Pergamon

Child Abuse & Neglect, Vol. 23, No. 12, pp. 1239–1252, 1999

0145-2134/99/$–see front matter

PII S0145-2134(99)00096-4

ABUSE OF CHILDREN IN FOSTER AND RESIDENTIAL CARE

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ABSTRACT

Objective: There have recently been many debates in the UK about how to provide good care for children placed away from home. Professionals have realized that the level of child abuse in foster care and children's homes is high. This research examines the characteristics of physical and sexual abuse of children in foster and residential care in a city in England. The number of cases of abuse reported by pediatricians in this group was compared to the number reported by the same pediatricians for the population of Leeds as a whole.
Method: This is a retrospective study of 158 children, fostered or in residential care who were involved in 191 episodes of alleged physical and/or sexual abuse assessed and reported by pediatricians over a 6 year period from 1990 to 1995 in Leeds, England. Details of the child including the reason for placement in care, their physical and mental health, abuse characteristics, including perpetrator and case management were studied.
Results (see Table 1): 158 incidents of abuse in 133 children in foster/residential care are described.

- In foster care, 42 children were physically abused, 76 were sexually abused, and 15 experienced both forms of abuse.
- In residential care, 12 children were physically abused, 6 were sexually abused, and 6 experienced both forms of abuse.
- In foster care 60% of sexual abuse involved girls and 60% of physical abuse involved boys.
- In residential care almost twice as many boys as girls were reported to be abused.
- Foster carers perpetrated the abuse for 41%, natural parents on contact for 23%, and children 20% of incidents.
- A significant proportion of abuse was severe with 1 death, 8 children with burns, 18 with genital, and 34 with anal penetration.
- Long-standing emotional, behavioral and learning difficulties were common. Most children (80%) had been abused prior to entry into care.
- Foster children were 7–8 times and children in residential care 6 times more likely to be assessed by a pediatrician for abuse than a child in the general population.

Conclusions: Children in foster or residential care form an at risk group for maltreatment. Their special needs include additional measures to protect them from abuse. © 1999 Elsevier Science Ltd

Key Words—Child physical abuse, Child sexual abuse, Foster care, Residential care.

INTRODUCTION

CHILDREN WHO ARE abused and neglected or those who cannot be cared for by their families for various reasons may be placed in the protective care of the local authority. There is an

Submitted for publication March 23, 1998; final revision received February 8, 1999; accepted March 5, 1999.

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Table 1. Details of Children Referred With Concerns Regarding Abuse in Foster and Residential Care

	Physical	Sexual	Physical and Sexual	Total
Total Children	42	76	15	133
Boys	25	30	4	59
Girls	17	46	11	74
Mean Age (Months)	84.1	73.8	86.4	79.7
Range (Months)	22–178	12–214	34–183	12–214
Perpetrators				
Foster Mother/Father	29	22	8	59
Child	4	24	1	29
Foster Child	2	14	1	17
Natural sibling	1	7	0	8
Child of foster family	1	0	0	1
Other child	0	3	0	3
Natural Parent	8	21	3	32
Other Relative	3	3	3	9
Other	1	1	0	2
Unknown	2	7	1	10
Experience Prior to Care*				
Physical abuse	16	24	5	45
Sexual abuse	19	43	10	72
Emotional abuse	5	10	0	15
Neglect	12	16	5	33
Failure to thrive	6	2	1	9
Abandoned	2	2	1	5
Ill health in mother	3	8	1	12
Unknown	8	10	2	20
Behaviour Difficulty	20	30	8	58
Sexualised Behavior	6	28	3	37
Mental Health Professional Involved	4	13	0	17
Any Mention of Above	23	47	8	78
Learning Difficulties/Handicap	12	20	3	35

*Children may experience >1 adversity prior to admission to care.

expectation that although there may be inherent difficulties of care within an official public system that at least children will be protected from further maltreatment. The converse however appears to be the case despite the duty put on the local authority that "children living away from home are entitled to the same level and standard of protection from harm as is provided for children in their own homes" (Working Together, 1991).

In England and Wales there are about 48,000 children "looked after" by the local authority, of who 31,800 are in foster care, and 8,000 in residential care. Both the number of children in children's homes and the size of the homes have fallen with currently on average 10 children in each home: 65% of children were fostered in 1995 (58% in 1991).

Previous studies suggest that children in foster and residential care form an "at risk" group as a consequence of earlier abuse, neglect, abandonment and inadequate care at home (Benedict, Zuravin, Brandt, & Abbey, 1994; Bolton, Laner, & Gai, 1981). Ball (1991) estimated that 66% of "looked after" children had been previously abused, and Chernoff (1994) in looking at the reason for placement described a history of abuse in 81% of their sample. Certain children are more vulnerable. These include young children, children with disability, and children with behavioral and emotional difficulties (Utting, 1997). These problems are often greater in children in residential care (Polnay, Glaser, & Rao, 1996). Many children entering care have already been harmed psychologically and emotionally and have developed difficult behaviors experienced as dysfunctional to new carers. Foster carers may also care for more than one foster child with such difficulties

Table 2. Comparison of Data on Children Referred With Concerns Regarding Abuse in Foster and Residential Care

	Foster Care	Residential Care
No Abused Children	133	25
Physical Abuse (NAI)	42 (32%)	12 (50%)
Sexual Abuse (CSA)	76 (57%)	6 (25%)
NAI and CSA	15 (11%)	6 (25%)
% Children CSA	60% girls	33% girls
% Children NAI	60% boys	67% boys
Mean Age of Girls (Range)	79.6 month	153 month 12.75 years
Mean Age of Boys	12–214 month	148 month 12.36 years
Past History of CSA	34%	Similar to children* in foster care
Past History of NAI	24%	Similar to children in foster care*
Abuser		
Foster parent	41%:CSA < NAI	32%:NAI (staff)
Birth parent (on contact)	24%:CSA > NAI	16%:NAI/CSA child/home
Child	20%:CSA > NAI	52%:NAI/CSA-child outside home
Unknown	7%	
Rate of Referral cf. General Population	7–8× greater	6× greater

**Note*. Incomplete data.

and sometimes care for many such children. Their experience, training, and support will be crucial to any success in meeting these children's long-term and complex needs. Risks may increase in long-term foster care had particularly where the foster carers have had care of the child for a long time, and may have been less well supervised (Utting, 1997). A further factor which may reduce protection for these children is a criminal justice system which is not working "in a way which protects children against abuse" (Utting, 1997)

Recently extensive abuse has been uncovered in children's homes in North Wales. People who wish to exploit children seek occupation or voluntary work, which gives them easy access to their prey (Utting, 1997). The Warner Report (1992) focused on tighter regulations around the appointment of staff but many of the recommendations were not implemented. Previous reports (Utting, 1991) have looked at safeguards for children in residential settings but again not all the recommendations were implemented. However it is now expected that with current changes in practice, the North Wales situation will not be repeated. Finally it should be noted that many of the confirmed reports of maltreatment in out-of-home placements are serious in nature (Rosenthal, Motz, Edmondson, & Groze, 1991).

Aims and Methods

Pediatricians in Leeds, a large city in the North of England, became aware that they were being asked to see an increasing number of children who were in foster or residential care where there were concerns that they may have been abused, either physically or sexually or both. A small number of high profile cases included one in 1986 and one in 1995 where a child who was fostered was killed by a foster carer. The question was asked whether these children suffer increased vulnerability to abuse?

Leeds is part of West Yorkshire, which has rates of referrals for legal proceedings under the Children Act 1989 above the national average (Children Act Advisory Committee, 1993). No evidence was found, however, on review by a senior judge of over-reporting of cases to the legal system.

The study aimed to determine the frequency and pattern of abuse and neglect of children seen by pediatricians and who were placed in foster or residential homes over a 6-year period.

Table 3. Children Abused in Children's Home

Girls: Characteristics	8 Girls: mean age: 12.75 years Majority abused pre-care
Girls: Abuse	4 Girls NAI 1 Girl CSA 3 Girls CSA/NAI
Boys: Characteristics	17 Boys: mean age: 12.36 years Majority abused pre-care
Boys: Abuse	8 Boys NAI 5 Boys CSA 3 Boys CSA/NAI
Behaviour of Total Cohort	42% Behavioural problems 10% Sexualised behaviour 13% Learning difficulty
Abuser	NAI: 8 by staff member NAI: 2 by child in home NAI: 4 by child outside home CSA: 2 by child in home CSA: 9 by child outside home
Management	Information not available

The reasons for placement of the child in care and problems the child was experiencing were also studied. Comparison of the frequency of referred cases of children in foster and residential care with those referred from the general population to the same pediatricians was made. In addition the interagency response to these children was examined in terms of investigation, protection, and management.

Children in foster or residential care in whom there were concerns regarding physical or sexual abuse over the 6-year period 1990–1995 were identified retrospectively from medical reports written following full assessments by pediatricians experienced and specially trained in this work. Information was extracted from the reports and case records and analyzed. It is the local inter-agency policy that children with inadequately explained, unusual, or repeated injuries are referred to the specialized pediatric team for assessment as soon as such injury is recognized. Pediatric follow-up appointments at the clinic provide continuing assessment and support with on-going care. At the follow-up appointment a further physical examination is carried out if there are worrying symptoms or signs, for example, bruising, vaginal soreness, specific behaviors (sexualized or an unexpected change in behavior).

The details of the author's diagnostic approach to both physical and sexual abuse have been dealt with in previous publications (Hobbs, Hanks, & Wynne, 1993). The diagnosis is constructed in the same way as a jigsaw puzzle with information being added until a picture is assembled.

RESULTS (TABLES 1–3)

The Children

Foster care.

- 133 children in foster care were identified following concerns regarding abuse in 157 episodes over the 6-year period.
- 18 of these occurred in kinship foster placements, that is, where the child was fostered within the extended family.
- There were 59 boys and 74 girls with a mean age of 79.6 months, range 12 to 214 months.
- 25 boys and 17 girls were physically abused.
- 30 boys and 46 girls were sexually abused.

- 4 boys and 11 girls who experienced both physical and sexual abuse.
- Girls were the predominant sexual abuse victims with 60% of sexual incidents involving girls.
- Boys were the predominant victims of physical abuse being involved in 60% of incidents.

The diagnosis of abuse.

- The diagnosis was assessed according to criteria described in previous studies (Frothingham, Barnett, Hobbs, & Wynne, 1993; Hobbs, Wynne, & Thomas, 1995).
- Cases were classified as suspected, probable or confirmed and refer to the 157 episodes of possible abuse.
- A suspected case (51 children) was one where there were grounds for concern but these were insufficient for full child protection procedures to be commenced. These cases were usually followed up while continuing to discuss the concerns with parents and professional colleagues.
- A probable case (66 children) was one where a summation of findings was sufficiently worrying in the view of the pediatricians to warrant immediate or continued involvement of protection agencies for the development of a specific plan of investigation.
- A confirmed case (40 children) was one where the child provided a clear disclosure of abuse, or a perpetrator admitted the offence, or where physical injury or gross physical signs of genital or anal trauma without other reasonable explanation were present.

Reasons for placement in foster or residential care.

- 34% had been sexually abused.
- 24% had been physically abused.
- 15% had suffered neglect.
- 7% had been emotionally abused.
- 4% were failing to thrive.
- 5% had mothers with ill health. This was usually mental ill health that had lead to the need for alternative care.
- 2% had been abandoned by parent(s).
- 9% were encountered where the reason for alternative care was unknown.

Context of abuse including likely abuser.

- 41% of incidents took place in the foster home and the child was abused by the foster parents.
- 23.8% of incidents took place during contact with the parents of family of origin.
- 6.3% of incidents took place in the home of relatives of the family of origin, usually involved in kinship fostering.
- 20% of incidents involved another child as abuser. Of these:
  - 53% of the abusers were other foster children
  - 31% of the abusers were siblings
  - 16% of the abusers were children of the foster family or other unrelated children
  - 7.0% of incidents were encountered where the identity of the perpetrator remained unknown.

Perpetrator in relation to details of the abuse.

- Foster parents were the perpetrator of physical abuse (28 children) and sexual abuse (22 children).
- Natural parents were the perpetrators of sexual abuse, which occurred on contact (22 children).
- Children were perpetrators in 24 cases of sexual abuse.
- Children abused both physically and sexually were abused by foster parents (8 cases), natural parents (3 cases), relatives of family of origin (3 cases), and in one case by an older child.

Presentation of abuse.

- Disclosure—43 children. Disclosure in many cases was made to their social worker, a key person in their care.
- Behavior—29 children demonstrated behaviors, which alerted adults to new difficulties for the child and these were carefully assessed. Concerns included unexplained changes in behavior, new behaviors, and the resurgence or prolonged continuation of behaviors previously associated with abuse before coming into care.
- Injury—29 children
- Routine pediatric follow up consultation—7 children
- Physical symptoms (for example vaginal soreness, vaginal discharge)—13 children
- Concerns from school (lack of progress and worrying behavior)—8 children
- Abused another child—6 children
- Witnessed being abused—1 child
- Neglect—1 child.

Details of physical injury.

- One child aged 2 years died following a severe shaking injury. The foster mother was prosecuted and convicted.
- 72 had bruises including 6 with petechial bruising.
- 8 had burns.
- No fractures.

Details of sexual abuse.

- 91 children had concerns regarding sexual abuse.
- 39 had abnormal genital signs.
- 18/39 the signs were consistent with genital penetration.
- 53 children had abnormal anal signs.
- 34/53 the signs were consistent with anal penetration.

Behavior problems encountered in the children. Many of the children had long-standing behavior problems:

- 59% had a persistent and significant problem causing concern to a carer, including sexualized behavior or was known to be receiving help from a mental health professional as a result of emotional or behavioral difficulty.
- 62% of sexually abused children had problems, compared with 53% of sexually and physically abused children or 55% of physically abused children.
- 26% had significant learning difficulties, a statement of special educational need, or were attending a special school. This included 1 child with Down's syndrome, 1 with cerebral palsy, and 1 with severe hearing impairment.

Management of Abuse in Foster Care (Table 4)

In England and Wales, Area Child Protection Committees are required to have formal procedures for the investigation of suspected abuse to children in foster or residential care (Working Together, 1991). These are essentially the same child protection procedures as for children living at home. However, it should be noted that "actions to investigate allegations of abuse of foster children should also include consideration of the safety of any other children living in the household, including the foster parent's own children" (Working Together, 1991, section 5.19).

Table 4. Outcome Following Concerns Regarding Abuse in Foster Care

8 Children	Child Protection Conference
10 Children Abused in Contact	Supervision increased
117 Children Abused in Foster Care	
18 Children	Returned home
14 Children	Placed in children's home
8 Children	Placed in different foster home
1 Child	Placed in adolescent unit
26 Children	Plan to move child, uncertain outcome
43 Children	Plan not ascertained
1 Child	Abusive child removed out of family
6 Children	No apparent action

A medical assessment by a pediatrician is an important part of these procedures. In Leeds it is usually one of the first actions to follow concern being raised. There were eight incidents identified where a formal case conference was held. Case conferences remain a central part of the procedures for protecting children in England (Preston-Shoot, 1997). This figure is much lower than expected. As pediatricians are routinely invited to case conferences this figure is likely to be complete.

Other information regarding subsequent management after concerns had been identified was incomplete in some cases. The response to concerns arising with regard to abuse occurring when a child was in foster care depended inevitably on the context in which the maltreatment occurred. Where it was identified that a parent abused on contact, then arrangements for contact were modified so as to protect the child. This occurred with 10 children. In other cases where abuse occurred within the foster home, children were moved to another home. In 18 children the move was a return home, in 8 to another foster home, in 14 to a residential children's home, and in 1 case to an adolescent unit. In 26 children it was identified that there was a plan to move the child but it was not possible to identify to where the child moved. In one case the perpetrator, a child, was removed. There were 43 cases where the outcome could not be ascertained from the records and 6 where it appeared that no further action had been taken following the concerns being raised.

There were three families identified in more than one report for abuse. One family was identified who appeared in three separate reports involving seven children. In two families there were each two separate reports relating to different children at different times. Discussion with Social Services indicates that none of these families are continuing to foster children.

The number of previous placements that the child had at the time the child was seen was also recorded. There were 112 children for whom detailed information was available. For 59 this was their first foster care placement. 39 had either two or three previous placements and 14 had had four or more. The latter figure compares with the recently published report of the inspection of six local authority fostering services (Social Services Inspectorate—Department of Health, 1996, Inspection of Local Authority Fostering, 1995–1996) where 12% of a sample of 120 children had more than three moves of placement.

Abuse in Residential Children's Homes

During the same time period, a pediatrician assessed 25 children, living in residential children's homes, with concerns regarding physical or sexual abuse. Nineteen were seen on one occasion, and three each on 2 and 3 occasions providing a total of 34 incidents. Details include:

- 8 girls (mean age 12.75 years)
- 17 boys (mean age 12.36 years)
- 13 children for whom information was available showed that the reasons for care were similar to those recorded for the fostered children with the majority having been abused prior to coming into care

Table 5. Comparison of Referral Rates to Paediatricians Due to Concerns of Abuse in Children in Foster and Residential Care

Population	No. children/"home"	Rate of referral/10^3
General Population	153.430 Total	$3.9/10^3$
Foster Care	50 Fostered	$29.54/10^3$
Children's Home	178 in Residential home	$23.3/10^3$

- 42% had behavior problems (10% sexualized behavior)
- 13% had learning difficulty
- Four girls were physically abused, one sexually abused, and three both physically and sexually abused
- Eight boys were physically abused, five were sexually abused, and three both physically and sexually abused
- Eight children (all physical abuse) were abused by a staff member
- Four children (two sexual and two physical) were abused by another child within the home and 13 (nine sexual and four physical) by a child outside the home.

Comparison of Referral Rates for Abuse in Children in Foster and Residential Homes and for Abuse of Children in the General Population (Table 5)

One hundred and thirty-three children in foster placement were the subjects of a pediatric report for suspected, probable, or confirmed physical or sexual abuse over a 6-year period providing an average yearly total of 22.16 children reported per year. Leeds has about 750 children in foster placements looked after by 300 carers (Leeds Children's Services Plan, 1997/99). This gives an annual rate of foster children reported by pediatricians for abuse of 29.54 per 1,000 placements.

There are 178 placements in residential children's establishments in Leeds. Over the 6 years there were 4.16 children per year reported by pediatricians for abuse giving a rate of 23.3 per 1,000 places per year in residential care.

In the 3 years 1994 to 1996 inclusive, the same pediatricians assessed 1,800 children from the whole population for concerns (suspected, probable, or confirmed) regarding physical or sexual abuse. Figures for 1990 to 1993 are not available. This provides an average annual yearly total over the 3 years of 600 children. Leeds has a population in the age range 0–17 years of 153,430. The rate of abuse reported by pediatricians in Leeds is around 3.9 per 1,000 children age 0–17 years in the general population.

From this it can be concluded that a foster child is 7–8 times and a child in a residential home 6 times more likely to be assessed and reported by a Pediatrician for physical or sexual abuse than a child in the general population. It is important to emphasize that the true prevalence of abuse in these different populations cannot be assessed from these results. Obviously children in foster and residential care are under much closer monitoring than children in the general community where abuse can be more easily concealed. However as the pediatric assessments involve the same doctors, referral pathways, and diagnostic criteria, comparison of the foster/residential group and the general population group has validity.

DISCUSSION

The majority of children looked after by local authorities in the United Kingdom are placed in foster care. On 31st March 1995, 49,000 children were being looked after by social services

departments in England of whom 31,800 (65%) were fostered (Social Services Inspectorate—Department of Health, 1996, Inspection of Local Authority Fostering, 1995–1996).

The local authority fostering service is a major component of services provided for children and families under the Children Act 1989. There has been little research into the adequacy of current practice and whether children's needs are being met.

This is surprising given that foster children clearly represent a selected population known to be at risk for physical, mental health, and developmental problems. It is reasonable to assume that these health and behavior characteristics are important factors contributing to maltreatment in foster care. The prevalence of emotional, behavioral, and developmental problems among children in foster care has been well documented in several studies (Bamford & Wolkind, 1988; Benedict, Zuravin, Somerfield, & Brandt, 1996; Hochstadt, Jaudes, Zimo, & Schacter, 1987). Swire and Kavaler (1979) found that between 30–80% were moderately to severely impaired psychologically, 90% were deemed to have two or more behavior problems, and 50% four or more. Common symptoms found include depression, poor self-esteem, substance abuse, sexualized behavior, and aggressive behavior and school difficulties (Browne & Finkelhor, 1986). Truancy, suicide attempts, promiscuous behavior, wetting, soiling, and self-harm also appears to be prevalent in abused children (Thompson, Authier, & Ruma, 1994). The present study similarly found a high incidence of emotional, behavioral and developmental problems among the foster children which could not all have arisen from abuse while in foster care. Fifty-nine percent of children had significant and long-standing behavior problems, which caused carers concern. Many children with emotional and/or behavioral difficulties were receiving help from mental health professionals. Sexually abused children especially had high rates with 62% suffering from an emotional or behavioral problem and 26% had significant learning difficulties for which many were attending a special school.

Clearly placing such children in poorly prepared foster homes creates the risk that they may be maltreated again. Foster parents often struggle to cope with the demands of these emotionally vulnerable children whose maladjusted behavior and patterns of communication may be misinterpreted. A child's behavior is termed maladjusted in the sense that it appears bizarre to new carers and inappropriate for his new environment although it may be appropriately adjusted to the abuse previously suffered. There is considerable evidence to suggest that those children maltreated in care are more likely to exhibit behavioral and psychological problems than children not maltreated while in care as Benedict and colleagues (1996) concluded from their study on abuse in foster care.

Children living in children's homes tend to be older and have the most severe emotional and behavioral difficulties. Despite this, less than 50% of residential staff are trained and the child may be thought "too difficult to foster." These children are likely to be the survivors of several unsuccessful placements, including foster care, and are further harmed by their mobile life style.

The main factors identified in previous studies which predicted maltreatment in care were:

- Female gender
- Non-kinship foster placement
- Emotional/behavioral problems
- Developmental problems/disability
- Young children
- Children with parents overseas
- Children in residential institutions with fewer than four children including private foster homes
- Children in prison—there are 2,600 children under 17 years in prison in the UK (Benedict et al., 1996; Utting, 1997).

Prevention of Child Abuse in Foster and Residential Care

The discussion highlights aspects of foster and residential care where abuse of children could be prevented. This also includes early recognition of abuse when it occurs in a placement. The study supports the need to evaluate the foster and residential care system and the extent to which it is providing adequate care for an at-risk vulnerable population of children. The obvious difficulties of placing any child in a new home with new parents are further exacerbated by the emotional and behavioral difficulties of many foster children coming from a background of abuse or neglect. Both the needs of foster children and of foster parents need to be assessed in some detail and met.

Research into the adequacy of current approaches used to meet the needs of children and parents in the foster care system including the present study suggest that many needs are not being met. Aspects of social work practice are beyond the scope of this study and the professional expertise of the authors. However it is sufficient to say that the individual social worker needs time, should be able to give the child some continuity and be a consistent advocate for the child. Some specific points include:

1. Prevention of abuse during contact visits. Natural parents abused 24% of children in the present study on contact visits. The need for skilled, vigorous, and disciplined supervision of all contact especially where there is a history of sexual abuse within the family should be appreciated. Abuse can be perpetrated in many subtle ways. Parents have been known to abuse children on visits to the toilets and while sitting them on their knees. The children are frequently encouraged to remain silent.
2. Careful pediatric follow up of all children in care is essential. Few children receive the formal health care checks they should receive (Butler & Payne, 1997). Health assessment is generally haphazard and medical services are sought largely in response to illness (Utting, 1991). The present study supported these findings with few children presenting with abuse through formal health checks.

   Theoretically a range of concerns would be considered at each regular pediatric assessment or by early referral because of new problems. The content, quality and frequency of these appointments requires local audit (Butler & Payne, 1997) to ensure not only that they do take place but that are competently carried out with attention to:

   - Child's health and well being. Listening to the child is important
   - Child's growth
   - Review of health problem associated with previous abuse, such as sexually transmitted disease
   - Review of behavioral/developmental difficulty
   - Recognition of re-abuse
   - Support to parents, foster-parents and discussion with social worker.

   Unexplained changes in growth or behavior, injuries including burns, and bruises should be noted and histories sought. A large number of the cases in this study arose from observed behavior changes and injuries or a disclosure to the social worker highlighting the importance of careful follow-up and continued support for foster children previously abused.

3. Child Protection Register: Not all children who have been placed in care following abuse at home will remain on the Child Protection Register and health workers need to be aware of this. Placement in care certainly does not guarantee safety and freedom from maltreatment as the present study indicates but rather the evidence suggests that children in care are at increased risk of further maltreatment relative to children not in care.
4. Support for Carers: The present study highlighted some of the important issues surrounding the often-difficult behavior of abused children and the difficulties faced by carers. The finding that

foster parents were more likely to engage in physical abuse supports the view that maltreatment may often be triggered by difficult child behavior, and the carer may view the physical assault as "reasonable chastisement." Behaviors such as wetting and soiling, commonly seen with abused children, have been found to precipitate foster parent maltreatment (Ryan & McFadden, 1986). Other behaviors which carers can find difficult to cope with and which may provoke physical abuse include aggressive and sexualized behavior. Clearly there are major issues for the training of foster carers (Sanders & McAllen, 1995).

5. Extra provision for children who have been victims of CSA and have become sexualized and/or become abusers. There is a high incidence of sexual abuse involving other children as perpetrators. This highlights the problems of re-integrating sexually abused children into normal environments when their behavior has become sexualized and maladjusted. Again there are implications for placing sexually abused children together and a need to consider the effect that abused children may have on other children within the foster family or children's home. Children were perpetrators in a total of 20% of incidents and predominantly the abuse was sexual. A very high proportion of abuse taking place in children's homes involved child perpetrators and was sexual in nature. This clearly has implications for placing vulnerable abused or neglected children together in the same home.

The present study recognized that children who have been the victims of sexual abuse may also become perpetrators of abuse toward other children. It is essential that the potential for this transition from victim to perpetrator is recognized and all steps taken to prevent it. Professionals must be vigilant to the development of signs of abusive behavior of children in care.

There is a general shortage of treatment for sexually abused children in the UK and probably elsewhere. Frank (1980) reported that trained social workers rated only 2/227 children as having received adequate treatment for their psychological problems during 5 years in foster care and Swire and Kavaler (1978) found that only 25% of 334 children in foster care with psychological problems had received therapeutic help. More recently in Leeds, Frothingham (1993) found that only 1/3 of all children who had been sexually abused had received assessment or treatment by a mental health professional. There is an urgent need for more therapeutic help.

6. Better Planning. Difficulties in planning for individual children have been highlighted elsewhere. Laming (Social Services Inspectorate—Department of Health, 1996, Inspection of Local Authority Fostering, 1995–1996), who wrote to Social Services following the report of the inspection of the local authority fostering services said: "The report shows some very good work undertaken by social workers and foster parents and there were some impressive examples of care plans and effective partnerships with parents. Contact with schools was generally good. However there were also significant concerns including many areas where minimum statutory regulations were not being met." Areas highlighted were:
   - Lack of information regarding the characteristics of children to assist planning insufficient range of placements available.
   - Significant numbers of children were not assessed comprehensively and had no individual care plans and reviews.
   - Supervision of children did not always meet statutory requirements.

7. Investigation of allegations of abuse within the care system. Although there are clear procedures, findings suggest some difficulties:
   - Only eight Child Protection Conferences took place.
   - Criminal proceedings taken in only one case (the single death).
   - Focus of investigation was primarily within the Social Services Department.
   - Families found where more than one incident took place.
   - Recent recommendations for local authorities include (Utting, 1997):

* Audit of long term foster carers
* Maintain records of allegations of abuse
* Policy on when children should be removed from the foster carers register
* Inform the Department of Health Consultancy Index (exchange of information between local authorities).

CONCLUSION

Children in foster and residential care are more likely to be assessed for physical or sexual abuse by a pediatrician than are children in the general population. The abuse may be very serious. Although more children are likely to be recognized as abused in foster and residential care there are good reasons to believe that these children are at a real risk of increased harm. This is a situation that is obviously of concern and points to the need for a comprehensive evaluation of the foster and residential care system with a view to meeting more adequately the needs of children and carers. Eighty percent of children in this survey had been abused before entering into care. Foster parents and supporting professionals should anticipate that the child is likely to have ongoing, often complex needs that are difficult to meet and may be very disruptive to the carers and other children in the household. Over half the children had persistent and significant behavioral or emotional problems and a quarter significant learning problems. The harm which children have suffered at home may be compounded by abuse in care, large numbers of placements and the "drift" of the most difficult children eventually into children's homes where the mean age is higher.

Finally, a system needs to be in place to record incidents of concern regarding a particular foster family. This is especially important where more than one local authority, different agencies or different offices or departments within an agency in a large town or city are involved. Case conferences should be held not only in cases where adults are thought to have abused but also in the case of a child who is the abuser.

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RÉSUMÉ

Objectif: Comment prodiguer de bons soins aux enfants qui sont placés à l'extérieur de leur foyer est un sujet de grande discussion au Royaume-Uni. Les interenants se rendent compte que les enfants en foyer d'accueil et dans les institutions sont souvent maltraités. Cette recherche porte sur les caractéristiques des mauvais traitements physiques et sexuels d'enfants en foyer d'accueil et en institution dans une ville anglaise. Les cas de mauvais traitements parmi ce groupe d'enfants, lesquels ont été signalés par des pédiatres, ont été comparés à des cas signalés par ces mêmes pédiatres dans l'ensemble de la population de la ville de Leeds.
Méthode: Ceci est une étude rétrospective comptant 158 enfants dans des foyers d'accueil ou dans des institutions, qui ont été victimes de 191 épisodes de présumés mauvais traitements physiques et/ou sexuels, échelonnés sur une période de 6 ans depuis 1990 à 1995 dans la ville de Leeds en Angleterre. On a étudié divers facteurs y compris les raisons pour lesquelles l'enfant fut placé, sa santé physique et mentale, les caractéristiques des mauvais traitements, l'agresseur et la gestion du cas.
Résultats (voir le tableau no. 1):

- 158 incidents de mauvais traiatements affectant 133 enfants en foyer d'accueil ou en institution; en foyer d'accueil, 42 enfants ont été maltraités physiquement, 76 ont été maltraités physiquement, 76 ont été victimes d'agressions sexuelles et 15 ont connu les deux types de mauvais traitements; en institution, 12 enfants furent abusés physiquement, 6 furent abusés sexuellement et 6 ont été victimes des deux types de mauvais traitements; en foyer d'accueil, dans 60 p.c. des cas d'abus sexuels, les filles en furent les victimes tandis que 60 p.c. des cas d'abus physiques furent perpétrés envers les garçons; en institution, deux fois plus de garçons que de filles ont été maltraités; les familles d'accueil étaient responsables de 41 p.c. des mauvais traitements alors que les parents biologiques ont été les agresseurs dans 23% des cas et les enfants ont eux-mêmes agressé leurs pairs dans 20 p.c. des cas; une proportion importante de mauvais traitements fut considérés graves: on a constaté un décès, 7 enfants qui ont subi des brûlures, 18 enfants qui ont été victimes de pénétration génitale et 23 p.c. de pénétration anale; on a noté un grand nombre de difficultés émotionnelles, d'apprentissage et de comportement. La plupart des enfants (80 p.c.) Avaient déjà été vicimes de mauvais traitements avant d'arriver en foyer d'accueil ou en institution; les enfants des foyers d'accueil étaient 7 à 8 fois plus aptes à être jugés victimes de mauvais traitements par le pédiatre que les enfants de la population générale; pour ce qui est des enfants en institution, le taux était de 6 fois plus élevé.

Conclusions: Les enfants vivant en foyer d'accueil ou en institution song un groupe à risque et leurs besoins spéciaux justifient la nécessité de prendre des mesures additionnelles pour les protéger.

RESUMEN

Objetivo: Recientemente se ha debatido mucho en Inglaterra sobre cómo ofrecerle un buen cuidado a los niños colocados fuera de su hogar. Los profesionales se han dado cuenta de que el nivel de abuso a los niños es muy alto. Esta investigación examina las características del abuso físico y sexual en niños de cuidado sustituto e internamiento en una ciudad de Inglaterra. El número de casos de abuso reportado por pediatras en este grupo fue comparado con el número reportado por los mismos pediatras en toda la población de Leeds.
Método: Este es un estudio retrospectivo de 158 niños, de cuidado sustituto o residencial, quienes estuvieron envueltos en

191 episodios de alegatos de abuso físico y/o sexual evaluados y reportados por pediatras en un período de 6 años del 1990 al 1995 en Leeds, Inglaterra. Se esutdiaron los detalles de los niños que incluyen la razón de estar en cuidado sustituto, su salud física y mental, características del abuso, incluyendo el perpetrador y el manejo del caso.

Resultados: (vea Tabla 1) Se describen 158 incidentes de abuso en 133 niños en cuidado sustituto/residencial. En cuidado sustituto, 42 niños fueron físicamente abusados, 76 fueron abusados sexualmente, y 15 sufrieron ambas formas de abuso. En cuidado residencial, 12 niños fueron físicamente abusados, 6 fueron sexualmente abusados y 6 sufrieron amas formas de aabuso. En cuidado sustituto 60% del abuso sexual incluía a los varones. En cuidado residencial, casi el doble de los varones que de las hembras fueron reportados como abusados. Los cuidadores sustitutos le infligieron el abuso a 41%, los padres naturales en contacto al 23% y los niños el 20% de los incidentes. Una proporción significativa del abuso fue severa con 1 muerte, 7 niños con quemaduras, 18 con penetración genital y 34 con penetración anal. Ordinariamente se presentaban dificultades permanentes emocionales, conductuales y de aprendizaje. Muchos niños (80%) habían sido abusados antes de entrar en cuidado sustituto. Los niños en cuidado sustituto eran 7–8 veces y los de cuidado residencial 6 veces más propensos a ser evaluados por un pediatra por abuso que un niño en la población general.

Conclusión: Los niños en cuidado sustituto o residencial forman un grupo de riesgo para el maltrato. Sus necesidades especiales incluyen medidas adicionales para protegerlos del abuso.