

# Developing an effective response to neglect and emotional harm to children.

Ruth Gardner

University of East Anglia  
and  
The National Society for the Prevention of Cruelty to Children

January 2008



*“All children and young people everywhere, whatever their background or circumstances, need a childhood that they can enjoy and which allows them to thrive and develop their full potential”. Cabinet Office (2007)*

© 2008

***Ruth Gardner, Senior Research Fellow***

***Centre for Research on the Child and Family,  
School of Social Work and Psychosocial Sciences,  
Elizabeth Fry Building, University of East Anglia, Norwich NR4 7TJ  
<http://www.uea.ac.uk/swk/>***

***And***

***National Society for the Prevention of Cruelty to Children (NSPCC),  
Weston House, 42 Curtain Road, London EC2A 3NH  
<http://www.nspcc.org.uk>***

***Available online at: <http://www.nspcc.org.uk/inform/>***

***No part of this publication may be reproduced without the prior written permission of the author.***

## **CONTENTS**

	page
1. Executive summary	3 - 10
2. Methodology	11 - 14
3. The context: current debates	15 - 28
4. The context: what we know	29 - 44
5. This study: the important issues	45 - 68
6. What is making a difference?	69 - 88
7. Tackling the issues: the bigger picture	89 - 100
8. Improving joint work	101 - 106
9. Information sources and references	107 - 114
10. Appendices	115 - 123

## **ACKNOWLEDGEMENTS**

This report is based on 100 interviews and a specialist seminar conducted in England.

Thanks are due to the professionals who were interviewed and the specialist seminar delegates and members of Local Safeguarding Children Boards who set up the interviews.

Invaluable support was provided by Professor David Howe, Marian Brandon - Senior Lecturer and Dr Valerie Dagley - Senior Research Associate at UEA, Phillip Noyes - Director of Public Policy and Dr Jeff Mesie - Head of Evaluation at the NSPCC.

Expert help was given by Ms Sue King, Ms Katherine Roberts, Ms Kelly Myhill and Ms Julia Warner at UEA and Ms Lee Barmby, Dr Fiona Colquhoun, Ms Carol Curtis and Ms Sue Woolmore at the NSPCC.

## **DEDICATION**

To Helen Gardner.



# 1. EXECUTIVE SUMMARY

## **A vision for tackling child neglect**

The findings reported here challenge the “failure in the mind” that is one response to the neglect of children; the attitude that no action will make any difference. Other responses to neglect were familiar to the professionals (one hundred, across all the main disciplines involved) who were interviewed. These responses included anger, avoidance, fear, blame, disagreement and denial. Some thought that they mirrored the feelings of many parents and the powerless state they often felt themselves to be in.

On the other hand there were also many examples of families, community members and professionals who overcame huge practical problems, engaged others to help and reinforced parental responsibility. Innovative and supportive resources were delivered. Occasionally the child could not remain with the family but, with the right support, the great majority were able to do so safely.

The report outlines what we believe is a strong and urgent case for a national strategy for child neglect that better reflects the holistic policy framework of Every Child Matters. Evidence-based strategies and international comparisons are discussed.

Analysis of the literature and interviews with professionals made it clear that this is one area where the scale and nature of the problem require a systemic and systematic response. Neglect makes up half of all child protection registrations (cases requiring a multi-agency protection plan); up to three quarters in some areas when joint categories of registration are included. A high proportion of children who are looked after have suffered neglect. All professions agreed that thresholds are so high that these figures represent the extreme tip of a much bigger phenomenon. Community based workers such as head teachers, school nurses and health visitors in some areas described up to eighty per cent of children they saw as showing signs of neglect.

Above all the response to neglect needs to be active and pre-emptive. Child neglect is always a sign of serious underlying problems that must be addressed if children are to be safeguarded. To be systemic it needs to be equipped to deal preventively with early signs of child neglect as well as ready to step in if a child’s health and welfare are endangered. It also needs to be multi-layered (reaching from families to government) and multi-agency (from all those working directly with children, to all agencies whose work affects outcomes for those children).

On all these fronts the response has to be focused on improving outcomes for children at risk of and suffering neglect of whatever kind. It has to be a major and continuing element of policy and practice in safeguarding children and in helping families overcome difficulty.

There should be no conflict between policy for children and for families, or between safeguarding and support, because at every level the principles are the same; honesty and openness in work with families, which may include many challenges, to ensure children's safety and best prospects.

A national strategy means, among other things, a review of the law and professional guidance on child neglect; working agreements or protocols between all the services (including adult services) that need to co-operate to deal with neglect effectively; raising community awareness through schools, primary health care, leisure and emergency services; high quality, rolling programmes of education and training for children, parents and carers, para-professionals and professionals to enable them to identify and respond to neglect more assertively. All this, plus active roll-out of the approaches known to work, will mean real investment.

The alternative is acceptance of the massive yet largely avoidable human and economic cost of developmental difficulties in children, who as a result of neglect, are unable to achieve their potential in terms of happiness, health, education and social functioning, quite apart from the costs to family life. In the worst case scenarios this means instances of child death or serious injury illustrated in press reports and Serious Case Reviews. The evidence shows that a high proportion of serious incidents are preceded by signs of child neglect.

Based on research, best practice and professional experience, this report seeks to show that many costs could be avoided by a radical re-think of how we use resources collectively. This has already been initiated with the debate on integration of services at various levels (e.g. DfES, 2005). Government's continued drive to push service boundaries nearer to families still losing out on them (Cabinet Office, 2007) is very relevant here. Many families feel that they are themselves neglected and left to cope without effective support. The same is true of front-line professionals, many of whom said that, with exceptions, they lack the level of training and continuous skills improvement necessary to the enormous challenge of this work. Exceptional cases of good practice and service or policy development are described here or in referenced articles and web-sites.

The following diagram, reproduced from the Every Child Matters web-site [www.ecm.gov.uk](http://www.ecm.gov.uk), shows the various service levels that should be actively engaged to achieve the best possible outcomes for children suffering from neglect and emotional harm. The project report makes the case that this is an absolute necessity in reversing the problem of child neglect and associated emotional harm.



## **The Project**

The project is a collaborative venture between the University of East Anglia, the National Society for the Prevention of Cruelty to Children, and Local Safeguarding Children Boards (termed LSCBs in this report) in England.

Within a limited time frame (2006 to 2007) we set out to:

- *Profile* current challenges and achievements in work with children and families where neglect and associated emotional harm are issues
- *Review* recent research and theory-based practice development
- *Provide* concrete examples of improvements to joint practice, and if resources permit
- *Develop* an all-agency strategy for addressing neglect in the short, medium and long terms with one or more LSCBs.

The first three of these aims are reported on here. Development work is currently being planned.

The methodology is detailed in the next section (p11). It included interviews across England, a national seminar and a focussed literature review. The project was linked to two other studies, one to develop a Public Service Agreement on safeguarding children for the UK Government (Mesie et al, 2007) and the second, an analysis of Serious Case Reviews 2003 to 2005 (Brandon et al, 2007).

### **The effects of neglect: emotional harm**

This report is based on a number of premises concerning neglect and emotional harm, drawn from the robust research findings referred to in Section 4 (p29). Neglect of a child can take a variety of forms (see p15). Emotional harm is linked with neglect throughout the report. It is one possible outcome of all forms of maltreatment, and we draw attention to the strength of current evidence that all forms of neglect are particularly associated with damage to children's emotional competence - their sense of identity, their self-esteem and confidence with others, in ways that compromise *all* of the Every Child Matters outcomes. Signs of such damage emerge from the pre-school years onwards and can endure into adulthood. Successful substitute care becomes increasingly hard to achieve (see p37, quote p47). This can happen whatever form neglect takes, and whether it is intentional or otherwise.

## **Neglect and other forms of maltreatment**

Emotional abuse is treated in this paper as a separate form of maltreatment often with implications of intended harm (see p15). It can co-exist with emotional and psychological neglect, particularly in the form of emotional unavailability, indifference or coldness.

The overlap between neglect and many other forms of maltreatment to children is one of the many challenges the report identifies. For example, over-discipline of a child by one parent may mask neglect by another, and adults' problems often have a similar effect of making the child invisible. Neglect is associated with future maltreatment (p24) and the most serious and life-threatening abuse is often found to follow a history of increasing neglect (see p25). It is therefore vital to achieve consistency across agencies in the understanding and use of definitions by the various professionals involved, and in how these are applied to thresholds for action. Agencies should not revise their definitions and thresholds without full consultation, which may itself clarify issues of joint working.

Otherwise the debate ("is this neglect?") has to be repeated at length case by case, delaying the response to a child's or a family's needs. Professionals were unanimous in feeling that best practice should mean a sensitive but prompt and pre-emptive response to early signs of child neglect (i.e. if in doubt, respond), rather than the current prevalent "wait and see" approach, which was at best potentially damaging and at worst dangerous. The report describes tools that assist multi professional groups in achieving a more rapid joint assessment of neglect. It pulls out salient features of neglect identified in the study and proposes action points.

## **KEY FINDINGS**

The statements that follow (which refer to England unless otherwise stated) have a firm evidence base set out in the subsequent sections of the report.

Neglect is a major form of maltreatment that has not yet been effectively addressed.

All forms of neglect (physical, emotional, environmental) are associated with measurable developmental damage, including to the child's emotional and social functioning. This can emerge at the pre-school stage and endure into adulthood.

Without effective intervention, neglect can lead to active victimisation of the child both within and outside the family. In some cases this results in multiple abuse and death through attrition, murder or the child's suicide.

Neglect is multi-faceted and demands a systematic response from government through to the front line. This should include:

- agreed information-sharing and recording of concerns about child neglect
- greater precision in legal and procedural terms and thresholds
- each LSCB having an inclusive strategy for addressing neglect, including a crisis response
- good quality information for children, parents and concerned others, with identified contact points
- universal and targeted provision for children and parents (separately and together) that addresses specific components of neglect
- located responsibility for achieving best practice on child neglect, in all relevant services - including emergency, community and adult services
- staff development and training plans that address staff security, health and safety, knowledge base, supervision, audit and case work etc
- assessment and risk analysis specific to child neglect, linking identified problems to relevant services.

The challenges that face all safeguarding endeavour can become insurmountable in work with neglect. They include:

- loss of momentum and follow through of plans
- difficulty joining up adult and children's services
- desensitisation and demoralisation of practitioners
- failure to track referrals
- concern about blame where the parent is not intentionally abusive
- difficulty with legal thresholds
- lack of training and reflective practice.

Neglect and emotional harm are some of the most highly stressful and demanding areas of work for individuals and groups of professionals. Interviewees from all disciplines and levels of experience recommended the following as essential to effective work in this area as well as preventing burn-out:

- leadership and support in sound planning and review of cases
- regular research and best practice updates
- single and joint agency training
- off-line consultation and reflection opportunities
- updates on best practice in neglect
- regular case audit.

There is heightened interest in learning about neglect and applying this knowledge to joint safeguarding practice. Both central government and local safeguarding children boards (LSCBs) are seeking ways of improving early intervention and treatment to prevent recurrence of neglect.

The report details approaches that have been evaluated and are being used to address neglect and emotional harm earlier and/or more effectively. Positive messages are that:

- *The Every Child Matters framework is particularly useful to generate multi agency strategy in this area, because neglect has harmful effects in many areas of child development.*
- *Addressing neglect of children more energetically pays off for some LSCBs. Specific approaches e.g. a focus on best practice and on improving staff skills and safety levels are detailed in the report.*
- *There are instances of helpful typologies and checklists for neglect which, in specifying the harmful outcomes of various kinds of neglect, assist in designing appropriate interventions, as well as meeting the legal challenge more effectively.*
- *The concept of parental responsibility and its components (i.e. to provide children with safety and security, emotional and physical care, promote attainment etc) provides an asset rather than a deficit model for tackling neglect. It has the added advantage of including all those with a caring responsibility for the child.*

The depth and range of challenges that parents are struggling with are better understood, as well as the ways in which these interact. Interventions are being developed for some of these, but knowledge is often confined to specialists. Families can end up surrounded by professionals who are unaware of one another's roles. The issues for families can include:

- history of abuse and neglect
- history of negative associations with professional intervention (or its lack).
- multiple births
- multiple losses
- multiple moves
- hardship and long-term unemployment
- no/patchy/unsafe support network.
- mental ill-health
- personality disorder
- drug and alcohol misuse
- associated crime and violence
- domestic violence.
- learning difficulties
- chronic ill health
- child or children with disabilities, or/and ill-health.

The report discusses some of these topics in greater depth.

*Specialist services addressing the above issues must therefore be better linked to children's services, in order to contribute more effectively to the prevention and treatment of child neglect. Protocols, outreach, advice and crisis services, consultancy, assessment panels, and training events are examples of ways of doing this.*

- *Tools are being designed or adapted for specific use in neglect cases. They include The Common Assessment Framework and various planning tools detailed in the full report.*
- *Services going in to families need to be organised and managed to achieve specific, agreed outcomes that include consistent promotion of the child's development and welfare.*
- *There is evidence of good outcomes for early, structured and intensive intervention with child neglect. Families benefit from contact and access to advice after active work has concluded. Updated information should continue to be recorded across the relevant agencies to ensure a timely response in future if necessary.*

## 2. METHODOLOGY

This section describes how the project was undertaken.

A short literature review was completed. This looked at:

- research that shows a major influence on thinking in this area
- studies over approximately the last decade that demonstrate advances in methodology, knowledge and/or practice in this area
- serious cases and other reviews of practice in this area and local, national and international government material specifically relevant to this area. This included sources in the UK, Scandinavia, the USA, Canada, and Australia.
- in this report we cover studies that relate to the issues raised in the interviews.

The project aims were sent to LSCBs across England. Over twenty LSCBs made enquiries and twelve expressed interest in becoming study sites. The project manager visited these LSCBs. Interviews were set up with senior practitioners and managers in a variety of disciplines (see below for details). A semi-structured questionnaire was used. One hundred individuals were identified by LSCBs and interviewed, of whom 19 were seen in groups. One hundred completed questionnaires, plus notes of all individual and group discussions were transcribed and analysed using nVivo, an analysis software package.

A national seminar was held in 2007 with 15 LSCB representatives and 12 acknowledged experts in this area. Structured small group discussions were recorded and transcribed and included in the NVivo analysis, some 120,000 words in all.

Separately and independently of the researcher the data analyst at UEA identified major themes in the various discourses, set out below.

### **The interviews**

No identifying case data such as names, addresses or dates of birth were collected and any illustrative examples given in the quotations have been further anonymised.

Of the interviews with this data, approximately 80% of respondents were female. The majority of male interviewees were managers in social care or police officers.

Of the interviews with this data, the average number of years qualified was 18 years and the range was from 2 years to 33 years. Police officers have limited tenure of 3 years (exceptionally, renewed) in Child Abuse Investigation Teams.

## **The questionnaire**

The majority of the respondents (N=100) were interviewed using a short questionnaire (which is appended p117) to structure the discussion. This covered their understanding of neglect and emotional harm; the scale of the problems with any examples; what helped or hindered a successful resolution, and specific tools or training in the field of neglect and emotional harm. There was an open question to elicit other observations and comments.

Respondents answered the questions without prompts and follow-on questions were then asked as appropriate. A minority (N=19) were seen in groups because of time constraints. They completed the questionnaire separately to one another. Each question was briefly revisited in a group discussion. Notes were taken throughout which were subsequently transcribed.

## **Seminar discussion groups**

A national seminar was held in London in March 2007, attended by representatives from six Local Children's Safeguarding Boards, and twelve experts in this area. The latter included senior academics in social work, public health, nursing and midwifery; all of whom had researched and/or published in this area; consultants working with service providers in mental health and safeguarding children; a Detective Superintendent of Police, consultant child psychiatrists and paediatricians.

The programme for the day is appended (p115). The six small group discussions were recorded and transcribed, then analysed alongside the interviews for common themes.

## **Analysis**

All of the transcripts were entered into an analysis software package (NVivo). This allowed the responses to particular questions to be collated and compared. In addition each transcript was read and coded according to the content it contained. For example when respondents were answering question 6, which asked for examples of cases they had met, several of them mentioned parental use of drugs or alcohol and so "addiction" became a code. New codes were added as more transcripts were read and following discussions within the research team. Eventually 13 codes were grouped under the heading "family", 8 under "children" and 4 under "professionals", with one extra code covering comments about the "complexity" of EHN. Overall 1,753 passages of text were coded.

Further analysis of responses to questions included entering some of the data into Excel spread sheets for counting, for example how many times certain terms were used when respondents were defining neglect and emotional harm.

These were then grouped into common themes and quotes were selected that represented the most typical views and also the more unusual ones. Responses to other questions were entered into tables to allow comparisons or sorted into categories and lists. Some of the data was presented visually in diagrams. Interim analysis of the early data took place in April 2007. This was discussed by the researchers and then further reiterations took place between April and September as more data was received and more discussions and thinking took place.

### Professions interviewed

The table below gives a broad idea of the professional setting in which the interviewees worked. Of the 100 respondents, 53% were from Children's social care, 15% education, 9% police, 16% health and 7% other.

Area	Children's social care	Education	Police	Health	Other (voluntary, community, legal)	Total
A (city W)	3	3		4		10
B (city M)	12	3	3	4		22
D-Indnboro'		5				5
H-Indnboro'	3	1	2	2		8
Shire	4	1		3		8
S (Nmet)	3			1	5	9
T-Indnboro'	28	2	4	2	2	38
<b>Total</b>	<b>53</b>	<b>15</b>	<b>9</b>	<b>16</b>	<b>7</b>	<b>100</b>

The professional categories shown in the table are broad. Many professionals had a background in one or more different public services, and a few in the private and voluntary sectors. They held a range of positions from front-line to senior strategic management. In other words, the study drew on both breadth and depth of experience across services for children.

Children's social care professionals included one or more; social work team managers, LSCB managers, integrated partnership managers for children with disabilities, senior practitioners on the duty and assessment team, quality assurance officers, family support practitioners, Family Group Conference organisers, community resource officers, independent reviewing officers, (GAL) Guardians Ad Litem, (YOT) Youth Offending Team staff. Thirteen of the children's social care professionals were members of a multi-disciplinary disability team.

Health professionals included; health visitors, child psychiatrists, school nurses, general practitioners, paediatricians, midwives, child and adolescent mental health service (CAMHS) staff, community psychiatric nurses.

Educational professionals included teachers, head-teachers, welfare liaison officers, educational psychologists, school counsellors, members of a Behaviour and Education Support Team (BEST), Connexions staff.

Police included police and detective constables, sergeants, and administration officers for Child Abuse Investigation Teams (CAIT).

Other respondents included volunteers in child protection and Sure Start, solicitor, a probation officer and social workers with adults (for example in substance misuse, mental health, domestic violence etc).

Professional histories included a social worker who had been a teacher, a school nurse who had been a midwife, a quality assurance officer with a background in social work and industry, a reviewing officer who had been a health visitor and a school nurse, and a health visitor working for Sure Start. One youth offending worker had previously worked in social care, hairdressing, sales and also as a district nurse and counsellor.

## **Summary**

The project was designed to review current knowledge and expertise in work with children who are or may be neglected and their families. The intention was to highlight important issues and advances in dealing with neglect.

The primary source of data was questionnaires and interviews with a hundred experienced professionals across relevant agencies. Other sources were discussion groups with senior professionals and experts researching and writing in this area, and an international literature review of recent research and best practice. The interviews and discussion groups were transcribed and independently analysed for recurrent or illustrative material. No data that identified families was provided.

### 3. THE CONTEXT: CURRENT DEBATES

This section sets the scene for the detailed project findings. It outlines some of the debates currently underway in the field of neglect and emotional harm, each of which is cross-referenced to later sections. These debates have been conducted in the popular media, in professional journals and in academic literature. They were reflected in the hundred interviews and the specialist seminar.

#### **How neglect is identified and addressed**

The UK government provides guidance for child protection specialists (Working Together, 2006). Here, the definition of neglect is as follows:

*Neglect is the persistent failure to meet a child's basic physical and/or psychological needs likely to result in serious impairment of the child's health and development.*

*It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of or unresponsiveness to a child's basic emotional needs.*

The most common use of the term “emotional harm” is as one possible outcome of any form of maltreatment including neglect. The evidence for the emotionally harmful effects of neglect is covered elsewhere (see p37 onwards).

Emotional abuse is generally seen as a distinct form of maltreatment with its own literature. However, there is overlap between many forms of child maltreatment and this is especially true of neglect. The official definition of emotional abuse implies long-standing neglect of a child's emotional and psychological needs:

*the persistent emotional maltreatment of a child, such as to cause severe and persistent effects on the child's emotional development.*

*It may involve conveying to children that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying, causing children to frequently feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child though it may occur alone. (Working Together, 2006).*

Iwaniec (2006) describes emotional abuse as distinct from, but overlapping substantially with forms of neglect. This is because both *are shown in the nature and quality of the relationship between the emotionally abused child and its abusive parent or carer.*

There is cumulative evidence that a poor early affective bond between parent and child is a key element in determining whether other factors, such as stress, lead to active neglect, dislike and/or abuse of that child (Howe, 2006).

Iwaniec quotes a definition from the American Professional Society on the Abuse of Children (APSAC). This includes our traditional understanding of “neglect” within the term “psychological maltreatment”:

*Psychological maltreatment means a repeated pattern of care-giver behaviour or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs. It includes spurning; terrorising; isolating; exploiting/corrupting; denying emotional responsiveness; and mental health, medical and educational neglect (APSAC, 1995).*

There are several advantages to this approach. Firstly, there is an emphasis on the *type and patterns* of behaviour towards the child, rather than simply its persistence over time - and this is the correct view, according to the majority of our interviewees (see p38 and p63). Secondly, emotional abuse is broken down into succinct categories which link clearly with neglect. Illustrations of the categories are separate from the definition. Thirdly, the very term “psychological” suggests that many of adverse effects on the child are observable and measurable, which is increasingly the case (see Section 4, p29 onwards). Finally, it acknowledges the deep significance of psycho-developmental neglect that gives rise to a wide range of symptoms.

In the UK, Glaser and Prior (2002) have adapted the above classification of emotional abuse, with neglect as a major component:

- emotional unavailability, unresponsiveness and neglect
- negative mis/attributions to the child
- developmentally inappropriate or inconsistent interactions with the child
- failure to recognise or acknowledge the child's individuality or psychological boundaries
- failure to promote the child's social adaptation.

The official definitions in Working Together suggest that neglect and emotional abuse are characteristically chronic, “persistent” conditions. This implied to many of our interviewees that in terms of a formal threshold for intervention, and short of a potentially criminal incident, neglect does not constitute significant harm unless and until it endures over time.

The existence of a separate crime of neglect (Children and Young Persons Act 1933, S.1) seemed to make it harder in some cases to satisfy a court of evidence to meet the non-criminal threshold for neglectful maltreatment under the Children Act 1989.

Section one of the CYPA 1933 is entitled *Prevention of Cruelty and Exposure to Moral and Physical Danger* and includes the crime of neglect:

*Section 1.(1)*

*If any person who has attained the age of sixteen years and has the custody, charge or care of any child or young person under that age, wilfully assaults, ill-treats, neglects, abandons, or exposed him, or causes or procures him to be assaulted, ill-treated, neglected, abandoned, or exposed, in a manner likely to cause him unnecessary suffering or injury to health...that person shall be guilty of a misdemeanour, and shall be liable...*

The Act then details aspects of physical neglect, including a carer's failure to seek support or overlying a child while drunk:

*Section 1.(2) For the purposes of this section -*

*(a) a parent or other person legally liable to maintain a child or young person shall be deemed to have neglected him in a manner likely to cause injury to his health if he has failed to provide adequate food, clothing, medical aid or lodging for him or ...has failed to take steps to procure it to be provided under the Acts relating to the relief of the poor*

*(b) where it is proved that the death of an infant under three years of age was caused by suffocation (not being suffocation caused by disease or the presence of any foreign body in the throat or air passages of the infant) while the infant was in bed with some other person who has attained the age of sixteen years, that other person shall, if he was, when he went to bed, under the influence of drink, be deemed to have neglected the infant in a manner likely to cause injury to its health.*

It is of interest that the Act takes account of preventive action that diminishes the impact of neglect. Legal and social care practitioners still express concern about such action "diluting the evidence":

*Section 1.(3) A person may be convicted of an offence under this section –*

*(a) not withstanding that actual suffering or injury to health, or the likelihood of actual suffering or injury to health, was obviated by the action of another person*

*(c) not withstanding the death of the child or young person.*

Practitioners spent much time and energy on the question:

*What degree of failure of care does this child need to undergo, for how long, before there is a mandate for intervention?*

For some of them this meant permanent anxiety because monitoring could not be continuous. Inconsistent care was hard to track and recurring failures might escalate to endanger a child's health and welfare.

### **Neglect and significant harm**

In addition to Working Together, government has provided a guide to safeguarding children for the non-specialist or interested lay-person that explains key terms such as "significant harm" (*What to do if you're worried about a child* (2006) DfES).

Significant harm is a key (though again, less than clear) concept in child safeguarding in England. It constitutes the legal threshold for a court's approval of compulsory intervention to protect a child. Harm is defined as follows:

*"Harm means ill-treatment or impairment of health or development*

*"Development" means physical, intellectual, emotional, social or behavioural development*

*"Health" means physical or mental health*

*"Ill-treatment" includes sexual abuse, and forms of ill-treatment which are not physical. (Children Act 1989, S.31).*

The Adoption Act 2002 amended the Children Act 1989 to apply the term "significant harm" to "impairment from seeing or hearing the ill-treatment of another".

However, "significant" is not defined within the Act. The 2006 guide states that:

*there are no absolute criteria on which to rely when judging what constitutes significant harm. Some children live in families where their health and development are neglected. For them, it is the corrosiveness of **long-term** emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm (emphasis inserted) (DfES, 2006).*

The reader could reasonably conclude that neglect *only* meets the significant harm threshold when it is prolonged, and more worryingly that children who are neglected have to undergo "corrosive" abuse before formal intervention can take place. Many of the professionals we interviewed thought that these descriptors create problems in convincing the courts that neglect in the form of inconsistent patterns of care can constitute actual or apprehended significant harm.

There is a real difficulty with the two legal provisions dealing with neglect, the Children Act 1989 within child and family law and the Children and Young People's Act 1933 within the criminal law. There was evidence from our interviewees of confusion about when either of these would apply. Some cases fell between the two provisions. Neither the child nor the family received the help they needed.

Even when children showed strong evidence of neglect, a parent's action or inaction did not necessarily meet the criminal threshold, while recurring incidents just below the "significant harm" threshold were often not recorded and considered for their cumulative effect as meriting intervention under the Children Act. There was some concern that expert witnesses could not point to sufficient robust research in the UK to demonstrate that significant harm results from neglect of various kinds. The case might be dropped with neither child nor family receiving help, or the family history put to one side in an effort to "turn a new page".

This issue is explored further in Section 5 (p63 onwards).

While most practitioners knew the official definition of neglect, the interviews and seminar discussions for this study raised many concerns about current definitions and associated procedures relating to neglect and emotional harm. These include:

- dangers inherent in viewing neglect as only a chronic phenomenon and hence waiting for neglect to persist before intervening
- dangers in seeing harm caused unintentionally as less serious and more remediable, when this may not be the case
- lack of specificity in the definitions
- unwillingness on the part of the courts to accept neglect as significant harm without traumatic incidents or evidence of developmental damage over a prolonged period
- lack of emphasis on outcomes for children and how even short term neglect can seriously compromise these
- absence of a positive account of what carers (not only the primary carer) can and should contribute to preventing neglect
- absence of specific joint practices to support a parent's specific caring responsibilities - for instance, play, nutrition, safe sanctions
- resources (staff time etc) lost in debating what constitutes neglect and a threshold for action rather than what the child is experiencing and how to improve that experience.

The recently published HM Government consultation document on safeguarding children (DCFS, 2007) states that:

*we expect a reasonable standard of life for all children and young people and where this is not offered, where a child is going hungry or being left on their own, we more readily recognise the signs and act upon them.*

However, the concerns listed above raise doubts that the response to neglect is actually consistent, prompt and focussed on improving the child's experience.

### **The public debate**

Cases of neglect are frequently reported in the press and it seems that the public response is ambivalent. The public seems to be concerned about emotional harm and neglect - but unsure that they warrant state intervention. There is concern for children but also for parents under stress in a risk-averse culture. Following a child abduction, The Times (May 9, 2007) held an on-line debate about possibly neglectful scenarios. Legal commentary on a scenario relating to children aged under three who were left alone was that:

*leaving children alone in this manner is not desirable but parents have to balance the demands of life and will probably have to consider such issues regularly. A parent needs to ensure that children are safe if they are left alone. Leaving them for a short while, asleep, in a locked room with regular checks is acceptable. Leaving them for two hours or with unlocked doors is not.*

These issues remain contentious:

*The law gives no detail of what amounts to neglect or abandonment. Prosecution and/or conviction depend largely on the circumstances. The punishment can range from a fine to ten years' imprisonment.*

Recent reports illustrate the range of dispensations on incidents that can be described as child neglect. They include a mother fined £2000 for abandoning children aged six and nine on a dual carriageway after an argument in the family car (Metro, June 7, 2007); a verdict of accidental death recorded on a child of four who died in a fire after trying to wake his father "who had been drinking and smoking cannabis. The inquest heard the fire may have been started by (the child) trying to copy the drug practices he had seen many times" (Metro, February 22, 2007); and a verdict of manslaughter by gross negligence on a father whose two year old was killed playing in his scrap yard (Metro, November 21, 2006). The number of such reports suggests that the problem extends far beyond the reach of the formal child protection system.

## Incidence

Children in need are children who have been referred to Children's Social Care services and who receive an initial assessment and if appropriate a further service. This may include temporarily accommodating the child with parental agreement. Data is collected on these children as a separate category to those who require multi agency safeguarding plans and are on child protection registers. Even so, the largest category of children in need is made up of children about whom there are safety concerns.

The most recent data calculate over half a million (552,000) referrals to Children's Social Care in 2005, of whom 385,300 were assessed as children in need. 73,300 children in need were looked after by the local authority under various legal provisions (National Statistics and DfES, 2005).

Previous surveys (DH, 2003) indicate that 35 percent of children in need raised concerns about possible abuse or neglect, rising to 55 percent of children looked after.

Children found to require formal inter-agency protection plans are grouped under categories of child protection concern including neglect. Assuming a similar profile of children in need, there are at any one time an estimated 87,000 children in need (including more than 24,000 looked after in local authority accommodation) about whom neglect is a serious concern. These figures are limited to children already within the social care system.

Children on child protection registers (CPRs) are also referred to as children for whom an inter-agency child protection plans (CPP) is required.

Neglect is the largest single category of harm on child protection registers in England and Wales, rising from 39 percent in 2001/2002, to 44 per cent 2006/2007. (The figures for emotional abuse were 18 per cent in 2001/2002 and 23 per cent in 2007.) Mixed categories and categories not recommended in guidance made up another 10 per cent of registrations in 2007, increasing the likely proportion of neglect to nearer half of all registrations (DfES, 2007). Some LSCB websites show the proportion of registrations of, or including, neglect at 75 per cent.

While overall the numbers of cases requiring inter-agency protection plans has reduced, the proportion of neglect cases has risen. Jones et al (2006) discuss the possible reasons for a relatively striking reduction in identified cases of sexual and physical abuse over the past decade (both in the US and in England), alongside a proportional increase in identified neglect cases. The authors feel justified in attempting to find out more about these trends on the basis that:

*in the absence of plausible interpretations by those with real expert knowledge about child maltreatment, others with only superficial knowledge or ideological agendas may move in to fill the vacuum.*

They speculate that in the US over the past decade, neglect may actually have been in decline alongside physical and sexual abuse, a trend that would be expected given overall child welfare improvements. Improved identification of neglect may mask this trend. The supportive evidence is that some States with relatively more resources show proportionally more cases of neglect.

This analysis does not necessarily translate completely to the UK. Another factor not discussed by Jones et al is the recurrence of a proportion of neglect cases (see p23). More active monitoring of cases may increase the number of re-substantiated reports, making short-term resolution and lowering of incidence rates less likely.

In England the rise in the proportion of emotional abuse may well be due to changes in procedure with domestic violence, involving the referral of many children in these cases for child protection investigation (see p51).

In 2005, 12 per cent of children on registers in England and Wales were looked after children (and of these, half were accommodated with the parents' agreement).

In 2005, 12 per cent of children on CPRs had been re-registered (some more than once) of which nearly a third (30 per cent) had occurred within twelve months of de-registration.

Re-registration means that a multi agency plan was made and implemented, with the result that a decision was taken to remove the child's name from the CPR, but subsequently the child's situation became sufficiently unsafe for a new plan to be required.

Interviewees for this project thought that neglect cases tend to remain registered for longer, and/or that re-registration is more common than with other categories of harm. In their view this indicated the intractability of neglect and our current lack of means to address it effectively. Research suggests that these concerns are not confined to the UK system (see p31).

One of the LSCB managers at the project seminar explained how she had tried to encourage more purposeful planning with cases of neglect in order that they did not return into the system:

*In our area de-registration was closely associated with children suffering from child neglect. We've taken a view now that children who were on the register under the category of neglect will not be de registered after three months, because if a child has reached the threshold to be registered, the evidence indicates that will not be resolved within three months. After a year we are not re-registering as frequently and hopefully those children are safer (LSCB Manager).*

In the U.S., a 300-fold variation in the rate of emotional abuse has been reported (Hamaran et al, 2002). One reason is likely to be the continuing variation in definition and thresholds for referral or recording. In the UK the combination of demography and local practice makes this complex to analyse.

Registration (including for neglect) and re-registration vary hugely by area and indeed by ward. The reasons for this are unclear (see Glaser et al (2001); Gardner (2005)).

In a single deprived ward of one metropolitan area we interviewed in, nearly half (48 per cent) of child protection registrations are re-registrations. Yet the quadrant of the city where this ward is located has fewer re-registrations than elsewhere.

Oliver et al (2001) studied possible reasons for the wide variance in rates of registration in England. They concluded that where lower rates were combined with positive ratings (through audit etc) for safeguarding children, there existed all or some of the following:

- good information that was actively used to learn about the service
- good quality and range of preventive services
- strong work with families
- inter-agency ownership of risk
- strong professional social work ethos and continuity.

These findings, particularly on the *inter-agency ownership of risk* are of particular interest as they strongly echo the account of best practice in neglect that emerged from the interviews.

## **Prevalence**

Research indicates that neglect and emotional abuse, broadly defined, are fairly common. For example, six per cent of young adults recall inadequate care and 18 per cent report humiliation and/or attacks on their self-esteem in childhood, and this is probably an under-estimate (Cawson et al, 2000).

Emotional harm is considered an outcome of all forms of abuse (Aber, quoted in Glaser, 1993; Bentovim op cit); including neglect of a child's emotional needs (Hart et al, cited in Geffner and Rossman, 1998). Horwath quotes Roditti (2005) as arguing that increased substance misuse in parents may contribute to higher (absolute) levels of child neglect .

## **Recurrence**

A large-scale American study (Fluke et al, 1999) is discussed in greater detail elsewhere (see p29 onwards). It indicates strongly that neglect is more likely to be identified repeatedly than other forms of maltreatment, suggesting that, even in relatively well-resourced administrations, a substantial proportion of neglected children are not reached effectively by either preventive services or safeguarding systems.

Hindley et al (2006) undertook a systematic review of 16 American and Australian cohort studies investigating factors associated with substantiated recurrence of maltreatment. Across all but one of these studies they also found that neglect was the type of abuse associated with the highest risk of future maltreatment. The only stronger predictor of future maltreatment was the number of previous substantiated episodes; two studies indicated that previously maltreated children were six times more likely to experience further maltreatment than the controls.

Two other strong indicators of future instances of child maltreatment were parental conflict and mental health problems. Previous research reviews have shown a similar range of factors:

- number of previous substantiated episodes
- neglect
- severe and/or multiple types of abuse
- lack of acknowledgement or co-operation
- young and/or multiple children
- substance misuse
- young and/or step-parents
- isolation.

This list is virtually identical with the common factors in case reviews of deaths and serious injuries (see p42).

While families where children suffer repeated neglect show many of the features described here, these features cannot predict precisely which children will suffer in this way. Many more families showing these features do *not* contain neglected children.

One combination that unlocks this puzzle is the relationship or affective bond between one or more carers and the particular child at any particular time, plus the interaction over time between the stressors described above, and those crucial relationships (see p16, p33). Howe (2005) emphasises the widespread symptoms thrown up by psycho-developmental neglect.

The review quoted above recommends a professional response; stronger joint assessment which includes. but is not limited to factors associated with recurrence, more structured management of risk and improved inter-agency collaboration, all of which are explored further elsewhere (Section 6, p69 onwards).

As noted above (p19) neglect has often been labelled a “chronic” condition as if recurrence is intrinsic to the condition and perhaps inevitable. This study encourages us to look at projects achieving real success with early prevention. There is now much stronger evidence on which to base a structured response to neglect, but this still relies heavily on shared professional observations and judgements. It is therefore crucial to ensure that the evidence and the professional response are continuously updated and speak to one another faster and more effectively than has hitherto been the case.

## The seriousness of neglect

There is evidence that neglect features in a large proportion of cases where children are at greatest risk of serious or fatal harm. Neglect and emotional abuse often interact with long term serious family dysfunction, in ways that prove extremely difficult for professionals to recognise, understand and address effectively, at least prior to crisis and tragedy (Islington ACPC, 1995; Laming, 2003; Sinclair and Bullock 2002; Brandon et al 2002).

This study was related to a concurrent piece of research, the Third Biennial Analysis of Serious Case Reviews 2003 to 2005 (Brandon et al, 2007). These reviews are undertaken locally in accordance with government requirements. Data on them has in recent years been compiled on a national basis, to aid learning and practice development. The third review focussed on a number of sub topics of which one was neglect.

Neglect was a common thread running through many of the accounts of child deaths and serious injuries. It was identified as the primary cause of the serious or fatal incident in a fifth (21 per cent) of the full sample where basic data was available (N=161 cases) and in the same proportion (21 percent) of the intensive sample (N=47 cases where much more information was available).

Additionally a history of neglect preceded the incident in 14 per cent of the full sample of cases where this data was available (N=148) and in nearly one fifth or 19 per cent of the intensive sample (N=47). This data is examined further for specific learning points in the next section (see p40).

Another recent study in the UK reinforces this view. It concerns 93 cases of serious multiple abuse linked to accusations of “possession” and “witchcraft” of which 38 were examined in depth (Stobart, 2006). The children involved belonged to a number of different ethnic and cultural groups and the report draws out common features of their abuse.

Schools were the source of referrals in nearly two-thirds of the cases, and in many instances the earliest concerns were of neglect:

*A significant number came to attention via their teachers who noticed signs of neglect. Some of the children came to school hungry and brought no food with them. Others were unkempt and uncared for - with dirty, unlaundered clothes.*

The problem was that these cases at this stage *did not reach the social care threshold criteria for engagement. Children were left with or returned to carers with no further action.* Neglect escalated (sometimes rapidly) into life-threatening abuse in the cases described in the study, and there was evidence in some of them of professionals avoiding action until this had happened.

Early intervention and preventive services should be able to provide active monitoring of signs of neglect in children and offer contact points and advice for children and carers. Stobart's report recommends community and faith-based organisations trained and supported by child protection specialists. Services-often school-based - that positively value children and allow them a route to express themselves and develop self-esteem are vital in these cases, for example anti-bullying work, mentoring, peer or other forms of counselling. This could be an element of the pre-emptive policy outlined above (p3). Some LSCBs and community based services such as religious centres and schools are rising to this challenge. However, interviewees mentioned that key services, particularly in primary health care, were prey to re-configuration and variations in funding that limited their ability to provide the necessary level of preventive service and monitoring to families in difficulty.

### **Improving joint practice**

The project found great interest in seeking ways to improve joint practice in neglect and emotional harm; when we approached Local Safeguarding Children Boards for interviews, twenty made contact. Managers said they were particularly concerned about neglect, some of the reasons being that:

- more cases of serious neglect are being identified and referred into the child welfare and protection systems
- a Serious Case Review or audit had identified shortfalls in relevant resources and/or practice
- a lack of knowledge and expertise in this area was felt to result in defensive practice
- support and treatment services were under-developed to respond to the needs of neglected children and their families
- staff skills and training (notably key front line professionals) in this area were not specified or supported adequately
- pressure of this type of case leading to low morale, staff sickness and turnover.

In other words the foundations for a robust response to child neglect were thought to be shaky or absent in many areas.

Different types of learning have been drawn on in this report - research and evaluation, development projects and practice wisdom. Section 7 on Tackling the Issues (p86 onwards) outlines an initial "road map" for improved practice.

### **Local and national strategy for keeping children safe from neglect**

Policy developments such as the Common Assessment Framework, Lead Professional and Every Child Matters have provided an incentive for some Local Safeguarding Children Boards to re-think their approach to neglect and emotional harm.

Every Child Matters is the main plank of the government's improvement strategy for all children's services ([www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)), Change for Children, 2004). The Every Child Matters structure is particularly useful in re-framing neglect and emotional harm. In setting broad goals relating to children's education, health, economic and social well-being, it offers a way of de-constructing neglect and emotional harm, which can be shown to compromise children's development in all these domains, into very clear and specific messages for improvement in each and all of these areas. Other jurisdictions have taken this approach and opened the door to constructive planning for improvement, rather than dwelling only on what has not worked to date.

Staff we interviewed wanted a lead from senior managers in this difficult area of work. Only the most senior officers have the authority to bring the key agencies together, to sustain fresh thinking across organisations and to reverse the inertia that can settle around the subject of neglect.

Some Local Safeguarding Children Boards have used their new remit to overhaul policy and practice in this area. Since April 2006, Local Safeguarding Children Boards co-ordinate and monitor member agencies' efforts to safeguard and promote the welfare of children, set policy and procedures, and also establish local screening teams who will analyse the data with the aim of reducing local childhood death or injury (DfES, 2006).

According to recent inspection and inquiry reports, LSCBs will need to develop relationships built on good levels of expertise, confidence and trust in sharing a complex task. They need to engage senior representatives of all key partner agencies to ensure shared strategic leadership. Commitment to safeguarding children and accountability is needed both between and within agencies (senior managers to practitioners) (Chief Inspectors Report 2002, Laming Report 2003).

Prevention of, and safeguarding from, maltreatment need to be on the agenda of professionals working in early intervention as much as for those working at tier three. There is a particular need to recognise the presence of neglect as early as possible.

A frequent comment from experienced practitioners in a number of disciplines (health, social care, education, and police) was that over time their expectations of achieving improvement in this area had lowered. Some said that they had lost the initiative due to sheer overload.

This need not be the case. Evidence and indicators of neglect and emotional harm *can* be detected and acted on early, especially when different agency perspectives are pooled to give a coherent, in-depth picture (Milner 2003; Crittenden 1993, 1997). However, this means all agencies being willing and able to share concerns even when they are less than precise. In one Education Authority the project found a team of advisors on safeguarding to whom concerned Heads and teachers could turn if they were considering referral to social services.

We know from all too many case reviews and enquiries that responding effectively to neglect at all levels demands high-quality communication and collaboration, both within and between agencies.

If LSCBs are to develop relationships between agencies that are robust, clear and shared, they will need to grapple with issues of definition, recognition, aetiology, interpretation, trust and communication (see Cooper et al 2003).

## **Summary**

There is lack of clarity about what constitutes child neglect and in what circumstances intervention is warranted. This is likely to contribute to an unacceptably high threshold for intervention, to uncertainty and delays in preventive action.

Concerns about child neglect are present in a significant proportion of cases of children in need assessed by children's social care departments. In England the overall numbers of children receiving protection plans has reduced but the proportion of neglect cases in this group is increasing, and in a number of areas is the majority of registrations and re-registrations. There is worrying evidence that a proportion of cases of child neglect come back through the system and these children may be suffering repeated, unresolved neglect, and/or other forms of maltreatment.

There is strong evidence that neglect can be the precursor to serious victimisation and, in some cases, life-threatening abuse. The evidence collected for this project suggests that early signs of neglect often fall below thresholds for child protection intervention and are not collated and collected for their cumulative significance. The community-based services that would undertake this work and offer preventive support to children and parents, good links to relevant adult services and monitoring for improved outcomes in children, are extremely patchy. Inter-agency collaboration is not consistent. There was evidence of some successful early intervention that was strongly co-ordinated and followed up. To replicate this requires both national and local strategy on neglect that is endorsed and followed through as a major programme of work, not limited to demonstration projects.

## 4. THE CONTEXT: WHAT WE KNOW

This section provides an overview and summary of evidence in three key areas. It points to important areas of learning on which to build improvements in joint work with neglect and emotional harm.

The areas of evidence relate to:

- the characteristics of neglect
- the adverse outcomes of neglect on children
- what can be learnt from serious cases.

### **Characteristics of neglect and emotional harm**

Researchers and writers on neglect and emotional harm have attempted to find their salient features, and whether these are associated with different parent and child profiles or child outcomes. Clearly if this is the case, treatments could be differentiated accordingly; specific outcomes could be identified and evaluated. If, for instance, depression were a key feature in a significant proportion of neglect cases it makes sense to address this in an active way alongside the other contributory factors.

This section provides illustrative summaries of evidence on different aspects of neglect. References are given for those readers who want a full account of the studies.

### **Neglect: the failure of prevention?**

Fluke and colleagues (Fluke et al, 1999) researched data on reported recurrence of maltreatment over a 24 month period, from ten American states. Their aim was to *provide a broad-based, multi-state comparison of child maltreatment recurrence*, defining recurrence as *the presence of one or more subsequent maltreatment report-child pair (report event) associated with the same child between (given dates)*. It is important to note that the findings below refer only to this definition of recurrence.

The methodology included setting up a recurrence data-set for 1994 and 1995 from multi-state case level data from the National Child Abuse & Neglect Data System. These data were available for ten states including a range from 2,419 to 99,288 substantiated or indicated report-child pairs per state. A common set of data constructs lent consistency to data construction and analysis while preserving differences in policy. Event History Analysis (survival) techniques were used.

The size of the data-set meant that differences in policy and procedure across the administrations could be allowed for and *highly consistent patterns of recurrence were observed*. With important caveats, they concluded that:

*as an outcome measure against which to assess the success of interventions and as criteria for validating risk assessment instrumentation and implementation, recurrence has a significant role.*

The relevance of their study to neglect is that they found:

- neglect is most often associated with recurrence and children in older age groups are less likely to experience recurrence.

They also note that the likelihood of maltreatment is greater after each subsequent maltreatment event, so that:

- *for all ten states*, the overall likelihood of a third event (second recurrence) was 45% greater compared to the likelihood of a second event (first recurrence)
- *for most states*, a fourth event (third recurrence) was 15% to 20% more likely compared to the third event
- *all ten states were characterized by shorter times to recurrence* for the third recurrence compared to the first. All these differences were statistically significant.

The authors conclude that:

*with regard to maltreatment the findings of Levy and colleagues (1995) and Inkelas and Halfon (1997) suggesting that neglect is most often associated with recurrence is supported in all but one state. The idea that neglect and poverty are intertwined is hardly new in the field and the difficulty of defining neglect in relation to a specific incident is also recognised. The data across states support the idea that neglect is a more chronic condition.*

This statement needs to be analysed carefully. It can lead us to the conclusion that neglect is somehow intrinsically a chronic or recurring condition. The reality may be that, as many of our interviewees recognised, it can still “slip under the radar” of preventive and safeguarding services, which are not yet sufficiently responsive to the signs. Or the reality may be somewhere between these two positions. It is possible that services respond, but deal with neglect too superficially; in many cases, only by monitoring, in which case they are arguably more likely to see recurrence.

If family issues such as key relationships are not resolved and/or continuing support is not offered, the underlying problems recur. In other words, in relation to neglect identification and monitoring may have advanced further than treatment.

This view would sit with the findings of Jones et al in the US (see p21) that decline in identified neglect has been much slower than that of physical and sexual abuse.

It also sits with the comment by Fluke et al that some states formally consider physical and sexual abuse as being relatively more serious than neglect. In these states the threshold for identifying and reporting incidents as maltreatment (and hence for intervention) is higher for neglect, and their reported recurrence rates for neglect are depressed. Despite mandatory reporting, one state did not record neglect incidents at all. It would be of interest to know what proportion of neglect cases receive attention only if or when physical or sexual abuse take place and are identified.

There may, indeed, be a “chronic neglect” of neglect itself, by the very systems designed to identify and respond protectively. The researchers note that a population of known children within the safeguarding system are not being protected. These “chronically maltreated” children are likely to have first come to the attention of safeguarding systems due to neglect. Most worrying is the possibility that the label “neglect” may give permission for low-level monitoring, so that other forms of abuse are not seen. Some interviewees in this project thought that cases of neglect were too often allocated to less experienced workers with inadequate support.

Fluke et al conclude that:

*the results provide evidence that this phenomenon (increasing risk of recurrence with each event) is common to many states regardless of differences in the protective services and is the most consistent finding of the analysis. Furthermore, children who experience two or three recurrences may belong to a group of children that comprises a chronically maltreated group, or a group that may exhibit characteristics that are distinctive compared to children who experience one or no recurrence. At the very least, contrasts between children who have experienced different frequencies of recurrence need to be addressed in formulating the knowledge base in this area. A clear direction for future research in this area is to examine subsets of children who experience multiple recurrences and to compare them to children who do not.*

Recognising such concerns, a study reviewing performance measures for child protection on behalf of the Australian government (Gain and Young, 1998) concluded that the most robust measures would focus on *keeping children safe from subsequent reported abuse in the short, medium and long term*. Targets involving monitoring for *sustained* safety would certainly be helpful in telling us whether neglect has been effectively prevented from recurring.

## **Typologies of child neglect: effects on children's behaviour**

Dubowitz and colleagues, in the USA, (2004) set out to identify and measure three distinct subtypes of child neglect to see whether they aided understanding and treatment. They undertook home evaluations and two interviews with mothers of 173 children aged five (followed up at age six years) who were attending clinics. They identified three sub-types of neglect - physical, psychological and environmental - and looked for distinct associations between the three sub-types of neglect and children's subsequent behaviour patterns. They compared these results with referrals of children to child protection services (CPS) for neglect, when they had controlled for sexual and physical abuse.

They found different patterns of child behaviour at age six were associated with their initial classifications. For example, physical neglect was significantly associated with the child having problems with peers; environmental neglect (see p59) was significantly associated with child behaviour problems (both identified by the parent); while both physical and psychological neglect were related to peer problems, at school, as rated by a teacher.

Dubowitz and colleagues found that unspecified neglect (the mean of the subtypes) and child protection referral were not as clearly associated with specific child behaviours as their subtypes. They concluded that it could be helpful to find ways of disaggregating different types of neglect, in order better to understand its likely effects on children and possible remedial strategies.

## **Typologies of neglect: mothers' characteristics**

Wilson et al (2005) studied 100 mothers (again in the US) where neglect was cause for concern and clustered parenting attitudes and behaviours into five groups.

Clusters were similar in terms of maternal education, family size, monthly income; women reported similar levels of depression and amounts of social support. They differed on ratings of neglect, life stressors, resource problems and adult problems.

Cluster group one included women who were most challenging to work with. They had multiple life difficulties including relationships, disability, substance misuse etc and were also more likely to have suffered early, pervasive deprivation.

Cluster group two was similar to the first, though these mothers were more verbal and confident. A third grouping was much lower in confidence and motivation. The remaining two groups were of women with less long-standing difficulties.

The common features and differences between these groupings are all of interest. The researchers thought that their findings *present(ed) avenues for further exploration into the lives of neglectful families as a means by which more tailored interventions may be established to minimize the effects of the most common form of child maltreatment.*

They concluded that mothers in the different groups would benefit from discrete, tailored interventions. For example, those in clusters one and two were dealing with a level and complexity of issues that meant that they would be likely to need expert individualized attention (before or as well as family or other interventions) in order to recognise and address their children's needs. Mothers in cluster group three were thought to benefit from small group or individual work, the provision of structure and confidence-building. Two further clusters were of (firstly) less needy mothers who had specific issues that needed to be addressed and (secondly) a similar group where attitudes to parenting could be enhanced through early support and group work.

### **Theoretical frameworks for understanding neglect**

In the UK, theories of development, cognition and attachment have provided building blocks for models of parenting. Crittenden (1999) is frequently quoted, as she analyses several layers of communication between parent and child which may fail in cases of neglect. She suggests that the parent may need specialised help in any or all of these areas: to pick up the child's signals; to interpret them; to select a response; and to implement it effectively. She also offers an (unproven) typology of neglectful parenting, which she describes as made up of cognitive and emotional processes; the three main types are disorganised, depressed and emotionally neglecting or unavailable.

With reference to attachment theory, Crittenden's model is developed by other writers on neglect, notably Howe (2005), Stevenson (2007) and Horwath (2007). Howe gives detailed case study accounts of types of neglect; the nature of cognitive and behavioural responses and attachment patterns in the child; and some promising interventions. All would be highly useful training material in this area. Horwath (2007) sets out the impacts of six forms of neglect:

- medical
- nutritional
- emotional
- educational
- physical and
- lack of supervision and guidance.

She also refers to "societal neglect"; the actions of agencies in withdrawing or reducing essential services such as early health checks and home visits. These policies impact disproportionately on parents in difficulty and on children who are neglected, as well as other front-line services (see p97 for interviewee's comments). Further evidence of such systemic neglect including criminalisation and social exclusion, is discussed below (p36 onwards).

Attachment theory was one basis for the large-scale, controlled longitudinal study of child development (Sroufe et al, 2005) detailed more fully later in this section (p37 onwards).

Physically neglected children showed anxious and ambivalent attachment which could lead on to behavioural disturbance such as extreme attention-seeking. If severe, the child might become withdrawn and depressed. Emotionally neglected children (including children whose parent was emotionally unavailable) show anxious/avoidant attachment, where the child may cease to respond or play. Early attachment behaviour, independently observed and rated, was highly associated with later developmental outcomes.

### **Fathers and neglect**

Fathers and father-figures are notable by their absence from the greater part of the debate on neglect, whether research, policy or interventions. This is cause for major concern. There is a growing interest in working with fathers and some approaches (e.g. use of trained volunteers) are promising. All the available evidence indicates that:

- work to improve maternal care is likely to be more successful where the father's and/or the male partner's support can be enlisted
- the majority of children want, and benefit from, positive contact with their father or a male carer
- mothers benefit directly from the support of a partner
- male care-givers in cases of neglect are often struggling with a range of health and other problems, including their own maltreatment as children.

In many cultures it is difficult for men to seek help, men are not recruited into the helping services and those services are not geared to fathers who need support and advice.

Horwarth (2007) helpfully discusses the risk factors associated with men who maltreat or neglect their children, the importance of the dyad (father - mother) and triad (father, mother and child) relationships and of grand parents.

Sroufe et al (2005) concluded from their longitudinal study that for both boys and girls, the presence of a caring father-figure was protective. Parental monitoring during adolescence was in general higher where there was a stable male presence and this higher monitoring was associated with fewer behaviour problems for boys.

On the other hand, they found that father/male partner characteristics associated with neglect were particularly damaging for boys in the longer term:

- an unstable adult male presence was worse than no man involved at all
- witnessing violence in early child hood leaves a legacy that appears during the adolescent years

- the combination of early disruption (succession of male figures) and low adolescent support (from father figure) was a strong combination in predicting externalising behaviour.

In English law parental responsibility is defined in general terms and tends to rest with the resident parent or care-giver, usually the mother (see p92 for a fuller discussion). The mother is the focus of assessment and remedial action.

Yet in the worst cases of maltreatment, including neglect, males are as frequently involved as females in incidents that lead to serious injury or fatality to a child (see p40). The involvement, history and even the identity of the fathers and/or male caregivers (the plural being important in some cases) and, equally important, their families, can remain unknown. While this may be due to concealment in some cases, in others questions are not asked nor the answers fully recorded and it is unusual for professionals to seek proof of identity. One interviewee described a case in which the presence of a father of one of the children in the household for a lengthy period was not noted until a Serious Case Review took place.

Interviewees for this study thought that violence towards the mother and/or visitors to the home was not always addressed adequately, particularly where it involved subtle threats and an atmosphere of intimidation. This in turn compromised the ability of professionals to work with either parent or to monitor the child's safety and progress. Fear of intimidation was sometimes used to justify workers avoiding fathers and male partners in cases of neglect, or hoping they will "move on". Workers might quote the mother as saying that her partner's threats or violence were "normal" and accepting this without challenging what it meant for the child's development.

These issues contributed to the sense of helplessness that characterised some cases of long-term neglect that went from crisis to crisis without resolution. Strong inter-agency planning and support to front-line workers is needed to counter this situation and sustain purposeful work in order that children are safeguarded and develop normal social relationships. In particular, emergency and statutory services including adult services need robust arrangements for joint intervention.

Some professionals we interviewed had developed skills and confidence in ensuring the father's role was taken seriously:

*You need a good working relationship with fathers. You have to have the difficult discussion about their behaviour and its impact on the family. I go with another worker if the person can be violent. You need to drink their tea and show some respect, perhaps say "things aren't good for you I know – what do you think will happen?" Often men will have a cry - they have no employment and they feel no use. (Children's team worker).*

The skills to work with fathers need to be developed and supported much more actively.

Daniel and Taylor (2005) look at the role of fathers (and male carers) in cases of child neglect and make helpful recommendations for improved practice, including:

- *fathers must be rendered visible*
- *comprehensive assessment should include all significant or potentially significant adults*
- *children's own views about who is important to them should be ascertained*
- *the complexity of relationships must be recognised*
- *the potential for a father to pose a risk must be assessed carefully*
- *it may be helpful to look at the father's sense of efficacy as a parent*
- *children may benefit if fathers are offered support with problematic areas of their lives*
- *fathers can be encouraged to develop nurturing relationships with their children*
- *fathers may have an important role to play in supporting school performance and enjoyment*
- *family centres should aim to work effectively with both mothers and fathers.*

### **Adverse effects of neglect on children's development**

For children who have suffered neglect, developmental outcomes set out in the Every Child Matters and National Standards Frameworks are likely to be severely compromised. Given the scale of the problem this is a significant hurdle for government programmes such as Change for Children (DfES 2004), the extended schools agenda and work to address social exclusion (Cabinet Office, 2007).

The research shows clearly that by school age neglect affects children's capacity to socialize, play and learn and that if these effects are allowed to accumulate they can reach into adulthood, *whether or not the child is removed from the neglectful care environment*. Similarly, emotional abuse has been shown to adversely affect child growth, development, welfare and well-being (Iwaniec, 2003). It has been associated with physical syndromes such as failure to thrive and hyperphagic short stature syndrome (Kavanagh 1982 cited in Iwaniec 1997; Gilmour and Skuse 1999). Students who had suffered "emotional neglect" reported current psychological distress (Wark et al 2003).

Children who had experienced neglect in early childhood show problems in language development and behaviour by age four (English et al 2005). Children who have been "selectively rejected" by their birth parents and have associated emotional difficulty are likely to have deteriorating behaviour patterns and poorer outcomes with new families in the first year (Dance et al 2002).

## Neglect and long-term outcomes

A comprehensive longitudinal study (The Minnesota Study) tracked 180 children throughout childhood and into early adulthood. Its focus was the *identification and evaluation of critical factors in individual development; both their relative predictive power and how they work together to shape development.* (Sroufe et al, 2005).

The methodology relies on multiple measures and sources of information including direct observation. Children received multiple assessments to age four, then yearly to elementary school then every two to three years. These included parenting, peer relationships, temperament, cognitive functioning; plus interplay of all these factors. There was also ongoing assessment of contextual factors such as child and parent IQ, personality, family-life stress, disruption, social support and socio-economics.

Looking solely at findings directly relating to maltreatment and neglect, 44 out of 180 (24%) children were seen to experience instances of “extremely negative parental behaviour and/or care inadequate enough to be judged maltreatment”. The four main patterns of maltreatment were; physical abuse; physical neglect or failure of physical care; psychological unavailability (which could be identified as psychological and emotional neglect) and verbal abuse. Later in the study, seductive behaviour and sexual abuse were added.

Of the four main patterns of maltreatment, it was an aspect of neglect which had unexpectedly high negative impact:

*Psychological unavailability was an especially important pattern. It involves a complete lack of emotional engagement or emotional responsiveness to the child. The mother is either affectively flat or simply does not resonate with the child's emotional expressions. It is the psychological counterpart of physical neglect.*

It is important to note that in many UK studies there is overlap between physical and psychological neglect.

The study relates these parenting issues to early attachment patterns. In very young children they note that chronic emotional unavailability might seriously compromise the infant's capacity to organise behaviour around the caregiver in the first place.

Pre-school age neglected children had difficulty in adapting to being taught when they reached four and a half to five years old:

*Children in the physical abuse and psychologically unavailable caregiver groups showed a significantly higher level of negativism and non compliance than did comparison children.*

The children who had experienced a psychologically unavailable caregiver group were distinguished by avoidance of and anger towards their mothers. Those in the physical neglect group were primarily lacking in persistence and enthusiasm.

Children in these groupings who were doing comparatively well at school had experienced better early parental care (i.e. at 30 months had a caregiver who was significantly more involved in their care at home and at 42 months, a parent who scored significantly higher on every care-giving scale).

Poor performance in secondary school is equally seen to correlate with early experience of maltreatment, specifically neglect:

*Membership of the neglect group was the only predictor of school achievement problems once SES (socio- economic status) was controlled...Severity of early neglect (for example) was significantly correlated with both math and reading achievement. Neglect remained a significant predictor even after controlling for socioeconomic status, a rigorous control since SES correlates with neglect and predicts reading and math achievement substantially.*

Maths proficiency in particular is based on regular attendance and continuity, and this finding reinforces the view that key characteristics of neglect such as poor attachment, inconsistency of care patterns and lack of helpful routines are as harmful as the actual duration of neglect. (see p16).

Not only poor attainment but anti social behaviour is strongly linked to neglect:

*Every form of maltreatment was related to delinquency with a history of psychological unavailability being the strongest predictor. We reasoned that this was because of both the legacy of anger, negativity and defiance in these children and the lack of monitoring provided by their parents in adolescence. It is likely that for the latter reason, neglect also predicted delinquency even though these children tended not to be aggressive or defiant. Those in the psychologically unavailable group were distinguished by the pattern of aggression, social problems and isolation as manifested in elevated suicide attempts. (Egeland, 1997).*

A small study using a control group (Shipman et al, 2005) found that children who had been physically neglected also showed severe adverse emotional outcomes. Physical neglect (defined as failure of the mother to meet the minimum *physical* needs of the child e.g. supervision, shelter, food) had been substantiated in 24 children with no known history of physical or sexual abuse. The control group comprised 24 children not known to have been maltreated recruited via community organisations. The groups were similar in terms of the child and mother's age, gender and, race or family income and size. All the children were interviewed in their own homes.

Children who had been physically neglected tended to expect less support and more conflict from mothers in relation to emotional display. They also showed:

- less emotion to their mothers
- significantly lower levels of emotional understanding (i.e. having more difficulty understanding the causes and consequences of emotions)
- less effective coping strategies for anger and sadness
- fewer adaptive skills in terms of emotional regulation (e.g. appropriate affective display, empathy, emotional self-awareness)
- more emotional lability.

The research concluded that as a result of these emotional deficits, physically neglected children may show many behavioural, social and communication difficulties that compromise future social and emotional functioning, including their own future parenting.

These children may in future life either:

- misinterpret or fail to process emotional messages, placing them at risk in interpersonal relationships (including risk of abuse)
- tend to deny negative emotions - (this may be adaptive at home but prevent learning about emotional cues)
- indicate that they would avoid another's negative emotions rather than offer support
- appear to rely only on the self rather than others when handling distress - (again, this may be adaptive, but could later interfere with interpersonal relationships, and prevent them obtaining support)
- receive less modelling and teaching of perspective-taking skills from parents.(both important to the development of empathy and the scaffolding for developing emotional awareness)
- display more emotional lability and negativity and thus be at risk for emotional and behavioural difficulties associated with emotional regulation.

Perhaps unsurprisingly the list above, if applied to a parent, contains many elements of psychological unavailability and neglectful parenting.

This list indicates why parents who were themselves neglected as children may avoid help or have distorted expectations. They require assertive but sensitive support.

## **Learning from serious cases**

The third biennial analysis of Serious Case Reviews (Brandon et al, 2007) has already been referred to (see above, p25). All the neglect cases in the intensive sample (N=47) were analysed retrospectively. There were many issues in common with those that emerged in interviews for this study (see Table of Themes, p42).

What follows is an edited version of the sections of the analysis dealing with cases of neglect. The reader is referred to the full report for contextual data and analysis.

Cases in the intensive sample tended to cluster naturally into three broad groups with distinguishing characteristics; neglect (N=15 cases); physical assault (N=17) and cases involving children aged over 13 years old (N=15). The cases of neglect included instances of 'overlying', illness, accidents and house fires, as well as more common indicators of neglect or emotional harm. Six of the fifteen 'neglect' cases included very young children under the age of one, and the remainder covered a spread of children's ages up to the age of eleven.

Three additional cases where neglect was a significant feature involved a teenager aged over 16 years. The profile of the small number of older children who had lived with neglect for long periods was an alarming one, featuring self harm and suicide attempts which in some cases resulted in the child's death.

Where the review concerned very young children suffering serious neglect, the child in question was often the last to be born in a long series of pregnancies, some of which were losses. Most of the young children who were neglected had difficulties at birth. In spite of this their mothers would often discharge themselves and their babies early. Attendance at ante and post natal appointments was poor. It is possible that maternal expectations of another child living were low and that it was too frightening to invest hope in a child when children had previously died or been removed. The cumulative extent of these losses had often not been apparent before the review and the mother had either not sought and/or not received help to resolve them. This fear and denial had, either not been addressed, or not successfully.

Babies tended to receive inappropriate physical care or discipline and/or be physically abused. Many babies were left with inappropriate carers, for example other children, or with individuals who were in an unfit state, for example due to alcohol or drugs, to care for a young child.

## **Mutual avoidance between families and agencies**

Parents tended to avoid agencies, but sometimes agencies also appeared to avoid or rebuff parents. Where there was also a fear of violent and hostile men, workers could become paralysed. The work became reactive to specific incidents and tended to lurch rather than progress in a planned way. Confidence in the professionals (including their own) was lost. Examples might be a succession of workers, case closures and re-openings, lost files or key information, re-assessment, referring on, initiation of court proceedings and then dropping them, and so on.

The significance for parenting of early severe maternal deprivation from which the parent has not recovered was rarely acknowledged, nor was the impact of severe early trauma, parental death, abuse, or mental illness. In particular, multiple pregnancies and losses were not “counted” in terms of their cumulative effect. The build up of such severe hindrances to parenting often came to light only during the serious case review.

## **Identification of patterns of behaviour**

Through being alert to a changed pattern of parental behaviour, and by contrasting past and present patterns, it was possible to recognize mounting stresses, to notice, for example, an escalation of substance misuse and/or domestic violence, and a worsening record of attending health appointments.

As isolated observations, these elements do not necessarily signify substantially increased stress or risk to the child. If professionals are able to piece them together, a powerful message emerges of parents failing to cope.

The Third Analysis of Serious Case Reviews found that one way of dealing with overwhelming information and the feelings of helplessness generated in workers was to avoid looking for these recurrent patterns, put aside knowledge of the past and focus on the present in what was termed the ‘start again syndrome’.

This scenario was one in which a family change (such as a new partner, a pregnancy, a move or else a change of worker) presented a justification for wiping the slate. In some cases, all that had gone before was discounted. Sometimes this was the result of a court case that asked the local authority to try again with a family. A new record might be started and no full summary or chronology from previous files maintained.

The danger here is of losing the benefits of previous work and denying the interagency group any clear and systematic understanding of the case informed by the knowledge gleaned from past history. Where a fresh perspective on a case is needed this should be gained by jointly and thoroughly reconsidering earlier judgements in the light of what is known, or/and by sensitive audit or review that supports reflective practice. Previous patterns of behaviour and concerns about children are crucial data in joint planning. In the study reported here, there were many examples of practitioners finding such information by painstaking research, including travelling to read files in another part of the country.

Third biennial analysis of serious case reviews (Brandon et al, 2007)

Table of Themes N=47

<b>Child factors and experiences</b>	<b>Family and environmental factors</b>	<b>Practice/professionals, agency factors</b>
Very young babies	Domestic violence	Agency context, capacity and 'organisational climate'
Illness in babies	Substance misuse	Preoccupation with thresholds e.g. CP threshold not met
Older child, hard to help	Mental ill health	Professional anxiety and reluctance to act
Sexual exploitation	Fathers, hostility, criminal convictions	Professional challenge
Going missing	Patterns of hostility and compliance	Supervision
Bullying	History of neglect	Ethnicity challenges
Suicide	Previous child death	Understanding and dealing with neglect, 'start again syndrome'
Disability, chronic illness	Poverty	Communication
	Poor living conditions	Keeping track of families
	Frequent house moves	Child not seen/ heard
	Accidents	

**Summary**

Robust evidence is now available on the characteristics of neglectful behaviour and the key role of the parent-child relationship in mediating other stressors associated with neglect. We also know much more about the damaging effects of child neglect in the short, medium and long-term with children of either gender and in various age-groups. We need investment in research on child development following neglect, and in evaluation of interventions.

Several typologies of neglect have been developed, breaking down the umbrella term into different behaviours with different effects that would benefit from different responses.

Topics that have hitherto been under-researched in relation to neglect are now receiving more systematic attention (e.g. men's understanding of fatherhood and their role in direct and indirect parenting, mental ill-health and personality disorder, substance misuse; criminality, violence, intimidation, poverty, social isolation and the associations between all these factors).

Characteristics of seriously neglectful parenting are found to be similar across a number of studies. Equally, the challenges to effective joint work have been identified. They include a tendency to underestimate the harmful effects of even short periods of neglect, giving neglect cases to less experienced staff members; lack of full assessment of household members and their interaction with children; loss of momentum in planned work with families, avoidance of families, failure to address problems of access, not recording the cumulative effects of disparate instances of inadequate care; failing to take account of the full history when starting a new piece of work.

Resources now have to be applied to sharpening both individual and joint professional responses. Learning ("what we know") must be structured in a way that can contribute to a strategic, planned "assault on neglect".



## 5. THIS STUDY: THE IMPORTANT ISSUES

This section sets out issues that were identified across the hundred interviews as central to improving joint work with neglected children. They are listed below, and then some are selected for further discussion. The next section (p69) (**What makes a difference?**) gives specific examples of current practice that professionals across several disciplines mentioned as promoting good joint work in this area. If the practice has been evaluated a reference is given.

The following section (**Tackling the issues**, p89) gives ideas and strategic actions drawn from both the one hundred interviews and the specialist seminar. Professionals thought that, if implemented, these would create the energising and constructive policy environment essential to reduce child neglect substantially.

With regard to children, most frequently mentioned concerns were as follows:

- the child's development (mental, physical, emotional, social)
- cleanliness (clothing was a related concern)
- child home alone (accidents were a related concern) and
- the overall complexity of child-related concerns in many of these cases.

Regarding the family, most frequently mentioned concerns were:

- assessing and addressing parental capability
- working with fathers, male partners
- addiction (alcohol, drugs, etc)
- violence or threatening behaviours
- mental health.

Other important family issues were: understanding and working with the families' social and cultural network, with the family history including asylum, addressing parental responsibility and empowerment, family and other relationships and service avoidance by families.

With regard to the environment, key issues were:

- housing (including working with housing departments where their policies were felt to be punitive); crime; poverty; debt; and unemployment.

Regarding professional input, they were:

- definitions and thresholds
- assessment and lead professional issues
- (lack of tested) interventions and services
- interagency working, including legal and policy context
- (lack of) training and supervision
- (lack of opportunity to develop) judgement, reflective practice.

## **Issues regarding children**

### ***Child development***

Most of the professionals had experienced several cases of serious neglect; some had known many. These included examples of repeated observations before intervention took place. There was concern that these instances went unrecorded, especially in an area of high need:

*We have repeated incidents of the same child going round the school looking in the bins for something to eat or stealing from a lunch bag or smelling of urine. Such cases are referred by the school, the police, or a health visitor. They often have “slipped under the radar”. If the child actually gets to school they are often tired, hungry, unwashed, without a coat. This has often been going on for months before referrals are made, let alone investigated.*

(Education Advisor)

Children in such a poor physical state also faced victimisation:

*The child was going to school smelly with torn clothes causing them to be bullied severely. (Head teacher).*

*We had seen the 12 year old frequently. She collapsed in school. Problems with severe head lice, hygiene, clothing, obesity, low self esteem, and being bullied. (School Counsellor).*

However difficult, school was sometimes preferable to home:

*The child came to school as a refuge from home conditions, unkempt, unwashed, smelling of urine, having infections and developing medical complications. (School Nurse).*

### ***Emotional harm***

The prevalence of emotional harm was in no doubt to many professionals:

*We received 3,500 referrals last year and I would say all the children suffered some degree of emotional harm. Every day we get domestic violence cases where there are children in the home, and cases of physical and/or sexual abuse, neglect; four or five home alone cases a week. Often alcohol or substance misuse plays a part. (Metropolitan Area Police CIAU Officer).*

Many aspects of emotional harm were attributed to neglect within flawed family relationships:

*The key in neglect is a negative relationship, the child's needs firstly not recognised and secondly not met, therefore a "nice" home can still include a neglectful parenting relationship. I'm not sure we know enough to define neglect properly. (Health visitor).*

One concern was that emotional unavailability could turn to active avoidance of the child and this in turn might become more hostile and emotionally abusive over time:

*Often the mother is depressed and there is a lack of availability to the child. It is not necessarily deliberate but it can become so over time. (Sure Start Manager).*

*A child's deaf needs were completely ignored by the family. The young person grew up feeling his family/relatives did not want to talk to him or love him. Because of his deafness, family restrained him from going out or seeing friends and undermined his skills. He had no friends or social life. He was growing up completely frustrated and feeling he lacked any identity and was unwanted. (Disability team worker).*

As with neglect, emotional harm could lead to long-term damage, but it was felt that this would be hard to evidence:

*In terms of child protection this is partly due to the forensic aspect. Other types of harm are easier to evidence. The effects of emotional harm are seen in looked after children as lasting a long time, even with excellent care and huge support. (Children's Services Manager).*

To address emotional harm, it was thought that direct engagement with the parent, patience and persistence would be needed; in the first instance using an educational rather than a punitive approach:

*It is often hard to differentiate neglect and emotional harm. Parents may be unaware of their neglectful behaviour and it takes a while to get them to see the longer-term emotional impact because day to day, for example at school, the child's functioning may be ok. (Social worker).*

## **Children home alone**

Between them the hundred professionals gave over thirty examples of children who had been left “home alone” in a manner that gave cause for concern about neglect. This was described as a way of life for some children, where parents could not find the time for them:

*Mother went on holiday, left the child a note (the child couldn't read). She returned a week later, having left the child alone all week. (Social worker).*

*We know families where the children are virtually living alone. They come home, the parents are at work. They use security locks and so on. They sit and watch television. They have no real childhood. The parents don't know their own children. This is becoming increasingly “normal”. As a result of this solitary activity children are under-stimulated so in other areas of their life they become hyperactive and very demanding. I see this as neglect of parental responsibility and it is undermining the child's potential for attachment. (Educational psychologist).*

As well as teachers, ancillary staff in schools (welfare liaison officers, school nurses, counsellors etc) often become aware of children home alone:

*Another example was a child alone when I phoned. The child had been locked in at aged six. So I had to call the police. About twice a year I will find a child has been left home alone. This is because I phone the home when the child is not in school and I am sometimes told that mummy and daddy are not here. If I can't contact a parent, I always get the police in these circumstances. (School-home liaison officer).*

Police interviewees emphasised that if possible they should always be called to the address in these circumstances, rather than the child removed, because they need evidence of the environment the child has been left in. They added that the criminal standard of evidence (of both intention and harm) was hard to meet:

*Home alone situations can be contentious. There is a crime of neglect, assault or wilful abandonment under the Cruelty to Children and Young People Act 1933. However, you have to prove the intentional aspect. The criminal threshold was not met simply due to the fact of the child being left alone. The cases were lost in court because we had not proved a harmful result. Alternatively if we felt action necessary, we could give the parent a caution which would generate a record. We used to keep a record of borderline concerns where no formal action was taken but we were told to destroy them.*

*(Detective Constable, Child Abuse Investigation Team).*

Situations like this were some of the most difficult. When there was no consistent improvement, professionals were apprehensive:

*It is difficult to sit and wait for something to go wrong. You go in every month and if there is something tangible, e.g. the child is left alone or if there is an accident, you can take some action but if it is bumping along, it is a terrible situation. I use the Children Act 1989 in terms of evidence of significant harm but this is difficult.*  
(Social worker).

Where no preventive or support services had been made available to parents, legal intervention in neglect was felt to be heavy-handed by some. There appeared to be more hesitation than with other forms of significant harm. Where services had been offered and not taken up, or not made the hoped-for difference, legal action was taken more willingly if only to mark the degree of concern about significant harm.

There was much concern that neglected children may be lost between the legal provisions; the police hoping action would be taken under public law and social care professionals thinking that the case might meet the clearer thresholds of criminal law. This issue is explored in Section 3 (p17 and p18).

### ***Long-term harm and resilience in children***

*With regard to emotional harm to a child caused by a parent's lifestyle; this is a long-term problem as we aren't going to change things overnight. We have to look at what else might be available in the child's life and at research on resilience to keep things going.*  
(Adult mental health service manager).

Some respondents were concerned that poorly understood theories of resilience were being used as a basis for allowing children to cope with insufficient support in emotionally harmful situations. Instances given included children caring for a physically or mentally ill parent or/and for siblings when a parent had addiction; children coping with conflicted separations and contact arrangements, with domestic violence, or with distorted or dysfunctional family systems.

Support was sometimes (though not always) offered to the child. Interviewees feared this process could result in collusion with situations that were potentially emotionally exploitative and (intentionally or otherwise) damaging to a child. On occasion, the child's opinion was asked in a context that made it difficult for him or her to talk about negative experiences. Some were concerned that the adults' intentions and functioning became the focus of debate and that as a result, adverse effects on the child might be sidelined. There was seen to be a fear of criticising or potentially undermining the adult's parenting role when this might be one of their very few sources of self-respect, even if the price was turning the child into a carer.

*I sometimes wonder if we are colluding with neglect of some children's needs - sometimes we put a child carer, a child who looks after a mentally ill parent, down as a factor reducing risk in the family - but risk to whom? (Adult MH services manager).*

The arguments for bolstering a child's resilience to cope was being challenged in relation to domestic violence in some areas, though not without controversy (see p49). This was perhaps because responsibility for the emotional neglect and damage to a child could be more easily attributed to an adult's behaviour in such cases. Where there were other parental problems e.g. long term mental illness, disability, learning difficulties, this was harder to do.

Identifying sources of a parent's neglect of their own child (e.g. early abuse, depression, fear of violence, drugs) might well make such behaviour more understandable and could help to target support more effectively on the root cause.

From the child's perspective, however, understanding the parent and wanting to help do not necessarily mitigate the developmental damage being done. A child feeling for a parent's suffering without the power to effect real change may add to the child's underlying guilt and helplessness. Even if a child appears to manage such a situation well, they will not necessarily have the emotional maturity to cope in the long-term. Support systems were variable and many such children missed out on peer relationships, quiet time and recreation.

Rutter (in Haggerty et al 1996) points out that "*children who appeared resilient in terms of social competence were often non-resilient when judged in terms of the presence of emotional disturbance*". He adds that resilience may develop or erode over time:

*A focus on isolated life-events is not the most appropriate way of viewing most stressors. it is the aggregated **accumulation** of events over time that contributes to the emergence of psychological resilience or vulnerability in individual cases...*

*The question is not one of finding the basic cause (of resilience or vulnerability) but rather of gaining an understanding of the mechanisms **over time** that may be involved.*

Sroufe (2006) argues that "resilience" is complex:

*Resilience is not an individual trait but a feature of the developmental system (including) positive expectations even in tough times, flexible self-regulation and an array of competencies and supports.*

In this context the idea of children's resilience is equivocal and may be used to avoid adults taking responsibility. Respondents gave examples that had caused them to revise their views:

*I worked with a teenager age 16 whose mother was a heroin addict. He provided most of the consistency in the care of her baby, and he tried to get to school. In the end he could not cope with her chaotic lifestyle and the risk to his sister of addicts entering the house day and night. He went to the top of the local car park and tried to jump off and kill himself. It took this level of desperation for the authorities to take action. (Child psychiatrist).*

Emotional damage could be hard to detect in some children. The skills to identify it are at a premium as are the resources to persist with an emotionally damaged child who had learnt to hide from and mistrust adults' intentions.

## **Family issues**

### ***Parents and domestic violence***

Current policy has emphasised the criminality of domestic violence. As a result the adverse effects on children of witnessing and/or being involved in domestic violence are increasingly understood and acknowledged.

In some areas, police and social care professionals were attempting to use a more direct joint approach to protect children from emotional harm associated with domestic violence. This was not without difficulty. After a certain number of incidents or a particularly serious incident of domestic violence, the police asked for a strategy meeting with children's services. Over time proportionally more children were being registered for emotional abuse associated with domestic violence. The mother (usually victim of domestic violence) was often called on to exercise parental responsibility to protect her children.

*We refer all cases where we attend a domestic violence incident with children to Social Care, we screen them and ask for or attend strategy meetings where necessary. The numbers are such that we now have two social workers attached to the Unit just on assessments of domestic abuse and we need more clerical support. (Police constable, CIAU).*

The police in one area felt that their investigation of the child's experience and family circumstances was a thorough one:

*We have adapted our risk assessment for adult victims to children. We ask what are the risks for that child in that situation, what are their fear levels likely to be? We start where the family is and we ask questions about mental health etc, we ask to interview the father. Domestic violence officers build a long-term relationship and they keep at it - if they can't see a woman at home they will see her at the school, and try to get her some legitimate help.*

*We would not close a case simply because no-one answered the door. (Detective Sergeant, CAIU).*

They commented that past events and patterns of behaviour needed to be assessed in the present context:

*I found on a file that there was a child death in the family. I was told "that was ten years ago". They knew but they just hadn't used the information. (Police Constable, CIAU).*

Fear was seen as a hurdle to safeguarding children in many cases of neglect; fear about personal safety with violent or threatening men and of "making things worse" for the mother and child by intervening. The training and professional authority of the police was seen as an advantage in this respect:

*whereas in other agencies responsibility for risk tends to get pushed up the line, as a police officer you are out there and you have to take decisions for yourself; there is often no access to a manager. You are always making risk assessments and being creative. You want enough change to ensure the health and safety of that child; it's called Problem-Oriented Policing. (Police constable, CIAU).*

Aspects of joint work with other agencies were also seen as positive. Police in Child Abuse Investigation Units commented as follows:

*The levels and thresholds in the CAF are helpful to share.*

*The joint work on Signs of Safety is helpful, it includes the parent and it is quite honest with them. It makes you look at risk and protective factors with them, and we are working on dealing with domestic violence in this way. (see p77 for further information).*

*It is invaluable to actually meet and put the evidential jigsaw together; we always try to attend when invited.*

It is of interest that despite pressure of work, police attended meetings whereas general practitioners said they found this very difficult (see p61 and p95).

### ***Parental substance misuse***

Some of the most challenging cases that included child neglect were of parental substance misuse enmeshed with or leading to long-term mental health problems and debt (see Cleaver et al, 2007). This could mean children being brought up in a household involved with crime, intimidation, violence and abuse.

We spoke to Children's Guardians (representing the child's views and wishes in care proceedings). They thought neglect featured in at least half of the cases they reported on and that parental alcohol and/or heroin abuse were factors in most of these cases. If substance misuse became a priority for the parent, the child could become invisible.

*Often the need for the drug is to dull something that has happened - rape, abuse. The parent's health is undermined, they forget contraception, they forget to buy food, they forget to pay the rent and in the end they forget the child is there. (Children's Guardian).*

The following quotations are from Children's Guardians who described cases where faced with the loss of the child, drug users kicked the habit, but this required special support. More often they felt that advocacy for the parent on the part of Drugs Teams could sometimes be unrealistic in the child's time scale and children's social workers sometimes lacked confidence or failed to see the whole picture.

- *We asked to see the child's father and found he had been in the home every day for two years but the social worker had never met him.*
- *There is a lack of understanding about personality disorder and attachment, different forms of substance misuse and the signs and effects on a child. For instance, the home is often dark all day because the light affects heroin users' eyes. How would this be for a child?*
- *Psychological assessment or residential assessments are often not completed until the court asks for them because of costs and because they can then be done to the court's requirements. But this can mean long delays for the child.*

### **Parental mental health**

Interviewees described family situations where there was interplay between one parent's mental health problems, the other's attempt to adapt to these (for instance, living in another part of the accommodation) and the child or children showing symptoms of neglect and emotional harm. Where a parent's past trauma (e.g. loss, violence, abuse or neglect as a child) had not been resolved and where there was ongoing substance misuse and/or violence, the issues were compounded. It was hard for the many agencies involved to unravel them and co-ordinate their response.

Particular challenges that were mentioned included untreated anxiety, depression or psychotic symptoms as well as what was termed "fundamentally untreatable personality disorders". Such disorders can be part of a vicious circle of anti-social behaviour, drug abuse leading to criminal associations, unemployment, poverty and violence. One interviewee commented:

*there is a lot of co-morbidity between personality disorders and long-term substance misuse. This can change but it means changing a life-style and it is not easy. You cannot quickly change a history of poor education, no support network etc. In some cases the children's basic needs, their belongings, their schooling may be neglected and there is emotional damage.*

*They begin to repeat the pattern with youth offending or mental health problems. Parents can transfer their problems onto workers who become paralysed with all that dependency, and interventions become increasingly desperate. (Manager, adult mental health services).*

Particularly complex cases include the proportion of violent or sex offenders, (nearly all male) who also have mental health problems or learning difficulties and who are monitored by Multi-Agency Public Protection Arrangements (MAPPA). Their counterpart in terms of planning to protect victims of violence is the Multi-Agency Risk Assessment Conference or MARAC, often dealing with women and children. There are information sharing protocols between the agencies represented on these groups which include health, education, social care and the police as well as other agencies involved in service provision.

Inter-agency practice, so essential in cases of severe child neglect, is being developed in this context. This learning urgently needs to be applied more widely and at an earlier stage across all such cases.

Resources urgently need to go into an infrastructure that joins specialist services better to mainstream services. Demonstration projects for joint provision such as the Personality Disorder Service described below need greater investment. It has to be recognised that such projects, if effective, will inevitably identify other potential needs (including safeguarding needs) within families where there are serious problems. Information systems need to be adapted more speedily to requirements for effective joint planning across services.

Examples were given in the interviews:

*We have a central government grant over five years for a multi-professional personality disorder service. It is well resourced to provide individual and group therapy and there is input from social workers and psychologists. There are skills facilitators to train the team and within this structure people feel supported and stay. Without that support people do the work, but they quickly get burnt out or move on. (Senior manager, Adult services).*

This well resourced service was able to:

- identify neglect and emotional abuse and ask for an assessment of the child's needs
- refer children who seem to be exposed to serious mental ill health of a parent e.g. psychosis, or who may need temporary alternative care e.g. while a parent is in hospital
- work jointly on cases where children are effectively carers, to give them support
- ensure that the health and safety of a child is protected e.g. a child who is locked out, or without food.

The capacity of children's services to respond was less clear. Practitioners in adult services said, for instance:

*We still do not have clear enough working protocols between adult and children's services so everyone knows what is expected of them. (Adult Services Manager).*

*Children's services often cannot do an assessment unless there is a very specific risk. (Mental health practitioner).*

*Children's workers need training on mental health e.g. anxiety disorder, neurosis and psychosis, effects of schizophrenia, substances etc. Many cases are of co-morbidity and without training and support workers don't know what to look for, so how can they take appropriate steps? Also it can be very scary and you need a supportive team. (Substance Misuse team member).*

## ***Families including children with disabilities***

The factors described above that appear in many cases of severe neglect, may heighten the stress for families with a disabled child. The initial bond between parent and child may be hard to form, particularly if the child has difficulty in responding and communicating; there may well be increased isolation and discrimination, or lack of understanding; a fragmented or hostile family network may make the necessary support and substitute care hard to find.

*Mothers who do not attend ante-natal classes, discharge themselves from hospital prematurely and are socially isolated are more likely to be punitive in their disciplinary style, particularly if their child has a disability. A critical time for parents is when they are first told of their child's condition. Parents who receive sensitive support at this time "are more likely to accept their children and as a result are likely to be less distressed and more attentive and positive toward their children than parents who are not helped through the early days (Lewis, 2003 p304)". (Howe, 2006).*

We interviewed members of multi-professional teams working with disability. They said that children perceived as "different" could be neglected, especially where a disability had not been accepted by either or both carers. Neglect could take the form of not giving or seeking appropriate support for the child to reach his or her potential, or it could include emotional and physical deprivation and/or other maltreatment. Practitioners working with children with disabilities commented:

- *The child was left for hours in a dirty wheelchair, another had a tracheotomy and the tubes were not kept clean and she was not helped to use a spoon.*
- *If a child has complex needs you have to tailor your assessment to that child and his or her developmental targets and ask: What does the child need the parents to be doing and what are the implications? Are the expectations reasonable /acceptable? How do we monitor this?*

Very often the family was under great stress and professionals disagreed about what should be done and the point at which support would be seen as no longer viable. Even extreme cases were very difficult to present in court because of divergent expert opinion, and the emotive nature of the cases.

*There is a lot of anger in everyone about disability. Many professionals would rather provide more support than challenge the carers to take responsibility - for instance, by accompanying a child to school or by visiting the school. Sometimes it takes a child protection conference to identify that the child is being harmed and that putting in more services does not always solve this.*  
(Team Manager).

The setting up of co-located multi-disciplinary teams in some areas has made for a quicker, more sensitive service response and better quality of information. This should perhaps be considered for a wider range of vulnerable children such as those at risk of neglect.

*We can share responsibility for these very demanding cases so that if someone is not around they do not get lost. Single-agency assessments in complex cases are often a waste of resources. (Practitioner, children with disabilities team).*

Such a development is overdue as parents of children with disabilities have long complained of fragmented services and repeat assessments. Howe (2006) quotes research to the effect that:

*Sensitively co-ordinated and improved collaborative services by key health and social care agencies appear to reduce family stress and improve the quality of the parent-child interaction.*

### **Attitudes to parental responsibility and parenting capacity**

Heads and teachers referred to parents who in their view did not fulfil their obligations:

*Parents who do not offer talking, touching, social skills, spiritual and other guidance; who put their own needs first. (Teacher).*

*You ask a parent to look out for their child who has been seen on the streets at night and is under achieving and you get told it's "none of your effing business". (Head teacher).*

*Recreational drugs are so common that the parents are on them, never mind the children, and this often leads to neglect. (Head teacher).*

*The child was living out of a suitcase; he wasn't sure who would be caring for him over the weekend. (Teacher).*

One respondent said:

*I've seen "middle class neglect" in my own extended family and friendship network. (Team manager).*

Professionals in schools and other community agencies took different stances on such cases. Some simply saw parents as irresponsible. Others partially or completely justified the behaviour on the grounds that the neighbourhood showed high levels of general neglect and deprivation (see p63) and/or there were many children in the same state. Yet others thought this was no justification and wanted each and every example to be challenged:

*The school here tends to tolerate neglect; they say it's normal for most children to be more or less hungry and dirty most of the time. Well I think they need to get all the parents in for a talk and run some sessions on diet and hygiene. (Health visitor).*

Some thought that simply challenging parents, for example with warnings, would largely be ineffective unless accompanied by an effort to engage with them and their difficulties:

*The new head teacher would not accept children coming in late, half asleep, no lunch, wrong clothes etc. She visited all those families and she stood outside the school every morning and met them and then she phoned them or had a chat, and slowly things changed. (Designated doctor, LSCB).*

*The social workers said "if we do a CAF (assessment) on one child referred from that school we'd have to do one on nearly all of them". They decided to do just that, they got a whole group of workers together from different agencies, and as a result they saw some patterns and they made a case to set up some services for parents with the school. It was great inter-agency learning. (Head teacher).*

One interviewee added:

*It's about commitment to the child; the parent's of course, but also the professional's. You have to show you want the best for their child and you have to show understanding as well as being able to challenge and not back down. (Social worker).*

*So often when you describe the child's problems the parent will say "what do I need to do? I didn't realise ...". If they are willing to behave differently and you can follow that through with them, then why alienate them? (Health visitor).*

## **Environment**

### ***Home conditions***

There were many examples of poor home conditions, over half of which included an account of the child or children also showing poor physical care. Descriptions of home conditions varied from it being:

*Bare and grubby. A lack of food and warmth. (Health visitor).*

to life threatening conditions, suffered over prolonged periods:

*The child was brought up in unhygienic home conditions, stench, rubbish, dog faeces. Child bed wetting constantly, sleeping in urine-sodden mattress. (Social worker).*

Some of the accounts included the notion, discussed elsewhere, that such situations of physical neglect have to be seen to be persistent or recurrent. Indeed, the term “historical neglect” raised the picture described above, of neglect extending throughout childhood. This would not be tolerated with physical or sexual abuse.

*It was another example of historical neglect - no carpet, cold house. The child in primary school with head lice and matted hair, repeatedly not treated. (Head teacher).*

However, once poor physical conditions had been tolerated it became harder to “draw the line” and make an active judgement that they were inadequate or dangerous for a child. Whatever the justification for previous inaction, some practitioners recognised such a situation had to be tackled urgently, first safeguarding the child and also engaging with both the parents if possible:

*You could smell the flat through the letter-box. We bought cleaning equipment and got the Home Care squad to go in as an emergency and clean up room by room with mum, and that was the turning point, although we removed the children we were able to return them in due course and she has managed ok, we keep in touch and visit whenever we are passing. (Social worker).*

*We were very directive i.e. going into the house and saying this is not clean enough, and she responded to that, because she wanted to improve. For some families this would not work. (Social worker).*

Interviewees thought that “agreements” to improve such conditions over time, without active engagement to help a parent make that happen or to monitor the children’s welfare, was not only unrealistic but high-risk for children.

*Thresholds are very vague with neglect, and very value laden. For instance, making judgements about home conditions - I have been involved in a case where there was written agreement with the family about the home conditions required over a 12 month period but there was no improvement and in that case it is futile. I came into this case cold on duty and when I saw the conditions I said "this is ridiculous" and went for an Emergency Protection Order that day.*

*The house was filthy. Faeces on the floor, the children aged nine, five and two had no clothes on. The youngest had engrained dirt that had obviously been there for ages and the parents said "he has been walking in the plant pots".*

*(Social worker, Intake and Assessment.)*

A worker who had experience in America thought these circumstances were a sign of much more serious problems and that other jurisdictions took those signs more seriously:

*Disgusting physical conditions are never just about cleaning up. There are usually other problems but it may be hard to find out what they are. In the States, once the court is involved in such a situation, you are ordered to do a full range of inquiries such as psychology, alcohol, drugs, for tangible evidence of what is going on there. If one child is in a bad way the others would be considered at risk - whereas here it seems to be the opposite; if one is ok you are told to go away and try harder with the others.*

*(Social worker).*

It is important to note that home conditions do not have to be unsanitary to be inimical to a child's development. It takes skill to identify this and act on the implications:

*The home was beautiful, spotless. There was a row of candles lit along the hearth. So I asked where the child played and it turned out he was never taken out of his push-chair. The back of his head was flattened where he had sat in it all day every day and he could not walk at all. We had the paediatrician in the same day.*

*(Health visitor).*

## **Professional issues**

### **Avoidance**

The possible reasons for parents avoiding agencies have been mentioned elsewhere (p39). Difficulty dealing with neglect was compounded by mutual avoidance in some cases. On the professionals' side, this might have to do with the worker simply lacking confidence, or knowledge of the steps to take. It could include fear or apprehension about visiting a private space where they might experience violence or intimidation, or see interactions that demanded a decision. One professional described such a situation:

*I happened to visit out of hours and the father shouted the whole time at the two year old, he just stared and hid behind his mother. I thought it was abusive. But I just turned my back on dad because I did not want to see what he was doing with the child. I felt completely at a loss, I didn't think anyone I contacted would have taken action and if they had it might have made things worse. Mother said to me "don't worry, he is always like this". I suppose I really ought to talk to my manager about it now.*

Front-line professionals tried to get around this, but it raised their concerns. A health visitor commented:

*Many fathers who are drug dealers still accept the health visitor coming in. Where there is violence we try to visit when the man is not there. Sometimes you see mother with a black eye and she says "it's normal" - but what is that like for a child? (Health visitor).*

*How must it feel like to be a child in that family? If you were the adult and terrified of what you were encountering in that household, what do the children think about it on the way home from school? (School nurse).*

Many managers thought the extent of this problem had not been acknowledged:

*When I comment that "people make different decisions on a Friday afternoon to a Monday", there is always this sigh of relief, that someone has actually said this and I think it is the same about visiting certain families - you knock on the door and just hope and pray they don't answer. Supervisors need to acknowledge this reality and help practitioners to address it and indeed to use it. (Team manager).*

In some cases the refusal to face the threat leads to the agency backing off and effectively abandoning the family, often in the very cases (such as serious neglect) where visiting is essential. The result is institutionalised neglect:

*In this case no-one would say "I am scared, you know, I am". There was a room full of people and nobody was assessing the family because the guy was violent. So the outcome was "well we've had a health and safety risk assessment so we won't visit". Organisations are getting very risk averse. Of course you don't want your staff raped or put in situations of danger but there are other ways of managing and dealing with that. At the end of the day, you've still got children there who need services and nobody is going in and seeing them, but it is much easier to deal with in more obvious cases like physical harm. (Senior Manager).*

### **Definitions and thresholds**

A third of the professionals interviewed (N=34) did not offer a definition of neglect and even more (N=39) gave no definition of emotional harm - perhaps indicating their lack of confidence in this area.

There were common themes in professionals' descriptions of neglect.

The child's needs (emotional and physical needs, care, education, safety and health) not being met:

*Failure to provide love, care and security on a regular basis. Ignoring the needs of the child so that their development is retarded or deformed. (Police Constable).*

Teachers often referred to denial of a child's right to receive educational opportunities and to be able to take them up:

*Neglect is where children are not accessing their entitlement to grow and develop to their full potential. (Head-teacher).*

Interviewees described long-term damage to the child's development, including their social and emotional skills:

*It can affect the child's sense of self and later relationships, even though this is not always obvious in physical ways. (Social worker).*

*The impact from a young age can be devastating; the child will never fully recover. (Social worker).*

Comments indicated that the damage could be either intentional or otherwise:

*Parents, consciously or otherwise, unable to provide the right environment. (Practitioner, children with disability team).*

Several comments concerned the chronic or long-term nature of neglect as discussed elsewhere, but equally important was lack of regularity, predictability and consistency of child care. Most damaging was an *erratic pattern of care*, rather than the length of time it went on for:

*The child's physical and emotional needs are not met consistently.*  
(Teacher).

This *irregular pattern of care*, often attributable to pressures external to the family, was a characteristic of neglect that made it hard to track. The worker could unintentionally collude with the ups and downs of the child's standard of care. Having done so made any future intervention harder.

*Neglect tends to drift in over a period of time so can go unnoticed. If the worker is not aware of what is "good enough" parenting then this can slip in under the radar. It is one of the most damaging forms of abuse potentially. It can get rooted in as a way of parenting. Practitioners in an area where neglect is common can get desensitised to it.* (Social Care Manager).

Without regular checks, personal (and group) thresholds could easily be distorted. Local deprivation could mask such distortions:

*How do you know whether your thresholds are in any way comparable to your colleagues' (whether in your own team, or in another agency) unless you have opportunities to share that information on a regular basis?* (General practitioner).

*This was a local serious case review about a family that were actually prosecuted for neglect. One problem was that while other professionals were concerned, the school weren't, because the kids attended and while they looked scruffy, the school's view was that "40% of our children come to school like that, so what, why the concern?" I think it can also be the case that in a deprived area thresholds are so high now, how do you gauge seriousness of neglect? Thresholds maybe high, but it doesn't mean its right.* (Child protection manager).

### **The "why act now?" problem**

Many hurdles had to be overcome in court proceedings. Firstly, clear evidence of the significant harm the child is suffering or likely to suffer as set out in the Children Act 1989 S31 (2) being met *on the date on which the local authority initiates proceedings*. Secondly, the court has to be satisfied that any order sought would be preferable to no order. Then there are many potential arguments about the definition of neglect.

There are also problems in specifying what is reasonable to expect from any particular parent, especially in circumstances of stress, duress or disability. There are questions about what constitutes "persistent failure" to meet a child's needs or "significant impairment" to their health or development.

Dickens (2007) argues that “catapult” incidents (undue discipline, an accident) help galvanise decision-makers including the courts, even when they do not represent any departure from the previous evidence. The legal emphasis on the here and now may see a dramatic event as more convincing in the court room than a lengthy history of inconsistent care.

Minimal, and/or belated co-operation by a parent might also lead some legal advisors to suggest postponing proceedings to “wait and see”. This tendency may explain why many serious incidents occurred at or near key decisions, when stress is at its highest (Brandon et al, 2007). On the other hand a subsequent clear risk to the child such as a serious accident would mean that the local authority could be criticised for delay. Further, the same neglectful conditions have a variable effect on different children, so the court may argue that if one child seems to show fewer ill effects, more work needs to be done with others.

The definition “persistent failure” means that workers are often asked to build up evidence of poor care and damage to a child’s development over time (e.g. from missed health appointments). Having waited, they are then challenged as to when and why poor care became a matter of actual or apprehended significant harm. They may have to decide whether to allow deterioration in the standard of parental care or put in what may have to be semi-permanent support systems that effectively substitute for the parent.

Overt incidents of neglect (e.g. a child left home alone or in unsafe or unhealthy surroundings) may be treated differently by different professionals. One school nurse reported that if she phoned a parent and found the child was home alone she would always call the police if she could not get hold of the parent. Others said this had happened without the police being called out on more than one occasion. Sometimes this tolerance was based on assumptions, such as that working parents were doing the best they could, that travelling children were resilient to lack of supervision, that some African parents expected children to cope alone at a young age.

Several interviewees were of the view that the varying threshold for action on neglect is not the only issue; knowledge, confidence, support to act and services to put in are also crucial. Without these, professionals have no real choices to make with cases of neglect.

Workers did not always receive management support in acting on their judgements, due to vacillation about “why act now?”, worries about the strength of the evidence and pressures to close cases. Short -term decisions were sometimes thought to be counter productive. For example minor improvements sometimes saw the case closed and support withdrawn. Sometimes such decisions were dangerous:

*We need a structure that challenges and persists. To just close a case means effect is lost. It’s done because of pressure to avoid costs and hit targets, not to keep cases open, not to register or re-register and not to take into care.*

*The issues are of professionals' (including managers') competence, confidence and authority in instructing legal representatives, who tend to advise in neglect cases that "it will be difficult to get an Order". An example was a case of pure neglect where social worker, support worker and health visitor had put in help for years. The social worker visited to find the child soaked in urine, locked in and in the dark.*

*She went back and told the manager "we have to go to court". She got the response "well what has changed in the family?" She then told the team because she wanted her views on record. The child was not removed but a new manager later had the child received in to care. But even then, despite a very good core assessment as to the developmental impairment, and the child being on the register, the health visitor had problems getting a child development assessment done. There is lack of confidence about the point at which you move and what is "enough" for a costly court case. (Children's Guardian).*

There should always be the possibility of discussing a case such as this with a senior manager. In circumstances like these, community services are not always aware of police powers to act under the Children and Young Person Act 1933 (S1), in circumstances where the child is left alone or in surroundings that are a risk to health and safety.

The court wants to see a completed core assessment preferably with an independent view point and a clear analysis and realistic care plan. In neglect cases it may be a tall order to summarise very lengthy records, and the independence of assessments will often be challenged. Even if court proceedings do not obtain a swift adjudication they may serve to test the evidence, to negotiate, obtain assessments in front of the court (often sharing costs), and also to share responsibility for outcomes with the court. Not to do this might later result in being sued for inaction under the Human Rights Act (see Dickens, 2007).

## ***Training and supervision***

Half of the interviewees gave no answer to the questions about training they had either received or would like.

Ten (10%) mentioned specific input in relation to neglect and emotional harm, and they were from a minority of the authorities involved. Some of these were very positive:

*We have a two hour course from the LSCB on recognition of neglect and a multi agency course on neglect for 2 days.*  
(Health visitor).

There were worrying gaps in basic training:

*I have never been taught how to observe the interaction between a mother and child in order to understand flawed bonding or lack of attachment. The only material I know is The Robertson tapes of children in hospital from the 1950's.* (Health visitor).

Regular multi-agency training in this area was a much appreciated rarity. In one area this followed a Joint Area Review recommendation:

*I have had lots of helpful inter-agency training and a course over 4 months on child protection.* (Health visitor).

*We have excellent training on emotional harm and neglect.*  
(Sure Start practitioner).

Multi-agency training could become a problem where one agency received criticism from others on training events and ceased to attend. It seemed that training was sometimes not led and managed to a high enough standard, with learning objectives and mutual expectations clearly set out.

Well over 90% of the interviewees had not had any training input focussed on neglect and emotional harm. Comments included:

*No training specifically on neglect and emotional harm.*  
(Council Solicitor /LSCB member).

*None specifically on neglect and emotional harm.* (GP/LSCB member).

*No specific training in this area.* (Social worker).

*It was only mentioned in passing on the child protection training.*  
(Teacher).

*Only generic child protection training.* (Probation).

*Self taught, experience, reading.* (Police officer in CAIU).

*There is a core programme, two days of general child protection training every two years and another day annually; but not enough on neglect. (School Nurse).*

Input had usually been one-off events rather than training, for example:

a day conference on neglect run by the LSCB, either as a special event or after a Serious Case Review

a seminar run by an organisation such as Making Research Count or Research in Practice

input for a particular professional group, e.g. the social work post qualification (PQ) award.

The subject might have been referred to, for example as a case study, in training on Child Protection generally, the Common Assessment Framework, Lead Professional or similar.

Some individuals had been able to draw relevant information from these.

There were many suggestions as to what training in relation to neglect should cover, including:

- signs, symptoms, appropriate actions, reaching a judgement
- thresholds and what to do if you're worried
- identification and assessment tools for neglect
- the child's perspective
- the effects of neglect or inconsistent care on emotional development
- attachment and neglect
- case-studies or scenarios, multi-agency training and reflection
- research and practice development, what works with various types of neglect and emotional harm
- recording and presenting evidence related to neglect
- specific subjects relevant to neglect and emotional harm e.g. cultural differences, disability, mental health, addiction, domestic violence, poverty, debt.

## **Summary**

Certain issues were raised repeatedly in the course of the interviews. They underscore the literature review. Professionals see child neglect as frequently being the result of an interplay of unresolved or untreated issues, each of which might be the responsibility of a different helping agency.

Sometimes no one of these issues quite reached a threshold for specialised help; and/or one issue emerged and resolved only to be replaced by another; and/or family members either did or could not seek the help they needed; and/or local services were not geared to a multi-agency response. This configuration, particularly when compounded by violence or intimidation, presents professionals with a major challenge in knowing whether, when and how to act in the best interests of children.

Most professionals, of all disciplines and levels of experience, had struggled with these issues and welcomed a more coherent and timely joint approach to child neglect. Where there are serious and/or complex family difficulties (such as mental ill-health, domestic violence, addiction, very poor physical environment), the child or children's needs should always be assessed and addressed fully, including the family history and context.

## 6. WHAT IS MAKING A DIFFERENCE?

This section provides examples of specific practices and policies that address neglect and emotional harm and the associated professional challenges which were described in previous sections.

Practitioners and managers across locations and professions endorsed what follows. In the interviews they gave examples of positive outcomes for children and of families who said they had found the practices helpful. These methods of tackling child neglect were seen as promoting:

- a more preventive, less crisis-oriented approach
- a focus on *both* safeguarding children *and* improving their day-to-day experience and likelihood of future welfare
- increased awareness of neglect in general, the family in question, and the necessary steps to be taken
- a “can-do, will-do” culture in efforts to improve outcomes for children
- a culture of sharing risk and responsibility for action to safeguard a child between agencies and with the parents and extended family
- more effective, relevant and positive communication systems
- more creative interventions.

### **A strategy for improved joint practice with neglect and emotional harm**

According to our interviewees this should include the following elements:

- gathering and analysing relevant evidence (e.g. service data, demographics, research)
- taking on board the views of children, parents, extended family and concerned members of the community in planning such a strategy
- leadership in identifying neglect as an area for active and continuous improvement
- setting positive expectations at a strategic, cross-agency level with plans, resources and follow-through; that is, not only in response to criticism or case reviews. Leaders or “best practice champions” should be identified by name in every service
- purposeful, sustained planning to reduce neglect and improve outcomes for children who experience it. This has to take place within and between all agencies involved with parents and children, and at all levels of intervention from the individual family, to local institutions and communities, to the whole authority.

It would mean developing *effective working policies and protocols* between children's services and all emergency and adult services, to ensure:

- genuine efforts to engage both parents and other significant adults
- tracking of families
- clarity on confidentiality
- high quality information exchange
- access to vulnerable children, challenging intimidation
- prompt and sensitive action to support and protect children in all situations posing a risk to their health, wellbeing or safety.

Structures that offer both support and challenge to all those involved, including practitioners and family members, so that no one is working alone, would include opportunities for:

- parents and carers to have supported "time out" to reflect and plan
- joint work across teams with facilitators
- cross-agency training
- reflection and study time for professionals
- case /clinical supervision
- off-line counselling and support.

*New practice would be disseminated, shared and adapted* openly and clearly, so that it can be understood easily by family members and by different professionals.

### **Basic good practice with neglect**

Interviewees mentioned the following elements:

- timely response to all expressions of concern about neglect
- an understanding of the child's day-to-day experiences
- adequacy of child care must be addressed as the priority
- engagement with mothers, fathers, male partners and extended family
- clarity on parental responsibility and expectations
- full assessment of the child's health and development
- monitoring for patterns of neglect and change over time
- avoiding assumptions and stereotypes
- tracking families whose details change (name, address, school, GP etc)

- regular update of records/communicating updates quickly and accurately
- regular, systematic planning and review of outcomes and service effectiveness; including the views of children and family members
- addressing underlying problems (poverty, isolation, violence, mental health, substance misuse) in a systematic way
- regular, independent case audit.

The project gathered evidence of success for specific forms of tracking, assessment, case management and intervention with neglect. Some are detailed below and others can be found via the References (p108 onwards).

## **Practice with families**

### **1) Nurse-Family Partnership**

This programme, originating in the US, is highly specified and has been rigorously evaluated. It involves qualified and specially trained nurses (in England, health visitors). They offer one to one visits to low-income mothers who have had no previous live birth, at regular intervals from pregnancy to the child's second year.

The Nurse-Family Partnership is currently being trialled in ten English primary care trusts. This trial is funded by government until 2008 as part of its social exclusion plans to reach families that may be left behind by existing preventive programmes such as Sure Start (Cabinet Office, 2007).

It is important to note that the programme is set up in areas willing and able to provide the necessary infrastructure (see above) to improve chances of success.

*Careful attention has been given to ensuring that organisational and community contexts are favourable for the development of the programme, to providing excellent training and guidance to the nurses in their use of the programme's visit-by-visit guidelines, to monitoring the functioning of the programme with a comprehensive clinical information system and to improving performance over time with continuous improvement strategies. (Olds, 2006).*

This echoes important findings from early intervention programmes, including some in the UK with regard to deprived populations, notably on reading and parent participation in learning (Desforges and Abouchar, 2003; MacKay, 2006). They provide strong evidence that a specific intervention with families is most effective and cost effective where it is set in the context of an assertive whole community ("bottom-up") and professional development ("top-down") strategy. This sets out to raise standards and expectations in the chosen area of child development, to engage the relevant stakeholders, and to provide a supportive context for the initiatives.

Within the Nurse-Family Partnership, visits follow prescribed guidelines in order to achieve:

- positive developmental and health outcomes for child and family
- more sensitive and competent care of the child
- improved life course for the parent
- supportive personal networks
- links to other sources of help and advice e.g. re health, education and work.

The results of several large scale randomized controlled evaluations with different populations (see Olds, 2006) indicate favourable outcomes for both parent and child. This section deals with positive effects on outcomes for children, which makes the programme of interest where neglect is a potential concern. For instance, with regard to the child staying safe:

- 80% fewer verified cases of abuse and neglect in first 2 years (difference in referrals for abuse and neglect reduces over 2 years after programme end, probably due to increased vigilance and active linking to services at programme end)
- increasing positive difference in number of verified cases of abuse and neglect (from ages 4 to 15).

With regard to the child staying healthy:

- 32% reduction in A&E visits (compared to controls) in second year of life
- fewer health emergencies in 2 years after programme end (to approx age 4).

With regard to children achieving and making a social contribution:

- long-term (15 year) follow-up of children as adolescents indicates the best results for the most deprived and at-risk families (mothers who had been low-income and single)
- children whose mothers had been through the programme had fewer running away incidents, fewer arrests and convictions, fewer sexual partners, less cigarette/alcohol consumption than controls.

Savings (on later services) for low-income unmarried mothers attending the programme exceeded costs by four to one, over childhood.

## **2) Video Home Guidance (VHG); Video Interaction Guidance training (VIG)**

VHG (or VIG) has been used widely in the Netherlands and in Scotland, but only by a few agencies in England. Home video of family interactions is used to provide a tool for behavioural and/or therapeutic change in situations where parents are experiencing acute difficulty with their children. It is also used in schools and with children with learning disabilities in Scotland, to improve their communication skills and confidence.

With the family's permission, a trained worker takes a short (10 to 15 minute) film of an activity or interaction chosen by the family. The worker then analyses it in detail for a short piece (two to three minutes at most) in which the parent responds to the child's approach appropriately. The parent is asked for their comments. The skills and abilities shown in the clip are used in work to develop the parent's:

- sense of capacity, self-control and worth
- ability to discuss the difficult interactions
- trust in seeking support with family interactions
- detailed observation of specific aspects of the interaction and the home environment
- range, appropriateness and sensitivity of response to the child
- evidence for seeking appropriate referrals for specialist services.

Other advantages of the method are that:

- the majority of young people and parents are comfortable with video, more so than with lengthy verbal descriptions
- the method is confidential to the family (with the usual caveats) and most families welcome a neutral setting in which to reflect on what needs to change
- the parent has the opportunity to gauge the child's physical and emotional environment at home
- the method offers a concrete and specific route to resolve difficulties
- the child is visibly part of the change process
- with improvements, self-esteem and mutual respect between family members increase
- the professional group can focus on positive change
- relevant referrals can be made for other support to the child and/or family.

One voluntary organisation uses the approach in a range of cases including where a child is on the child protection register, subject to legal proceedings, has been returned home from care etc. They have had success with cases of physical neglect at both the preventive stage and after children have been on the child protection register for some time.

Specific steps are taken to improve the parent-child relationship, using a simple framework with the parents as follows:

- being attentive (e.g. eye contact with the child)
- giving encouragement (e.g. with body language)
- taking turns, responding to the child rather than at them
- co-operating, giving and asking for specific realistic help
- guiding and directing; learning methods to increase the child's sense of security.

### **3) Parenting and play skills training**

Parent training includes teaching skills to parents. It also encourages a collaborative ethos, in which parents develop and share their own experiences and approaches, in other words they learn to teach as well. It addresses issues central to the prevention of neglect as it is intended among other things to improve the parent's confidence and communication; their engagement with and enjoyment of their child; their active involvement in their children's progress and learning; their use of non-punitive strategies and creative skills; their own learning and support network.

Play is used with younger children, directly addressing the child's cognitive, social and emotional learning. Parenting courses draw on theories of child development, attachment and behavioural psychology to reinforce children's positive behaviour and discourage disruption.

#### **3.1) The Parent-Child Game**

The Parent-Child game was developed in the US (Forehand et al, 1984) and is used in a number of centres in the UK. The aim is to work collaboratively with parents, helping them to understand what might be reinforcing child behavioural problems, for instance non-compliance or defiance. They can then encourage alternative positive behaviours and in a child-centred way.

The approach includes:

- observation and rating of parent-child interaction
- building on existing strengths and skills
- using a microphone and ear-bug link to parents to help with the interaction
- modelling and role play
- play work
- review and feedback
- weekly tasks to ensure skills are transferred to the home.

Staff and volunteers (including parents) have the opportunity to undertake training and to participate in staffing the programme. This brings a range of skills and experience to the service and also offers learning opportunities to those involved. It shows parents that they are not passive 'recipients' but can also become providers, an important contribution to building group support, trust and self-esteem.

The service consists of an initial assessment followed by five sessions of structured work. They develop skills in purposefully *attending* to a child (i.e. noticing what a child does without questioning or criticising); *rewarding*; *ignoring*; *giving directions* and *time out*. There is a manual for those presenting the sessions, each of which last for one hour a week with two workers. They can be done in or out of the home setting and the game can be adapted to individual children's needs.

Parents reported improvements in:

- children's own skills in handling their environment and expressing their needs
- the parent-child relationship
- parental confidence and skills in negotiating with the child rather than simply using pressure
- parents' ability to deal with adult relationship difficulties, for instance by using family group work and advocacy in negotiating with agencies

In one evaluation of the programme, while parental attitudes to discipline had not altered significantly, in over half the cases their methods of dealing with difficult behaviour and the behaviour itself had changed in the carers' view. This change was maintained after three months. Additionally, evaluation of stress levels led to the conclusion that:

*Overall, the mental health of these families has improved, with positive effect for all members. It is hypothesised that improved parenting skills will prevent future child behaviour problems and act as a buffer to external stress. (Gill, unpublished thesis).*

### **3.2) Incredible Years**

Carolyn Webster-Stratton has developed a number of parenting programmes for parents who are having difficulty with conduct they perceive as problematic in their children. It has been widely used in Head-Start early intervention services in the US and adopted in some Sure Start and other services in England. There is a large evaluation literature that includes control populations (see for instance Webster-Stratton and Hancock, 1998).

Emotional and social dysfunction in children is one frequent result of neglect (see p32 and p38). A parent who feels de-skilled, helpless, guilty and/or angry that they cannot handle their children may become detached and/or hostile and use coercion by over-reacting or withholding any response to the child. Well-structured programmes may have the potential to prevent or reverse early signs of such developmental problems.

The original twelve week programme (known as “The Incredible Years Parent Training Programme”) builds a resource bank for parents in dealing with young children that includes play skills; ways of using praise and incentives, and setting limits. The programme is illustrated by a “Parenting Pyramid” that visually links each parent skill and strategy to specific benefits for the child. The therapist or trainer uses principles of collaboration and group support, and plans carefully for long-term support beyond the close of the programme (an important issue in neglect).

A variety of methods and tools such as video tapes of various parenting strategies, role-play, home assignments, keeping in touch by phone and weekly evaluation are used to engage and maintain parents’ motivation.

Evaluation found that the measurable benefits from the programme could be limited by external stressors such as depression, marital conflict, isolation and socio-economic stress. In response to this finding, a further eight to ten (“Advance”) sessions were designed to help parents deal with such stressors. These include work on communication skills, talking about feelings, managing negative thoughts and stress, and problem-solving techniques. The authors conclude that the most important, but elusive skill for the therapist or trainer in this work is to create a collaborative ethos:

*not just between the therapist and parent but among groups of parents and with teachers and other community members to strengthen awareness of the tremendous and largely untapped support that can be developed.*

(Webster Stratton and Hancock, 1998).

Groups can then benefit from (and bolster) the wider infrastructure of local support.

An evaluation of four Webster-Stratton programmes in one of the study areas for this project found consistent improvements on standardised measures of children’s behaviour and parental stress and depression. There were good attendance and retention rates. Despite this, for some individuals the group experience itself was stressful. The evaluation concludes that to minimise this stress, training of facilitators must be high quality and resources are needed to support and prepare for the inclusion of participants who may otherwise not gain benefit or drop out. They include parents who are required to attend; those with particular stresses that need one-to-one support as well; black and ethnic minority parents, and fathers. Interestingly, referred parents (often required to attend) saw similar levels of improvement to other parents (Nationwide Children’s Research Centre, 2002).

A systematic review of the effectiveness of parenting programmes in improving maternal psychosocial health (Barlow et al, 2001) found that they are likely to have an important role to play in the promotion of mental health. There is evidence both of direct effects of such programmes on the mental health of mothers, and also, of the indirect effects that improved maternal mental health is likely to have on the development of sound mental health in children and future generations of adults.

Of relevance in this review of best practice is a comparison of three methods of delivering the programme - an individually self-administered method, a group discussion with therapist input, and a group discussion with video-tape modeling and therapist input (Webster-Stratton et al, 1988). They concluded that the self-administered mode of delivery increased self-efficacy by allowing families to solve problems and be responsible for their own treatment, and that this method of delivery also allowed for privacy, flexible scheduling, self-pacing, and self-control, all of which are difficult to achieve in a group setting. With a motivated population, or following a successful initial group experience, such an approach could be cost effective.

They found that group discussion with video-tapes of parenting approaches and skilled therapist input was successful in significantly reducing mothers' reports of parenting stress. This method of delivery resulted in higher consumer satisfaction scores, lower drop-out rate, and higher attendance.

#### **4) Case management and joint decision-making**

##### **4.1) Signs of Safety**

Interviewees stated that parents were often unclear as to what had to change in cases of neglect and what precisely was expected of them. Signs of Safety is an approach originally developed in Australia with child protection workers, in response to this issue:

*One of the most consistent complaints made by families investigated for child abuse is that they did not know what the statutory agency wanted of them. (Turnell and Edwards, 1997).*

Turnell and Edwards take the practical view that:

*The only avenue toward lasting protection of children, - except the extreme measure of permanently removing them from home - depends on establishing a co-operative relationship between the parents and care worker.*

(Weakland and Jordan, 1990 quoted in Turnell and Edwards, 1997).

To achieve a better working relationship, the Signs of Safety approach asks the statutory agency for greater transparency, and to specify exactly what will indicate enough safety to close the case. Family members' perspectives on competencies, existing safety and goals are actively sought. The goal is to *build partnerships with parents and children in situations of suspected or substantiated child abuse and still deal rigorously with the maltreatment issues* (Turnell and Edwards, 1997).

A risk assessment and case planning format are used that set out all elements of safety and danger to the child. The child's current situation is scaled using a simple format (see below). This is available to all involved including parents, and the child can be involved if he or she is willing and able to be. The decision-making group can then set goals for both the family and agencies that will increase safety and reduce danger to the child. The benefit of a scale or continuum from extreme risk to safety is that it brings detail and specificity to an endeavour that otherwise can easily become polarised into "them" and "us".

In England some children's departments are adopting this approach to improve decision making in child protection. Interviewees from all agencies involved (Police, Social Care with adults and children, Children's Guardians) thought it especially useful with neglect because:

- parents say they are clearer about what is expected of them and receive more relevant support
- the approach is open and encourages transparent decision-making
- the professionals had to be specific about their concerns for the child's safety
- this encouraged better presentation of evidence
- the degree of protective elements and of actual or apprehended risks could be set out visually on a scale, easier for all to understand than lengthy reports
- once set out, the risks did not have to continually be revisited
- the group could acknowledge strengths and meetings could focus on how to achieve safety.

## **Signs of Safety Assessment and Planning Form**

- *Danger: list all aspects that demonstrate likelihood of maltreatment past, present or future*
- *Safety: list all aspects that indicate safety (exceptions, strengths, resources, goals, willingness etc)*
- *Safety and context scale: rate 1= not a situation where any action would be taken to 10 = the worst case the agency has seen*
- *Agency goals: what will the agency need to see occur to be willing to close this case?*
- *Family goals: what does the family want generally and regarding safety?*
- *Immediate progress: what would indicate to the agency that some small progress had been made?*

Professionals we interviewed who had used this approach with cases of serious child neglect said that it was helpful.

*Signs of Safety is a useful approach because it makes everyone, the family and the professionals, think about what success would look like - i.e. how to make sure the child will stay safe. Everyone at a case conference, or core group meeting or review, including family members if they are there, has the opportunity to say how safe or otherwise they think the child is with their reasons. It is put up on a white board so it's there, it's transparent and we do not need to repeat the problems again and again - we can move on to how we are going to improve the situation.*  
(Child Protection Conference Chair).

*We see the Signs of Safety work very helpful as we can assist with the risk assessment aspect and it looks at protective factors as well, and gets the parents involved.* (Police DC, CIAU).

Scaling questions are also helpful in giving detail and specificity:

*It is useful to ask family members routinely a question like: "on a scale of 1 to 10 – where 10 means things in this family are just the way you want them and 1 is the worst they can be - where would you rate things right now?" This can be complemented by a specific safety scale "where 10 means you are certain this sort of incident won't happen again and 1 is you think there is every likelihood it may". The reality is the work is carried out somewhere in the space between total risk and complete safety. Scaling questions tap this sense of continuum and by the nature of their construction embrace the possibility of change.*  
(Turnell and Edwards, 1997).

The model is not prescriptive. It is being developed with practitioners in projects in a number of countries including in the UK. It also aims to engage practitioners in supportive networking and learning from successful practice (Turnell A and Edwards S, 1997; Myers S, 2005).

#### **4.2) Family Group Conferences (FGCs)**

There have been several evaluations of family group conferences, the majority giving positive results (Marsh and Crow, 1998). FGCs are network meetings where the wider family, and any other key persons, make decisions about a child or young person who has been identified (either by the family or service provider) as needing a plan to safeguard or promote their welfare.

An independent co-ordinator is appointed who identifies the network with the young person and her or his carers. Its members do not necessarily all have to be present at the same time, but all who wish to will have their views presented. Professionals attend to give information about issues (such as child safety), services, resources etc, and then the family is left to agree the following:

- a plan to meet the needs (including safety) of the child or young person
- contingency plans
- how to monitor and review the plan.

The referrer, FGC co-ordinator and key professionals meet again with the family to hear the plan and negotiate resources. The co-ordinator writes up the plan which becomes a working tool leading up to any review meeting.

FGCs are now used or in development in over half of English local authorities in a range of situations such as cases of children in need, children in need of safeguarding, children at risk of offending etc. They are also in use in Wales, Scotland, America, Australia, New Zealand and Scandinavia.

Charities in Scotland express the view (Community Care Oct 2006) that family group conferences should systematically be part of an early intervention strategy to address the needs of increasing numbers of children neglected by drug-abusing parents, not all of whom need to enter state care.

The process can be helpful to:

- bring extended family and friends (who may not have been identified before) into the picture
- better understand the family dynamics
- give members who are habitually silent (including the child) a voice, and establish and share responsibility for the child's safety and welfare.

Family Group Conferences can be especially helpful in cases of neglect and emotional harm where the helping agencies are kept at bay by some family members or have differing accounts of the family's situation. They can often be a precursor to kinship care or supervision. A Family Group Conference Manager gave several examples:

*In one family the mother felt undermined by her mother who constantly criticised the (rejected) child's father. They used demeaning language to one another. The FGC led to placement with grandfather and his new wife.*

*In another case the mother had an alcohol problem which she was trying to manage and the FGC was held to create a plan that supported her child's care. Her two aunts wrote a very positive letter and having initially refused to let them attend she heard this read out and phoned them asking them to come along. They are now part of that plan.*

*Family group conferences lead to discussion of the family systems problems that often underlie neglect.*

*With an FGC the parent makes a choice and can exercise responsibility. So it is not just about plugging in services but creating possibilities. Currently professionals dominate the child protection process with the result that families do not know how to move on for themselves.*

*FGCs spread responsibility; they bring in grandparents including the father's family who often would like a role; also fathers and male partners. The FGC project has to have direct access to families in case social workers do not offer it as a genuine option.*

A successful project requires leadership from the top in encouraging use of FGCs; a genuine choice; independence of the project and the co-ordinators; good training and support for all involved; and follow-up. They can be labour intensive in the early stages of planning and researching the family members.

The co-ordinator needs good negotiation and mediation skills to ensure all voices are heard. Professionals may feel "out of the loop" and need training to understand the process. Without leadership to make FGCs a genuine option (for instance all teams meeting regularly with the FGC manager to go through possible cases) the approach may remain peripheral.

## **5) Assessment**

### **5.1) The Graded Care Profile (GCP)**

The distinctive feature of the GCP is that it was designed by a health professional with child neglect in mind, and used and refined with practitioners across agencies. Like the Signs of Safety approach, the GCP is based on a continuum of care. It uses a qualitative linear scale based on child development theory. This profiles the child's care in a range of developmentally sensitive areas or "dimensions". Each of these can be constructed along a continuum (see Srivanasta et al, in Taylor and Daniel (eds), 2005).

Where a child's development and/or parental care give active cause for concern, the GCP is a way of achieving greater clarity and transparency about the nature and degree of those concerns. It thus helps to specify responsibilities and actions to address them.

In discussion with parents and carers (and children in some cases), professionals draw the evidence together to grade the child's care on four broad areas or dimensions of care: 1) physical care, 2) safety, 3) love and 4) esteem. Each of these has sub areas. Each dimension and sub-area can then be graded, as follows:

- Grade 1 All child's needs met; child first; best care
- Grade 2 Essential needs fully met; child priority; adequate care
- Grade 3 Some essential needs unmet; child and carer at par; equivocal care
- Grade 4 Most essential needs unmet; child second, care poor
- Grade 5 Essential needs entirely unmet/parent hostile; child not considered; worse.

For example, the dimension *esteem* breaks down into four sub areas:

- 4.1 Stimulation
- 4.2 Approval
- 4.3 Disapproval (of undesirable behaviour)
- 4.4 Acceptance.

The sub area *disapproval* could be constructed along a continuum from "mild verbal, consistent" to "cruel - (the child is) terrorised, ridiculed". The GCP has two components - A manual which contains the full scale, descriptors and instructions; and a record sheet to note and aggregate the scores.

Although some professionals are worried about “quantifying” care or making negative judgements, this is balanced by advantages put forward by interviewees (across a number of agencies) in this project who had used the approach, listed below:

- the Graded Care Profile directs the practitioner to a judgement, backed with observation, about the *adequacy of care the child is experiencing*, without confusing this key issue with other (important but separate) issues such as causes and intentions
- parents and children can be involved in the process and their views included
- there is the possibility of identifying positive aspects of care and tracking both deterioration *and* improvement, much more precisely.
- all agencies - health, education, social care - find it useful in joint work with neglect
- it identifies difficulties in specific aspects of care so can be used to target intervention
- it can assist with monitoring of progress over time
- it assists with multi-agency assessment and can inform the Common Assessment Framework.

A health visitor commented in her interview that:

*we have used the Graded Care Profile - it helps us to think of the various dimensions of neglect and how much of each aspect of care is present or absent? How many of the aspect of care are lacking and how much of each aspect? This includes hygiene, care, safety, emotional responses etc. It helps us to work more effectively.*

The originators of the GCP conclude from their evaluations that joint use of the tool has improved practice with child neglect as it:

*complements conventional assessment methods in providing an objective sense of direction, particularly in chronic cases and in between detailed assessment points. Some professionals had used it with carers, some with other professionals and some with older children to get an insight into their perspectives on their own care. It was generally felt to be working but needed a rolling programme of interactive refresher sessions to monitor the quality of its use and to address such difficulties as arose. Since the inception (of its use) there had been a significantly enhanced focus on identifying issues of neglect, both at early stages and within the child protection arena.*

Several children's services departments are now using the GCP in cases of actual or apprehended neglect. Luton has trained staff in its use and launched an evaluation of its impact on case work effectiveness (see website in References).

## **5.2) Childcare and development checklist**

A multi agency project group in one of the project areas had used research to devise a checklist of features in child, the parents or carers and the home environment that are associated with neglect. This is reproduced in Appendix 3, p121.

Data to complete the checklist is compiled from agency records and interviews. It has many advantages in bringing together a mass of evidence in a relatively succinct format. The checklist records and monitors features where there are concerns about neglect; informs multi-agency assessment; highlights specific cases in a deprived area where they may go undetected; provides a baseline for routine contacts and assists organisation of information in case notes in an accessible and useful form. The checklist is relatively quick to complete once data is collected.

On the other hand, evaluation found that it can be time-consuming to retrieve the data from files due to cursory contact or failed appointments. Some health data is thin, all agencies had poor data on home conditions, and there were few recorded observations of child-parent interactions, even where the child was on the child protection register.

Interviewees who had used it felt it was an important monitoring tool for neglect:

*It's a very useful list and you can use it to identify signs of concern and check things are going the right way for instance if a child is no longer registered.*

## **5.3) Common Assessment Framework (CAF) and lead professional (LP)**

The Common Assessment Framework, when used as intended, provides a structured developmental tool to support professional discussion and judgement. Given a supportive infrastructure of training inter-agency work, the results were said to be positive. Assessments could be completed in community settings resulting in earlier intervention:

*We have done quite a few CAFs from the school and they've been generally good – got things going when we would have been getting worried otherwise. But I can see us being victims of our own success if we take on too many – it's not what we are here for primarily. (Head teacher).*

*We find the levels in the CAF useful and we work to them.  
(Police constable).*

Some practitioners referred to adaptations of the Assessment Triangle (which includes the child's developmental needs; parenting capacity, family and environmental factors) that ask specific trigger questions related to neglect. A number of studies of neglect contain such protocols or trigger questions and it remains to evaluate their use and whether these targeted assessments result in improved outcomes for children as a result.

The Lead Professional role could also be a helpful way of bringing in key agencies. Comments included the following:

*Schools are accepting the LP role and school nurses are very active.* (Head Teacher).

*Ours is an integrated multi-disciplinary service and so we are all expected to do CAFs and Lead Professional, health and education colleagues find it a good learning experience.*  
(Member of Children with Disabilities Team).

As with many joint developments, the framework of monitoring and mutual support is key to success. The task could be onerous:

*Lead professional is a good idea but very hard to have several of these cases in a tough area; very stressful, exhausting, despairing work.* (Social Worker).

Not all Lead Professionals were fulfilling the role adequately:

*It's a good idea but a lot of LPs are not visiting the home and seeing the conditions e.g. the urine soaked mattress the child is sleeping on.* (Team Manager, Children's Services).

## **6) Other practice and policy development**

### **6.1) Local procedures on neglect**

A brief review of local safeguarding procedures was undertaken for this project, using those available on the LSCB websites. References are given (p108 onwards) to a selection of procedures that reflect research and practice development in the field of neglect.

## **6.2) Lessons from America**

The US Department of Health and Human Services analysed ten demonstration projects working with aspects of neglect, for common lessons (National Clearinghouse on Child Abuse and Neglect Information, 2004).

Among many other relevant findings they report the best results when:

- intensive services were provided for at least a year, and included follow-up
- services were provided to the whole family including one-to-one work with older neglected children
- crisis support was provided including 24 hour help-lines
- services were delivered flexibly
- practical services were offered to begin with
- relationships were developed with as many family members as possible, including fathers
- one-to-one work was used to start with if this was preferred to a group
- culturally appropriate providers and approaches were used
- incentives to engagement e.g. transport, child care, social events, validation and variety of content were provided
- staff were prepared and supported fully e.g. shadowing of experienced staff; individual and group supervision; staff safety; joint responsibility for cases.

Effective approaches included:

- using an empowerment approach with active participation by families e.g. in setting goals
- on-going staff training
- multi-disciplinary teams
- partnership with trusted community organisations
- centre as well as home based provision
- an advisory committee with stakeholders
- maintaining collaboration with local leaders, participants and organisations.

## **Summary**

Neglect and emotional harm present multiple challenges which many Local Children's Safeguarding Boards, individual agencies and practitioner groups are trying to address. They are creating and adapting tools for identification, assessment, intervention and long-term monitoring for families where child neglect is an issue.

The approaches all provide a common language and structure, not appropriated by any one profession or group. They focus on achieving a joint understanding, engaging the family and acting in a way that consistently supports and challenges family members to promote the welfare and safety of each child, addressing their individual needs.

They provide a means of improving the standard of information collection and the quality and transparency of inter-agency communications and decisions. As a result risk and responsibility for change can be shared with individuals including family knowing what is expected of them. More consistent information means that learning from practice can be shared to provide better support to professionals.



## 7. TACKLING THE ISSUES: THE BIGGER PICTURE

Evidence was drawn together by this project from three main sources. Primary sources were interviews with professionals directly engaged in work with children and families, and group discussions between experts from a range of disciplines and backgrounds. Secondary sources were derived from reviews of research, policy and best practice in this area.

The evidence collected here consistently shows that only a thoroughly co-ordinated and systemic approach is likely to be effective, because child neglect usually involves different strands of difficulty. It may occur in the context of one or many factors referred to in the literature; for instance a difficult pregnancy, illness, addiction, poor relationships, poverty or other factors - some temporary and some more lasting.

While these strands are found in all safeguarding work, serious child neglect is a stark signal that multiple deep-seated problems need attention. The combined number and depth of them often paralyses the professionals as well as the family. One issue emerges from behind another and planning and intervention has to be flexible enough to address them as and when they arise. If child neglect is to be turned around, workers need to have the resources to assess and respond to the family's environment and circumstances; individual family member's characteristics; specific concerns with individual children; plus all the associated legal, organisational, professional and procedural issues.

This section looks at strategic planning and infrastructure for service provision, and gives (national and international) examples that could assist in addressing child neglect and emotional harm.

### ***A broader view of child welfare***

A recent Cabinet Office report (2007) considers precisely the issues referred to above, in relation to "families at risk" with multiple problems for whom "single-issue" services are inadequate. Although child neglect is not the focus of the report there is a clear overlap in its subject-matter. The list of family "risks" is near enough identical with the list derived from case reviews of neglected children, and the case studies are similar to those described in our interviews.

One of these concerns a single mother with a history of Class A drug use, associated debt and:

*history of broken, dysfunctional relationships (children have witnessed arguments and domestic violence). Thirteen year old child suffered as a result of mother's history of drug misuse; she was bullied at school and has become increasingly withdrawn and her school work is suffering; concern over both children's diet and dental problems. (Cabinet Office, 2007).*

Evidence discussed above indicates that both children here are suffering physical neglect and emotional harm (at the very least) and that the older child's social and academic future is compromised.

Many issues central to addressing neglect are considered in the Cabinet Office report. One is the poor engagement between some families and services intended to help them. Service providers may regard the family as chaotic, challenging and unmotivated; the family sees services as narrowly focussed, intimidating and belated.

Another relevant issue that the report draws attention to is the tendency to address individual symptoms or behaviours rather than linking services to work on the underlying difficulties:

*Even the most effective integrated responses from children's services will only ever ameliorate the impacts of parent-based risk factors on a child. To reduce the actual risk at source, joint working with adults' services is required to tackle the parents' problems.*  
(as above, 2007).

A third concern very pertinent to child neglect is the cumulative effect of multiple difficulties which just fail to meet different service thresholds;

*We know that the more disadvantages a family has the greater the risks of negative outcomes. However, service responses do not usually take into account the accumulated needs identified by different services as each agency is restrained in its intervention by its own eligibility criteria. It may be possible for some families to have a range of problems, all of which fall just below eligibility thresholds but which in combination pose very significant risks. One example was of mental health services not working with an adult in the family as their needs were not deemed severe enough. This was hindering the effectiveness of drug treatments with the parents and affecting the child's school attendance.*  
(as above, 2007).

A fourth issue in common with this study is how to motivate and support staff in cases where families' engagement with the service *may often have been chaotic and requires a level of coordination beyond the capacity of the individual front-line worker* (as above, 2007). Ideas such as individualised budgets for families, a "shared script" of outcomes across agencies, multi-agency approaches and more sensitive targets for improving outcomes in difficult cases are all discussed. Many services illustrated in the Cabinet Office report have been used to address child neglect.

The connections between these areas of policy need to be explicit. Strategies within the Every Child Matters sphere, intended to support families and prevent child neglect as well as to safeguard children when it occurs, need to be actively linked to the broader agenda of reaching out to the most vulnerable families. This would energise and motivate many who are currently struggling with massive tasks of assessment and risk management.

### ***Child welfare indicators***

Work in the United States on indicators for child well-being is highly compatible with the Every Child Matters agenda and with a more constructive, preventive joint approach to multi-agency issues such as child neglect.

It fits well with the broader child welfare approach adopted by schools in the UK that provide extended services, with children's centres and other community-based provision.

It would provide a useful framework for LSCBs to audit their effectiveness both overall and in relation to a strategy for neglect specifically. For instance, improving poor immunisation or dental check up rates is an important target in itself but also helps with early identification of neglect.

Chalk et al (2002) make a case for the routine inclusion of **child well-being indicators for all children in contact with welfare agencies**. They argue that this would achieve key policy goals to:

- develop a focus in data collection on action to improve positive future outcomes for children, rather than seeking evidence for such actions only from retrospective data on harm
- provide more realistic interim indicators for agencies in achieving national child welfare goals of child safety, permanency and well-being
- shift from procedural compliance, towards evidence-based performance measures and outcomes
- help shift public and media attention towards a more informed, representative debate on children's safety and well-being rather than focussing on extreme but comparatively rare risks.

The authors' conceptual framework for their chosen indicators includes:

- The child: His or her background and history, in terms of his/her status and well-being
- the system: the child welfare system, in terms of delivery and performance
- the family and environment: the family setting and community environment, in terms of their capacity to support and keep the child safe.

All of these strands are then analysed to provide child and adult outcomes and indicators.

They also provide a helpful review of current US Federal and State Policies, set out in tabular form, to show how they meet the six priority areas for improved child outcomes. These are broadly comparable to Every Child Matters. They concern the child's:

- safety and well-being
- attachment and engagement
- education and cognitive development
- social and emotional well-being
- health status
- violence and victimisation experiences (both in the home and the community).

Their review of the evidence concludes that every element has to be monitored to ensure that children are effectively safeguarded. The evidence set out in this report suggests that this is especially true of neglect. If for example the child is out of school or attachment with the carer is threatened, safeguarding services and processes are undermined.

They provide a sample of indicators that meets “guiding principles” of utility, ease/economy of collection from existing sources, and evidential rigour etc. All are relevant to neglect and emotional harm (Chalk et al, 2002):

- measures of healthy beginnings e.g. birth-weight and pre-maturity
- measures of mental health e.g. (number and percentage) of children taking medication for mental health disorders
- measures of healthy and safe environments e.g. (number and percentage) of children with injuries requiring medical assistance; e.g. who have witnessed domestic violence
- measures of participation in early childhood education programmes e.g. (number and percentage) of children with developmental delays and learning disabilities who participate in pre school programmes
- measures of home environment and child development e.g. proportion of children aged less than 13 yrs in latch key situations e.g. child feels safe
- measures of developmentally appropriate behaviours and attitudes e.g. (number and percentage) of children with good conflict resolution and interpersonal problem-solving skills
- Measures of youth development e.g. (number and percentage) of youth age 15 and older with basic life skills.

### ***A graded definition of neglect***

In order to assist professionals in understanding the child's experience, the Ontario Child Welfare Eligibility Spectrum sets out a number of elements of safeguarding concern as follows (Ontario Association of Children's Aid Societies, 2005-7):

- physical/sexual harm by commission
- harm by omission
- emotional harm
- abandonment/separation
- caregiver capacity.

Each of these elements is subdivided into a number of topics with Rating Scales. For example "harm by omission" includes scales for:

- inadequate supervision
- neglect of child's basic physical needs
- caregiver response to child's physical health
- caregiver response to child's mental, emotional, developmental condition
- caregiver response to a child under 12 who has committed a serious act.

Each scale provides examples from "not severe" to "extremely severe" and offers an intervention threshold. Each scale is cross-referenced to the appropriate section of Canadian children and family law with a full interpretation using research references and checklists for that topic where appropriate.

We heard from interviewees that approaches using scales were particularly helpful in addressing neglect (see p77 and p82). This helps evidence areas of care that are stronger and whether overall, care is safe. It will also help to track several strands of difficulty (see above, p89) for accumulated improvement or deterioration, meeting a key failing in current services, where a family has to reach a specific threshold for each service (see above, p89).

### ***Clarifying parenthood***

Some of the professionals interviewed for this study stated that to deal with neglect it is crucial to understand *what being a mum or a dad means* for that particular woman or man – for instance, if a child has died, the idea of becoming a parent again may create fear. This was often not considered early on, nor in the context of a full family history. Active promotion of a positive idea of parental responsibility would allow a better joint understanding by professionals. It could help pinpoint at an earlier stage where and how a parent needed help to ensure a child's safety and welfare. It also fits well with tools such as the Common Assessment Framework and Signs of Safety.

*We tend to look at the behaviour and - not until we do a CAF or a child protection investigation might we consider what being a parent means to them. The crucial thing with neglect is the parent's own understanding of what being a parent is about.*  
(Senior Manager, Children's Services).

It would also help parents and carers to know what is expected of them:

*I am not now allowed to examine a child's head for nits without the parent's express permission due to the Human Rights Act - nor can I supply a treatment, much less treat the child. Of course it is the very children who are repeatedly infested, whose parents I cannot reach.* (School Nurse).

Section 3 (p15) discussed the problems that arise from current definitions of neglect, including the high threshold that means they are often applied only when the child is suffering severe, avoidable deprivation. The concept of parental responsibility could provide a more positive way of setting out what the majority of parents aspire to, and importantly would engage fathers and male carers in this aspiration. It could be the basis for education in parenting and for community based interventions with parents and carers.

The law currently defines parental responsibility in broad terms:

*All the rights, duties, powers, responsibility and authority which by law a parent has in relation to the child and his property.*  
(Children Act 1989 S3 (1)).

Others link the exercise of parenting responsibility to the desired outcomes for a child:

*The activities and behaviours of parents necessary to achieve the objective of enabling children to become autonomous...(they) change as the child develops. Thus parenting as an activity is firmly linked to child outcomes.* (Jones, in Horwath (ed) 2001).

Henricson (2004) argues that work is needed to clarify the concept of parenting responsibility. In her view, tensions are emerging between different pieces of legislation. The responsibilities and rights of fatherhood remain unclear. Legal, genetic and social parenthood all need clearer definition:

*The question of who carries responsibility for parenting, who is not appropriate to do so and who is entitled to do so is a fraught one, particularly taking place as it does against a backdrop of social change towards serial partnership and a high incidence of single parenthood.*

*Lobbyists might also make the case that there has been insufficient service investment particularly in early preventive relationship support to demonstrate the government's full commitment to the business of supporting the couple relationship - in whatever form that might take.* (Henricson (2004)).

She uses neglect to illustrate how, in the absence of clarity about parental responsibility, the issue is often decided purely in pragmatic terms of who is “holding the baby”. This highlights a:

*need to clarify the differences in the nature and degree of parental responsibility between resident and non-resident parents. Presence in the child’s home has major implications in terms of child protection responsibilities and in many cases a (resident) adult, parent or not, will be more open to potential accusations of neglect than a non-resident parent. Presence and absence is a crucial determining factor in relation to the reality of physical and caring responsibility that requires greater clarification.*

(as above, 2004).

Henricson sets out the main elements of parental responsibility. They are: **to maintain the child; to provide safety, emotional and physical care; to support education and pro-social behaviour.** She draws on current legislation, guidance and policy in other countries, the Human Rights Act 1998 and UN Convention on the Rights of the Child 1989. It could be extended to the responsibilities of those in loco parentis.

This approach can potentially clarify the meaning of neglect. For most of the practitioners and experts we interviewed, these were the key aspects of both parents’ care that need to be reinforced in work on child neglect. It would therefore make sense to incorporate them in official guidance, if not in a revised definition. Each aspect can be further broken down into specific behaviours (e.g. p82).

Within the context of parenting responsibility a working definition becomes much more straightforward - neglect being *the situation of a dependent (child or adult) whose needs (developmental, welfare, safety etc) are not being met by responsible adults.*

Parenting responsibilities, Henricson adds, can be set alongside the parents’ rights, in relation to their child, to regulate the child’s residence, guide their upbringing and act as their legal representative. These would include a proviso along the lines that *any entitlement may be overridden by the best interests of the child and would need to be reconciled with children’s rights.* Public institutions have a duty to respect family life and provide appropriate financial support, services, advice and information.

### ***Inter-agency ownership of risk***

This concept was introduced earlier (see p23). A study of variance in rates of child protection registration concluded that it is essential to effective strategies for safeguarding children (Oliver et al, 2001). Other essential elements of such a strategy are:

- good quality information used for continuous improvement
- good quality and range of preventive services
- strong work with families.

All of the above were mentioned frequently by interviewees as essential to deal with child neglect. Developing inter-agency ownership of risk is a particular challenge. According to Oliver et al, there has to be a joint commitment to:

- sharing and monitoring intra and inter-agency thresholds
- clarity and transparency as to how decisions are taken
- robust complaints and problem-resolution processes
- joint audit
- recruitment and retention of social work expertise with a strong professional ethos.

Many illustrations in this study support this idea as central and it would provide an excellent basis for an LSCB strategy to improve practice in neglect. A few examples follow.

### ***Extending ownership of risk: accident prevention and neglect***

Some LSCBs have started to broaden the safeguarding base of their work to organisations within the community. This could include, for example, voluntary, commercial and/or faith organisations and/or emergency services. An inclusive approach often has a beneficial spin-off where neglect is concerned:

*We have the fire service represented on the LSCB. It happened because they have a grant from central government to address fire prevention and children in some of our areas are at high risk for fire accidents, areas where neglect crops up. It's great to have them involved - the fire service do prevention visits, make sure smoke alarms are working etc. In other words they talk to parents about safety. (LSCB manager).*

### ***Extending ownership of risk: primary health care and neglect***

There was agreement that many instances of neglect and emotional harm could be avoided by improved provision of basic child health and safety education for parents, in the community and the home. This would be along the lines of the Nurse-Family Partnership (see p71) but on a very much wider scale.

To address the family issues that often surround child neglect, the service would need to be adapted for delivery to particularly vulnerable populations e.g. parents with learning difficulties, those dealing with substance misuse, and violence in the home. There would need to be close, preferably joint working arrangement with adult services.

*People who are not motivated e.g. depression, alcohol, need a very assertive approach. Once they turn up, that is half the battle. You are not likely to go to the community alcohol service if you are depressed and on half a bottle a day, it should go to you. Plus men under-report their mental health problems - they tend to abuse substances and/or become paranoid, jealous and sometimes violent.*

*Forty per cent of children on the register here have parents with mental ill-health including substance misuse and poor anxiety management. A better protocol is needed between children's services and adult mental health services. We have quite good primary mental health care with the community psychiatric nurses running clinics in GP surgeries - but we ought to be able to do a mental health assessment whenever there is a concern about a parent and a child protection referral.*

*The community drugs team needs to be attached to both crisis intervention and assertive outreach services. We should use the CAF much earlier with depressed parents; those psycho-social problems can come out as hostility or even violence. (Mental health services Manager).*

The involvement of primary health services in the Every Child Matters agenda was extremely variable, both between the areas visited, and over time. Some services were in recurrent crisis. This means for instance that early screening for genetic or constitutional problems, which may be mistaken for, or exacerbate neglect, is not consistently available. Referrals for specialist help were not made because of uncertainty and lowered expectations.

*The cuts in PCT services have left us tearing our hair out. (Midwife).*

*Health visiting services have been slashed and numbers of nursery nurses will halve due to crisis in the PCT, yet health visiting is supposed to be the focal point for young children. (General practitioner).*

*School nurses are to be cut yet about 80 per cent of their work is with aspects of neglect and emotional harm. (Educational psychologist).*

*The community psychiatric nurse service is now under threat. (General practitioner).*

## ***The National Standards Framework***

The NSF was developed as part of the Change for Children agenda and is based on the five ECM outcomes (NSF, 2003). It sets standards for work with children by health agencies that apply to interagency work, of which the relevant standard is NSF standard 5:

*All agencies work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed.*

Chambers and Licence (2005) have already applied the NSF to general medical practitioners' inter-agency practice in both safeguarding and child protection. They comment that it has traditionally been difficult to involve GPs in this area of work, and they clearly see the NSF standard as a way of raising the health profile of safeguarding children.

The authors set out both organisational and individual standards with regard to interagency education and training; advising GPs to apply the Clinical Governance Framework for both organisational and individual monitoring of performance management, clinical standards, risk assessment and user involvement:

*Treat child abuse like any other life threatening chronic disease, a clinical governance matter for yourself, your practice and your PCT.*

They recommend a "system-wide approach" to safeguarding and use set standards in GP practice with regard to:

- promoting positive parenting
- identifying vulnerable families (e.g. post natal depression, learning difficulties, substance abuse)
- urgency of referral of child protection concerns
- assessment of concerns
- management of ongoing relationships
- working with survivors of abuse.

General practitioners face many challenges in safeguarding work, including confidentiality and maintaining their relationship with parents, fear of complaints etc. However, there is now stronger guidance on actions required by them when a child is at risk (GMC, 2007). Many GPs lacked training and confidence with families:

*I have done one day's vocational training myself on child protection. There are "protected afternoons" for training and one of these is child protection, but it isn't required and it is not a priority as it isn't paid though some do it anyway. I think pictures of abused children is old hat, we need help in how to talk to children and parents about harm, neglect and domestic violence. (General practitioner).*

The idea of an on-screen training pack with practical scenarios and an interactive approach was welcomed as a very exciting idea, because it could be fitted into the working schedule, and help “skill up” practitioners and motivate attendance at training events.

## **Summary**

Professionals we interviewed mentioned a number of “bigger issues” that they thought contributed to their difficulties in addressing child neglect. Very often these were not on any specific agenda, or they were partially addressed and then dropped.

*The UK government has taken a positive stance on improving child well-being and outcomes...They also intend to push resources further towards families with multiple or complex problems, who are currently poorly served by traditional services.  
(Cabinet Office, 2007).*

A high proportion of children suffering significant harm are neglected, physically and emotionally, within such families. Sympathy for, or professional commitment to, parents in difficulty can never justify failure to act on neglect; indeed such action may be a first step towards helping parents. We know enough to avoid much of the human and economic costs of such harm with confident, multi-skilled and well-resourced services responding to the early signs. We need to revise our terminology, skills and resource allocation to develop a progressive rather than the current residual strategy on neglect.



## 8. IMPROVING JOINT WORK

This final section gives a resume of key Learning and Action Points raised by the project, concerning the way forward in improving joint work with child neglect and emotional harm.

- 1) Child neglect is a major form of maltreatment in the UK; it has not yet been effectively addressed either preventively or in treatment.
- 2) There is now sound evidence that all forms of neglect (physical, emotional and environmental) are likely to have damaging effects on child development and socialisation, both in the short and long term.
- 3) Without effective intervention, neglect can lead to chronic maltreatment and death, sometimes after many years of abuse.
- 3) The project found a lack of clarity and authority concerning definitions, thresholds and interventions in the field of neglect. These concerns crossed professional and status boundaries. They contributed to avoidable delays in taking preventive action.
- 4) The depth and range of problems that parents are struggling with are better understood, as well as the ways in which these interact. All professionals need to be able to act on awareness that any of these issues can result in child neglect and must be actively addressed.  
They include:
  - history of abuse and neglect
  - history of negative associations with professional intervention (or its lack)
  - mental ill-health
  - personality disorder
  - drug and alcohol misuse
  - associated crime and violence
  - domestic violence
  - learning difficulties
  - chronic ill health
  - children with disabilities or/and ill-health
  - multiple births
  - multiple losses
  - multiple moves
  - hardship and long-term unemployment
  - no/patchy/unsafe support network
  - severely deprived and neglected environment.

- 5) The nature of neglect presents real challenges to workers engaging with families and to joint work. This report started with a description of some familiar reactions to working with families in which children face neglect and emotional harm. Despite the best intentions, professionals can become demoralised, anxious, uncertain of their own judgement, and insensitive to what in other circumstances they would see as totally inadequate parental care.

It is important to re-iterate that these effects were described by professionals in all fields and at all levels of seniority. They were seen to reflect the real challenges of work with families sometimes struggling with a heavy burden of environmental and personal difficulties, whose expectations of themselves and of helping agencies were minimal, and with a minority of violent or intimidating individuals.

Inter-professional work faces the same challenges multiplied, and could at times be characterised by confusion, disagreement and mutual blame. In the worst scenarios the agencies avoided both one another and the family, sometimes with dire consequences. Therefore, staff welfare and safety are essential to a successful strategy for continuous improvement in this area.

Responsible bodies at all levels need to consider the following possible ways forward in improving joint work on neglect and emotional harm:

- build on the Every Child Matters framework which covers many of the child development outcomes compromised by neglect
- engage parents by using outreach and flexible budgets to tailor services, as suggested in recent government proposals (Cabinet Office, 2007)
- focus on best practice and on equipping staff (through training and service development) to address neglect more actively
- ensure that staff are as safe as possible in the work
- break down the concept of neglect and emotional harm in ways which may assist in agreeing joint thresholds and designing appropriate interventions as well as meeting the legal challenge more effectively
- ensure that thresholds are not rigid and that accumulated risks from a number of sources are taken into account
- use the concept of parental responsibility as an asset model and include all those with a caring responsibility for the child
- design active interventions, through joint work with adult services, to meet the range of problems that parents are struggling with
- have clear working protocols between children's services (including children with disabilities) and the relevant adult services including domestic violence, substance and alcohol misuse, disabilities, mental health, MAPPA and MARAC
- review and adapt existing tools for their application to work with neglect.

Elements of a strategy to address neglect and emotional harm:

- leadership in identifying neglect as an area for active and continuous improvement, at a strategic, cross-agency level with plans, resources and follow-through; that is, not only in response to criticism or case reviews
- purposeful, sustained planning to reduce neglect and improve outcomes for children who experience it. To be effective this has to take place within and between all agencies involved with parents and children, and at all levels of intervention from the individual family, to local institutions and communities, to the whole authority
- joint policies with emergency and adult services to ensure tracking of families
- ensure safe access to vulnerable children, address intimidation, and act to support and protect children in any situation posing a risk to their health and/or safety
- structures that offer both support and challenge to all those involved, including practitioners and family members, so that no one is working alone; e.g. consultancy, proactive case review, learning from success
- new practice disseminated, shared and adapted openly and clearly, so that it can be understood easily by family members and by different professionals
- taking on board the views of children, parents, extended family and concerned members of the community.

Other possibilities being trialled or debated included the following:

- develop inter-agency ownership of risk as described above
- encourage wider debate on parental responsibility and neglect within the community
- create the widest possible constituency to support this debate including faith and community groups, housing, emergency services, private and voluntary organisations, businesses, police and probation, adult services
- review legal advice, professional and public guidance in this area
- e.g. consider a “what to do if you’re worried a child may be neglected” guide
- focus on improving joint practice and outcomes for children who experience neglect at various stages and levels; including its recognition, early prevention of its escalation and protective action
- break neglect down into manageable areas for action and target vulnerable groups, e.g. infants; children with disabilities; parents with personality disorder/mental health etc

- regularly and frequently disseminate research findings and best practice on neglect, including guidance for parents and carers, in accessible formats
- consider an advisor on safeguarding children from neglect in every service unit, linking its core business to relevant best practice, research, training etc
- develop sensitive targets, standards and incentives for post qualification training in safeguarding children, specifically in respect of neglect, across all key disciplines
- set up a rolling programme of training on neglect, develop on-site sessional training e.g. lunch-time seminars, virtual scenarios and discussion groups; include research findings; experiences and outcomes for children; associated adult problems; joint working; what works with neglect; legal issues
- each agency to have transparent procedures and thresholds for action on neglect. Use joint case audit, case study seminars and case panels to maintain a working consensus, aid understanding and share risk
- debate and clarify issues of confidentiality, communication and recording with clear guidelines
- review tools in use e.g. Procedures, CAF and LP processes, conferences etc, to ensure they include indicators of and responses to neglect. Consider tools (see above) which engage family members and encourage participation.

There is evidence of good outcomes for structured and intensive intervention with neglect, preferably at an early stage. The report has described ways in which neglectful, avoidant and defensive patterns of behaviour can be altered. The various practices and tools set out here have all been used effectively to counter neglectful and avoidant behaviour with a consistent, attentive and assertive approach.

The evidence reviewed by this study suggests that successful interventions:

- are supported by a sound infrastructure of training, guidance and supervision
- start with the child's lived experience and a realistic picture of the family
- attend to the child's immediate needs
- maintain purposeful contact with each child
- address concerns about worker safety to ensure access to children
- establish a consensus as to the level of neglect each child experiences
- break down the problem areas
- are specific and very clear with parents, carers and colleagues about outcomes for children and adequate day to day care

- engage parents and carers in describing what success will look like and the process for getting there
- maintain contact with the family, including updated information recorded across agencies
- seek out specific interventions and resources to achieve change
- identify responsibility for addressing issues, including all carers
- establish a time frame based on each child's needs
- provide direction and leadership to planning (e.g. to sort out professional differences)
- sustain consistency and clarity for the family despite external changes.

To conclude, success is never guaranteed and sustaining these assertive approaches presents one of the hardest challenges to “working together”. Interviewees gave a clear message that we must strive to improve our communication and shared learning in order to achieve a happier future for children who are suffering neglect, and for their families.



## 9. INFORMATION SOURCES AND REFERENCES

### **UK Websites**

[www.dcf.gov.uk](http://www.dcf.gov.uk)

[www.dcf.gov.uk/everychildmatters](http://www.dcf.gov.uk/everychildmatters)

[www.dfespublications.gov.uk](http://www.dfespublications.gov.uk)

[www.cabinet-office.gov.uk](http://www.cabinet-office.gov.uk)

[www.gmc-uk.org/guidance/](http://www.gmc-uk.org/guidance/)

[www.integratedcarenetwork.gov.uk](http://www.integratedcarenetwork.gov.uk)

[www.signsofsafety.net](http://www.signsofsafety.net)

[www.luton.gov.uk/internet/health](http://www.luton.gov.uk/internet/health)

(Click on child protection/safeguarding children then safeguarding interagency procedures)

[www.staffsscb.org.uk](http://www.staffsscb.org.uk) (Click on procedures then on chapter 13 neglect)

[http://www.hackney.gov.uk/child\\_neglect](http://www.hackney.gov.uk/child_neglect)

[www.frg.org.uk](http://www.frg.org.uk) (Family Group Conferences)

<http://women.timesonline.co.uk/to/>

[itdoesn'thappentodisabledchildren\\_wda48257.html](http://www.nspcc.org.uk/informhub_wda48257.html)

[http://www.nspcc.org.uk/informhub\\_wda49931.html](http://www.nspcc.org.uk/informhub_wda49931.html)

Childcare and development checklist (p115/6); [www.hallyandoliedoctors.org](http://www.hallyandoliedoctors.org)

### **Overseas websites**

Ontario Child Eligibility Spectrum

[www.oacas.org/resources/eligibility/index.htm](http://www.oacas.org/resources/eligibility/index.htm)

## **References**

American Professional Society on the Abuse of Children (APSAC) (1995). *Guidelines for the psychological evaluation of suspected psychological maltreatment in children and adolescents*. APSAC.

Barlow J, Coren E, and Stewart-Brown S (2001) *Systematic review of the effectiveness of parenting programmes in improving maternal psychosocial health*. Health Services Research Unit: University of Oxford.

Barth R et al (2005) Parent-Training Programs in Child Welfare Services: Planning for more a more evidence-based approach to serving biological parents. *Research on Social Work Practice* Vol 15(5), pp 353-371.

Brandon M, Belderson P, Warren C, Howe D, Gardner R, Dodsworth J, and Black J (2007) *Analysing child deaths and serious cases through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005*. DfES.

Browne K, Hanks H, Stratton P and Hamilton C (2002) *Early prediction and prevention of child abuse*. A handbook: Wiley.

Burton P (2002) *Using Video Interactive Guidance (VIG) in a Learning Disabilities Team*. Foundation of Nursing Studies.  
[www.fons.org/ahcp/grants2000](http://www.fons.org/ahcp/grants2000)

Cabinet Office (2007) *Reaching out: think family: analysis and themes from the Families At Risk Review*.

Chalk R, Moore K A and Gibbons A (2003) *The development and use of child well-being indicators in the prevention of child abuse and neglect*. Child Trends [www.childtrends.org](http://www.childtrends.org).

Chambers R and Licence K (2005) *Looking after children in primary care, a companion to the NSF*. Radcliffe Publishing.

Crittenden P M (1999) Child neglect: cases and contributors. In H Dubowitz (ed) *Neglected Children, Research, Practice and Policy*. Sage

Cleaver H, Nicholson D, Tarr S and Cleaver D (2007) *Child Protection, Domestic Violence and Parental Substance Misuse, Family Experiences and Effective Practice Quality Matters*. Jessica Kingsley Publishing.

Dance C, Rushton A and Quinton D (2002) Emotional abuse in early childhood: relationships with progress in subsequent family placement. *Journal of Child Psychology and Psychiatry and Allied Disciplines*. Vol 43(3), pp 395-407.

Dickens J (2007) Child neglect and the law: catapults, thresholds and delay. *Child Abuse Review* Vol 16(2), pp 77-92.

Desforges C and Abouchar A (2003) *The impact of parental involvement, parental support and family education on pupil achievement and adjustment: a literature review*. DfES research report RR 433.

DfES (2004) *National Services Framework for children, young people and maternity services*.

DfES (2005) *Multi-agency Working Toolkit*.

DfES (2006) *Working together to safeguard children*. Stationary Office.

DfES (2006) *What to do if you're worried about a child*.

Dubowitz H (ed) (1999) *Neglected children. Research, practice and policy*. Sage.

Dubowitz H et al (2004) Measurement of three major subtypes of child neglect. *Child Maltreatment* Vol 9(4), pp 344-356 Special Issue (U.S.).

Egeland B, Jacobvitz D and Sroufe LA (1988) Breaking the cycle of abuse. *Child Development* Vol 59, pp 1080-1088.

English, D. et al (2005) Toward a definition of neglect in young children. *Child Maltreatment* Vol 10(2), pp 190-206.

Gain L and Young L (1998) *Outcome measurement in child protection: international literature review and critical analysis of child protection and alternative placement outcome measures*. Australia: Steering Committee for the Review of Commonwealth/State Service Provision.

Gardner R (2003, 2005) *Supporting families: child protection in the community*. NSPCC Wiley.

Gardner R and Cleaver H (2007) Working effectively with parents. In *Safeguarding Children – a shared responsibility*. Leicester: NSPCC.

General Medical Council (2007) *0-18 years: guidance for doctors*.

Gill A (1998) *What makes parent training groups effective?* Doctoral thesis, University of Leicester.

Gilmour J and Skuse D (1999) A case-comparison study of the characteristics of children with a short stature syndrome induced by stress (hyperphagic short stature) and a consecutive series of unaffected 'stressed' children. *Journal of Child Psychology and Psychiatry* Vol 40(6), pp 969-978.

Glaser D (2002) Emotional abuse and neglect (psychological maltreatment) a conceptual framework. *Child Abuse and Neglect* Vol 26(6), pp 697-714.

Glaser and Prior (2002) Predicting emotional abuse and neglect. In Browne K et al (eds) *Early prediction and prevention of child abuse: a handbook*. Wiley.

Haggerty R J, Sherrod L R , Garmezy N and Rutter M (1996) *Stress, risk and resilience in children and adolescents*. Cambridge University Press.

Henricson C (2004) *Government and Parenting*. Joseph Rowntree Foundation.

Hindley N, Ramchandani P G and Jones D P H (2006) Risk factors associated for recurrence of maltreatment. *Archives of disease in childhood* Vol 91, pp 744-752.

H M Government (2007) *Reaching out: progress on social exclusion*. DfES (Ref 280255/0307/D8).

H M Government (2007) *Staying safe: a consultation document*. DCFS (Ref 00571-2007DOM-EN).

Horwath J (2007) *Child neglect: identification and assessment*. Palgrave Macmillan.

Howe D (2005) *Child abuse and neglect; attachment development and intervention*. Palgrave Macmillan.

Howe D (2006) Disabled children, maltreatment and attachment. *British Journal of Social Work* Vol 36(5), pp 743-760.

Fluke J et al (1999) Recurrence of maltreatment: an application of the national child abuse and neglect data system. *Child Abuse and Neglect* Vol 23(7), pp 633-650.

Forehand R L, Furey W M and McMahon R J (1984) The role of maternal distress in a parent training programme to modify child non compliance. *Behavioural Psychology* Vol12, pp 93-108.

Iwaniec D (1997) An overview of emotional maltreatment and failure-to-thrive. *Child Abuse Review* Vol 6(5), pp 350-388.

Iwaniec D (2003) Identifying and dealing with emotional abuse and neglect. *Child Care in Practice* Vol 9(1), pp 49-61.

Iwaniec D (2006) *The emotionally abused and neglected child*. Wiley.

Jones D (2001) The assessment of parental capacity. In Horwath J (ed) *The Child's World*. Jessica Kingsley Publishing.

Jones L M, Finkelhor D and Halter S (2006) Child maltreatment trends in the 1990's: Why does neglect differ from sexual and physical abuse? *Child Maltreatment* Vol 11(2), pp 107-120.

Lewis V (2003) *Development and disability*. Blackwell.

Marsh P and Crow G (1998) *Family Group Conferences in child welfare*. Blackwell.

MacKay T (2006) *The West Dunbartonshire Literacy Initiative: the design, implementation and evaluation of an intervention strategy to raise achievement and eradicate illiteracy*. Phase I research report: West Dunbartonshire Council.

Mesie J, Gardner R and Radford L (2007) *Towards a Public Service Agreement on safeguarding children*. DfES.

Moffitt T E (1993) Adolescence-limited and life-course-persistent antisocial behaviour; a developmental taxonomy. *Psychological Review* Vol 100(4), pp 674–701.

Myers S (2005) A signs of safety approach to assessing children with sexually concerning or harmful behaviour. *Child Abuse Review* Vol 14(2), pp 97-112.

National Clearinghouse on Child Abuse and Neglect Information (2004) *Child neglect demonstration projects: a synthesis of lessons learned*. Washington DC. <http://nccanch.acf.hhs.gov/profess/promising/index.cfm>

National Statistics and DfES (2005) *Children in need in England: preliminary results of a survey of activity and expenditure as reported by Local Authority Social Services Children and Family teams for a survey week in February 2005* (SFR 52/2005).

Nationwide Children's Research Centre (2002) *Parents and children videotape series: Parenting programmes 2001-2002*. Brian Jackson House, HD15JP.

Norris R (2006) Set up to fail? *Community Care* Oct 26 to Nov 1, p50.

Olds D L (2006) The Nurse-Family Partnership: an evidence-based preventive intervention. *Infant Mental Health Journal* Vol 27(1), pp 5-25.

Oliver C et al (2001) *Local authority variance on child protection indicators*. Institute of Education.

Parton N and O Byrne P (2000) *Constructive social work towards a new practice*. Macmillan.

Quinton D and Rutter M (1984) Parents with children in care; II. Intergenerational continuities. *Journal of Child Psychology and Psychiatry* Vol 25(2), pp 231-250.

Raine A, Brennan P and Mednick S A (1994). Birth complications combined with early maternal rejection. *Archives of General Psychiatry* Vol 51(12), pp 984-988.

Roditti M G (2005) Understanding communities of neglectful parents. *Child Welfare* 84(2), pp277-298.

Rutter M (1989) Intergenerational continuities and discontinuities in serious parenting difficulties. In Chicchetti D and Carlson V (eds) *Child maltreatment: theory and research on the causes and consequences of child abuse and neglect*. Cambridge University Press pp 315-348.

Shipman K, Edwards A., Brown A, Swisher L, and Jennings E (2005) Managing emotion in a maltreating context: A pilot study examining child neglect. *Child Abuse and Neglect* Vol 29(9), pp 1015-1029.

Schnitzer P G and Ewigman B G (2005) Child deaths resulting from inflicted injuries; household risk factors and perpetrator characteristics. *Pediatrics* Vol 116(5), pp 687-693.

Slack K et al (2004) Understanding the risks of child neglect; an exploration of poverty and parenting characteristics. *Child Maltreatment* Vol 9(4), pp 395-408.

Srivastava O P et al (2003) Common operational approach using the Graded Care Profile in cases of neglect. In Taylor J and Daniel B (2005) *Child neglect: practice issues for health and social care*. Jessica Kingsley Publishers.

Sroufe L A, Egeland B, Carlson E A and Collins W A (2005) *The development of the person: the Minnesota study of risk and adaptation from birth to adulthood*. The Guildford Press, New York: London.

Stevenson O (2007) *Neglected children and their families*. Blackwell.

Stobart E (2006) *Child abuse linked to accusations of "possession" and "witchcraft"*. DfES Research Report RR750.

Stone B (1998) *Child neglect: practitioners' perspectives*. NSPCC.

Tanner K and Turney D (2003) What do we know about child neglect? A critical review of the literature and its application to social work practice. *Child and Family Social Work* Vol 8(1), pp 325-338.

Tanner K and Turney D (2006) *Understanding and working with neglect. No 10 research and practice briefings*. Nottingham.  
[www.rip.org.uk/publications/researchbriefings/asp](http://www.rip.org.uk/publications/researchbriefings/asp)

Taylor J and Daniel B (2005) *Child neglect: practice issues for health and social care*. Jessica Kingsley Publishers.

Tunstill J et al (2007) *Improving children's services networks: lessons from family centres*. Jessica Kingsley Publishers.

Turnell A and Essex S (2006) *Working with "denied" child abuse: the resolutions approach*. Open University Press.

Turnell A and Edwards S (1997) Aspiring to partnership; the Signs of Safety approach to child protection. *Child Abuse Review* Vol 6(3), pp 179-190.

Utting D Monteiro H and Ghatte D (2006) *Interventions for children at risk of developing antisocial personality disorder*. Policy Research Bureau.

Wark M J et al (2003) Emotional neglect and family structure: impact on student functioning. *Child Abuse and Neglect* Vol 27(9), pp 1033-1043.

Webster-Stratton C, Kolpacoff M and Hollinsworth T (1988). Self-administered videotape therapy for families with conduct-problem children: comparison with two cost-effective treatments and a control group. *Journal of Consulting and Clinical Psychology* Vol 56 (4), pp558-566.

Webster-Stratton C and Hancock L (1998) Training for parents of young children with conduct problems: content, methods and therapeutic processes. In Schaefer C E and Briesmeister J M (eds) *Handbook of parent training*. pp 98-152: Wiley (New York).

Webster-Stratton C (1999) *How to promote children's social and emotional competence*. Paul Chapman Publishing Limited.

Wilson S L, Kuebli J E and Hughes H M (2005) Patterns of maternal behaviour among neglectful families: Implications for research and intervention. *Child Abuse & Neglect* Vol 29(9), pp 985-1001.



## 10. APPENDICES

### Appendix (1)

#### **Developing Joint Practice in Emotional Harm and Neglect: a shared inquiry.**

The University of East Anglia & the NSPCC

Venue: Conference Room, Floor 5 Weston House, 42 Curtain Road, EC23NH

#### **Agenda**

**09:30**     **Arrival, refreshments etc**

**09:50**     **Session One: Background to the day**

#### **Welcome and Introductions**

**09:50**     **Chair's Introduction:**

The UEA/NSPCC project and today: Prof David Howe

**10:10**     **What Needs to Change - the project to date:**

Ruth Gardner

**10:50**     **Session Two (in groups): What We Know**

Introductions around each table.

Sharing evidence about joint practice that has had sustained positive impact for children in cases of emotional harm and/or neglect. Identifying and recording the distinctive features of this practice.

**11:30**     **Coffee**

**11:40**     **Session Three (plenary): Key Statements**

Discussion of emerging themes and issues from the morning.

**12:20**     **LUNCH**

**13:00**     **Session Four (plenary): Applying what we know to improve practice**

Re-cap the Key Statements from the morning: how can we raise our game in these areas?

**13:45**     **Session Five (in groups): Planning a change agenda**

Using the Key Statements, outline an improvement plan for more effective joint work for children in cases of emotional harm & neglect.

**14:30**     **Session Six (plenary): Priorities for Change**

What have we learnt? What can we do NOW? What could we start to plan?

What do we want to see that's different in one, five or ten years' time?

**15:10**     **Summing up: what will be done with the day's output**

**15:30**     **Tea and depart**

## **Purpose and Notes for the day - please read carefully**

**WHY?** The purpose of the day is to share evidence we have gathered between us that may help to improve outcomes for children who are emotionally harmed and/or neglected. (This includes practice and management experience, evaluation and research).

**WHO?** Everyone invited brings special knowledge in this area from a variety of disciplines.

**HOW?** As this is a one day event we need to distil what we know about this area as much as we can without ignoring its complexity. We will use a “shared inquiry” approach to pool our knowledge and experience on the day. We trust the day will be both stimulating and helpful.

**WHAT?** A conference report will be sent to all participants. The report will not name individuals or locations without permission and you will be asked for comments on the draft. Any practice tools or publications you share will of course be fully acknowledged in the report.

**BEFORE THE DAY** could all participants look at the questions below from their own professional/knowledge perspective, and consider ways of conveying their thoughts to an audience outside their own discipline. Please could you avoid or else explain all professional terms and acronyms.

- **What elements of practice could improve outcomes (safety, health, education etc) for children who are emotionally harmed or neglected?**
- **How do we know? (please bring concrete examples)**
- **How can this practice be reproduced?**

For example the suggestion “improve practitioner skills” may be too general, we need to know which practitioners? Which skills? How can these be developed? Where there are knowledge gaps we would like to identify these as well.

## APPENDIX (2)

### Developing best practice to safeguard children from emotional harm and neglect

(EHN) Profile Questionnaire

(1) Ruth Gardner, University of East Anglia, March 06

NOTE: this questionnaire is about your own experience and views on the topic and no identifying information will be collected. Completion is entirely voluntary. If you decide to give your contact details, they will help us get back to you for clarification but they will not be used for any other purpose and will be stored confidentially and destroyed at the end of the project.

- 1) What is your professional background?
  
- 2) How many years have you been qualified in this profession?
  
- 3) What do you understand by the term "neglect" in relation to a child?
  
- 4) What do you understand by the term "emotional harm" in relation to a child?
  
- 5) In your own professional experience, (approx) how many children have raised concerns re EH&/or N? How many families?
  
- 6) Please give as many e.g.'s as you can of presenting problems you have found related to EH&/N, in:
  - 6A) Child
  - 6B) Mother
  - 6C) Father
  - 6D) Family
  - 6E) Other

7) Which of the above (if any) have triggered concerns about possible harm?

- 
- 
- 

8) What other circumstances might trigger concerns about possible harm?

- 
- 
- 

9) Who has raised these concerns and where?

- 
- 
- 

10) What actions or services have you found most helpful in addressing these problems?

- 
- 
- 

11) What has been unhelpful in your view?

- 
- 
- 

12) What Guidance, Procedures or other tools are available to you relating to EH&/orN?

- 
- 
- 

13) What tools would you find helpful?

- 
- 
-

14) What training have you received relevant to EN&/orN?

- 
- 
- 

15) What training would you like?

- 
- 
- 

16) Other comments/illustrations (NO names or identifying data).  
If you can think of a particular situation or situations that illustrate an important issue, please use a separate sheet to tell us about this.

IF YOU WISH:

Your Name (CAPITALS PLEASE):

Your daytime contact number:

MANY THANKS.

Any queries, please contact Ruth Gardner.



## APPENDIX (3) CHILDCARE AND DEVELOPMENT CHECKLIST

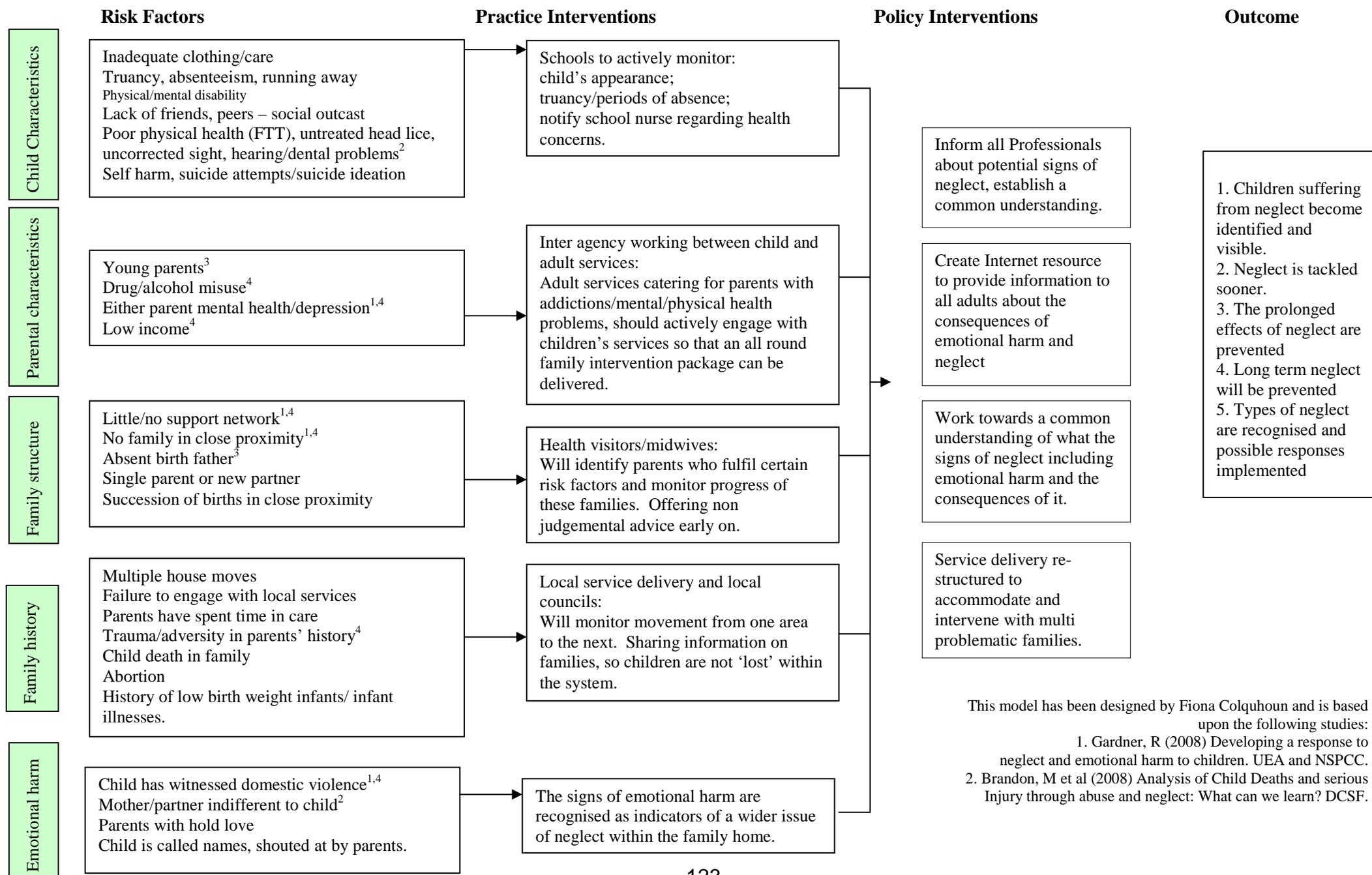
FEATURES OF CHILD					
NAME OF CHILD:		DATE COMPLETED:			
Symptoms and signs	Absent	Borderline	Clear	Not known	Not applicable
<b>DEVELOPMENT AND EDUCATION</b>					
Delay in vocalisation/speech/language					
General developmental delay of unknown cause. Failed development checks.					
Poor educational performance or learning difficulties					
Frequent nursery or school absences and/or lateness or fetched late from school.					
<b>HEALTHCARE</b>					
Delay in seeking medical attention and/or consistently missed appointments					
Recurrent or resistant nappy rash or failure to manage skin conditions e.g.eczema, parasitic infections					
Recurrent minor infections/ or frequent clinic/ casualty attendances					
Child not registered with GP in area					
Poor dental hygiene, inadequate immunisations, failure to attend to hearing or visual problems(specify which apply)					
<b>SUPERVISION</b>					
Poorly supervised outside or in the home (poor choice of carer, young child caring for sibs, risky situations, wandering, whereabouts unknown)					
Unexplained bruising and frequent minor injuries or frequent accidents					
<b>FEEDING AND EATING</b>					
Poor weight gain or below the third centile or short stature, looks malnourished(include gross obesity)					
Reported feeding problems					
Voracious appetite. Stealing or begging for food. Bizarre eating habits, hoarding food					
Child fed an inadequate or unbalanced diet					

Symptoms and signs	Absent	Borderline	Clear	Not known	Not applicable
<b>APPEARANCE</b>					
Inappropriately dressed for weather conditions, age or sex. Clothes incorrect size.					
Smelly. Unchanged nappies. Wetting and soiling in older children					
Dirty, grubby or unkempt					
<b>EMOTION AND BEHAVIOUR</b>					
Under stimulation					
Excessive crying, difficulty in settling					
Attention seeking/ over familiar with adults					
Overactive or poor attention span					
Severe behavioural problems. Destructive or aggressive					
Stealing					
No friends, poor or inappropriate friendships. Socially isolated.					
<b>ATTACHMENT AND EMOTIONAL CARE</b>	mo. Fa	mo. Fa	mo. Fa	mo. Fa	mo. Fa
Child fails to respond to or seek parental attention (positive or negative). Poor attachment					
Parents observed not to show an appropriate response to child's' emotional or physical needs					
Parents unable to supervise child or set limits in an age appropriate manner.					
<b>OTHER FEATURES NOTED</b>					
<b>TOTAL:</b>					

Hall, A (2007)

Contact: [hallyandoli@doctors.org](mailto:hallyandoli@doctors.org) for further information.

# APPENDIX (4) INITIAL OUTLINE OF RISK FACTORS SURROUNDING NEGLECT AND POSSIBLE INTERVENTIONS.



This model has been designed by Fiona Colquhoun and is based upon the following studies:

1. Gardner, R (2008) Developing a response to neglect and emotional harm to children. UEA and NSPCC.
2. Brandon, M et al (2008) Analysis of Child Deaths and serious Injury through abuse and neglect: What can we learn? DCSF.