICATORS OF ABUSING PARENTS: PHYSICAL ABUSE

(PAGE 1)

- absurd explanations for injuries
- abnormal pregnancy and labour
- abusive
- apathetic futile personality
- baby said to be too demanding at feeding
- below poverty line
- births reported as difficult
- bothered by crying
- child told was bad
- child forced sit on pot long period
- child punished for lack bowel training
- child told not loved
- character disorder
- commenced toilet training before 12 months
- cold
- compulsive
- depression in parent
- deprivation in upbringing
- dependent personality style
- detached
- depressive
- disappointed over sex of child
- divorce
- disciplinarian
- distortion of reality
- drug abuse
- emotional disturbance noted maternal nursing notes

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TABLE 21

INDICATORS OF ABUSING PARENTS: PHYSICAL ABUSE

(PAGE 2)

- expectations beyond child's ability
- failure to learn parenting skills
- fabricated story
- father young 16 - 21
- father not interested in child
- father unfavourable reaction to pregnancy
- few preparations for baby's arrival
- frequent physical punishment
- history emotional depression
- history trauma in childhood
- high mobility
- husband jealous of mother's time with baby
- identity - role crisis
- illness of child in first year
- illness of mother in first year of baby
- immature
- impulsive behaviour
- inability to talk out problems
- inadequate child spacing
- isolated extended family, social services
- isolation
- job dissatisfaction
- large family
- lack of control over personal habits
- lack of self esteem
- lack of sense of child as person
- lack of sense of independence
- lack of understanding of self
- lack of social roots in community
- lack supportive extended families
- less able in verbal skills
- limited ability to accurately perceive environment
- low intelligence
- low birthweight
- low incidence breast feeding
- marital conflict
- mental illness
- mental retardation
- medical problem in child in first week
- minor criminal offences
- mother lacked affection when young
- mother rejected by own mother when young
- mother under 20 with first child
- mothering incapacity noted by nurses
- mother does not comfort baby crying
- mother no empathy children

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TABLE 21

INDICATORS OF ABUSING PARENTS: PHYSICAL ABUSE

(PAGE 3)

- mother says changing nappies repulsive
- mother does not have fun with baby
- mother makes unverified complaints about child
- mother feels hopeless
- mother feels like crying herself
- mother relinquishes baby control to nurses
- mother seen hospital social worker
- mother states does not enjoy caring for child
- negative verbs to baby
- negative identification with child
- negative words to others about baby
- neonatal separation
- neuroses
- new baby admitted to special car
- no eye contact
- no meaningful support to mother by anyone
- nurturing needs
- parents lack of guilt
- parents blame sibling for injuries
- parents delay seeking medical care
- parents discourage social contact
- parents fear of losing control
- parents trust no-one
- paranoid features
- parents live in fantasy world
- parents ignore good behaviour and attend bad
- passive - aggressive
- personality disorder
- perceive baby as below average
- personality abnormality
- pervasively angry
- poor behaviour towards child
- poor general health
- poor reactions to crises
- poor impulse control
- poor social circumstances
- poor emotional control
- poor support systems
- poor use medical services
- precarious financial situation
- premature children visited less
- prematurity
- prematurity or postmaturity
- psycotic
- rare praise for being good
- react temper tantrum by hitting
- reacts to temper tantrum by screaming

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TABLE 21

INDICATORS OF ABUSING PARENTS: PHYSICAL ABUSE

(PAGE 4)

- reserved
- role reversal
- schizoid personality
- severely frustrated dependency needs
- separations in first six months
- seriously considered abortion in pregnancy
- social isolation
- stress from living situation
- supervision poor
- unemployment
- unrealistic expectations of child
- unplanned pregnancy
- unrecognised physical handicap
- unrelated mental abnormality
- unrelated physical abnormality
- violent upbringing
- way parent expresses anger

Table 21, 'Indicators of Parental Abuse: Physical Abuse' presents 138 signs and symptoms from studies of parents who physically abuse their children. These Indicators relate to emotional states, parental history, family dynamics, and interaction with the child.

Neglect:

Table 22, 'Indicators of Abusing Parents: Neglect' describes 50 signs and symptoms relating to the parents.

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TABLE 22

INDICATORS OF ABUSING PARENTS: NEGLECT

- adverse affective state
- alcoholism
- all children in family similarly abused
- below poverty line
- character disorder
- commenced toilet training before 12 months
- defective object relationships
- deficient in mothercraft
- drug abuse
- failure to learn parenting skills
- family problems
- family separation
- father alcoholic
- father does not care for family
- father too young
- father unwilling to work
- few preparations for baby's arrival
- father not interested in child
- frequent physical punishment
- history emotional depression
- history trauma in childhood
- isolated extended family, social services
- job dissatisfaction
- large family
- limited capacity for concern
- low intelligence
- low affect
- limited ability to perceive own needs
- marital conflict
- mental illness
- mental retardation
- mothers abnormal psychological profiles
- mothers poor social background
- mother too young
- mother no empathy children
- one room for 3 or more families
- overwhelming family problems
- passive
- perceive baby as below average
- physical disabilities
- poor communication between parents
- poor impulse control
- psychological disorder
- severely frustrated dependency need
- suicide attempts
- supervision poor
- unemployment
- untreated medical conditions
- wife battered

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Table 23, 'Indicators of Abusing Parents: Neglect' describes 50 signs and symptoms relating to the parents.

Sexual Abuse:

TABLE 23

INDICATORS OF ABUSING PARENTS: SEXUAL ABUSE

(PAGE 1)

- alcoholic
- dependent mother
- disturbed family pathology
- disturbed marital relations
- early marriage long duration
- family subservient to father
- family fear disintegration
- family not known to social agencies
- family superficially stable
- father discourages socialisation by family
- father craving young children (paedophile)
- father involved sexual molestation of other children
- father rigid restrictive control on daughter
- father sexually promiscuous
- fathers own parental model faulty
- indiscriminate sexuality / child object
- mother promiscuous
- mother unable to communicate with abused child
- mother frigid
- mother condones incest
- mother ambivalent about future
- mother dominated by partner
- mother history inadequate contraception
- mother in de facto relationship
- mother physically and emotionally exhausted
- mother poor sexual relationship
- mother unable cope with child's needs
- mother unplanned pregnancy marriage
- mother unrealistic expectations for childrens' help
- mother family disruption as child
- mother incomplete education
- mother not close to own mother
- mother poor mothering experience
- mother states marriage failed early
- mother unable to show affection to children
- mother denies incest
- multiproblem family

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TABLE 23

INDICATORS OF ABUSING PARENTS: SEXUAL ABUSE

(PAGE 2)

. no guilt
. parents avoided sexual intercourse
. parents offences
. parent rationalises
. problems well concealed
. projection
. psychopathic personality in the male
. psychopathology
. sexually exploited as child
. silent agreement between parents
. violent domestic situation

Table 23, 'Indicators of Abusing Parents: Sexual Abuse' describes 49 signs and symptoms of sexual abuse. These are general Indicators and do not provide adequate detail as a guide to interview.

Emotional Abuse:

Table 24, 'Indicators of Abusing Parents: Emotional Abuse' describes 31 signs and symptoms of emotional abuse. The small number of Indicators reflects the poor documentation of this type of abuse in the literature.

The four surveys of the literature presented in Tables 21 - 24 provide a basis for investigation of child abuse by identifying signs that can be observed and symptoms that the parents report themselves that are related to the form of abuse suffered by the child.

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The literature and the Brisbane Case Study provide a wide range of Indicators related to the parents which are a basis for investigation. The combination of these Indicators with Indicators in relation to the Child presented in Chapter 2, present the police officer with a breadth of information to use in planning his investigation and in conducting interviews with parents and the child victims. Details on interviewing procedures that are recommended and the use of these Indicators in operations are given in Chapter 4, 'Recommendations'.

TABLE 24

INDICATORS OF ABUSING PARENTS: EMOTIONAL ABUSE

- ambivalence to child
- call child by derogatory names
- conscious hostility
- disparaging, hostile, bitter
- father, concerned but dependent mother
- father minimal contribution to family life
- incompatibility with fostered, adopted child
- lack of concern over illness
- lack of concern over nutrition
- lack of imagination
- lack of normal concern
- lock child in room
- marital disharmony long period
- mother sometimes openly admits abuse
- mother deprived in childhood
- mother conscious of rejection but denies
- mother denies showing other thriving children
- mother separated from child
- mothers chronic, severe ill health
- parents give double messages to child
- parents stimulate / frustrate needs
- poor intelligence
- projection, marital problems on child
- reactive depression
- reward siblings for abusing, ignoring child
- sudden switching in emotions
- terrorise, berate, reject child
- unconscious rejection
- untreated medical condition
- verbal abuse, hate, ugly, stupid
- wife battered

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2. POLICE ACTION IN THE MULTIDISCIPLINARY TEAM

In 1980 Duffy, the Assistant Commissioner for Crime and Services stated that the police department would be placing child abuse investigations amongst its top priorities. He acknowledged that more was needed to ensure the protection of children from abuse and neglect than well trained and qualified police officers. An effective programme was envisaged through the police working in SCAN teams. Duffy stated:

> "If we as police are to be accepted by the community in this role, we must be seen as a team member; to be acting in the best interests of the child and not acting alone".

In participating in the SCAN teams the police were recognising the need for flexibility. Duffy stated that the department extended sympathy and understanding to the reasons for behavioural lapses of parents or guardians but that efficient investigations are the role of the police as it would be imprudent to assume that there would be no repetition of the offence by the parent.

Duffy further stated that early identification of the maltreated child necessitated the involvement of the community, and professional persons and that it was vital that the police officer become involved at the earliest possible moment.

The priorities of police responsibility were firstly to protect the child and secondly to gather evidence for possible prosecution. Duffy stated that when confronted with a case of obvious suspected child abuse the police would adhere to the procedures for local SCAN management and unilateral action would only take place in emergency circumstances. Decisions concerning the prosecution of abusing parents were also to be made in concert with plans for care and assistance of the abused child and other children in the family.

In the three years 1980 - 1983 the J.A.B. has required its officers to participate in SCAN teams wherever they were established throughout Queensland. For the purposes of this study the police participation was observed in the two Brisbane children's hospital teams

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and in three teams in Townsville, Ayr, and Charters Towers. In the two latter teams, uniformed police officers fulfilled the role of police representatives as there were no J.A.B. officers in these towns. The Queensland police have been able to integrate themselves into the multidisciplinary approach over the three years and this has led to closer contacts with medical and social welfare staff in the hospitals and in the Department of Children's Services. The J.A.B. training course also relies heavily on members of the multi-disciplinary concept as a core to their training.

In the United States an example of similar close cooperation between police and social workers is found in the Sexual Assault Centre, Seattle. Conte et.al. (1980) says that:

> "Until recently, relationships between police officers and social workers have been characterized by mutual distrust and suspicion. The causes for this antagonism are complex, but appear to be based on assumptions held by both groups that their roles are fundamentally different and are incapable of working together".

The police officer's opinion of the social worker is that they are "do gooders" who lack understanding of problems faced by police and social workers see the police as insensitive to the offender and victim. In Seattle new procedures were established and formal training sessions and informal meetings, and weekly joint meetings led the social workers to increase their understanding of police procedures. rules of evidence and the process of developing a case. Police personnel became more aware of offender psychology and needs of sexually abused children and their families.

Similar results have occurred in Queensland following the SCAN team cooperation. The J.A.B. officers involved in SCAN teams in Townsville and Brisbane value the informal contacts that result from the SCAN meetings and extend their contacts to social lunch or after work gatherings which allow members to discuss joint procedures in a relaxed way. The SCAN meetings appear to have a significant function in providing mutual support to members in cases of child abuse which create strains because of the emotional response to injury or risk to children. The decisions by these teams have immediate

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and obvious major effects on family life and on the child concerned and it appears that participating members need some form of group support while undertaking this responsibility.

TABLE 25

SUSPECTED CHILD ABUSE: FIRST REPORTED TO POLICE BY -

FIRST REPORTED TO POLICE BY	NO	%
1. NEIGHBOUR OR FRIEND	15	4
2. CHILD BEING ABUSED	6	1
3. PARENT OF CHILD	10	2
4. PERPETRATOR NOT ELSEWHERE INCLUDED	0	0
5. OTHER RELATIVE OF CHILD	3	1
6. SCHOOL OR PRE-SCHOOL	7	2
7. COMMUNITY HEALTH	2	1
8. SCAN	304	76
9. DEPT. OF CHILDREN'S SERVICES OR CRISIS CARE	22	6
10. POLICE DETECTION	18	4
11. ANONYMOUS	0	0
12. OTHER	13	3
TOTAL	400	100

Table 25 'Suspected Child Abuse First Reported to Police By:' shows the pattern of reporting in the Brisbane case study from 1980 - 1983. Seventy-six percent of cases have come to police notice through SCAN. Six percent of cases came through the Department of

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Children's Services officers or Crisis Care and four percent from neighbour's or friends of the family.

TABLE 26

CHILD ABUSE: ACTION BY POLICE

ACTION BY POLICE	NO.	%
1. REFERRED TO SCAN & NO FURTHER ACTION	2	1
2. NO ACTION TAKEN	1	0
3. ATTEND SCAN AND NO FURTHER ACTION	170	42
4. INVESTIGATION AND NO FURTHER ACTION	24	6
5. INVESTIGATION AND LIAISON WITH OTHER AGENCIES RE: CARE OF CHILD	60	15
6. INVESTIGATION AND COURT ACTION FOR CHILD'S CARE	140	35
7. OTHER	3	1
TOTAL	400	100

Table 26, 'Child Abuse: Action by Police' shows that in 42% of cases the police role was to attend SCAN and no further action was initiated apart from the case being noted. In 6% of cases there was a preliminary investigation with no further action and in 15% of cases the police role was to investigate and liaise with other agencies, principally the Department of Children's Services for the care of the child. In 35% of cases there was investigation and court action for the child's care. This percentage shows that the cases in which the police became involved were generally the more serious or more obvious ones when compared to all cases of child abuse and neglect in the State.

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TABLE 27

POLICE ACTION X AGE OF CHILD

AGE	POLICE ACTION: ATTEND SCAN & N.F.A. NO.	%	INVEST'N AND N.F.A. NO.	%	INVEST'N & LIAISON FOR CHILD NO.	%	INVEST'N & LIAISON COURT NO.	%	OTHER NO.	%	TOTAL NO.	%
1 - 3 MTHS	22	58	4	10	0	0	12	32	0	0	38	100
4 - 11 MTHS	20	45	1	2	7	16	14	32	2	5	44	100
1 - 2 YRS	30	45	1	2	8	12	26	39	1	2	66	100
3 - 5 YRS	26	34	4	5	12	16	32	42	2	3	76	100
6 - 8 YRS	21	45	5	10	7	15	14	30	0	0	47	100
9 - 11 YRS	15	34	4	9	11	25	14	32	0	0	44	100
12 - 14 YRS	7	20	3	9	6	18	18	53	0	0	34	100
15 - 17 YRS	4	27	2	13	7	47	2	13	0	0	15	100
TOTAL KNOWN	145	-	24	-	58	-	132	-	5	-	364	-
NOT KNOWN	25	-	0	-	2	-	8	-	1	-	36	-
TOTAL	170		24		60		140		6		400	
PERCENT	42		6		15		35		2		100	

Table 27, 'Child Abuse: Police Action by Age of Child' shows that in 42% of cases of children aged 0 - 3 months who came to police notice, there was some police action. In 55% of cases aged 4 - 11 months, 1 - 2, and 6 - 8 years there was police action. The 3 - 5 year olds and the 9 - 11 year olds had the highest percentage of police action: 66% of these cases led to direct action.

Table 28, 'Child Abuse: Type of Abuse by Police Action' shows that in 40% of neglect cases, 45% physical abuse, 27% sexual and 38% emotional cases the police role was to attend SCAN and there was no further action.

Investigation and liaison with other agencies, principally the Department of Children's Services, for the child's care, was the prime police role in 14% of neglect cases, 12% physical abuse, 26% sexual abuse, 12% emotional abuse and 15% other including at risk cases.

Investigation and liaison with other agencies principally the Department of Children's Services, for court action was the police role in 40% of neglect cases, 36% physical abuse, 30% sexual abuse, 47% emotional and 19% of other, including at risk cases.

These figures show that police action for court cases is between a third and a half of all cases coming to police notice. However, as the group of cases in Brisbane which have come to police notice through SCAN appear to be the more serious cases these figures would not apply if police were involved in all cases notified to the Department of Children's Services.

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TABLE 28

CHILD ABUSE: TYPE OF ABUSE BY POLICE ACTION

TYPE OF ABUSE X POLICE ACTION

ACTION BY POLICE	TYPE OF ABUSE: NEGLECT		PHYSICAL		SEXUAL		EMOTIONAL		OTHER		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
ATTEND SCAN & NO FURTHER ACTION	34	40	76	45	17	27	13	38	30	62	170	42
INVESTIGATION & N.F.A.	3	4	8	5	11	17	0	0	2	4	24	6
INVESTIGATION & LIAISON FOR CARE OF CHILD	12	14	20	12	17	26	4	12	7	15	60	15
INVESTIGATION & LIAISON FOR COURT ACTION	34	40	62	36	19	30	16	47	9	19	140	35
OTHER AND NO ACTION	2	2	3	2	0	0	1	3	0	0	6	2
TOTAL	85	100	169	100	64	100	34	100	48	100	400	100

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CHAPTER 4

SUMMARY OF RECOMMENDATIONS

The six recommendations from the evaluation of the J.A.B. involvement in child abuse 1980 - 1983 are:

1. A change in the structure of the J.A.B. to centrally coordinate and supervise child abuse cases throughout Queensland.

2. Development of a state wide Child Abuse Information System within the Information Bureau, to include information on all reports of child abuse and information on infant deaths.

3 AND 4. A change in the operation of SCAN in hospitals and in the community by operationalising the existing teams and using monthly SCAN meetings for policy discussions and training.

5. To use a Child Abuse Operations Manual for standardising police operations in child abuse cases throughout the State.

6. An extension of existing training schemes for J.A.B. officers to incorporate new information on child abuse and to provide in-service training annually to all J.A.B. officers. This recommendation also includes the suggestion that an invitation to jointly attend these sessions be extended to Social Workers from the Department of Children's Services in training.

RECOMMENDATION 1. A CHANGE IN THE STRUCTURE OF THE J.A.B. CHILD ABUSE WORK.

The first recommendation from the study of J.A.B. operations 1980 - 1983 is that the structure of the State J.A.B. be further developed in two directions, the first to allow the Child Abuse Unit in Brisbane to become a central unit for the whole of Queensland.

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The Detective Inspector Commissioner's Office (Juvenile Aid Bureau) supervises all child abuse cases in Queensland. Daily monitoring and specialist supervision of all cases would be achieved through the Child Abuse Unit.

The second development is that J.A.B. officers throughout the State be involved in all initial investigations of suspected child abuse following notification to the Department of Children's Services or the police of suspected cases of child abuse. The present division of Child Abuse Unit and J.A.B. Juvenile work would be flexible depending on the urgency of a case to be investigated and manpower availability. This provides a pool of all J.A.B. officers for child abuse investigation and monitoring when needed in Brisbane. It also provides for J.A.B. officer involvement in the Regions as there is no special child abuse expertise outside the Brisbane Child Abuse Unit.

A. <u>The CHILD ABUSE UNIT role is to become one of</u>:

i. Monitoring and Supervision of ALL reports and police action on child abuse in police regions.

ii. Direct Intervention and Case Management of all cases in Brisbane and supervision of J.A.B. officers who are not members of the Unit for any cases where local J.A.B. management is considered more appropriate by the Unit or where an emergency call has involved officers outside the unit who are able to continue with the case.

iii. Collection of information on Legal and Forensic evidence (including information from infant deaths) for use in preparation of court cases throughout the State and in ensuring a high quality of supervision by the senior officers of the Unit. Information from infant homicides provides Indicators of serious types of child abuse for other investigations. In addition there is the role of investigating siblings of any case where child abuse is suspected.

iv. To prepare and implement prevention programmes on child abuse by participating in the development of increased professional reporting by doctors, nursing staff, teachers and principals, maternal and child welfare staff, social workers, and solicitors. To prepare community education programmes and visit schools to discuss child abuse.

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To liaise with the media, and with the Police Public Relations Department for increased community reporting by abused children, family, neighbours and anyone witnessing child abuse.

CHILD ABUSE UNIT STAFFING would require the following:

1. An estimated 14 officers (who are experienced) and three supervising officers in Brisbane to manage 1,000 cases from all of Brisbane notifications and to supervise up to 2,000 cases elsewhere in the State. This estimate is based on the Department of Children's Services (DCS) notifications represented in Figure 1, 'J.A.B. Response in Suspected Cases of Child Abuse: Brisbane 1982 - 1983' which shows 975 notifications in Brisbane 1982 - 1983. (The DCS Brisbane notifications are exclusive of some areas within the Brisbane statistical division including Woodridge so the estimated reports may increase beyond this number for the police region in 1984 - 1985).

Increases in notifications can also result in any year where there is a directed media and institutional campaign so staffing in relation to child abuse work requires a method for assessing sudden increases in workloads. A case method is suggested as an alternative to existing procedures.

The number of officers recommended for the Child Abuse Unit is based on a calculation of 76% of the Unit's 1,000 cases as average cases taking 17 hours of an officer's time and 24% court cases of 39 hours of an officer's time. These figures are drawn from the Brisbane case study where an estimated 140 in 600 cases were court cases and therefore required extended hours of work by officers. A previous study by the Child Abuse Unit had reported hours of work by officers totalling on average 39 per case. In a theoretical 1,000 cases there is a total of 22,280 man hours of work. When this is divided by 1610 hours which is the theoretical hours an officer is available, 14 officers can manage 1,000 cases. The average time per case per officer is 3 man days. The calculation of hours per case is linked to the

Recommendation No. 3 'SCAN OPERATIONS'. One aim of Recommendation No. 3 is to reduce the existing man hours spent in meetings and to increase the operational time spent by officers on each notified case.

The three supervising officers for the Child Abuse Unit are recommended on the basis of the extended role of the Unit in supervising ALL cases throughout the State which on 1982 - 1983 Department of Children's Services' figures numbers nearly 3,000. In addition to the supervision with the aid of a new information system (Recommendation No. 2) the extended role of the Unit is to include development of forensic material from post mortems, medical and police evidence, from court cases and police investigations, and developing further legal expertise in the preparation of court cases. The third element of the senior role is the J.A.B. training courses at the Police Academy and the recommended annual in-service training within the Regions (Recommendation No. 6). These three senior roles are based on three officers who can interchange with any of the three tasks, i.e. Regional and Brisbane case monitoring and supervision; collection of forensic and legal information (and acting in any infant homicides); and training.

Staffing numbers should be calculated on a caseload basis so that overloading and underservicing of cases could be easily administered by monthly caseload figures. An estimated annual number of new cases per officer annually is 73. Therefore, a monthly new case figure of more than 6 new cases per officer when all officers figures are averaged would show, especially over a period of 3 months whether the Unit's caseload was growing beyond its capacity.

One other aspect of staffing is the effect of Recommendation No. 3 where the police role in SCAN is changed to include involvement with the Department of Children's Services in investigating all notifications of suspected child abuse. The inclusion of a 24 hour J.A.B. duty component in this recommendation to allow immediate response to community notifications provides an additional staffing factor to the recommended 14 officers and three senior supervisors.

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A final consideration on staffing is the degree of specialisation used in child abuse work and the necessity for some stability in staffing. This specialisation of the Child Abuse Unit is developed further in Recommendation No. 2 where data is to be entered onto a special Information File in the main computer. This adds to the current staffing figures by two clerical or technical assistants to oversee and prepare the data, check forms, and file the paper copies of all files in the files within the Child Abuse Unit.

B. Regional J.A.B. Child Abuse Response

The recommended changes require the Regional J.A.B. officers to be under the direct supervision of the Brisbane Child Abuse Unit so that a high quality of police work can be undertaken in any part of the State. The J.A.B. officers would be expected to respond in association with the Department of Children's Services or hospital welfare officers to all notifications of suspected child abuse.

Where no J.A.B. officer is available the child abuse work is to be undertaken by local officers who send reports to the Child Abuse Unit in Brisbane so that supervision is available. Similarly if families who have come to police notice, are being monitored to protect a child, and move to an area where J.A.B. officers are not available, local officers continue the monitoring visits to the family and report to the Child Abuse Unit.

A more detailed description of the J.A.B. officer's role with child abuse is given in Recommendation No. 3, J.A.B. SCAN OPERATIONS.

STAFFING arrangements for both the Child Abuse Unit and Regional J.A.B. officers provide little flexibility for choice of personnel in a specialised area of work. J.A.B. work within C.I.B. Branches in the State make it mandatory that officers be suited to both roles. This limits the selection of officers for child abuse work. It is suggested that arrangements be considered to extend the J.A.B. structure (in association with the change to a centralised supervision) so that movement and promotion is possible throughout the State. This assists with the previously noted need

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for stability of staff as senior positions are available and child abuse specialists can be retained with their valuable expertise. The suggestion does not counter the existing arrangement where C.I.B. and J.A.B. officers have related roles as it is considered that the officer's morale and expertise with adult offenders is enhanced by experience in C.I.B. work.

ACCOMMODATION arrangements for J.A.B. officers have been criticised widely and it is considered that some further investigation be made by the police force on the suitability of certain J.A.B. accommodation. The detailed recommendation on this issue in relation to J.A.B. structural changes is limited to the need for urgent attention to be given, within any premises where J.A.B. officers are interviewing children, to the provision of a suitable environment for children to wait and be interviewed. It is essential that a child's needs for security, emotional reassurance, and the J.A.B.'s requirement of an interviewing environment which relaxes and does not intrude on the child, be seriously considered.

Information from the Seattle Sexual Assault Centre in the United States (Stevens and Berliner 1981) suggests that the child be interviewed in a quiet private room which allows the child some exploration. A child cannot comfortably sit on a hard-backed chair for any length of time. Toys, books, crayons and drawing paper should be aids to occupying and relaxing the child.

It is suggested that each J.A.B. office have a room for interviewing children who are involved in child abuse cases that is specially prepared and equipped. This room can have a dual function with children's play and interview equipment taking up a corner. Children's needs can be recognised in the form of play equipment for all ages ranging from toys to a television for children who are waiting, and expressive and 'familiar' toys for boys and girls to allow them to feel in a familiar environment. These toys should represent common and attractive toys and educational equipment that a child may have in a home, kindergarten, pre-school or school. Toys should be designed around children's self expression, comfort in distress, and those items which allow for the development of stories of family life.

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The surrounding environment requires colours and pictures that soften the police room. Some form of floor covering is needed to allow seating and play on the floor, and relaxed seating at the child's height, (small chairs, rugs, bean bags) that allows officers to sit at this level or in comfortable adult chairs when talking to older children. Tables are also needed at two levels, the small child's play table and an adult table that can be used for talking, playing, and working on toys and equipment that tell the story of the abuse.

Other resources include a supply of blankets and clothing so that children who are inadequately dressed can be protected during transportation or interviewing.

The expertise for this type of development exists within the voluntary sector in Queensland and it is suggested that the Police Department approach voluntary agencies, commencing with Save the Children Fund (Queensland) who already have a Queensland Play Director operating within the Mater Children's and Royal Children's Hospitals. The specialised advice of this Director and a contribution of equipment to J.A.B. offices throughout Queensland would start to meet the psychological needs of children who are being assisted by the police in cases of child abuse.

RECOMMENDATION NO. 2 DEVELOPMENT OF A CHILD ABUSE INFORMATION SYSTEM AT STATE LEVEL

It is recommended that a special Child Abuse file be developed and established in the Information Bureau with a dedicated terminal with word processing facility (two word processing units) in the Child Abuse Unit. The Child Abuse Unit is to update the file daily with details of cases and current status in relation to police operations in Brisbane. Information is to be sent from Regional J.A.B. officers and other officers involved in any notification of child abuse in duplicate form to the Child Abuse Unit and the Information Bureau. The Child Abuse Unit is to input all regional data so that information is available on a daily basis on the status of each child abuse file.

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The effectiveness of police action will hinge in no small measure on the quantity and quality of information available to them from all possible sources. It is therefore necessary that this file contain historical data.

The file is to be used for immediate checks from throughout the State on child abuse history with requests to the Information Bureau to inquire Interstate when suspected offenders have a history of movement.

A report of all police cases of assaults involving children should also be passed through to the J.A.B. for inclusion on the file and investigated where child abuse within the family is suspected.

The file is also to be used to generate on call administrative information to the Child Abuse Unit on Officer's caseloads, and monthly and annual statistics on the work of the Unit and Officers throughout the State on child abuse.

The special file is also to provide hard copy to the Unit on all records inputted for internal files. This copy provides the basis for the J.A.B. files. The word processing capacity on the terminal and a second word processor provides a considerable staff saving in time for preparing court information, training information, and forensic and legal research. The word processors and terminal are an essential part in the calculation of the three administrative staff and 14 officers' capacity to oversee 3,000 cases throughout the State.

RECOMMENDATION NO. 3 IT IS RECOMMENDED THAT THERE BE A CHANGE IN THE OPERATIONS OF SCAN IN THE HOSPITALS.

The SCAN teams in Queensland have created a system for referral and management of cases of child abuse. The growth in numbers of children seen by the medical officers, social workers and police has been increasing to the point where many cases are discussed at each team meeting. It is suggested in this recommendation that there be an operationalising of the SCAN team to provide for greater efficiency in handling large numbers of cases.

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The development of the SCAN concept into operational teams of police, social workers and medical officers provides for joint decision making between members while working on the case. The formal SCAN meetings are reorganised to become important monthly sessions where policies are discussed in relation to case management and case presentations are made by team members to provide professional training.

Inderdepartmental liaison is suggested at three levels:

i. The workface where team members join together for the investigation and management of each case

ii. Liaison between the Director of the Department of Health, the Director of the Department of Children's Services and the Detective Inspector, Juvenile Aid Bureau

iii. The Co-ordinating Committee on Child Abuse.

This change is directed at replacing SCAN's committee system of case management with an operational approach. The SCAN committee's role is developed into policy and training throughout the State. The training aspect is an important method of widening the network of hospital based professional's involvement in child abuse, i.e. to extend the information, experience, and interest of medical officers, nursing staff, social workers, police officers and other professionals.

There are in addition to the above-mentioned reasons, significant facts about child abuse in Queensland which arise from this study's analysis of 400 cases.

These findings were reported in the preceding chapters:

1. Epidemiological studies of child abuse suggest that 1 / 1,000 children aged 0 - 17 are at risk of serious physical abuse, 1 / 200 are at risk of less serious injury and 1 / 100 at risk of any of the four major forms of child abuse - physical abuse, neglect, sexual abuse, emotional abuse. Population studies of Queensland show that in 1982 - 1983 7,564 children were within the total risk group.

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2. The sample of Brisbane child abuse cases 1980 - 1983 shows that:

   Abuse is chronic in 85% of cases, i.e. children have been suffering abuse for some period of time which can extend to a number of years in serious cases.

   Abuse is likely to be found in the siblings of the child who is initially diagnosed (in 92% of neglect cases and 68% of physical abuse cases).

   The age group of children coming to notice of the J.A.B. is most significant in the 3 - 5 age group (21%). Earlier intervention would reverse this finding and significant age group would be clearly within the first two years of the children's lives.

3. Reports of child abuse throughout Queensland to the Department of Children's Services numbered 2,904 in 1982 - 83. The J.A.B. were notified through SCAN and community sources of 404 child abuse cases in Brisbane out of a total of 975 Brisbane notifications. This shows an area for an extension of existing J.A.B. work for the early work detection and prevention of child abuse.

4. A study of present J.A.B. workload shows that 30 man / days per month are spent in decision making SCAN meetings. The proposal is to reoorganise this time to an operational joint investigation with a social worker, and consultations with the medical officer and nursing staff. It is suggested that the team use the case conference system for training, liaison and group support. The extension of the existing SCAN system is aimed at allowing a caseload of up to the estimated 1,000 referrals in Brisbane through the Hospitals to J.A.B. Child Abuse Unit and for a systematic involvement of Regional J.A.B. officers in all hospital cases.

It is considered vitally important for the Queensland Police to rationalise staff involvement in child abuse so that police can offer protection to all reported cases of suspected child abuse and neglect through a procedure of immediate investigation and long term monitoring.

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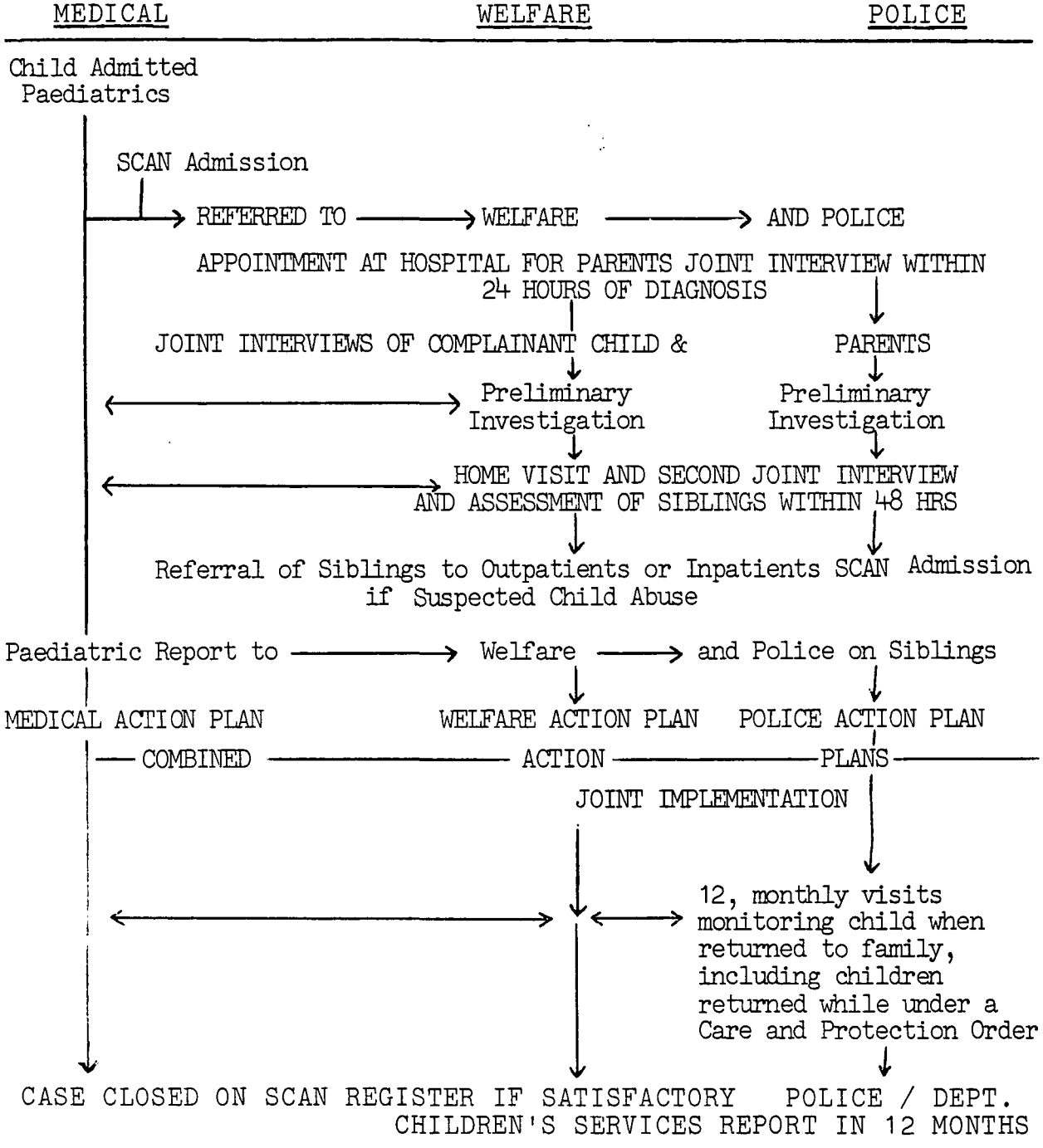
FIGURE 8

POLICE HOSPITAL SCAN OPERATIONS

DAILY COMMUNICATION WITH PAEDIATRICIAN AND NURSES

THROUGH MEDICAL CHARTS AND DISCUSSION



MONTHLY HOSPITAL SCAN MEETINGS OF POLICE AND DEPARTMENT OF CHILDREN'S SERVICES AND HOSPITAL WELFARE AND MEDICAL STAFF. ONE HOUR AGENDA FOR POLICY DISCUSSION ON DIFFICULTIES IN ACTION PLANNING AND HALF HOUR OPEN PRESENTATION OF CASES BY DIFFERENT TEAM MEMBERS FOR TEAMS AND INTERESTED HOSPITAL WELFARE, NURSING AND MEDICAL PERSONNEL.

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Figure 8 'POLICE HOSPITAL SCAN OPERATIONS' is offered as a suggested approach to the operationalising of SCAN within the hospitals and providing established procedures for case management.

This extension operationalises the J.A.B. role in child abuse to meet the increased workload by creating a set procedure for response in association with members of the SCAN trams (medical officers, hospital and Department of Children's Services social workers). The aim is to increase the workload capacity of existing officers by reducing the number of man days / month that are spent in conference and providing for joint investigations with social workers within the Department of Children's Services.

The SCAN operations have matured over the years 1980 - 1983 to the stage that police officers can now expect to work closely with other members of the team on a case by case, operational basis. This method emphasises the combined involvement of police and social welfare staff and medical staff at the time of implementing set procedures for interviews of parents at the hospital and home visits within a 48 hour period of the child being diagnosed as a suspected case of child abuse. Consultation is at the time of intervention with the family and the emphasis is on utilising the crisis of the child's admission to obtain clear details of the circumstances of admission.

Immediate intervention also can be used to obtain the cooperation of the parents in the investigation. An essential aspect of a family crisis is work by the team to open the family situation for investigation. A direct line of decision making by the police and welfare members of the team in consultation with the medical staff allows police and welfare staff to make judgements while jointly investigating, to come to a decision, and work with the family while the crisis is still new. A failure to intervene immediately demonstrates an incapacity of the team to offer immediate case to the family and the child and leaves the child in hospital which at times extends the risk of ill health when a 'well' child is kept in hospital until decisions are made.

It is recommended that the procedure for police SCAN operations in Figure 8 be implemented with the assistance of a Police, Health and Welfare Committee

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consisting of senior members of the Departments of Welfare Services and Children's Services, Health and Police.

The recommended procedure for SCAN hospital cases as shown in Figure 8 is as follows:

1. A planned procedure for medical referral by note of all cases of suspected child abuse to police and Department of Children's Services Social Worker (or hospital social worker when a Department of Children's Services officer is not available within 24 hours).

2. A system of Hospital Duty Officers within the J.A.B. Child Abuse Unit for Brisbane Hospitals and by J.A.B. Officers in the Regions. These officers to initiate their investigation on receipt of the referral and to attend with a social worker at an interview of the parents at the hospital that is arranged through the paediatric ward within 24 hours of the initial referral from the medical officer. If the Investigating Team has access to the Medical Notes or a system of information through the Ward Sister arrangements can be made for continuing communication by notes onto the chart with the medical staff and personal interviews as considered necessary. This system of information by police and social worker onto the child's chart provides the medical staff with daily information on the status of the investigation.

3. A procedure of a home visit by the J.A.B. officer and social worker within 48 hours of the initial interview to continue work with the parents and to assess any siblings under the age of 17. Where there is suspicion of abuse to siblings the team can request that the parents allow these children to be examined in the Hospital Outpatients or as inpatients.

4. The medical officer examining the siblings is asked to report on the findings and following this information the J.A.B. officers and social worker and medical officer can make a joint decision on the action plan which is in the best interest of the child.

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5. The J.A.B. officers are to provide a standard monitoring service for all children who remain in their homes following an investigation where the child has been found to be a victim of suspected child abuse. This service is to assist the parents and the child by the continuing involvement of J.A.B. officers in monthly visits over a period of 12 months.

6. The case remains registered as a SCAN case until closed by the monitoring J.A.B. officer, Department of Children's Services' social worker and SCAN medical officer at the end of 12 months - if the family situation is judged to offer no continuing risk to the child.

7. The J.A.B. team also provides a service in association with the Department of Children's Services to extend this monitoring role to children who return to their families while under a Care and Protection Order.

8. Team liaison and support continues through SCAN meetings at each hospital. A register of all active cases is maintained by the SCAN team but the meetings are on a monthly basis for one and a half hours. The aim of the meeting is to allow for one or two case presentations by different members of the team for teaching purposes. This is to extend the multidisciplinary approach so members of the team understand technical details of each role and also to encourage any interested members of the hospital, welfare, or police staff to attend for training purposes. The second part of the meeting is open only to SCAN team members to policies with difficult cases and general case management.

RECOMMENDATION NO. 4 COMMUNITY SCAN LIAISON

This is an addition to the general developments recommended in Recommendation No. 3 and embraces the notification of suspected cases of child abuse from the community rather than the hospital. It has been suggested in the first Recommendation that J.A.B. officers throughout Queensland be involved in the primary investigation of all reports of child abuse, and that the Child Abuse Unit have the role of community

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liaison to increase notifications. The concept of Community SCAN is developed to allow children to be assessed in the commuinty by identified welfare, medical and police teams. It is suggested that these teams be established within metropolitan and country areas with the participation of interested representatives from the fields of medicine, welfare, police, education, nursing, and the law.

It is also suggested that the community teams concentrate on community education and policy discussions on the operation of child abuse investigations. The core team in contact with the child would be the welfare officer of the Department of Children's Services, a medical practitioner and a J.A.B. officer. The recommended operation of each case follows the procedure in Figure 8 with the exception of the child being in the community rather than in hospital. Decisions would be made operationally between the three professionals involved. Meetings of the committee could be held monthly and parallel the education / policy role suggested for hospital teams.

RECOMMENDATION NO. 5 A CHILD ABUSE OPERATIONS MANUAL TO BE USED BY ALL MEMBERS OF THE QUEENSLAND POLICE FORCE.

It is recommended that the Queensland Police Force adopt an Operations Manual on the Identification, Response, Monitoring and Recording of cases of child abuse.

The Manual outlines:

1. Procedures for taking action in association with the Department of Children's Services, i.e. Response at the Scene, Management at Station level, and referral to J.A.B. These procedures are outlined in Recommendations 1, 2, and 3 where J.A.B. officers provide a 24 hour response to community referrals and hospital duty officers for hospital referrals. In areas where J.A.B. officers are not available other officers are to respond as soon as possible to any community call and within 24 hours of a hospital notification. The response is in association with a Department of Children's Services' welfare officer or a hospital social worker.

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Information on the child is to be sent in duplicate form to the Information Bureau and the Child Abuse Unit to allow for an immediate supervision by the Child Abuse Unit to commence.

2. Indicators of Child Abuse which summarise the tables 9 - 13 presented in Chapter 2, and Tables 21 - 24 in Chapter 3.

3. Interviewing techniques with adults and children. J.A.B. officers generally have established interview techniques which they have developed from experience with adult offenders and juvenile offenders. It is therefore essential that officers have flexibility in their methods and the main contribution to interviewing in cases of child abuse is to establish a number of principles for the officer to take into account in his interview.

The Seattle Sexual Assault Centre provides some information on these principles: (Stevens and Berliner 1981)

1. Alleviate the child's anxiety by establishing a personal rapport.

2. The interviewer should be relaxed and casual and preferably not in uniform.

3. Communication can be established by inquiring about child's interests, family, friends, pets, school, neighbourhood, and by ALLOWING THE CHILD IN TURN TO ASK QUESTIONS.

4. A simple explanation to be given of the functions of the interviewer and the police to help the child understand and cooperate.

5. Time is the most important factor to consider because of limited attention span in younger children.

6. The language and number and kind of questions used are crucial. There is a lack of credibility where a child does not understand legal jargon and answers incorrectly or incompletely. The perception of the

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child's comprehension, e.g. of time and dates, is important.

7. Time is important to consider when checking facts as the incident may remain in the child's memory but other details may become indistinct.

In addition to these important items the information in this study leads to several additional considerations in interviewing.

1. Plan the interview questions prior to the meeting so that full attention is given to the child as this will help to create a positive response.

2. Plan the environment in relation to Recommendation No. 1 so that the child and the police officers are relaxed.

3. Frame questions so that an answer will not make the child feel responsible for the abuse or for discussing his parents.

4. Use indirect discussion to elicit information about incidents of abuse where the child is obviously uncomfortable, denying the abuse, or too young to comprehend the seriousness of the situation. With young children drawings of the family and house, and construction toys provide materials for stories to be told.

5. Where possible develop a relationship that will enable you to discuss with the child any plans that affect his life with his parents, i.e. for temporary hospitalisation or planned fostering.

The police officer can establish a relationship with the child that allows him to feel cared for and secure if the officer is consistent in his words, is available to the child at the time of any separation from his family, and has a contact with the child in the hospital or foster placement.

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In situations where the child has suffered severe abuse by those who are in authority and responsible for him, there is the risk of psychological damage with a lack of trust in authority figures and a feeling that he himself is bad and unloved. It is therefore important that the police officer, as an authority figure has a satisfactory and comforting relationship with the child as this will remain a significant contact in the child's mind, if it is well managed.

RECOMMENDATION NO. 6 TRAINING

IT IS RECOMMENDED THAT THE QUEENSLAND POLICE FORCE ADOPT THREE LEVELS OF TRAINING ON CHILD ABUSE OPERATIONS.

LEVEL 1. THE INCLUSION OF 5 HOURS ON CHILD ABUSE WITHIN THE CADET TRAINING CURRICULUM TOWARDS THE END OF THE COURSE.

LEVEL 2. THE RESTRUCTURING OF THE EXISTING J.A.B. TRAINING COURSE TO INCLUDE AT LEAST 21 HOURS ON CHILD ABUSE.

LEVEL 3. A MINIMUM OF THREE HOURS IN-SERVICE TRAINING EACH YEAR FOR ALL J.A.B. OFFICERS IN QUEENSLAND CONDUCTED BY VISITS TO EACH REGIONS BY THE CHILD ABUSE UNIT.

In addition it is recommended that the J.A.B. Child Abuse Course be offered for in-service training for Social Workers within the Department of Children's Services who may work with police on child abuse cases. This provides an opportunity for joint learning on child abuse and the beginning of team work in investigation by police or welfare workers when a notification of suspected child abuse is received.

LEVEL 1. CADET TRAINING

The first recommendation is based on:

The estimates of cases throughout Queensland which may come to notice through a significant community relations campaign by the Queensland Police Force. The requirement for an immediate response to all community reports would lead to uniformed police officers becoming involved in the preliminary investigation where two J.A.B. officers were not available.

A long term consideration of an extension of juvenile and child abuse work to include the uniformed police working in association with the specialist J.A.B officers. Some long term monitoring of families and investigation work may become joint cases of J.A.B. and uniformed police particularly in areas where there are sudden increases in case reports which are beyond the resources of the J.A.B. and in country areas where a station does not have a J.A.B. officer.

A five hour training period for the cadets covers the basics of law, J.A.B. procedures for notification, Indicators of child abuse, medical and Department of Children's Services' resources. The inclusion of this section towards the end of the course allows for maturity within the cadets.

J.A.B. TRAINING COURSE

The suggested extension of Child Abuse training within the existing course is based on:

. Observations of the existing course in November 1983.

. Observations and interviews with J.A.B. officers in Brisbane and one Region (Townsville).

. The extensive findings on the characteristics of child abuse from the Brisbane study of 400 cases which provides local information of direct application to J.A.B. in addition to the detailed investigations in other countries.

. A conclusion made from observations of 2 SCAN meetings, the reading of 400 case files, and data analysis on

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J.A.B. involvement in abuse cases, that J.A.B. officers would be capable of preventative work in the community in cases that were less obvious and less serious than their existing caseload if their training was directed at identifying cases by means of interviewing and observations.

. The identification of less obvious cases of child abuse offers the child protection at an earlier stage in some instances and in other cases may allow more immediate intervention where there is serious abuse which is being well hidden by the parents. A comprehensive training programme with exercises also provides the J.A.B. officers with confidence and skills for dealing with adult offenders and the child victims. Another effect of training is to provide a professional approach which is appreciated by members of the social work and medical professions on the multidisciplinary teams.

The following Curriculum outline is a guide to J.A.B. training and is based on the findings explained above.

CHILD ABUSE

AIM:

The aim is to train J.A.B. officers on the philosophy of the police role in child abuse, procedures and operations in child abuse cases, and to work within a multidisciplinary community based team.

OBJECTIVES:

The objectives of the course are for J.A.B. officers to learn:

The Law in relation to child abuse and adult offenders and Care and Protection procedures.

Procedures for identification of child abuse through observations and interviews.

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Operational response to reports of suspected cases of child abuse through the SCAN team or the community.

Identification of child abuse, action planning and monitoring children at risk in association with the multidisciplinary team.

Administrative procedures for the recording of information on J.A.B. forms and for court proceedings.

STRUCTURE

The course is structured on a 'building blocks' approach or 'pyramid' so that students commence with a broad base of information on the Law, social data on child abuse, and J.A.B. procedures. The second level is more specialised with court procedures, Indicators and interviewing in child abuse cases, and liaison with the multidisciplinary community based team. The third level of teaching is directed at integrating the previous information blocks by an exercise which tests the elements of law, J.A.B. procedures, operations for interviewing and identifying cases, and multidisciplinary liaison.

The Child Abuse component of the J.A.B. course requires a minimum time of 21 hours teaching time or 7 half day sessions.

PHASE 1: The Law 3 hrs

Social data on child abuse 1½ hours
Definition, epidemiology, referral sourses, profile of adult offenders.

J.A.B. Procedures 1½ hours
Overview of J.A.B. child abuse work since 1980, information forms, general procedures.

TEST: 1 HOUR SHORT QUESTION / ANSWER

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PHASE 2: Court Procedures 2 hours

Indicators of neglect, physical abuse, sexual abuse, emotional abuse 2 hours

Interviewing techniques with adult offenders and child victims.
Theory of interviewing and methods 1 hour
Demonstration interview (video)
Role plays in 5 person syndicates of students: 1 observer, 1 Department of Children's Services officer, 1 J.A.B. officer, 1 child, 1 parent.
Pre-written role cards for each player and duration of ½ hour.
Syndicate reports.
Total time: 2½ HOURS

The needs of the Child.
Psychological effects of abuse, police officer / child relationship, preparation for separation, 1 hour.

SCAN teams 1½ hours.
Use of video of SCAN meeting.
Panel of Medical Officer, Department of Children's Services officer, J.A.B. officer each describing their role and case examples 3/4 hour.

Community Liaison 1½ hours.
3 guests in panel to discuss police role in the community for reporting and preventative work. 1 teacher / 1 agency or media representative / 1 J.A.B. officer.

TEST: CARE AND PROTECTION TEST 1 HOUR

PHASE 3: Exercise and test on Child Abuse procedures and operations 2 hours.

2 person teams to prepare and present decisions on Indicators, Interviewing methods, SCAN liaison, form completion for J.A.B. 1 hour.

Panels of 2 J.A.B. officers to receive written results of the teams work and question on procedures. 1 hour.

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IN-SERVICE TRAINING

A minimum of three hours / year per J.A.B. officer is recommended for in-service training for Child Abuse work. This allows the J.A.B. Child Abuse Unit to use its expertise throughout the State in teaching on forensic work, legal aspects, and procedures for information gathering and supervision by the Child Abuse Unit.

The requirement for in-service training is based on the following findings:

1. The need for a State wide system of data collection centralised in Brisbane through J.A.B.

2. The recommended role of the J.A.B. Child Abuse Unit as a specialist supervisory unit for all child abuse work in Queensland. This role involves monitoring all cases and advising on management including the input of information on specialised legal and forensic aspects.

3. The expected increase in officer's workload with a policy of increasing community reporting to the police by publicising the 24 hour response capability of the J.A.B. and uniformed officers. In addition targeting of schools for involvement in community SCAN teams will lead to an increased community liaison role and more cases.

4. The nature of child abuse work where officers experience some personal stress in close involvement with abuse to children. This creates anxieties and doubts which can be assisted in a meeting with the specialised child abuse team.

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GREGG, G.S. & ELMER 1972

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