



Childhood Neglect

Parental Difficulties and Neglect

Produced by Carla Thomas

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Acknowledgements

The training materials published on the DfE website as *Childhood Neglect: Improving outcomes for children* were commissioned by the Department for Education and produced by Action for Children and the University of Stirling.

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The ACE study (Adverse Childhood Experiences)

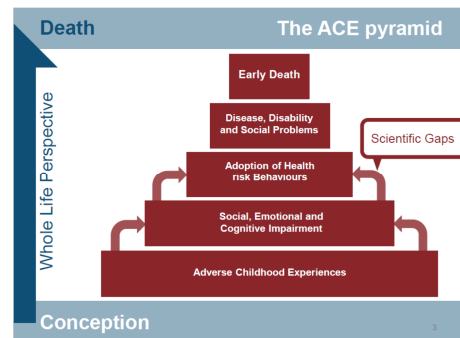
- Adverse Childhood Experiences and their relationship to Adult Health and Wellbeing.
- Child abuse and neglect.
- Growing up with domestic violence, substance abuse, mental illness, crime.
- 18,000 participants.
- 10 years.

(Anda *et al.* 2008)

Some findings so far...

Increased risk of:

- lung cancer
- auto immune disease
- prescription drug use
- chronic obstructive airways disease
- poor health related quality of life.



An introduction to brain development and neglect

- Brain plasticity
- Neurobiology
- The Romanian orphanage studies
- Perry and the Child Trauma Academy

At birth 6 years old 14 years old

Illustration based on Seeman (1999)

Brain Plasticity

During the development of the brain, there are critical periods during which certain experiences are expected in order to consolidate pathways – for example, the sensitivity and regularity of the interaction which underpins attachment with the caregiver.

Negative experiences such as trauma and abuse also influence the brain's final structure.

In cases of severe emotional neglect some pathways will die back.

The Child's brain will be smaller

Neglect and the Brain

- The 'new neurobiology': traumatology (especially PTSD) and developmental neuroscience.
- Neurobiological treatment goals.
- Brain plasticity.
- Differences between neglect and abuse.
- Genetic and environmental modifications.

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Developments in neuroscience have given us a greater understanding of the developing brain and the impact of abuse and neglect.

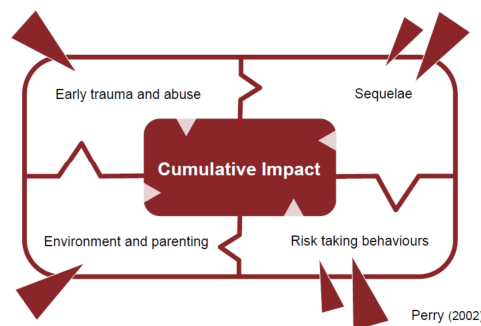
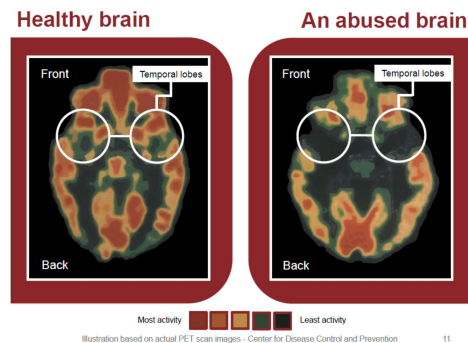
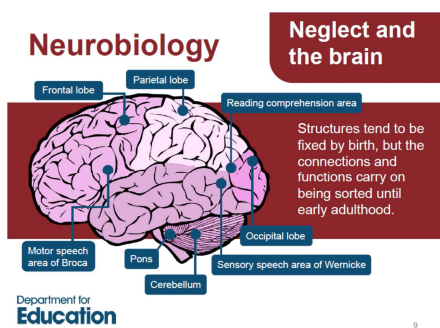
Our brains expect to have experiences. Our brains are experience dependant.

Chugani et al. (2001)

- Romanian Orphans.
- Persistent specific behavioural and cognitive deficits.
- Brain glucose metabolism.
- Significantly decreased metabolism.

The Child Trauma Academy

- The Child Trauma Academy (Perry et al.).
- The Child who was Reared as a Dog (Perry and Szalavitz 2007).
- Neglect: the absence of critical organising experiences at key times during development.
- Non-human animal studies.
- Institutional deprivation.
- Recovery after safe placement.
- Corroboration: Romanian orphans.
- Brain scans.



Identifying when parenting capacity results in neglect

Parents of neglected children

- Mothers and fathers of neglected children usually LOVE their children;
- however, they face many social and personal CHALLENGES; and
- these factors affect their capacity to provide what their children need to the extent that the children suffer, or are likely to suffer, significant harm.

Dimensions of parenting capacity

- Basic care
- Ensuring safety
- Emotional warmth
- Stimulation
- Guidance and boundaries
- Stability

Family and environmental factors

- Family history and functioning
- Wider family
- Housing
- Employment
- Income
- Family's social integration
- Community resources

Neglect and Deprivation

In a study of 555 families referred to children's social care about concerns of neglect or emotional abuse of the children:

- 57% had no wage earner in the household
- 59% lived in over-crowded housing conditions
- 10% had had 5 or more house moves in the previous 5 years
- 47% households headed by a lone parent
- 26% of parents and 24% of children had a disability or long term/serious illness
- 56% of parents reported high levels of emotional stress.
(Thoburn et al, 2000)
- 'poverty is not a predictor of neglect: it is a correlate of neglect'. (DiLenonardi, 1993, in Horwarth, 2007)
- The majority of people living in deprived circumstances parent their children effectively, but it is a lot harder.

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- Deprivation can interact with other stress factors resulting in children's needs not being met adequately.

Research tends to have focused on mothers and has suggested them to:

- be more likely to be poor
- be less able to plan
- be less able to control impulses
- be less confident about future
- be less equipped with sense of self-efficacy
- have psychological and psychosomatic symptoms
- have had poor educational attainment
- have a high sense of alienation...
- struggle to manage money
- lack emotional maturity
- be physically and emotionally exhausted
- experience depression
- lack of knowledge of children's developmental needs
- struggle to meet dependency needs of children
- experience feelings of apathy and futility. (Kadushi 1988, Polansky 1981, Crittenden 1996, Gaudin 1993, Giovannoni 1979, Horwath 2007, Mayhall and Norgard 1983, Taylor and Daniel 2005, Stevenson 2007)

Less research on fathers, but they are likely to:

- be unemployed
- be a less supportive partner
- be violent to the mother
- misuse substances.

The man in the household is:

- more likely to be the non-biological parent,
- less likely to have been in the relationship longer than 5 years. (Coohey 1995, Featherstone 2001)

Factors associated with neglect that affect parenting capacity –

- Own experiences of adverse parenting
- Lack of supportive network/family/other
- Learning disability
- Maternal depression
- Parental psychiatric illness

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- Parental substance misuse
- Abusive relationships with partner/domestic violence

Parental mental health issues

- One in four adults will experience a mental illness in their lifetime.
- Of these, between a quarter and a half will be parents.
- Their dependent children are at greater risk of experiencing health, social and/or psychological problems.
- Combined issues such as genetic inheritance, social adversity and psychological factors may lead to an increased chance of children experiencing mental health issues.
- The impact of mental ill health on parental capacity will depend on the parent's personality, the type of mental illness, its severity, the treatment given and support provided.
- Many mental health problems are manifested in intermittent episodes of symptoms.
- This can result in fluctuations between good and poor parental capacity.

Parental substance misuse

- Research carried out to inform the Advisory Council on the Misuse of Drugs report, 'Hidden Harm' (2003), estimated:
- 200,000-300,000 children of problem drug users in England and Wales
- this represents 2-3% of children less than 16 years.
- Between 780,000 and 1.3 million children are affected by parental alcohol use in England and Wales (Harwin et al. 2009).

Parents report effects on:

- providing a daily structure.
- being consistent.
- managing their children's anger.
- coping with children's transition into adolescence, especially if it involves experimentation with drugs.
- generally perceiving difficulties rather than positives in child's behaviour. (Coleman and Cassell, 1995)

Parenting Issues

- Parenting is challenging even in the context of extensive support and sufficient resources.

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- In the context of diminished financial resources, limited opportunities and social isolation, parenting is very demanding.
- When parents use substances to cope, and/or are living with domestic abuse and mental health problems their capacity to care effectively can be seriously eroded.

Cumulative harm

‘The main theories that have helped us to understand the way in which cumulative harm impacts on children are child development (including early brain development), trauma and attachment theories.

Researchers investigating brain development have used the term ‘toxic stress’ to describe prolonged activation of stress management systems in the absence of support. Stress prompts a cascade of neurochemical changes to equip us to survive the stressful circumstance or event.

If prolonged (e.g., if a child experienced multiple adverse circumstances or events) stress can disrupt the brain’s architecture and stress management systems. In children, ‘toxic stress’ can damage the developing brain (Shonkoff and Phillips, 2001).’

(State Government, Victoria 2007)

“Children may often be able to overcome and even learn from single or moderate risks, but when risk factors accumulate, children’s capacity to survive rapidly diminishes ...

Many factors that threaten or protect children are largely inert by themselves. Their toxic or prophylactic potential emerges when they catalyse with stressful events, especially where these are prolonged, multiple and impact on the child during sensitive developmental stages...

While acute life events may result in adverse psychosocial impacts, the available evidence suggests that chronic adversities are more strongly associated with risk.”
(Newman and Blackburn 2002)

Cumulative harm: emotional abuse and neglect

‘Emotional neglect is similar to emotional abuse in that they both constitute the air some children have to breathe, and the climate they have to live in, rather than isolated events or a series of events.

Emotional child neglect and abuse often appear to constitute a persistent ‘background’ which does not become noticeable until a striking event in the foreground alerts us to their importance.’ (Minty 2005)

In practice, the case history is often used to establish the pattern of behaviour to predict likelihood of significant harm – but not necessarily to assess the cumulative impact of events to evidence significant harm.

It can help with substantiation of neglect if the accumulation of acts of omission or commission resulting in the child suffering, or likely to suffer, significant harm are identified and documented.

Statutory intervention may be required to prevent further harm to the child.

Cumulative harm may be caused by an accumulation of a single adverse circumstance or event, or by multiple different circumstances and events,

The unremitting daily impact of these experiences on the child can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing. (Bromfield and Miller 2007)

Cumulative harm affecting adult life

- An accumulation of adversities can continue into adult life.
- Many parents of neglected children are also suffering from the effects of cumulative harm.
- An accumulation of factors will also elevate the likelihood of a child suffering neglect.

Main theories to help understand cumulative harm are:

- child development (including early brain development),
- trauma (including complex trauma), and
- attachment.
- Researchers use term 'toxic stress' to describe prolonged serious stress. (Bromfield and Miller 2007)

Stress is normal and releases chemicals in brain to help us respond, but prolonged stress can damage the developing brain.

Cumulative harm can overwhelm even the most resilient child; attention should be given to the complexity of the child's experience. (Bromfield and Miller 2007)

Each involvement treated as a discrete event:

- information not accumulated from one report to the next
- information lost over time
- assumption that problems presented in previous involvements were resolved at case closure
- files not scrutinised for pattern of cumulative harm.
- Language used to describe events - reduces context and meaning. (Bromfield, Gillingham and Higgins 2007)

Barriers to recognising cumulative harm

- Technical language not understood by outsiders.
- In the process of reframing children's and families experiences into departmental language the child and families' subjective experiences can be lost.

(Bromfield, Gillingham and Higgins 2007)

Implications for practice

Unlikely to receive a referral explicitly due to cumulative harm.

The majority of children who experience maltreatment experience:

- multiple incidents; and
- multiple types.

Need to be alert to possibility of cumulative harm in all reports. (Bromfield and Miller 2007)

Possible indicators of cumulative harm

Families who experience cumulative harm have:

- multiple inter-linked problems (i.e. risk factors) such as domestic abuse, alcohol and drug abuse, and mental ill health
- an absence of protective factors
- social isolation/exclusion
- enduring parental problems impacting on their capacity to provide adequate care. (Bromfield, Gillingham and Higgins 2007)

Be alert to:

- multiple referrals
- previous substantiations of maltreatment
- multiple sources alleging similar problems
- reports from professionals
- evidence of children not meeting developmental milestones
- allegations of inappropriate parenting in public.

(Bromfield, Gillingham and Higgins 2007)

Identifying cumulative harm (Bromfield and Miller 2007)	
Frequency	have there been previous allegations for similar issues?
Type	signs that child has experienced other types of child abuse and neglect in addition to those reported?
Severity	has caused or likely to cause significant harm if repeated over a prolonged period?
Source of harm	does current situation make child more vulnerable to other perpetrators?
Duration	how long have problems that lead to current involvement been present?

Making an Assessment

Practitioners need to make every effort to engage the families cooperatively to address issues of cumulative harm.

Coercive forms of intervention will sometimes be necessary, but this is a last resort.

What interventions might assist the child and family, in the short and long-term?

Include parents in planning and assist families in solution-focused thinking.
(Bromfield and Miller 2007)

Evidence for practice

It is important to consider what works and with whom it works taking account of the available evidence whilst noting that:

- the evidence base is still sparse
- is often based on findings in other countries
- and may conflate neglect with other forms of maltreatment.
- It is crucial to draw upon the available evidence base and provide support for children.

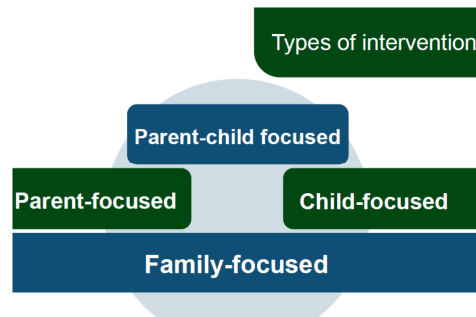
Intervention should:

- incorporate relationship building and attachment
- be long-term rather than episodic
- be multi-faceted
- be offered early as well as late
- consider both protective and risk factors
- involve fathers or male caregivers as well as female caregivers.

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Managed dependency

- The vast majority of parents rely on the assistance of others .
- Parents whose children are neglected tend to have no-one to turn to for support.
- Practitioner fears about parents becoming ‘too dependent’ can lead to episodic patterns of support.
- Therefore, instead, plan to provide long-term support in a purposeful and authoritative manner. (Tanner & Turney 2003)



Who works:

‘There is considerable research evidence to support the claim that relationship skills are important in helping people to change, whatever intervention method is being used.’ (Munro 2011 p.88)

Four factors account for the change process in work with vulnerable families:		
(McKeown 2000)		
40%	characteristic of the user	history, social support, socio-economic status
30%	relationship between worker and client	empathy and clear plans
15%	method of intervention	family therapy, cognitive – behavioural therapy
15%	verbal hope expressed by client	

‘Child-focused interventions predominantly aim to help children cope with the adverse effects of maltreatment such as stress, anxiety, and low self-esteem and address their immediate and long term adjustment needs.’(Davies and Ward 2011)

Examples:

- Therapeutic pre-school (Moore et. al. 1998).
- Peer-led social skills training (Fantuzzo et. al. 1996).
- Imaginative play therapy (Udwin 1983).

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- Treatment foster care. (Fisher & Kim 2007)/ Multidimensional treatment foster care.

School based support

- Many schools provide valuable practical support for neglected children.
- Neglected children's cognitive and social development can be supported within the school setting.
- Teachers, and other adults within schools, can offer children the experience of trusting, caring and reliable relationships.

Parent-focused interventions

- Research has tended to focus on cognitive behavioural programs; psychotherapeutic interventions, and home visiting programmes.
- The evidence base specifically relating to neglect is sparse.
- There is a need to address the factors associated with neglect such as substance misuse, mental health issues and domestic violence.

Assessing issues affecting parenting capacity

- Parental substance misuse
 - strengthening families (Kumpfer & Tait 2000)
 - parents under pressure (Dawe and Harnett 2007)
 - the Relational Psychotherapy Mothers Group (Luthar et. al. 2007).
- Parental mental health
 - tailored support such as psychotherapy and CBT.
- Domestic abuse
 - reparative work on mother-child relationship
 - Post-Shelter Advocacy Programme (Sullivan & Bybee 1999)

Child – Parent focused interventions

- Parent-Infant/child Psychotherapy Intervention (Toth et. al. 2006)
- Interaction Guidance (Benoit 2001)
- Parent Child Interaction Therapy (Chaffin et al. 2004).

Family focused interventions

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- Multisystemic Therapy for Child Abuse and Neglect (Swenson et al. 2010)

Guard against

- The 'start-again' syndrome (Brandon et.al. 2008).
- Frequent oscillation between care away from home and at home.
- Drift and unfocused intervention rather than authoritative practice.

4 patterns of case management identified:

- proactive throughout
- proactive case management that later became passive
- passive that later became more proactive
- passive throughout. (Farmer and Lutman, 2010 p.1)

Principles for effective interventions

- Proactive intervention with older children and adolescents is required.
- Intensive services need to be provided.
- Clear cases for legal proceedings should be built.
- Practitioners need skills in working effectively with 'non-compliant' parents.
- It can be helpful to bring in a 'second pair of eyes' to counteract common errors. (Farmer and Lutman 2010)
- When children are removed there needs to be clarity about what has to change before their return home.
- Parents should be supported to address the factors affecting parenting capacity.
- Regular and detailed reviews are required.
- Effective permanence planning is needed so that children can experience stability.

Measuring outcomes for each child

What are outcomes?

The benefits or changes for participants that occur as a result of activities, such as:

- greater knowledge
- new skills
- different behaviour
- changes in attitude
- changes in population conditions. (Hoggarth and Comfort 2010)

Why have an outcome approach?

'There are downsides to the outcomes approach as there are to other systems of planning and evaluation. But the question of outcomes is a perfectly legitimate one.

The number of visits made to a family is beside the point if the risks are not picked up and appropriate interventions are not identified to begin to help people deal with the problems.

The number of counselling sessions provided is hardly important if in the end they made no difference for the person seeking help. We must address outcomes in order to improve services.' (Hoggarth 2010)

Measuring change

In working with children in need, and their families, the key outcome is the child's developmental progress. The aims are to assess:

- whether the child has progressed and in which dimensions
- how improvements or deteriorations have come about. (Child and Family Training 2009)

Measuring outcomes means collecting evidence about the effects of activities and assessing whether any change achieved is partially or wholly as a result of our activities or interventions and in respect of:

- the child's development
- the factors or dimensions of parenting capacity, or family and environment which are having an impact on the child's development.

Why measure change in day to day work?

- Helps all parties to clarify what we are trying to achieve - improves partnership working.
- Keeps us focused - prevents drift - when working on longer term basis with neglected children.
- Helps assess parents' ability to respond to a child's needs and identify what changes need to happen.
- Supports service users to understand why work is taking place and therefore interventions become more meaningful.

Evidence of change

- Evidence is the information that demonstrates progress or improvement and the 'distance travelled'.
- This requires a baseline in order to be able to demonstrate that intervention has contributed to, or brought about, change or improvement.

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- The important issue is that information must be recorded so that change over time can be measured and that judgments of outcomes can be validated.

Measures

- Recorded observations, for example, interaction between a parent and a child.
- Standardised assessment, for example, completion of a questionnaire or semi-structured interview.
- Testimonials, for example, a child says that they are happier at school.
- Numerical, for example, school attendance records.
- Objective, for example, child's health and developmental milestones, including height and weight.

5 critical points – direct work with children

- seeing children
- observing children in different situations
- engaging children
- talking to children
- activities with children.

Building it into practice

- Outcomes that we seek should arise from assessment of the developmental needs of a child, their parents' capacity, and family and environment factors.
- Only then can we state what we hope to change and the means by which we intend to do so.



Making use of research

- The outcomes we seek, and the interventions selected, should be grounded in professional knowledge and research findings.
 - Research into neglect contributes to the interventions we provide to achieve the planned outcomes: the importance of building resilience; developing attachment; and reducing substance misuse.
- Research indicates that promising interventions include social network support, home visiting, and parent training.
- BUT outcomes should be grounded in the goals that parents and children want and can achieve.

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Make them SMART

Specific what is it we are trying to measure?

Measurable will it be possible to tell if an outcome has been achieved?

Achievable don't set unrealistic outcomes - intermediate outcomes (distance travelled) are important.

Relevant the outcomes should regularly be derived from the assessment and professional knowledge and research

Time review progress

- An 'indicator' is a way of helping to measure progress towards achieving an outcome.
- In order to measure and demonstrate movement in relation to our outcomes, we need to:
- identify qualitative and /or quantitative indicators that will evidence progress and identify sources for this evidence;
- choose methods and tools for collecting this evidence.

Examples

Outcome

'There is an improvement in the physical living conditions of the child or young person'

Outcome Indicators - how will you know if there is change?

Improvement from the baseline assessment using Home Conditions Scale.

Parents no longer at risk of losing their tenancy.

Activity

Weekly home visits by volunteer befriender to support and motivate parents.

Parent training course on child safety in the home.

Measuring tools

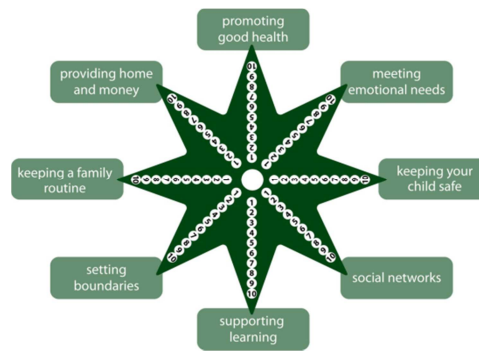
- Our every day practice in assessing children's needs, recording and reviewing our activities to see if the planned outcomes are being met.
- Tools that are valid and reliable.
- Measuring Tools that are also interventions.
- Clinical Scales – largely focused on psychological outcomes, but also developed for areas including educational attainment and social functioning.
- Standardised questionnaires and scales.

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Standardised questionnaires and scales (Department of Health, Cox and Bentovim 2002)

- Strengths and Difficulties Questionnaires.
- The Parenting Daily Hassle Scale.
- Home Conditions Scale.
- Adult Wellbeing Scale.
- The Adolescent Wellbeing Scale.
- The Recent Life Events Questionnaire.
- The Family Activity Scale.
- The Alcohol Scale.

Outcomes Stars



Appendix 1

Start with the child

It may seem an obvious statement to make but assessments of neglect are most effective and accurate when they take account of the child or young person's own lived experiences and are based on direct observation and contact with that person. However, in practice, it is a message which would appear to be very hard to take on board.

Research has repeatedly identified a number of key variables which affect the capacity of practitioners to maintain a focus on the needs of the neglected child. Some of these stem from the nature of children's developmental needs and the impact of neglect on their ability to be communicate their needs to adults.

Some issues relate to parents' interactions with professionals and some difficulties have been identified in professionals' own cognitive and emotional responses to working with neglect.

Children who have experienced chronic neglect are likely to have attributional models which conceptualise the "self" as powerless, of low value and ineffective and ascribe similar characteristics to caregivers and, by inference, other people including professionals trying to support them (Howe 2005). The impact of these early models is a position of "learned helplessness" (Seligman and Peterson 1986) where neglected children are more likely to view themselves and the people around them to be powerless to do anything to alter their position. Neglected children are less likely to know that they are being neglected or to know that something can be done about it.

Although there is now a greater recognition of the impact of neglect on older children, the immediate consequences of neglect for very young children creates particular levels of vulnerability. In almost all studies of serious case reviews, around 50% of the children were under 1 year old. Children's development is highly affected by neglect and abuse in the early years and infants and young children are the least able, developmentally, to signal their needs and distress to helping professionals.

Parents who neglect the needs of their children may be "lonely, unhappy angry people under stress" (Taylor and Daniel 2003, p.162). Parents themselves may have had experiences of being cared for which have resulted in them forming insecure and incomplete models of attachment. In times of stress, such as the intervention of statutory authorities, such models are likely to manifest themselves in the activation of attachment behaviours which seek to control and manipulate (Morrison 2008). 'Fight or flight' responses from adults can result in professionals losing contact with families. Angry, hostile and threatening adults can intimidate and frighten practitioners, which can result in case closure or a lack of authoritative and focused professional response in open cases.

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Alternatively parents who neglect their children may actually be quite endearing, if somewhat frustrating. It is a common feature of working with neglectful families that professionals may really quite like the parents and want them to do well. There are also links between poverty and learning disabilities and neglect which can mean that professionals are less willing to intervene as they may seek to avoid discrimination and may view the neglectful parenting as unintentional. Compassion and empathy for parents can interfere with a clear and subjective assessment of the child's experience of parenting. The same features of neglectful parenting may be the features which dominate and control professional interactions with the family. For example, failure to attend office appointments or to be in for home visits might mirror emotionally neglectful parenting. Home visits may be chaotic and confusing as the house is always full of friends and the television is always on, reflecting disorganised, neglectful parenting (Howarth 2007).

The impact of adversity on parenting capacity can have a significant impact on professional engagement with families. However, the way that professionals conceptualise and understand adversity can also have a significant impact. For example, it has been recognised that neglect of children with disabilities is often viewed by professionals as a facet of disability; creating a model which views the neglect as an expected consequence of the stress of caring for a disabled child. Concentration on the physical aspects of neglected children's lives (and the physical maintenance of the child's body) can result in the failure to recognise and understand the emotional and attachment needs of disabled children.

Children who are neglected are too often categorised as "hard to reach" when it would be more appropriate to view protective services as "hard to access". Children generally are unlikely to seek help directly from statutory agencies (Taylor and Daniel 2003). This places universal services (health and education) in an extremely important position in their potential to recognise the child in need and respond appropriately. Neglected children and young people are simultaneously in need and suffering harm and therefore at risk of falling between the artificial divide in services that encourages classification of children as "in need" or "at risk" (Taylor and Daniel 2003).

Professionals have been found to struggle to maintain a focus on the child's needs in neglect for a number of reasons. Dingwall, Eekelaar and Murray (1983) first identified the "rule of optimism" which too often has predominated thinking in assessments of neglect. This rule dictates that professionals tend to work from a premise of natural love and expect that parents love their children and do not normally seek to harm them. This can result in an undue and unquestioning over-reliance on what parents say. More recently, serious case review studies (Brandon et al. 2008 and OFSTED 2010) have identified that practitioners still place an undue level of acceptance on what parents (particularly mothers) tell them, often taking their word at face value in preference to the views expressed by the children in the family.

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Neglect can be cognitively and emotionally overwhelming for professionals. This can result in a number of unconscious self-protective responses by practitioners that may potentially be unhelpful or even dangerous. The enormity of the difficulty, paired with a feeling of hopelessness can result in professionals failing to engage with children and young people meaningfully (Horwath 2007).

Messages for good practice

- Concrete resources are beneficial but their impact needs to be focused on the child's needs and its impact reviewed and monitored.
- Relieving financial poverty does not necessary relieve emotional poverty.
- To keep children in mind we ourselves need to be kept in mind: supervision and support are crucial.
- Neglectful families are more likely to be isolated and struggle with informal support networks: facilitating better relationships within kith and kin may be advantageous.
- Volunteer support can be an effective part of a care plan.

Appendix 2 -Understanding neglect: parents'/carers' perspectives

Whilst the child's welfare must always be the paramount consideration, of central importance in working with complex cases is to provide a "dependable, professional relationship for families and children that is educative, supportive and provides timely help" (Thoburn 2009:7)

The relationship between parents/carers and professionals when there are child welfare concerns can be both complex and difficult. However, as nearly all children remain at or quickly return home, involving the families in the child protection process is likely to be effective. Moreover, partnership working is likely to lead to better outcomes for children.

So, while there are significant demands associated with developing partnership approaches, there are also clear rewards in terms of effectiveness. This was stressed in the Department of Health summaries of research findings: Child Protection: Messages from Research (Department of Health 1995), The Children Act Now: Messages from Research (Department of Health 2001) and Safeguarding Children Across Services: Messages from research on identifying and responding to child maltreatment (Davies and Ward 2012).

The essential elements of relationship-based psycho-social casework (combining elements of care and control) are based on evidence from research studies that services are unlikely to be effective if parents and children do not consider that they are treated with honesty and respect as a minimum, and cared about as individuals with needs of their own (as required by the Principles and Practice guidance published with the Children Act 1989 (Department of Health 1995).

The task then is to empathise and work with parents (wherever possible) while retaining a focus on the child and their welfare. Forrester et al (2008:24) suggest that specific challenges will include "how to be honest and clear with parents without creating hostility; how to be empathic without colluding with unacceptable behaviour; how, in short, to reconcile the different imperatives of the role within practice with parents." This, they suggest is sometimes understood as the challenge of working in "partnership" with parents.

In 1995 the Department of Health published The Challenge of Partnership in Child Protection (Department of Health 1995). Four approaches to partnership were suggested:

- providing information
- involvement
- participation
- partnership.

Appendix 3

Relevance of historical information

Research studies and file audits have repeatedly shown that historical information is not given the attention that it should be given in assessing the needs of children (Rose and Barnes 2008, Reder and Duncan 1999). In a range of studies, important information was variously not shared (O'Brien 2003), missing or lost (Laming 2003), particularly when the family moved geographically across boundaries or borders.. Evidence was available from past history but either not referred to or not analysed in such a way as to see the emerging pattern of increased risk of suffering harm (Munro 1999). The information gathered was not checked with family members to ensure accuracy. The focus of the process of gathering and recording information was the family rather than the individual child (Scottish Executive 2002). Workers tended to deal with each incident separately (Reder and Duncan 1999) so that a threshold for action was never reached (Brandon et al 2008) and the focus was on the 'here and now' and not the past (Farmer and Owen 1995).

Trying to predict future risk of neglect is a difficult task. However, practitioners appear to have been making this task even harder by failing to make a proper assessment of what has been happening to the child in the past. Neglect is cumulative and made up of the consequences of repeated failure to meet basic needs. The very nature of neglect means that good recording and good skills in interpreting chronologies are vital practitioner attributes.

There a number of reasons why practitioners should be concerned about gathering and making sense of historical information in assessment:

- prediction of future harm
- exploring the significance of events
- increasing reliability of evidence
- assessing motivation and parenting capacity
- therapeutic value.

Prediction

In the absence of any better indicator, '...the best guide to future behaviour is past behaviour' (Munro 2008, p77). When neglect is a possible concern, due attention and weight must be given to the level of care provided previously. Gathering information from across services will help to build a picture of previous patterns and whether circumstances have changed over time. A clearer picture can be built up of referrals to agencies and the impact of interventions in the past (Reder et al. 2003). By identifying these patterns it is easier to make reliable predictions of the likelihood of future neglect. Neglect is characterised by its chronic nature and the lack of critical incidents around which to base assessment practice means that holistic ecological

assessments are required to establish not 'what has happened?' so much as 'how is this child doing developmentally?'

Significance

Taking down a family history can highlight past conflicts which may still be impacting on family functioning. The meaning of events can be considered in terms of the interaction between the child's needs and the parents' ability to meet those needs and can provide pointers towards future risk of harm (Reder et al. 2003). The impact of some cognitive processes (such as the availability heuristic) can mean that practitioners are attracted to particular types of information and find it more difficult to notice other types of information (Helm 2010, Munro 2008). Typically, this means that recent events and vivid detail are more cognitively available to workers than dull and abstract information. In terms of neglect, we may become immersed in the noise and chaos of the present and fail to pay sufficient attention to the dull, abstract but vital information available in files and chronologies.

Reliability

There is a need to separate out information that is fact from information that is tentative or second hand and this information needs to be checked with family and compared with their account (Reder et al. 2003). Munro (2008) suggests that practitioners need to take care to separate out fact, opinion and hypothesis in chronologies. Existing recordings can take on a legitimacy which is undeserved and practitioners need to be critical in seeking evidence to substantiate and challenge recorded information.

Assessing motivation

Practitioners who are willing to help parents to fill in gaps in their past and in their understanding of their past will be more trusted and effective than a worker who ignores the past (Fahlberg 1994). Partnership working with parents can facilitate access to vital information which parents may hold but only be willing to share in the context of a trusting relationship built over time.

Therapeutic value

The developmental literature (for example, Daniel et al. 2010) recognises the benefits of adults having a coherent story of their childhood. Working with families to develop a chronology may provide a potential opportunity for family members to gain an increased sense of security, as well as a more cohesive sense of identity and resolve issues around difficult events in the past. Children may have partial and confused ideas of family history and many memories may be quite abstract and inaccessible to conscious retrieval.

Diligent and sensitive work with children can help a clearer sense of belonging and self (including both positive and negative aspects) and help children come to terms

with the past and can contribute to ongoing social and emotional development (McLeod 2008).

Chronology

In cases of neglect there needs to be a succinct, readily accessible chronology of events and concerns (Scottish Executive 2002, Laming 2003). Chronologies should be kept for individual children rather than sibling groups (Cleaver and Walker 2004). The nature of neglect means that often these chronologies will be kept by universal services and it is important that these chronologies are regularly reviewed and well maintained so that they can be retrieved and shared as and when necessary (Social Work Inspection Agency 2005).

Practice Challenges

Gathering information in child care assessments has been likened to building a jigsaw puzzle (for example, Munro 2008). However, this analogy assumes that the practitioner knows what the picture is that they are trying to complete and that they will know when they have all the pieces (Helm 2010). The use of frameworks for assessment of neglect is a vital element in ensuring that all the areas of a child or young person's developmental needs have been appropriately considered.

Chronologies are expected to be succinct yet contain all relevant information. Practitioners therefore are required to address two tensions around selection of information. The first is the matter of how much detail to place in the chronology. Too little information may result in dangerous gaps appearing in the chronology but too much information can make the chronology unwieldy and inaccessible. The second tension is the question of 'significance'. To whom is the information 'significant' and in what way? For example, the death of a pet may be of great significance to a child but not to the parents or professionals.

There is a need for shared theoretical frameworks to bring consistency and congruity to interpretation of historical information (Helm 2010).

There is a tension for practitioners here because many professionals feel that they do not have the right or mandate to ask families about their history and there are concerns that, for some practitioners, a lack of time, skill and knowledge may result in further harm as traumas are revisited in unhelpful or even damaging ways. Practitioners working with neglected children and young people may not be working regularly with child welfare and protection services. In such instances recording is less likely to be rigorous and structured and uncertainties persist about why, how and when this information should be shared.

Neglect is pervasive and has been likened to the air that some children and young people have to breathe (Minty 2005). The lack of single identifiable incidents can mean that current protective services struggle to identify and respond to the needs of neglected children. This means that some form of incident is usually required to

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'catapult' the child into the child welfare and protection system (Dickens 2007). Until such an event occurs, much chronological detail may go unnoticed and workers may fail to recognise the neglected child in need.

Appendix 4 - Adults who misuse substances

Hidden Harm (Home Office 2003) estimates that there are between 250,000 and 350,000 children of problem drug users in the UK. The report also showed that the parents with the most serious drug problems and the most chaotic lives are the least likely to be living with their children. In this handout, we look at the impact on children of parental problem drug use in more detail. This has been a particularly neglected area for research, with most of the limited number of studies being conducted in the US and only a handful in the UK. Nevertheless, these and other work in the fields of alcohol misuse and mental health enable some important conclusions to be drawn.

Problem drug use has serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Several features of problem drug use in the UK are of particular importance for their potential impact on children. Crises can occur at any time, for example due to overdose or injecting-related infection, or due to arrest and imprisonment or eviction.

First, most problem drug users use several drugs (polydrug use). Typical combinations are heroin and benzodiazepines or heroin and cocaine but many others may be used, depending on their availability. The vast majority of problem drug users smoke tobacco and many are heavy users of alcohol or cannabis. Taking drugs in combination greatly increases the unpredictability of their effects on the user.

Second, many problem drug users inject drugs, particularly heroin, for maximum effect and value for money. This puts them at greater risk of overdose, leading to unconsciousness and the risk of death, and infection with blood-borne viruses such as HIV and hepatitis B and C and other micro-organisms.

Third, many live in disadvantaged communities in conditions of poverty and social exclusion. Many have had difficult childhoods, fared badly at school or have significant mental health problems. Their drug use may thus be only one of several factors that may affect their capacity as parents. Where drug use has become heavy and dependency has developed, life for the user and those around them is often chaotic and unpredictable.

Of equal importance are the longer-term effects of drug taking over months or years for physical health, for example chronic illness due to HIV or hepatitis C infection, and for employability, income and relationships. The consequences of problem drug use for users themselves are thus extremely wideranging and variable. What about the impact on their children?

Growth and development

In order to understand the potential impact of parental drug use on the child, the complexity of the process of growth and development needs to be recognised. This depends on many interacting biological and social factors that can be grouped under three headings:

- conception and pregnancy,
- parenting; and
- the wider family and environment.

Common features of problem drug use

Physical

- major injecting-related problems, for example abscesses, blood-borne virus infections, overdose, accidental and non-accidental injury.

Psychological

- priorities dominated by drugs
- drug ingestion usually a daily event and an essential requirement for everyday functioning
- unpredictable and irritable behaviour during withdrawals
- chronic anxiety, sleep disorders, depression, suicidal behaviour
- post-traumatic stress disorder
- serious memory lapses.

Social and interpersonal

- family break-up
- loss of employment
- unreliability
- chronic or intermittent poverty
- rejection by former friends and community
- victim or perpetrator of physical, psychological or sexual abuse
- eviction and homelessness
- need to engage in property, crime, fraud, drug dealing or prostitution to pay for drugs
- association with other persistent offenders.
- Financial
- constant requirement to find large sums of money to pay for drugs
- substantial debts
- inability to pay for basic necessities.

Legal

- arrest and imprisonment
- outstanding warrants and fines
- probationary orders.

How a baby develops during pregnancy is affected by a number of factors, of which the most important are:

- genetic endowment
- the mother's general health and nutritional status
- foetal nutrition during pregnancy
- exposure to drugs and other toxins
- exposure to infection
- exposure to external trauma.

Parenting embraces a wide range of activities that directly or indirectly affect the wellbeing of the child. The most important of these are:

- basic care
- ensuring safety
- emotional warmth
- stimulation
- guidance and boundaries
- stability.

There are also many aspects of the wider family and environment, which can influence children's experiences in one way or another. These include:

- family history and functioning
- the extended family
- housing
- employment
- income
- family's social integration
- community resources.

The way the child develops thus depends on a wide range of influences. How these affect the child can be considered under four headings or dimensions. These are:

- health
- education
- emotional and behavioural development
- identity
- family and social relationships
- social presentation

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- self-care skills.

A child's needs and capabilities change over time, as do the potentially harmful experiences to which he or she is exposed and the consequent harm. Factors that might help to protect the child may also change over time.

Appendix 5

Key facts about domestic abuse

The Women's Commission: Women's Voices to Government (2010)

- World Health Organisations Multi-Country study into women's health and domestic violence against women found that between 1 in 2 and 1 in 10 women will experience some form of violence at some point in their lives.
- One in 4 women will experience domestic abuse from a partner in her lifetime.
- 54% of cases reported to the police in 2007/08 involved repeat victimisation.
- 92% of rapists are known to the woman they rape.
- 7 out of 10 women giving evidence in rape trials will be asked about their sexual history or character.
- 1,053 rapes or attempted rapes were recorded in 2007/08 in Scotland.
- There were 1,666 incidents of indecent assault in the same period.
- Female homicide victims are most commonly killed in a dwelling with the motive being rage/fight with a partner.
- Teenage mothers seem to be particularly likely to experience domestic abuse. An American study found that 70% of teenage mothers at one hospital were in a relationship with a violent partner.
- A study in 2007 for England and Wales estimated that nearly 66,000 women aged between 15 and 49 living in the UK had undergone FGM and over 20,000 girls were at risk.
- Between 78% and 86% of stalking victims are female, with between 18% and 31% experiencing sexual violence within the context of stalking behaviour.

<http://www.thewnc.org.uk/>

- An analysis of ten separate domestic violence prevalence studies by the Council of Europe showed consistent findings: 1 in 4 women experience domestic violence during their lifetime and between 6 - 10% of women experience domestic violence in any given year. [Council of Europe (2002) Recommendation 2002/5 of the Committee of Ministers to Member States on the Protection of Women Against Violence adopted on 30 April 2002 (Council of Europe: Strasbourg, France)].
- Approximately 42% of domestic violence victims have been victimised more than once. The British Crime Survey indicates that victims experience an average of 20 incidents of domestic violence in a year, which can often increase in severity each time. [Walby, S. and Allen, J. (2004) Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. Home Office Development and Statistics Directorate]

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- Domestic violence has a higher rate of repeat victimisation than any other crime. [Home Office, July 2002]
- Every minute in the UK, the police receive a call from the public for assistance for domestic violence. This leads to police receiving an estimated 1,300 calls each day or over 570,000 each year. [Stanko B 'The Day to Count', 2000]
- Approximately 77% of victims of domestic violence are women. [HM Government (2008) Saving Lives. Reducing Harm. Protecting the Public. An Action Plan for Tackling Violence 2008- 2011]
- In the case of domestic violence, nearly one in four victims is victimised three or more times [Povey, E., Coleman, K., Kaiza, P., Hoare, C., Jansson, K., (2008) Home Office Statistical Bulletin: Crime in England and Wales 2006/07. Supplementary Volume 2 to Crime in England and Wales 2006/07]
- Despite chronic under-reporting (and under-recording), approximately 16% of all reported violent incidents to the police are characterised as domestic violence related [Povey, E., Coleman, K., Kaiza, P., Hoare, C., Jansson, K., (2008) Home Office Statistical Bulletin: Crime in England and Wales 2006/07. Supplementary Volume 2 to Crime in England and Wales 2006/07]
- A thematic inspection by HMIC and HMCPSI in 2004 found across six police forces an under-recording of domestic violence crimes (not incidents) of 50%. [HMCPSI and HMIC (2004) Violence at Home, London]
- Domestic violence accounts for 16% of homelessness acceptances. [Women and Equality Unit (2003) Increasing Safe Accommodation Choices]
- 500 women who have experienced domestic violence in the last six months commit suicide every year. Of those, just under 200 attended hospital for domestic violence on the day that they committed suicide. [Walby, S. (2004) The Cost of Domestic Violence. Women and Equality Unit]
- A study of 200 women's experiences of domestic violence found that 60% of the women had left because they feared that they or their children would be killed by the perpetrator. nit] [C. Humphreys and R. Thiara (2002) Routes to Safety: Protection issues facing abused women and children and the role of outreach service (Women's Aid Federation England: Bristol)]

<http://www.avaproject.org.uk/>

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Tools and resources

Strengths and Difficulties Questionnaires

<http://bit.ly/1cR9mX4>

<http://bit.ly/H5ppU2>

www.sdqinfo.org

The Family Pack of Questionnaires and Scales (Department of Health, Cox and Bentovim 2000)

<http://bit.ly/1cR9mX4>

<http://bit.ly/H5ppU2>

Organisations

Centre for Excellence and Outcomes in Children and Young People's Services (C4EO)

www.c4eo.org.uk

Social Care Institute for Excellence (SCIE)

www.scie.org.uk