Suffolk Safeguarding Partnership

Neglect Guidance

Version 4.0

Policy Version History

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Contents

What is Neglect?

Neglect is complex and hard to define clearly. It differs by type, severity, frequency, and impact. Neglect often co-exists with other forms of abuse and indeed is often a pre-condition to allowing other abuse to take place. Increasingly, the psychological impact of neglect is being recognised.

Being clear about what the child experiences and the possible harm that may arise will allow for preventative safeguarding, rather than waiting for the impact on the child to become irreversible.

Definitions and descriptions of **child neglect** help to provide benchmarks for practice. In England, the official description – used by all professionals responsible for children's welfare and including children up to the age of 18 years – is set out in the government's statutory guidance *Working Together to Safeguard Children 2015*

'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect *may occur during pregnancy as a result of maternal substance abuse.*

Once a child is born, neglect may involve a parent or carer failing to:

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *protect a child from physical and emotional harm or danger;*
- *ensure adequate supervision (including the use of inadequate care-givers); or*
- *ensure access to appropriate medical care or treatment.*

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.'

(HM Government, 2015: Appendix A. p86).

What Makes it Harder for Professionals to Identify Neglect?

A recurrent theme in research on neglect is that there can be confusion and misunderstanding between professionals in identifying neglect. Issues include:

- Neglect is an act of omission – did this parent or carer intentionally neglect this child? The focus on this question can detract from identifying the causes of neglect.
- Who is neglecting the child? Are there organisational issues which mean that the child's needs are not met e.g. a disabled child not getting services, a young carer, a looked after child not in an adequate placement, or a child excluded from school/home schooled?
- Understanding both the parenting behaviours and the impact on the individual child of that behaviour is complex.
- An assumption that another service is seeing the child.

Neglect can present to professionals as a one-off incident, episodic (during a family crisis or a period of parental mental illness) or chronic.

Mothers, in the main, are the focus of practitioners when working with child neglect. However, partners of Mothers or Fathers may also play a significant role in contributing to the child experiencing neglect or they may be a protective factor.

Categories of Neglect

Child neglect falls into four main categories: physical, educational, emotional and medical neglect.

Physical Neglect is the failure to provide for a child's basic needs. It usually involves the parent or caregiver not providing adequate food, clothing or shelter. It can also include child abandonment, inadequate or inappropriate supervision, and failure to adequately provide for a child's safety or failure to adequately provide for a child's physical needs. For teenagers, it includes the parent forcing the young person to leave home. Physical neglect Physical neglect can severely impact a child's development resulting in failure to thrive; malnutrition; serious illness; physical harm in the form of cuts, bruises, burns or other injuries due to the lack of supervision; and low self-esteem.

Educational neglect involves the failure to ensure a child receives an adequate and suitable education, failure to show interest in education or support learning; failure to respond to any special needs related to learning; failure to comply with statutory requirements regarding attendance.

Emotional Neglect and Emotional Abuse

Emotional abuse is an extremely damaging form of abuse which may occur in isolation or may co-exist with neglect. Many research studies combine these two forms of abuse together under the term ‘psychological maltreatment’. Both neglect and emotional abuse can have long term consequences for children and lead to a wide range of problems in adulthood. Early intervention can prevent the long-term consequences of neglect or emotional abuse and improve the outcome for these children.

Examples of Emotional Abuse include:

- Ignoring the child’s need to interact.
- Failing to express positive feelings to the child, showing no emotion in interactions with the child.
- Denying the child opportunities for interacting and communicating with peers or adults.

Emotional abuse may be difficult to recognise as the signs are usually behaviour rather than physical. The manifestations of emotional abuse might also indicate the presence of other kinds of abuse. The indicators of emotional abuse are often also associated with other forms of abuse.

Emotional Neglect or Psychological Neglect can include:

- Ignoring a child's presence or needs.
- Consistently failing to stimulate, encourage or protect a child.
- Rejecting a child or actively refusing to respond to a child's needs, for example refusing to show affection.
- Constantly belittling, name calling or threatening a child.
- Isolating a child, preventing a child from having normal social contacts with other children and adults.
- Terrorising a child, creating a climate of fear and intimidation where the child is frightened to disclose what is happening.
- Corrupting a child by encouraging the child to engage in destructive, illegal or antisocial behaviour.

Severe neglect of an infant's need for nurture and stimulation can result in the infant failing to thrive and even infant death.

Emotional neglect is often the most difficult situation to substantiate in a legal context and is often reported as a secondary concern after other forms of abuse or neglect.

Medical Neglect is the failure to provide appropriate health care for a child, placing the child at risk of being seriously disabled, being disfigured or dying.

Concern is warranted not only when a parent refuses medical care for a child in an emergency or for an acute illness, but also when a parent ignores medical recommendations for a child with a treatable chronic disease or disability resulting in frequent hospitalisation or significant deterioration. In non-emergency situations, medical
neglect can result in poor overall health and compounded medical problems. This also includes dental neglect, where a child may have severe untreated dental decay.

Every health care provider must have in place a ‘Was Not Brought’ policy (previously Did Not Attend to ensure that the reasons for children not being brought for appointments are considered. ‘Following up missed appointments can ensure that children and families in early need of help are identified and that appropriate support is given.’ (CQC 2016).

Lack of Supervision and Guidance

Failure to keep a child safe, including leaving a child alone; leaving a child with inappropriate carers; failure to provide appropriate boundaries.

Signs and Symptoms of Neglect

Where any of the following are present the practitioner should discuss the child's needs with a senior member of staff to decide the most appropriate course of action:

Physical Signs e.g. growth not within the expected range. This is a complex issue with potentially many causes. However, in terms of meeting the child's fundamental need for nutrition, a child who does not gain weight and height, or who loses weight for no apparent medical reason, should be a cause for concern amongst professionals. Babies and small children who are not fed eventually stop crying –this should not be misinterpreted as a content child; recurrent infections; skin conditions; unkempt dirty appearance; inadequate clothing; unmanaged/untreated health conditions; scalds and burns; frequent accidents or injuries. Accidents are generally understood to be a sudden, unexpected event taking place without warning. However, the belief that an injury was caused accidentally should not simply be accepted.

It is extremely important that, in the circumstances described above, a paediatric assessment is seriously considered and discussed with a paediatrician.

Developmental Signs e.g. developmental delays; poor attention/concentration; lack of self-confidence/poor self-esteem; educational underachievement (including erratic or non-school attendance). Childhood neglect may also be associated with one of the many causes of language delay and communication, socio-emotional adjustment and behavioural difficulties. Studies have found that such difficulties can manifest themselves in children by their third birthday. The implications of this for the child are likely to be seen in preschool settings with difficulties in literacy, numeracy, and friendships.

Behavioural Signs e.g. over-active, aggressive, impulsive behaviours; indiscriminate friendliness, withdrawn with poor social relationships, wetting, soiling or destructive behaviours, substance misuse or running away, school non-attendance, sexual promiscuity, self-harm, offending behaviours. Attachment difficulties can be an early sign of neglect or emotional maltreatment. Disorientated attachment patterns can manifest themselves through behaviours such as repeated unsuccessful attempts to engage with a parent and failing to seek reassurance when upset or distressed.

Children deemed to be in the period known as adolescence are making the transition from childhood into adulthood. In older children the signs may include behaviours thought to be harmful to themselves or others, anti-social in nature and a disregard of risk with risk taking behaviour. Older children may typically be involved in crime, use drugs and alcohol or exhibit violent behaviour towards others. it is important to recall that an adolescent's tolerance of neglect does not indicate a positive choice to be neglected, nor should it be a reason to engage in blaming the young person. Physical neglect is likely to manifest itself in young people becoming stigmatised and bullied.

The time span during which a child might be deemed an adolescent is hugely variable and professionals should hold in focus the fact that children remain children until they are deemed adult in law, that is when they reach the age of 18. The cumulative impact of childhood neglect during this period is likely to become clearer and consolidate into patterns which will generate poorer outcomes throughout the rest of their lives.

Signs in the Home Environment e.g. dirty, hazardous environment, personal or environmental odour, poor state of children's bedding, inadequate ventilation or heating, lack of play opportunities, poor supervision, isolation of parents and children from the local community.

It is possible for children across the age range to experience neglect, and therefore no child in a household should be excluded from professional assessment because it is **assumed** that they are too old to suffer neglect or too young to experience their parent's substance misuse. Neglect is insidious – it will have an impact on all children in the household. Some children will be more vulnerable to neglect than others.

Some practitioners may be reluctant to identify neglect in vulnerable children where families have traumatic stories of huge adversity, violence or loss, i.e. disabled children, refugee children. 'Disabled children are more dependent than other children on their parents and carers for their day-to-day personal care; for helping them access services that they need to ensure that their health needs are met; and for ensuring that they are living in a safe environment. The impact of neglect on disabled children is therefore significant. This is not always recognised in time.' (Ofsted thematic inspection August 2012).

In some cases, professionals may inadvertently excuse signs of neglect because other positive factors may be in evidence. For example, the child may appear happy and playful, generally well-nourished and seemingly 'loved' by their parents. The potential impact of poor hygiene and poor physical care including oral hygiene is nevertheless a concern and it is important that professionals hold in focus the experience of the child and how this affects outcomes for them in their school, their community, and upon their development.

Practitioners should ensure that the judgements made about parenting are objective and not based on assumptions about different cultures or communities. For example, disabled children may be at increased risk due to communication difficulties or sympathy for carers affecting professional judgement and perceptions that the needs of a disabled child should be viewed differently from other children. The family and environmental factors identified above are no less relevant for disabled children and therefore professionals working with disabled children should always be prepared to have candid discussions when concerns begin to emerge about the care of a child.

Children particularly vulnerable to neglect are:

- Premature children, or with low birth weight
- Disabled children
- Adolescents
- Runaways
- Children in care
- Asylum seeking and refugee children
- Children from black and ethnic minorities
- Young Carers

Neglect in Babies

Marion Brandon in her reviews of Serious Case Reviews has commented that the use of both the concept and the terminology of 'rough handling' may mask the risks of physical injury or even death for babies and older children. A view may be formed that these injuries are less serious acts of omission, indicating inconsiderate and careless parenting rather than a potential indicator of underlying serous concerns and injuries. In some Serious Case Reviews, where children have died or been seriously injured, professionals had noted previous insensitive 'rough handling' of babies, and parents being verbally aggressive and smacking a toddler, and other inappropriate behaviours that imply physical aggression.

- All bruising in a non-mobile baby should be considered suspicious. There should be an assumption that a referral to Children's Services will be made and a paediatric assessment undertaken. The decision not to refer should be made in consultation with the agencies supervising senior with a clear explanation of the reasons for this recorded.
- The significance of bruising to older children MUST be interpreted in relation to the child's age, developmental capability and the care being received.
- A bruise also needs to be considered in relation to the parent's capacity to supervise in a way that is appropriate to the child's developmental needs.
- Older babies are more able to bruise themselves through falls and tumbles but where there are pre-existing concerns about neglect and emotional development, for example faltering growth and failure to thrive, workers should be concerned about bruising and consider specialist assessment by a paediatrician rather than a GP.

Neglect in the Early Years

"Neglect in the early years may be the most damaging from the point of view of long-term mental health or social functioning". Neglect can be as harmful as physical and emotional abuse especially in the early years. Brandon et al note that there is now a relatively robust consensus based on a range of empirical evidence that demonstrates its adverse impact on all the seven dimensions of development identified in the Assessment Framework: health, education, identify, emotional and behavioural development, family and social relationships, social presentation and self-care skills.

Neglect in Adolescence

Research commissioned in 2009 found that:

"Neglect is not only damaging in early years. A significant study has provided important insights into both the effects in teenage years of early neglect and the factors associated with onset of neglect during teenage years".

Adolescence is a time when, developmentally young people are 'individuating'. This process involves separating from parent as young people begin to form their own identities, values and perspective. It is also a time when young people spend increasing amounts of time away from the home. It is also a time when young people require a more developmental style of parenting and careful supervision.
For the neglect child, adolescence presents a range of increased risks including:

- Going missing from home or care.
- Poor school attendance.

- Risk of exclusion from school.
- Getting into trouble with the police and anti-social behaviour.
- Engaging in risk-taking behaviour such as substance misuse including peer abuse, online abuse.
- Increased risk of becoming the victim of child sexual exploitation.
- Increased risk of exploitation by gangs and other criminal groups (e.g. violent extremists).
- Increased risk of low mood, depression, self-harm, suicidal ideation, eating disorders and poor mental health as a result of the cumulative emotional impact of neglect.

The work of Marion Brandon on SCRs has found that whilst neglect features across all age ranges, however, the most common age range is 11-15.

Children with Disabilities

Children with disabilities are at higher risk of being abused and neglected (Sullivan and Knutson, 2000). However, children with disabilities are not a homogenus group and careful assessment of their unique circumstances is required. Some of the increased risk factors for children with disabilities are:

- They have a prolonged and heightened dependence upon their carers, which may make them more susceptible to neglect and, for example, may be isolated.
- The caring responsibilities for parents may increase stress levels and lower their capacity to parent effectively.
- Children with disabilities may be less likely to be able to protect themselves or be less able to speak out about their experience of being parented.
- Workers relate the signs and indicators of distress or harm to the disability and not necessarily to the possibility of maltreatment.
- Workers can accept a different or lower standard or parenting of a disabled child than of a non-disabled child (Brandon et al, 2012).

Culture

There are many differences in patterns and methods of parenting across cultures. Yet, there isn't any culture that accepts abuse and neglect of children. Parents may explain their approach to parenting in terms of cultural factors and it is important to explore and seek to understand the perspective of parents. However, caution is required in placing too much emphasis on cultural factors; the main focus has to be about the impact on the child's health and development.

Noticing the Neglected Child

Neglected children rarely ask for help on their own behalf. The experience of neglect is likely to erode the capacity to seek help. Children who are neglected may have little experience upon which to gauge what more effective parenting would feel like.

Parents too find it difficult to ask directly for help. Parents who misuse substances often have low self-efficacy. They are likely to be fearful of losing their children or they may be experiencing domestic violence.

Practitioners face barriers to recognising neglect that may include:

- Poor understanding of neglect
- Disguised compliance
- Sympathy for parent
- Misplaced optimism
- Distraction from poor parenting such as a child's diagnosis of ADHD or other disability or behavioural problem.
- Lack of understanding of significance of domestic abuse and non-attendance at appointments
- Poor and inadequate assessments
- Lack of information sharing and multi-agency working

The NSPCC pose some specific questions on neglect:

What you might notice in the main carer-child interaction in infants (less than 12 months old)

The main caregiver may not seem to be tuned in to their child's needs, or sensitive to their child's feelings. They speak little to them, and when they do it is often in the form of orders, with very little positive feedback. They describe their babies as irritating and demanding. Even within the first few days of life, you may observe that the main caregiver fails to engage with their child emotionally during feeds.

What you might notice in the main carer-child interaction among toddlers (1-3 years)

As the child becomes older, it may be obvious that the parent remains unresponsive and uninvolved with their child, or fails to respond to them appropriately (known as 'lacking attunement'). They are often critical of the child and ignore their child's signals for help. In some instances, they even seem comfortable when their child is struggling to complete a task. When the parents are critical or verbally aggressive, the child shows more anxiety.

What you might notice in the main carer-child interaction among older children (age 3-6)

In this age group, it may be evident that the parents are not engaged in playing with the child, they show little affection and are unlikely to reach out to the child to relieve their distress. The mothers may offer less praise and show less positive contact.

They speak little to the child, which may contribute to language delay that is evident in emotionally neglected or abused children of this age. Neglectful mothers are more likely to resort to physical punishment than other mothers.

What you might notice in a child age 5-14

Behaviour

The impact on behaviour is often greatest when neglect starts early in a child's life, or if the child is both neglected and emotionally abused. They may present as aggressive and hostile, for example, the child may be prone to angry outbursts or lashing out towards others. They may be more impulsive than other children and may show features seen in Attention Deficit Hyperactivity Disorder (ADHD), for example, poor concentration or impulsive

behaviour. Neglected children specifically, may be particularly quiet or withdrawn. Blame can be put on the disorder and not on the parenting of the child.

Relationships with other children

Neglected children may have difficulty with friendships and have more problems socialising, than other children do. They may describe another child as their ‘best friend’ but the other child does not reciprocate this. The child may have few friends and be perceived by other children as more likely to be aggressive or disruptive.

Emotional or self-perception issues

Neglected children may have little self-confidence, and the more severe neglect they experience, the lower their self- esteem. They are more likely than their classmates to experience symptoms of depression. They have difficulty interpreting emotions, such as anger or sadness. They may also experience more mood swings than would be expected for their age, or show levels of affection towards others, which are inappropriate for the situation. Neglected children may see themselves as being worthless to others. They often believe that what happens is beyond their control, which leads to anxiety and helplessness to do anything to improve their situation. Many of these children give up on tasks before they have even started, because they simply do not see the point in trying.

They have fewer effective coping skills than other children. When they become upset they are less likely to distract themselves through play or talk it over with someone else. They may become angry or restrict their emotional displays. Some children may think about, plan or attempt suicide.

School performance

Neglected children often have more difficulty than their classmates carrying out complex tasks, particularly when they are required to understand and follow instructions that involve visual and motor integration; this was tested by asking the children to trace geometric shapes of increasing difficulty against the clock. They are likely to have a lower IQ than their classmates, although results or numeracy assessments varied across studies. Despite poor performance in some areas, neglected children may be better at problem solving, planning and abstract thinking than other children.

Listening to and learning from the voice and experiences of children

The voice and experiences of children and young people is paramount A child-centred approach that involves listening actively to children, finding out their views and wishes and observing them should be adopted.

Relationships with parents

One study of neglected children showed that:

Living in the family can be lonely for both parent and child because there is little exchange of information, and there may be a lack of emotional warmth between them.

Some parents are more negative in comparison to non-neglecting parents. The parents may make more demands of their children and are unlikely to respond to requests from their children for support. Neglected children come to expect less support from their mothers, in comparison to non-neglected children.

Full details of the studies from which these points are drawn are detailed at:
core-info.cardiff.ac.uk

Brandon et al (2008) identify common factors amongst mothers in their study of Serious Case Reviews where neglect was a feature. These include a history of neglect in their own childhood by caregivers with possible mental or physical ill health (therefore having an attachment disorder).

- Time in care, frequent house moves.
- Concerns about sexual abuse.
- Leaving home in teens.
- Multiple pregnancies.
- Mental health issues.
- Alcohol and substance misuse.
- Strong ambivalence to helping agencies; and a sense of 'survival' without support.
- Fathers, where a history was available, shared these factors. Additionally, there was evidence of criminality.
- Where males in the house were not necessarily the father of the children there was sometimes ambivalence and hostility to helping agencies.

The NSPCC suggests that the neglect of disabled children has been invisible.

The heightened vulnerability to neglect of disabled children was measured and found to be 3.8 times more likely to be neglected (Sullivan & Knutson 2000), for many reasons including stretching the family's capacity to be able to care; not being able to communicate

their needs (Bovarnick: NSPCC 2007); and in part due to traits the child brings to the relationship with the parent (Howe 2005).

Kennedy and Wonnacott (2005) emphasise the importance of addressing 'disabling barriers' including discrimination; lack of service provision; pity for carers affecting judgement; and the perception that a disabled child is somehow worth less.

Brandon et al (2008), in their review of Serious Cases warn of the **'start again syndrome'**, where practitioners, overwhelmed by the complexity of the family, put aside knowledge of the past and focus on the present, supporting parents to make a fresh start. **Any new or re-assessment of a family must take into account the family's history in order to make sense of the present**.

Risk and Protective Factors Associated with Neglect

Factors in Parents/Carers

- History of physical and/or sexual abuse or neglect in own childhood; history of care.
- Multiple bereavements.
- Multiple pregnancies, with many losses.
- Economic disadvantage/long term unemployment.
- Parents with a mental health difficulty, including (post-natal) depression.
- Parents with a learning difficulty/disability.
- Parents with chronic ill health.
- Domestic abuse in the household.
- Parents with substance misuse (drugs and alcohol).
- Attitude to parenting.
- Early parenthood.
- Families headed ab a line mother or where there are transient male partners.
- Father's criminal convictions.
- Strong ambivalence/hostility to helping organisations.

Factors in the Child

- Age of the child.
- Birth difficulties/prematurity.
- Children with a disability/learning, difficult/complex needs.
- Children living in large family with poor networks of support.
- Children in larger families with siblings close in age.
- Level of vulnerability/resilience/
- Young carers.

Environmental Factors

- Families experience of racism/discrimination.
- Family isolated.
- Dispute with neighbours.
- Social disadvantage.
- Multiple house moves/homelessness and security.

Elevating Risk Factors	Strengths and Protective Factors
Basic needs of the child are not adequately met.	Support network/extended family meet child's needs. Parent or carer works meaningfully and in partnership to address shortfalls in parenting capacity.
Substance misuse by parent or carer.	Substance misuse is 'controlled'. Presence of another 'good enough' carer.
Dysfunctional parent-child relationship Lack of affection to child. Lack of attention and stimulation to child.	Good attachment. Parent-child relationship is strong.
Mental health difficulties for parent/carer. Parent/carer learning difficulties.	Capacity and motivation for change. Capacity to sustain change. Support available to minimise risks. Presence of another 'good enough' parent or carer.
Low maternal self-esteem.	Mother has a positive view of self. Capacity and motivation for change.
Existence of Domestic Abuse.	Recognition and change in previous patterns of domestic abuse and sustaining the change.
Age of parent or carer.	Support for parent/carer in parenting task. Parent/carer co-operation with provision of support services. Maturity of parent/carer.
Negative, adverse or abusive childhood experiences of parent/carer.	Positive childhood. Understanding of own history of childhood adversity; motivation to parent more positively.
History of abusive parenting.	Abuse addressed in treatment.
Child left home alone.	Appropriate awareness of a child's needs. Age appropriate activities and responsibilities provided.
Failure to seek appropriate medical attention.	Evidence of parent engaging positively with agency network (health) to meet the needs of the child.

Intervening Within Families Where There is Neglect

The impact of neglect for children is often cumulative, increasing gradually, and therefore there is a risk that agencies do not intervene early enough to prevent harm, or that

professionals become 'acclimatised' to the neglect as a family norm. It is important that all agencies identify emerging problems and potential unmet needs and seek to address these as early as possible, in an attempt to prevent actual neglect of the child's needs and welfare.

Working Together to Safeguard (2015) requires local agencies to work together to put processes in place for the effective assessment of the needs of individual children who may benefit from Early Help Services and interventions.

Assessment and Intervention of Neglect

To successfully assess and intervene in neglect cases, there needs to be a full understanding of all of the factors to understand what prevents adequate parental capacity to respond to a child's needs. It is important that practitioners do not confuse the ***symptoms*** of neglect with the ***causes*** of neglect, as any interventions must primarily tackle the cause. An example of this might be to focus only on ensuring that the family home is tidy and clean (a symptom) rather than ensuring that the parent or carer receives treatment and support with substance misuse or a mental illness.

Increased risk of neglect and emotional abuse may be more likely in homes where there is domestic abuse; substance misuse; unemployment; mental ill health; an absence or perceived absence of a helpful supportive network; lack of intimate emotional support or poverty. As with all child protection assessments, factors like this should be specifically explored when assessing the child, although their absence does not mean neglect or emotional abuse will not be present.

Assessment

Issues to keep in mind when starting your assessment:

- What is getting in the way of this child or young person's well-being?
- Do I have all the information I need to help this child or young person and what can I/my agency do now to help?
- What additional help, if any, may be required from others?
- Who or what presents the threat to the child's well-being?
- Where does the abuse occur and is the abuse an act of commission or omission?
- Is the harm isolated to a single event or cumulative, reflecting more than on risk factor?
- What is the actual or likely impact of any harm?
- Does the parent(s) have insight into self, child and circumstances?
- Is there a shared understanding of professional concern/s by the family?

- What is the parents/carers understanding of the need for change – is change possible?
- Are they willing to effect change, how long will it take and can they maintain the change required?

The parent themselves - e.g. are they very young? Do they have a learning disability or mental health problem? Do they exhibit behaviours that can impact on their ability to care

for a child e.g. do they misuse alcohol or drugs, or experience domestic violence? Are they vulnerable in their own right?

Was their **own experience** of being parented damaging enough to impact on the care they give their own child? Parents who have been in care themselves may neglect their own children because of the absence of a family support network or from family substitutes such as foster carers.

Are there wider environmental issues? - are they isolated in their community? Do they suffer discrimination and/or poverty? Families who are experiencing poverty do not necessarily neglect their children and poverty is not a single causal factor in neglect cases. However, many of those cases of neglectful families that come to the attention of professionals working in social care are experiencing poverty. Social isolation and lack of readily available support is a further risk factor that can make neglect more likely.

How is the mental health of the parents? It is important that practitioners think of undiagnosed mental health issues. Depression is the most common form of mental illness affecting mothers. This is especially concerning when it is post-natal depression as it can interfere with the mother's ability to respond to her children's needs (Howe 2005).

There is much more research about depressed mothers than fathers. But we do know that the presence of a non-depressed parent significantly reduces the developmental risk to the child (Howe 2005).

Parental Learning Difficulties - For Stevenson (2007) the key issues to understand are: the parent's ability to anticipate risk to the child; manage diverse and complex situations; the possible rigidity of the parent's thought processes, thus making adaptation to change difficult i.e. in the child's needs or behaviour.

Horwath (2007) identifies six key issues in assessing the parenting capacity of learning disabled parents:

- Cognitive functioning (an IQ below 60 is not a good indicator of adequate parenting capacity);
- co-morbidity i.e. a diagnosis of mental illness or substance misuse; poor self-esteem;
- a lack of positive role models;
- a lack of support;
- and adverse social conditions.

Parental Autism - Practitioners should also consider the possibility of undiagnosed autism, particularly in mothers/females where it can present differently to males. Rigidity of thinking, fixed or controlling behaviours or avoidant behaviours may all be indications

that further exploration is warranted. This sort of insight or understanding may help practitioners change their style of intervention with a family to positive effect.

Parental Substance Misuse - Howe (2005) asserts that the significant effect of taking 'mind-altering' substances is that they interfere with the reciprocal, trusting and responsive

communication between the parent and the child, rendering the parent unable to read the signals and increasing the child's confusion and distress when this occurs (2005).

Parental drug use increases the likelihood of children being at risk of neglect and emotional abuse, but not other forms of abuse. Where the financial and emotional resources are committed to the pursuit of drugs, the degree of neglect will be higher. The issue of children taking on inappropriate caring roles beyond their years should be emphasised.

Domestic Violence - It is now acknowledged in legislation that where children witness domestic violence it should be regarded as 'harm' (Adoption and Children Act 2002 s120). Horwath (2007) proposes the concept that the parents' pre-occupation with safety can become all-consuming, and lead to other aspects of parenting being in deficit e.g. the mother is exhausted, has low self-esteem, or is depressed.

The Child Themselves

Some children are particularly vulnerable to suffering neglect:

- Children born prematurely or with very low birth weight
- Children with disabilities
- Adolescents
- Runaways
- Children in care
- Asylum seeking children and refugee children
- Young carers

The neglect of children with disabilities has been largely hidden. The research that does exist indicates that disabled children are more vulnerable to maltreatment than non-disabled children (Miller and Brown 2014). Reasons for this can be complex but include communication difficulties and to access help and care. It should also be considered that the needs of children with disabilities are often demanding and can overwhelm a parents/carer's capacity to provide adequate care.

Stevenson (2007) says there are six pre-requisites for a good enough assessment of parenting:

- Knowledge of evidence on specific effects of parental issues on care-giving e.g. substance misuse, learning disability.
- Ongoing regular re-appraisal of the situation.
- A realistic picture about the parents' will to change.
- Realistic expectations of what is 'good enough' parenting.
- Identification of individual needs.
- Impact of poverty as an integral part of the assessment, not just a 'context' but as a daily stressor.

A Research in Practice briefing on Understanding and Working with Neglect (2005) highlights the following principles for best practice in assessing neglect:

- Pro-active assessment – don't wait for the accident/incident.
- Addressing the causes, not the symptoms.
- Using an ecological framework.
- Multi-disciplinary assessment – and access to research.
- Understanding families' histories and patterns of interaction.
- Matching interventions to identified needs.
- Appropriate timescales for intervention and change.
- Work with parents; and
- Work with children within a resilience framework.

You may find the following assessment tools useful:

SafeLives Dash risk checklist for the identification of high risk cases of DA, stalking and 'honour' based violence.

Suffolk Drug Use Screening Tool (DUST)

Safeguarding Children and Young People from Sexual Exploitation – Policy Guidance, Toolkit and Risk Assessment.

Collaborative Casework (previously ACCORD).

The Effects of Neglect

- Neglect is bad for brain development.
- Neglect is bad for the child's relationships and emotional development.
- Neglect is bad for the child's learning.
- Neglect is bad for the child's physical development.

Good Practice Principles in Tackling Neglect

The NSPCC Research Briefing (2010) identifies the following good practice principles in tackling neglect:

- 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 a 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)

Evidence-Based Approaches in Suffolk:

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1. Signs of Safety

In Suffolk, practitioners have been trained in the Signs of Safety framework model. This enables practitioners across different disciplines to work collaboratively and in partnership with families and children.

The Signs of Safety model is a tool intended to help practitioners with risk assessment and safety planning from early intervention to child protection cases. The tools are designed to help conduct risk assessments and produce action plans for increasing safety, and to reduce risk and danger by identifying areas that need change, while focussing on strengths, resources, and networks that the family have.

2. Standardised tool for assessment & intervention - the Graded Care Profile

Suffolk Safeguarding Partnership endorse the use of the Graded Care Profile 2 (GCP) to inform the assessment framework of Signs of Safety.
The **Graded Care Profile** is an assessment tool, initially developed by Dr Srivastava, which allows practitioners to produce an objective measure of the quality of care given to a child by looking at four key areas: physical, safety, love, and esteem, adapted from Maslow's hierarchy of human needs (Maslow 1954).

The assessment is an evidence-based assessment tool for evaluating levels of parental care. It identifies strengths and weaknesses to capture levels of physical and emotional care, identifies strengths and weaknesses and targets aspects of neglectful care. It provides evidence that can inform care and intervention plans.

The assessment gives an objective picture of the care that the child is **actually** receiving and highlights how parenting support and interventions can be targeted to improve the level of care the child receives.

More information on the graded care profile can be found on the Suffolk CYPS Good Practice Guide or Suffolk Safeguarding Partnership website.

References and Research

Child Neglect: Policy, Response and Developments in England

Julie Taylor1, Marian Brandon2, Dawn Hodson3 and Alice Haynes3

1 University of Birmingham and Birmingham Children's Hospital NHS Foundation Trust

2 Centre for Research on Children and Families, University of East Anglia

3 National Society for the Prevention of Cruelty to Children (NSPCC), London
Research, Policy and Planning (2016) **32**(1), 39-51

Despite headline reactions to child sexual exploitation and abuse or murdered children, child neglect continues to be one of our most pervasive and intractable child protection problems. It is the main reason why children's social care services become involved with families. Moreover, it has the largest impact on future outcomes for both children and society. In England the child protection system has evolved largely in response to high profile child protection inquiries but remains vague on what it considers to be its cornerstone: professional judgement about when a threshold for intervention is reached and at what level. Current austerity measures and funding cuts exacerbate the problem. Nonetheless there are a number of promising initiatives and models that highlight what can be done to help neglected children and families and an emerging evidence base that illuminates those areas where most ground can be gained. The role of place and community in neglect is increasingly being seen as the new frontier for intervention. Sustained involvement with families over the long term, interpersonal supportive yet firm interactions that keep children central are costly to deliver and are not crowd-pleasers. Nonetheless such programmes are key in making a difference for neglected children.

Core-Info: emotional neglect and emotional abuse in pre-school children.
Cardiff University, Department of Child Health and NSPCC [London]: NSPCC, 2012

Leaflet summarising what is known about emotionally neglected or emotionally abused children aged under 6 years. Based on a systematic review of research, the leaflet outlines the signs to look out for in mother-child interactions and in the child's behaviour. Also sets out practice issues professionals should consider. **core-info.cardiff.ac.uk**

Neglect matters: a guide for young people about neglect. [London]: NSPCC, [2010]

A guide for young people aged 11-17 years explaining what neglect is, how to recognise it, who can help and what you can do about it. A summary of how research and advisory groups of young people were used to develop this guide is also available: Neglect matters: the story of the guide (2010).

Ten top tips for identifying neglect. Beesley, Pat British Association for Adoption and Fostering (BAAF) London: British Association for Adoption and Fostering (BAAF), 2011

Provides guidance on identifying, evidencing and responding to neglect. Chapters cover understanding why parents neglect their children; lessons to be learned from serious case reviews; the impact of neglect on children; and how best to intervene. Aimed at social care practitioners and others working with children and families needing a quick reference guide.

Adolescent neglect: research, policy and practice.

Rees, Gwyther, and Stein, Mike, and Hicks, Leslie, and Gorin, Sarah London: Jessica Kingsley, 2011

Discusses the neglect of young people (11-17 year olds). Outlines how adolescent neglect differs from child neglect, the context of why it is overlooked, how it is defined, the causes and consequences of neglect, young people's views, and what professionals can do. Based on original research, this book establishes an evidence base and considers implications for policy and practice. Reflection points included throughout. Suitable for practitioners working with young people, particularly those in social work, health services and education, policymakers and students.

Recognizing and helping the neglected child: evidence-based practice for assessment and intervention. Daniel, Brigid, and Taylor, Julie, and Scott, Jane, and Derbyshire, David, and Neilson, Deanna London: Jessica Kingsley, 2011

Explores key issues around child neglect including: how neglect can be recognised, signs that parents need help, and signs that a child's needs are not being met. Covers how practitioners should respond, including assessment, planning and appropriate interventions. Also considers the prevention of child neglect, proposing a public health approach. Based on evidence gathered from a Department of Health and Department of Children, Schools and Families (now DfE) funded literature review. Includes practical case studies throughout and makes recommendations for policy and practice. Foreword by Enid Hendry of the NSPCC

Neglect matters: a multi-agency guide for professionals working together on behalf of teenagers. Hicks, Leslie, and Stein, Mike Nottingham: Department for Children, Schools and Families (DCSF), 2010

Guide for professionals to improve understanding of what adolescent neglect is and to offer suggestions for ways of improving multi-agency practice. Covers assessment, prevention and intervention and provides signposts to good practice. Answers the questions: what is adolescent neglect? what are the causes and consequences? whose business is adolescent neglect? what can I do about it? what practitioners need to know
and do? Based on material gathered during research. Based on a review of research (Stein et al., 2009).

Child neglect: identification and assessment. Horwath, Jan Basingstoke: Palgrave Macmillan, 2007

Aimed at practitioners and managers working to safeguard and promote the welfare of neglected children, this book is designed to help with the identification and assessment of child neglect. It highlights the relevant personal, professional and organisational factors and explores how current practice can be improved. Divided into the following four sections: 1) Defining child neglect: what it is and what it does to children. 2) Assessing the care-giver and the care-giving context. 3) Referral and assessment: practice reality. 4) Moving practice forward - which includes the assessment challenges and best practice and developing practitioner and organisational capacity.

Neglected children and their families. 2nd ed. Stevenson, Olive Oxford: Blackwell Publishing, 2007

Provides guidance for assessment and intervention in child neglect for all those studying in childcare, including social workers, health visitors and child nurses. Begins by defining and

understanding the problem and considers the family context such as poverty, social exclusion, community support, and ethnic and cultural factors. Chapter three focuses on parents and issues such as substance abuse, depression and learning disability. Chapter four considers the effects of serious and chronic neglect, including the implications for the development of delinquent behaviour, the concept of resilience, and attachment. Also contains chapters on working together and modes of intervention.

Child neglect: practice issues for health and social care. Taylor, Julie ed., and Daniel, Brigid ed. London: Jessica Kingsley, 2005

Addresses issues surrounding child neglect, including recognition, effective prevention, economic, cultural and social factors, and appropriate interventions. Includes chapters on the use of the Graded Care Profile in assessing neglect; emotional child neglect; lessons from serious case reviews; neglect of disabled children; failure to thrive; parental substance misuse; the role of mothers and fathers in child neglect cases; attachment and neglect; and working together in neglect cases. Aimed at practitioners, academics, and policy makers, draws on research and practice knowledge, and sets out the implications for social work and health practice and policies.

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Useful Websites

www.nspcc.org.uk

www.actionforchildren.org.uk

www.childrenssociety.org.uk

www.suffolkscb.org.uk

Note

Grateful thanks and acknowledgement to Cambridgeshire, Essex and Norfolk LSCBs, the NSPCC and Barnsley Metropolitan Borough Council.

Grateful thanks to Hampshire and Isle of Wight LSCBs for letting us reproduce Appendix 2 – Key Indicators of Neglect.

Appendix 1 - Supervision Checklist

A study by Gardner (2008) outlined the following elements of basic good practice with neglect.

- A timely response to all expressions of concern regarding neglect.
- An understanding of the child's day-to day experiences – have you asked the parent and child about the impact of their difficulty on daily life?
- Adequate child care must be addressed as the priority.
- Practitioners must engage with the whole family including extended family members.
- Clarity is required on parental responsibility and expectations.
- A full assessment of the child's health and development.
- On-going monitoring for patterns and changes over time.
- Practitioners should avoid assumptions and stereotypes.
- Track families whose details change and keep records updated.
- Regular systematic planning and review of outcomes and service effectiveness including the views of children and family members.
- Address underlying problems in a systematic way; and
- engage in regular independent case audit.
- Can you list the parental behaviours towards the child that you feel could cause harm to the child? How does their illness/behaviour impact on their function and on their responses to their child?
- Can you list the different ways in which you feel the child is being or could be harmed?
- Do you understand the child/care-giver/family history: are there previous incidents or episodes of neglect?
- Are you aware of other adults in this child's life – who does this child mean something to? Have you considered how other adults play a part in the child's life?
- Does the parental behaviour cause the child to take on inappropriate caring roles, either for their parents or carers or for their siblings?
- Have you asked about finances?
- Is their housing appropriate? E.g. wheelchair accessible; not crowded?
- Is there extended family that support the child and immediate family? What links does the family have in the community? Is there an adult who is literate living in the house?
- Does the child or family suffer from any sort of discrimination in the local community or at school?

Appendix 2 - Key Indicators of Neglect

Key Indicators – Emotional Neglect

	Universal/ Early Intervention	Early Help	Targeted Early Help	Children's Social Care
Characteristics of carers	• Cannot cope with children's demands • Parents may feel awkward/ tense when alone with their children • Inconsistent responses to child	• Failure to connect emotionally with child • Lots of rules • Lack of attachment to child • Unrealistic expectations in line with child's development	• Dismissive/punitive response to child's needs • Poor attachment to child	• Parental responses lack empathy • Not emotionally available to child • No attachment to child
Characteristics of children	• Over friendly with strangers • Over reliance on social media to interact • No risk CSE	• Frightened/unhappy/ anxious/low self-esteem • Know their role in family • Attention seeking • Mild risk CSE	• Withdrawn/ isolated • Fear intimacy and dependency • Self-reliant • Difficulties in regulating emotions • Very poor self esteem • Moderate risk CSE	• Precocious • Unresponsive/no crying • Oversexualised behaviour • Self-harm • Significant risk CSE
What professionals notice	• Ignore advice • Children spend a lot of time on-line • Lack of engagement with universal services • Materially advantaged • Child not included • Child always immaculately clean • Child and family isolated in Community • Poor dental hygiene	• Avoid contact • Missed appointments • Child learns to block expressions • Child 'shut down' • Risky behaviour on-line • Material advantages can mask the lack of emotional warmth and connection	• Deride professionals • Children unavailable • Children appear overly resilient • Poor social relationships due to isolation • Scapegoated child • Regression in child's behaviour • Pattern of step ups to social care • Severe dental disease	• May seek help with a child who needs to be 'cured' • Fabricated illness • Parents seeking a diagnosis/label for child • Pattern of step downs to early help

Key Indicators – Disorganised Neglect

	Universal/ Early Intervention	Early Help	Targeted Early Help	Children's Social Care
Characteristics of carers	• Demanding and dependant • Cope with babies (babies need them) but then struggle • Flustered presentation • Late • Low mood • Unstructured • Problem driven • Revert back to own needs • Everything 'big drama'	• Feelings of being undervalued or emotionally deprived as a child-so need to be centre of attention/affection • Lack of 'attunement' • Crisis response • Avoidance of contact • Poor attachment • Poor parenting • Not engaging with health	• Disguised compliance • Putting own needs before child • Drug/alcohol misuse • Depression • Not getting children to school • Escalation of mental health	• High criticism/low warmth • Continuous use of medical issues to cover up/disguise • Chaotic family • Escalation of depression
Characteristics of children	• Anxious and demanding • Infants-fractious/ clinging-difficult to soothe • Lateness at school/nursery • Overactive at school • No school equipment • Not able to sit still • Snatching • Struggle with quiet time • Vulnerable to unhealthy relationships • No boundaries or routines • Not at risk CSE	• Young children-attention seeking, exaggerated affect, poor confidence and concentration, jealous, show off, go too far • Fear intimacy • Missing school/nursery • Disruptive at school • Fretful • Crying • Angry • Afraid • Mild risk CSE	• Roaming late at night • Trouble during unsupervised times • Engaging in risky behaviours • Bullying • Aggressive • Jealous • Depressed • Poor school attendance • Speech and language delays • Moderate risk CSE	• Self-harm • Causing harm to others • Substance/ alcohol use • Offending • Left at home alone • Anti-social behaviour • Able to do what they want • Feral • Ignored • Danger to self/others • Head lice infestation • Significant risk CSE
What professionals notice	• Classic 'problem families' • Numerous pregnancies • Missed appointments • Messy house • Erratic changes in mood • Unable to acknowledge problems • Not reporting absences • Disruptive behaviour • Poor hygiene • Poor dental hygiene	• Annoy and frustrate but also endear and amuse • Chaos and disruption • Avoidance of home visits • Lots of contact • Regular lateness and absences • Family identify own need • No improvement • Persistent lateness • Children visibly tired	• Thick case files • Feelings drive behaviour/social interaction • Dependency on services to provide support • Lack understanding/ acceptance of issues • Exclusion from school • Severe dental disease	• Anti-social behaviour • Parents create new crises • Difficult to work with • Frequent exclusions • Non-engagement with education

Key Indicators – Severe Deprivation Neglect

	Universal/ Early Intervention	Early Help	Targeted Early Help	Children's Social Care
Characteristics of carers	• Contact with GP for depression • History of chronic mental health • Long term unemployed • Low cognitive functioning • Poor physical presentation • Socially isolated	• Contact with specialist agency for depression, mental health – in treatment • Postnatal depression • Poor attachment with children	• Carers with serious issues of depression, learning disabilities, substance misuse • Homeless • Not in treatment	• Institutional neglect • Suicidal thoughts
Characteristics of children	• Arrive late at school • Poor presentation • Hungry • Tired • Miss initial health checks • Lack confidence • Poor attachment with parents • Anxiety and low self esteem • Minor accidents at home • Poor dental hygiene • Poor school attendance • Not at risk CSE	• Inhibited, withdrawn, passive, rarely smile, autistic type behaviour and self-soothing • Relationships shallow, lack reciprocity • Disinhibited: attention-seeking, clingy, very friendly • Not accessing early years • High absence from school • Mild risk CSE	• Infants - poor pre-attachment behaviours of smiling, crying, eye contact • Children - impulsive, hyperactive, attention deficit, cognitive impairment and developmental delay, eating problems, poor relationships • School exclusion • Moderate risk CSE	• Self-harm • Mental ill health • Sexualised behaviour • Failure to thrive • Recurrent illnesses • Going missing • Out of education • Significant risk CSE
What professionals notice	• Clutter • Disorganised home • Hoarding • Not enough furniture • Lots of animals • Not attending appointments • Poor dental hygiene	• Dirty home and children • Poor physical and mental health • Poor hygiene • Regularly attending A&E	• Material and emotional poverty • Head lice • Homes and children dirty and smelly	• Urine soaked mattresses, dog faeces, filthy plates, rags at the window • • Children left in cot or serial care giving • Child essentially alone-severe neglect, absence of selective attachment. • Unable to get into house • Severe dental disease

Key Indicators – Depressed/Passive

	Universal/ Early Intervention	Early Help	Targeted Early Help	Children's Social Care
Characteristics of carers	• Often severely abused/neglected by own parents • Given up thinking and feeling • Withdrawn • Lack of meaningful engagement • Forgetting appointments • Can't impose boundaries • Focused on own needs • Not seen in school • Blame others for children's behaviour	• May seem unmotivated/mild learning disability • Learned helplessness • No structure/poor supervision • Stubborn negativism-passive aggressive • Missing appointments • Disorganised • Seeking services to solve problems (but not changing) • Emerging criticisms • One or two elements of toxic trio emerging • Change schools	• No smacks/no shouting/no deliberate harm BUT no hugs, warmth emotional involvement either. • Unresponsive to children's needs limited interaction • Avoiding appointments • Struggling to engage • Blaming services for lack of progress • Refuse to engage with early help	• Obstructing appointments • Blaming others • Combination of toxic trio reaching crisis • No ability to change • No boundaries
Characteristics of children	• Lack of interaction with carers • Presents as hungry • Lack of progression • Tired, withdrawn, isolated • Poor diet • Lateness at school • Dirty clothes • Developmental milestones not met • Attendance at A&E • Not at risk of CSE	• Infant-not curious, unresponsive, moans and whimpers but does not cry or laugh • Tend not to say much • Unwashed, ill-fitting clothes • Missing school • Repeated attendance at A&E • Unmet health needs • Obese • Mild risk CSE	• At school - isolated, aimless, lacking in concentration, drive, confidence and self esteem • Anxious • Goes missing • Poor school attendance • Self-harm • Self-isolating • Unresponsive • Moderate risk CSE	• Developmental delay • Absent from school • Regularly goes missing • Not accessing health services • Inappropriate behaviour for age • Morbidly obese • Significant risk CSE
What professionals notice	• Shut down and block out all information • Absence from school/nursery • Children appear hungry • Inconsistent engagement • Turn up late at school • Poor dental hygiene	• Parents do not believe they can change so do not even try • A sense of hopelessness and despair - which can be reflected in the workers too • Poor dental hygiene • Stealing food	• Material and emotional poverty • Homes and children dirty and smelly • Chaotic, dirty households • Children not saying anything or making excuses for their parents • Children attending appointments on their own • Repeated concerns reported by neighbours • Severe dental disease	• Urine soaked mattresses, dog faeces, filthy plates, rags at the window • Children parenting their parents • Offending behaviour • Difficult to work with • Not in for visits