West Sussex Safeguarding Children Board

Neglect Practice Guidance

With thanks to Luton LSCB and Dr Srivastava for kindly allowing West Sussex LSCB to use the Graded Care Profile and adapt their guidance documents

Contents

1. Introduction

This guidance has been produced because it is recognised that neglect is a complex and multifaceted issue, which can be difficult to address effectively. In contrast to other forms of abuse, where specific and critical incidents can highlight significant harm, the less tangible indicators of neglect, combined with its nebulous presentation, often make neglect cases more difficult to identify as child protection concerns. Furthermore, differences in opinion about what constitutes 'persistent failure', 'serious impairment of health or development', and 'adequate' makes deciding when significant harm is being caused more open to interpretation, resulting in potential confusion and lack of consensus amongst child care professionals.

It is well known that some families continue to provide good care to their children, despite adverse conditions whereas others do not. Therefore, a helpful way to view neglect is to consider what a carer could have done that they did not do, or is doing that they should not have done in terms of meeting a child's health and developmental needs. For example, poverty alone cannot justify shouting at a child or belittling a child or not praising a child.

Furthermore, poverty and other adverse social factors which often co- exist confound the issue even more. These may generate empathy for the carer and justification for their action or inaction, which could be detrimental to a child and could potentially result in harm continuing despite the provision of services.

The objective is to identify neglect early so that interventions, either in the community or through timely referral to the statutory agencies, can start early to minimise ongoing harm to children. This concept is at the core of this practice guidance and is facilitated by the use of the following tools designed for this purpose:

- **Neglect Identification & Measurement Tool** (West Sussex LSCB, 2011)
- **Neglect Risk Assessment Tool** (West Sussex Primary Care Trust, 2007)
- **Graded Care Profile** (*Srivastava et al 2007*)

(These tools and their relevant user guides are available on WS LSCB Neglect web pages, please refer to these for further guidance on why, when and how to use them.)

2. Defining Child Neglect

Working Together defines neglect as a form of significant harm which involves 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 and clothing, shelter including exclusion fromhome or abandonment, failing to protect a child from physical and emotional harm or danger, failure to ensure adequate supervision including the use of inadequate care-takers, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. (*Working together to safeguard children; HMSO; 2006 & 2010*)

The Framework for the Assessment of Children in Need and their Families *(2000, Chapter 2)* defines 'Child's Developmental Needs', 'Parenting Capacity' and 'Family and Environmental Factors' and identifies that these are all intrinsically linked to the overall wellbeing and needs of children. Reference should always be made to these areas when considering the possibility of child neglect.

If concerns are identified that a child's needs are being unmet, neglect can be considered as an hypothesis and tested in terms of significant harm and whether or not there exists a deficit in parenting capacity to cause the shortfall. It is important to remember that the recognition of unmet needs may not in itself indicate neglectful parenting unless it is shown that if parents had tried, these needs would have been met. A wide view of the child's circumstances and an effective assessment identifying why such needs remain unmet will always be required.

3. Recognising Neglect:

The recognition and prompt response to indicators of neglect is crucial if the neglected child is to be protected. The longer a child is exposed to neglect, the more difficult it will be to reverse the adverse effects of neglect. Signs and symptoms of abuse and neglect must always be viewed in context and conclusions must not be made without a thorough assessment of the child's individual circumstances.

Indicators of Child Neglect		
Physical	**Developmental**	**Behavioural**
Faltering growth /weight/height/ head circumference Late presentation with physical symptoms, e.g. impetigo, nappy rash Unkempt and dirty/poor hygiene Repeated accidents at home Obesity Delayed puberty	Late attainment of developmental milestone Language delay, attention span limited Socio-emotional immaturity Poor performance in relation to potential Low self esteem Poor coping skills	Attachment disorders, overfriendliness to strangers Lack of social responsiveness Disordered or few relationships Self-stimulating or self injurious behaviour or both Soiling/wetting Hyperphagia – over eating Conduct disorders, aggressive, destructive, withdrawn Poor/erratic attendance in school Runaways, delinquent behavior

4. Impact on the Child/Young Person

Neglect can have damaging long-term effects on all aspects of a child's health and development. However, the degree of impact will differ in relation to individual children and the nature of the parent/carer's neglectful parenting. The range of potential impact may lie on a continuum that starts with developmental delay and ends with significant long-term harm and in some cases death. (*Howarth 2007*)

Neglect and Brain Development: the hardware for intellectual and other developmental potential of a child is the number of neurones in the brain at birth (no more are acquired after this). This is dependent on genetic influences but their connections (called synaptogenesis) are influenced by genetic as well as environmental factors and continue to develop after birth. Although the former (number of neurones) is capped at birth and cannot be enhanced by careful nurturing, they can be affected adversely by events before birth, e.g. intrauterine malnutrition, maternal-foetal infections, maternal drugs, alcohol and substance use. The latter (neuronal connections), which continue to develop after birth, although influenced by genetic factors, can be very much influenced both positively and negatively by environmental factors.

Positive environmental input results in richer connections and negative input results in poorer connections. Positive environmental factors include:

- Physical: being touched & caressing, fed etc
- Social: being responded to in time, opportunities for assuring social interaction
- Emotional: being comforted, encouraged, praised and appreciated

It is a main body of knowledge in medical science that part of the brain called 'hypothalamus' has a specialised area which secretes hormones which control the 'anterior pituitary' gland. This in turn secretes hormones which control other glands at the end of this chain including thyroid, adrenals, and gonads (sex hormone secreting glands). Hormones from glands at the end of the chain control a number of vital functions in the body including the onset of puberty, growth and emotional state. The main controller, hypothalamus, is under the influence of higher parts of the brain which also regulates emotion. Hence a child with emotional neglect or abuse may have slow growth. There is some evidence that the precise calibration of this 'chain of command' in regulating hormonal functioning is done before birth under both genetic and environmental influences. This is where mother's emotional state and health during pregnancy are so important for the baby. Any event that disrupts this, like depression or domestic abuse, can affect the developing endocrinal biofeedback of the baby adversely.

In addition, softer elements which form the scaffolding for a child's development are very important. After all a baby's brain is a functioning brain from birth, though it has still to grow and differentiate (mature). It is capable of storing environmental inputs through its own experience in life which has a profound effect on how effectively a child uses his/her developmental potential.

Thus, the knowledge we now have of brain development, makes it clear

'young babies require not only food, shelter and a physically safe environment - but also their cognitive, emotional and social needs met from birth and, indeed considered, during pregnancy' (*Perry 1997*). Perry goes on to comment that the earlier the neglect occurs and the more extensive it is, the more likely the child will continue to suffer from its effects into adulthood.

Neglect and Socio-Emotional Development: A child who is able to feel confident in their carer's availability and who is able to predict their response with relative certainty, will feel safe enough to explore the world and, gradually, to become more autonomous. These children will also be supported to manage difficult feelings and emotions and this will help them to develop their own coping mechanisms over time. Thus a secure pattern of attachment is formed which will give the child the foundations for future resilience and the ability to manage other relationships. By comparison, a child who is neglected will not be able to rely upon their carer's availability or to feel the same level of confidence in the response they may receive from the carer. To cope with this, the child will develop strategies that will depend upon the way their carer relates to them.

According to Erickson's theory of social development a child develops 'trust' in a care giver during early infancy and if maintained during subsequent stages of development, forms the basis for social behavioural regulation. In toddler years when a child is mobile, needs external regulation to curtail and modify his/her behaviour to acquire a pro-social norm. External direction works because the child has trust in his/her carer. In absence of that trust it will not work that well. This external regulation gradually becomes internal reference so that by the time a child is ready for school, he/she would have developed set of core values for self-regulation in carer's absence. Development of trust earlier is pivotal in building this aspect of development. External direction works because of trust and another factor is consistency of external direction. (Trust used in this context signifies attachment).

Children who are securely attached to their caregiver develop better social competence and are emotionally secure. They are better able to withstand adversities than children who grow up insecurely attached. Insecure attachment is caused by certain characteristics of parent/carer which includes neglectful behaviour. There are two types of insecure attachment, anxious and avoidant:

1. Insecure anxious or ambivalent attachment: children who develop insecure or ambivalent attachment feel insecure about their care giver and would display a set of behaviour which reflects this - clinginess, attention seeking, approval seeking, lacking in confidence and anxious behaviour. Such children become too anxious when the carer is not around.

2. Insecure avoidant attachment: children who develop this type of attachment or no attachment display attachment-seeking behaviour towards other and are avoidant of their own carer. It does not matter to them whether the carer is around or not. Some will go on to become more self-reliant where as other may become very vulnerable to exploitation by others.

Neglect and Cognitive Development: Cognitive development can be affected by neglect in a number of ways starting from antenatal period through school age. It can be affected antenatally by various ways described above, and by lack of opportunity and experience of learning especially in early years. However, it needs to be noted that actual learning ability or intellectual development is primarily genetically determined but if neglect is severe and prolonged it can limit this development, especially those under seven years of age. In most cases, however, it is the performance which is compromised through lack of emotional motivational drive. If neglect is recognised in time and intervened, these can be reversed. Malnutrition associated with neglect can also have negative effect on performance.

Other factors such as poor school attendance, poor self-esteem, emotional-social behavioural problems and school exclusion can all contribute to poor school performance and in extreme cases social exclusion. Lack of provision of a safe environment can result in head injury or lack of immunisation can result in illnesses like meningitis which again can have detrimental effect on cognitive development.

Neglect and Physical Development

Growth is more readily affected in cases where there is emotional neglect or abuse but can also be affected by significant under-nutrition if it is prolonged (years). Under-nutrition also affects bone development which reduces its density. As food items containing carbohydrate are cheap and can be consumed in plenty even in neglectful conditions, obesity is becoming a feature of neglect. Obesity has direct negative impact on physical well-being including liver failure, heart failure and cardiovascular accidents. Providing and persuading a child to consume a balanced diet is required for optimum growth and physical wellbeing but this is also demanding of parents.

Although physical milestones are not affected by neglect in the long term, it may cause initial delay. Thus in turn skills that need focused learning in the early formative years, like handwriting, can be adversely and irreversibly affected. There are rare examples of neglect where an infant had been left strapped to a pram over a long period of time and in such situations this has affected walking irreversibly.

5. Child Neglect and Significant Harm

In order to evidence that concerns relating to child neglect require a safeguarding response, it is necessary for professionals to think of neglect in the context of actual or likelihood of significant harm. Working Together to Safeguard Children 2010 is clear that there are no absolute criteria upon which professionals can rely when judging what constitutes 'Significant Harm'.

There are no specific criteria that will explain exactly where the threshold for child protection intervention will begin or end. The point at which this threshold is crossed depends upon a number of factors and will be largely reliant upon professional judgement and the completion of an accurate and effective assessment using either the **Neglect Identification & Measurement Tool,** the **Neglect Risk Assessment Tool** and/or the **Graded Care Profile**.

6. Risk Factors Associated with Child Neglect

Risk factors raise concern that the care given by the parent/carer may be compromised, if the care itself is good it may dispel this fear. However, some risk factors may still affect care adversely in the future if the severity worsens or if the care required becomes more demanding (eg child is unwell) and some risk factors may affect care unpredictably (eg substance abuse, mental illness etc). **Priority should be to ensure the wellbeing of the child regardless of sympathy for the carer**.

The identification of the nature and extent of risk to a child is central to any assessment. The meaning of 'risk' in the context of neglect is the danger that is likely to cause significant harm to a child in respect of his/her well-being either physically, emotionally or developmentally. Any assessment of risk will include the various factors outlined as key elements in The Framework for the Assessment of Children in Need and their Families 2000. The main areas requiring exploration are:

These elements provide the basis upon which social workers and other professionals can obtain and evaluate information in a holistic manner. Given the nature of neglect, this is essential if an effective assessment is to be completed of whether or not neglect is suggestive of significant harm.

When assessing risk always consider neglect in terms of significant harm. A helpful way to evaluate levels of risk is to formulate a grid as below. Compare any identified risks against any strengths that would reduce the concern. The factors within the grid are not exhaustive and other areas of risk or strength may be equally relevant. The areas of risk primarily relate to the adequacy of parental care.

Elevating Risk Factors	Strengths (protective factors)
1. Basic needs of the child are not adequately met	Support network/extended family meets child's needs/parent or carer works in partnership to address shortfalls in parenting capacity
2. Age of the child	Child is of age where risks are reduced
3. Substance misuse	Substance misuse is 'controlled'/presence of another 'good enough' carer
4. Dysfunctional parent-child relationship 5. Lack of affection 6. Lack of attention and stimulation	Good attachment/parent-child relationship is strong
7. Mental health difficulties 8. Learning difficulties	Capacity for change/support to minimise risks/ presence of another 'good enough' carer
9. Low maternal self esteem	Mother has positive view of self - capacity for change
10. Domestic Abuse	Recognition and change in previous violent pattern
11. Age of parent or carer	Support for parent/carer - co-operation with provision of support/services/maturity
12. Negative childhood experiences	Positive childhood or understanding of own history of abuse

13. History of abusive parenting	Abuse addressed in treatment
14. Dangerous/damaging expectations upon children 15. Home alone	Appropriate awareness of a child's needs and age appropriate activities/responsibilities
16. Failure to seek appropriate medical attention	Evidence of parent engaging positively with agency network (health) to meet the needs of the child

During any professional contact with a child, consideration should always be given to the presence of the following factors which may indicate neglect is an issue. Where neglect is suspected the list can be used as a tool to help assess whether or not the child is exposed to an elevated level of risk. This list is not exhaustive or listed in order of importance:

Poverty: professionals should guard against the risk of 'excusing' neglect because a family is in poverty. Neglect is about a child's needs being unmet through carers action or inaction to such a degree that impairment of health and development may occur and in serious cases can result in cruelty. This can occur in families that are in poverty or in those who could be considered as 'well-off'. Conversely, some parents are able to bring up their children happily and effectively in spite of limited financial resources. However, abject poverty may not only affect material aspect of care like housing, clothing, hygiene etc it can also affect the attitude and motivation of the carer.

It can be difficult sometimes to distinguish between indicators of early neglect and those of poverty and this can present dilemmas when considering whether a safeguarding response is required.

In some families there may be a sub-culture of letting children fend for themselves underestimating the need for ensuring safety. Working cooperatively with parents and helping them may improve such behaviour and attitude and improve care in some such families. If it does not then, regardless of sympathy for the carer, protecting the child from neglect should be a priority.

Substance Misuse: If parents/carers misuse either drugs or alcohol and this use is chaotic, there is a strong likelihood that the needs of their children will be compromised. Any concerns of substance misuse need to be assessed thoroughly and the house carefully checked for dangers and risk of immediate harm.

Parental addiction can alter their capacity to prioritise their children’s needs over their own and in some cases alters their behaviour so that they display outright hostility towards children.

The key messages contained in Hidden Harm - Responding to the Needs of Children of problem Drug Users (2003) were that:

- Parental problem drug use can and does cause serious harm to children of every age

- Reducing the harm to children should become the main objective of drug policy and practice
- Effective treatment of the parent can have major benefits to the child
- By working together, services can take practical steps to protect and improve the health and well being of affected children.
- The number of affected children is only likely to decrease when the number of problem drug users decreases.

Whenever substance misuse is identified as a concern, a thorough assessment of the impact upon parenting and potential implications for the child must be completed.

Mental Health Difficulties: It is acknowledged that mental health problems in carers can significantly impact upon parenting capacity, depending on the type of mental illness and individual circumstances. As such, these should be considered as a possible contributory factor to neglect when the following is identified:

- Severe depression or psychotic illness impacting upon the ability to interact with or stimulate a young child and/or provide consistency on parenting.
- Delusional beliefs about a child, or being shared with the child, to the extent that the child's development and/or health are compromised.

Specialist advice as to the impact of mental health difficulties on parenting capacity must always be sought from an appropriate mental health practitioner in these cases. Please refer to the West Sussex LSCB Parents/Carers Experiencing Mental Ill Health and Child Protection Protocol and Good Practice Guidance for working with parents or carers experiencing mental ill health where there are concerns about their child(ren).

Learning Disabilities: Some carers with a learning disability could have a very good caring instinct while others may not, just the same as for those who do not have learning disability. However, even with a good caring instinct, a carer with a learning disability will be prone to have difficulty with acquiring skills to care, for example feeding, bathing, cleaning, and stimulating. However, those with good caring instincts show high level of commitment to improve.

This is where the assessment will be instrumental. It will capture areas of deficient care which can be specifically targeted and re-evaluated after a period of intervention. Improvement will depend on both level of commitment and severity of learning disability. If it improves then more sustained work will be needed to ascertain the level and length of support needed. If it does not improve, the child will remain exposed to harm or potential harm.

Where there is quite a significant learning disability, an assessment by the Learning Disability Team should be sought in order to inform the management plan. Parental learning difficulties impacts upon the 'normal' parent-child interactions, which, if affected significantly, can lead towards emotional and/or physical neglect.

Domestic Abuse and Chronic Unresolved Disputes between Adults: Growing up in a violent and threatening environment can significantly impair the health and development of children, as well as exposing them to an ongoing risk of indirect physical harm. Chronic, unresolved disputes between adults, whether these involve violence or not, would have adverse impact on the child's emotional wellbeing and hence emotional neglect would remain an issue. Professionals need to remain alert to the indicators of neglect whenever domestic abuse is raised as an issue. Carefully explore and assess the circumstances and if violence is recurrent, think of the likely consequences for the child in terms of impact on his or her emotional and development and well-being.

7. Action in the community (pre-referral)

If you are a professional working with children & families in West Sussex you should be familiar with the pan Sussex Child Protections and Safeguarding Procedures and adhere to this guidance. Where you believe that neglect is an issue you can use WS LSCB Neglect Identification & Assessment Checklist or WS Health Risk Assessment Tool:

Step 1. Record: Record your concerns, gather information from other sources that you can access to build a better picture, any remedial measures taken (discussion with carer/s, referral etc.), and progress made – this will constitute the 'Chronology''.

Step 2. Discuss with your supervisor &/or line manager

Step 3. Complete the assessment and analyse the results

Step 4. Draw up an Improvement Plan

Step 5. Provide & or coordinate appropriate interventions

Levels of **interventions in the community** (pre-referral) –

- Do what you can to support in your professional capacity and monitor.
- Refer to a colleague for additional support under the **existing pathways** (HV to the GP, or to a Community Paediatrician; School or Nursery to a School Nurse or HV respectively or to a Community Paediatrician; GP & Paediatrician to CAMHS or Drug & Alcohol team).
- Call a professionals meeting to pool resources.
- Complete a CAF form to access specialised support through MAFFS e.g. parenting courses.
- Refer as 'Child in Need' if additional services in needed e.g. in case of a child with disability.
- Refer as 'Child Protection'.

Continue to monitor care through re-applying the assessment after a period of community intervention until either concerns are resolved or a child protection referral is made or Child in Need assessment escalated by the CSC to a child protection level.

If you have concern that a child may be neglected but are not sure whether to refer:

- discuss it with the Children Social Care
- discuss with a senior colleague or your manager if you are a professional and concern arises in course of your professional work.
- Gain parents permission to refer to Children's Social Care

8. Referral to Children's Social Care as Child Protection

If you have sufficient concern that the child is being harmed or likely to be harmed, refer to the CSC giving name/s of the child or children, address and details of your concerns. It is advisable to let the carer know where it is possible.

- If there is concern that a child has been abandoned, is treated with cruelty, or is starved refer to CSC or the police straight away.
- If monitoring during community action stage shows that situation is not improving or deteriorating then make a referral with chronology and all the assessments done at various stages.

9. The Graded Care Profile in this context

The GCP is a tool devised as a measure of the quality of care given based on the parent/carer's commitment at the time of scoring. The GCP provides a continuum extending from most positive to most negative end. It is a five point scale where 'grade 1' is at the positive, 3 is intermediate, and 5 at the negative end. These grades are applied to all four domains of care:

1. Physical
2. Safety
3. Affection & Love
4. Esteem

Thus when scored each domain will have its own grade of care, some may show a positive while others may show a negative grade of care as the case may be. The scoring is done based on observation of what a carer is actually doing in respect of caring and what level of commitment they are showing (there is a manual which guides the scoring).

Only information gained from observation or other reliable sources is used. At the time of scoring no allowances are made for any risk factor identified; this is to minimise the bias. Adverse factors, where identified, need to be considered later alongside the GCP score to enable a fuller understanding, assessment and for drawing up an improvement or management plan.

A GCP score is always in the context of a specific carer in relation to a specific child. It usually reflects a steady state of care in the prevailing family and environmental circumstances. As it has not been specifically studied, it is hypothesised on the basis of other indirect studies that it can potentially change with change in supportive environmental dynamics e.g. loss of job, divorce, illness etc. It can also change by factors which can override parenting instinct e.g. drug-alcohol-substance misuse, significant mental illness, certain personality disorders etc. It has been observed anecdotally that these changes happen more if GCP care grades are clustered around 3 and less if around 1 or 2. Estimation of future care grades will depend on the nature and severity of these environmental factors which will need a separate assessment and analysed alongside current GCP scores at the present time until more evidence emerge.

The underpinning of the grades is done on the basis of level of carer's commitment towards the child measured by how s/he prioritises child's needs:

Grade 1 = Child first
Grade 2 = Child priority
Grade 3 = Child at par with carer
Grade 4 = Child second
Grade 5 = Child last or child not considered

Bibliography

1. Framework for the assessment of children in need and their families. DH;2000.
2. Howarth, J., 2007. Child Neglect: Identification and Assessment: Macmillan; 2007.
3. Perry, B.D., John, M., (1997). Impact of Abuse and Neglect on Developing Brain. Colleagues for Children; 7:1-4; Missouri Chapter of the National Committee to Prevent Child Abuse. (Cited on The Child Trauma Academy).
4. Srivastava, O.P., Polnay, L. Field trial of graded care profile (GCP) scale: a new measure of care. Archives of Diseases in Childhood 1997; p337-340. (April 1997).
5. Srivastava, O.P., Stewart, J., Fountain, R., & Ayre, P., (2004). User evaluation of the Graded Care Profile. Luton ACPC; 2004.
6. Working together to safeguard children; HMSO; 2006 & 2010
7. Advisory Council on the Misuse of Drugs. Hidden Harm - Responding to the Needs of Children of problem Drug Users (2003)
8. Brandon, M: Belderson, P; Warren, C; Howe, D; Gardner, R; Dodsworth, J; Black, J. Analysing Child deaths and Serious Injury Through Abuse and Neglect: What can we learn? A Biennial Study of Serious Case Reviews 2003 - 2005 (2008)
9. Department of Health. Messages from Research (1995)
10. Egeland, B. et al. The Developmental Consequences of Different Patterns of Maltreatment, Child Abuse & Neglect, 7 pp 459 - 469 (1983)
11. Gerhardt, S. Why Love Matters; how affection shapes the baby's brain. Routledge (2004)
12. Hildyard, C & Wolfe, D. Child Neglect: Developmental Issues and Outcomes,
    Child Abuse & Neglect, 26, pp679 - 695 (2002)
13. HMSO Children Act 1989 and 2004
14. Child Neglect: Identification and Assessment. Macmillan (2007)
15. Perry, B.D. The Impact of Abuse and Neglect on the Developing Brain.
16. Taylor, J: Daniel, B; (edited). Child Neglect: Practice Issues for Health and Social Care (2005)
17. The Stationary Office. Every Child Matters (2003)