Short Commentary

'Hidden' Successes and Failures in Child Abuse-Related Deaths

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INTRODUCTION

This review of Child-Abuse-Related-Deaths (CARD) in the UK and twenty Western countries brings together research from the past forty years from which we can learn new perspectives. Until the 1960's CARD were not issue until Kempe's seminal 1962 paper on `Baby Battering Syndrome', as the concept was inimical to `natural' feeling so when such tragedies occurred the media and public outcry was enormous. One such tragedy led to the first comparative international study of CARD, based upon WHO date from 1973 to 1988. Against media expectations, deaths had fallen in most Western countries, though USA had the highest rates throughout the period 1. The reduction of CARD can be described as a `hidden' success and have continued to monitor CARD, in which the latest study between 1989-91 to 2013-15 shows the UK, who was fourth highest is now third lowest 2.

Over-all average Western baby <1year rates fell from 29 per million (pm) to 18pm; whilst 0-4year CARD average fell from 14pm to 7pm. The latest USA <1 and 0-4 rates being 70pm and 31pm respectively, the UK was lowest at 2pm for bothbaby and 0-4year deaths, a `hidden' success indeed 2. However, CARD have always been `statistically' low, it's the media and policy impact that is so great.

But what of the `hidden' failure? The WHO Millennium goals were to reduce Child Mortality (0-4) Rates (CMR) by 2% pa but over the period 1989 to 2015, six countries, including the UK and USA failed to reach the target, though rates fell substantially. Western CMR average went from 1866pm down to 803pm, down 57%. America throughout the period had the highest rates, fell from 2420pm to 1249pm, down 48%, Britain went from 1929pm to 885pm a 51% fall.

For America this is a notable failure as fourteen other countries had significantly bigger falls than the USA over the period 2, 3. Furthermore, based upon World Bank data America had the widest income inequality, and Britain the third and fifth highest CMR.

In relation to CARD Britain had statistically bigger reduction than fourteen other countries, conversely, in regard to UK CMR, nine other countries had significantly greater falls than Britain 2. 3. Yet the established link with structural poverty is ignored by delinquent governments, so that the four countries with the lowest CMR had the narrowest income inequality and half America's CMR! 2, 3.

But these national figures tell front-line practitioners little of what action to take but two studies of Police records, enable us to identify the different types of Child Sex Abuser (CSA) and CARD assailants, to improve prevention and protection.

The CSA study was a two-year cohort from 4% of the English population.. Child Sex Abusers (CSA) fell into three behavioural categories, determined by court convictions - first the sex-abuser-only, second CSA with Multi none-sexual crimes - the CSA Multi-Criminal (CSAMC) and third, CSA with Violent and Multi-Criminal activity (VMCCSA) 4 .

The Police found the work helpful and invited us to study of a decade of Child-Abuse-Related-Death (CARD) assailants to reveal key factors in relation to who kill children. Based upon convictions from Police records from the same region, the results challenged a number of long held assumptions as it showed that we can identify from which category CARD assailants belonged, though Intra-family assailants had markedly different dynamics than Extra-family assailants 4. In the decade 33 children died with 23 assailants highlighting the statistical rarity of CARD.

In our initial report we focused upon risk levels of the Intra and Extra-family assailants based upon categories of potential assailants within the general the population. We now realise in the first report we had an inadvertent bias, wishing to avoid adding stigma to mental illness. To find that Extra-family assailants, all who were VMCCSA killed at a rate of 8000 per million, compared to the Mentally Ill Mothers rate of 70pm, distorted vitally important practice results.

First even the most dangerous assailant, VMCCSA, only 0.8% of these men in the general population killed. Whereas the Mentally- Ill Parent, who were the most frequent of Intra-family assailants (63%), as a percentage of such women in the general population was 0.007%, highlighting that the vast majority of mentally ill parents mothers do not physically harm their children 4. The remaining Intra-family assailants were 21% of Step-fathers/ cohabitees, who were also VMCCSA, the remaining 11% were `Inadequate -Negligent-Parents' (INP) whose 120pm was again statistically rare.

The MIP included those with frank psychiatric diagnoses, including severe personality disorders and alcohol and substance abuse. The psychiatric dimension was confirmed in that all blood father assailants committed suicide and half the mothers were Involved in severe suicidal behaviour, with a quarter actually dying. The paradox of the INP were that they truly negligent and deaths and de facto accidental. For example, in winter a single-mother met an ex-boyfriend. She hid her sleeping 3year old and went with him. Hours later she realised what she had done, rang the police but the child had died of exposure. Whereas, typically a MIP had killed in `psychiatric' confusion, some with severe paranoid delusional state and in one sense had killed their child `in love' to save them from the impending delusional catastrophe 4.

The Extra-family VMCCSA, all involved a sexual assault, whose behaviour was too extreme to describe. When confronted with horrendous photographs of victims, we sought to open the debate on whether such men, merited reviewable sentences, in effect preventative detention. Until seeing the actuality physical evidence I never dreamed I would contemplate such a proposal, but in the majority of these men's case-records, the final fatality was preceded by many similar attacks 5. However, the VMCCSA by definition and behaviour, could be described as severe personality disordered, therefore, the majority of assailants, 91%, could be described as psychiatrically/ mentally disturbed? Indeed, the rational for such a designation is that the International Classification of Diseases 10th Edition groups all these conditions in in the global category of `Mental & Behavioural Disorder'.

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Received date: January06, 2022;Accepted date: January14, 2022;Published date: January24,2022

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Of course, the dilemma for child protection services is how often preparators were erstwhile victims as we found in a study of adolescent who sexually abused other children, who were on the cusp of becoming CSA. Yet their family backgrounds were acutely disturbed, including victims of abuse and domestic violence 6. Yet in a controlled longitudinal study of an adequately resourced school social work service, major changed was brought about in a project that was cost-effective, based upon early intervention, reducing truancy, delinquency and school exclusion. Sadly school exclusion is well known to have subsequent mental health and criminal behavioural outcomes 7. In parenthesis, if school exclusions continue to increase, with the inevitable negative psycho-social and economic consequences, this is another `hidden' failure.

In an effort to provide a preventive approach we are building on our study that asked "who kill children?" 8. Reflecting back on of decade of CARD study, we appreciated that if the children's social workers had asked more about parental mental health, and, if adult psychiatrists had asked what might be happening with their patient's children, half the children might have been saved.

CONCLUSION

If we considered the considerable evidence surrounding adverse childhoods and subsequent mental health problems, we argue that the child protection-psychiatric interface needs to be recognised. Such an approach could help adult psychiatry be a potential preventative mental service so we seek to develop the concept of the `mental health syndrome paradigm' to help child protection services the better understand modern integrative psychiatry 9. This requires that we need to recognise the impact upon the bio-psycho-social development of a child of a mentally ill parent. Image what it must mean to have a parent sharing their delusional fears- to overtly contemplate a suicide pact "because Mummy does not want to leave you behind" – it is feared that in an effort not to stigmatise, we miss the daily reality of a child of parents with a severe personality disorder, attempted suicide or the roller-coaster emotions of bi-polar disorders. A major problem is that the child does not understand their parents' difficulties and may even blame themselves. Another is that the child becomes part of the parent's psychotic or behavioural paradigm, with older children fearing they will `inherit' similar situations. With help and support, especially to help the child understand their parents are ill, there is evidence from Germany and Norway, subsequent psychosocial problems can be reduced. Indeed, Norway have recently introduced a statutory requirement for the health and social services to provide support for children of mentally ill parents 10. Research has found that by helping the child and adolescent, via psycho-education, this measurably improves their coping skills. Classically, Nilsson et al (2015) concluded that the family should be the focus in all psychiatric practice 11. Whilst the European Union project `Camille' empowers children of mentally ill parents through psychos-education and the training of professionals working with such children and adolescents, to facilitate the necessary support 12. This had involved seven different University centres and results point towards a lessoning of tension, via an integrative psychiatric approach, namely psychosocial and psycho-pharmacological 12. By working together in an equal parentship with psychiatric and children's services, CARD risk levels can be reduced but even more importantly, such an approach reduces the negative parental psychiatric impact upon the psychosocial development of the child, 9-12.

In summary, a family focused child protection -psychiatric interface approach promises to reduce the longitudinal negative impact of parental mental illness on the child. Whilst CARD have never been lower, is a `hidden' success but `ordinary child mortality has not improved in Britain as in other countries, demands further incentive in the continued pursuit of social justice, not least to the children of mentally disordered parents.

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