



## Tameside Safeguarding Children Board

### Neglect

### Practice Guidance

<b>Contents</b>	<b>page no.</b>
1. Introduction	3
2. What is neglect?	3
3. The Impact of neglect	6
4. Assessing neglect	7
5. Factors which impact on parent's capacity to care	9
6. Barriers to recognising neglect	11
7. Successful responses to neglect	12
8. Levels of Intervention	14
9. Promoting Resilience	16
Appendix 1 - Impact of Neglect	18
Appendix 2 - Establishing a Day in the Life of a School Age Child	24
Appendix 3 - Model of change	27

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## 1. Introduction

This practice guidance has been developed to complement existing Thameside Safeguarding Children Board policies and procedures. The guidance considers the particular challenges that may be experienced when working with child neglect.

The aim of this guidance is:-

- To improve and develop our understanding of neglect and its impact on children
- Achieve a consistent approach across all organisations in recognising and responding to neglect
- To promote early, preventative interventions to minimise the impact of long-term neglect
- Support practitioners to implement successful interventions and improve outcomes for children who may be suffering some form of neglect
- To assist practitioners to recognise the signs and indicators of neglect.

## 2. What is neglect?

Neglect is 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 also 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)
- ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs for love, security and stability.

### **Neglect – related criminal offence**

Section 1 of the Children and Young Persons Act 1933 outlines the offence of 'Cruelty to persons under sixteen', which incorporates neglect. According to section 1, if anyone who is 16 years or over wilfully assaults, ill-treats, neglects, abandons or exposes a child in a manner likely to cause unnecessary suffering or injury to health they will be guilty of an offence.

The definition of neglect is outlined in section 2(a) of the CYPA33. The offence is committed if a parent, guardian or other person legally liable to maintain a

child has failed to provide adequate food, clothing, medical aid or lodging or has failed to take such steps as to procure these items. The neglect must be deemed to be of a manner likely to cause injury to the child's mental or physical health.

For an offence under section 1 to be committed there must be evidence that it was wilful. There is no statutory definition for 'wilful' although recent case law has given the term some clarification by saying that wilful misconduct means deliberately doing something that is wrong, knowing it to be wrong or with reckless indifference as to whether it is wrong or not.

However this still means that the judgement on when a minor act of neglect becomes a criminal offence (rather than poor parenting and/or the carer's lack of knowledge) is one that has to be taken case-by-case. Such matters are the subject of Police investigations, deliberations by the Crown Prosecution Service and decisions in criminal courts.

Nevertheless, it is important for all practitioners to be aware of the criminal context of neglect and if any practitioner is in doubt about whether the circumstances that a child experiences amount to a possible criminal offence, they should consult with the Police Public Protection Investigation Unit (PPIU) on 0161 856 9314.

### **Identifying Neglect**

More than any other form of abuse, understanding child neglect is often dependent on analysing seemingly small, un-dramatic pieces of factual information about events in the child's life. When collated, these often present a picture that may identify a child suffering from significant harm.

There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of neglect, the extent of pre-meditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements.

Sometimes, a single traumatic event may constitute significant harm, e.g. a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. In each situation, it is necessary to consider the assessment of neglect alongside the family's strengths and supports.

To understand and identify significant harm, it is necessary to consider:-

- The nature of harm, in terms of maltreatment or failure to provide care
- The impact on the child's health and development
- The child's development within the context of their family and wider environment

- Any special needs, such as a medical condition, communication impairment or disability, that may affect the child's development and care within the family
- The capacity of parents to meet adequately the child's needs
- The wider and environmental family context

Characteristics of child neglect include:-

- A lack of concern about physical household standards, including hygiene, which fall well below basic standards, quite often associated with animals in the household
- A failure to keep routine health appointments for the child, minimising or denying a child's illness or health needs, failing to seek appropriate medical attention or to administer medication or treatments
- Failure to stimulate and/or interact creatively or humorously with the child
- Difficulty in exercising appropriate discipline and control over the child
- Lack of judgment about whom to trust with care of the child
- Difficulty in putting the child's needs first
- Low parental self-esteem
- Poor or destructive relationships with extended family or local community – including anti-social behaviour
- Poor nutrition and inadequate diet
- Lack of awareness of general safety issues, which may be indicated by a number of attendances at either A&E or GP

**It is also essential when responding to child neglect to consider the following:-**

- Neglect is usually seen as the mother's failure to provide care
- Little is known about the male role within neglectful families
- A dominant feature in the mother's personality is low esteem
- The significance of the mother's physical health receives little attention
- There is little understanding by practitioners of why hygiene is extremely poor in some neglectful families

In cases of child neglect, there are often brief intervals when care is marginally improved. This may raise the hopes of those providing services, but improvements are usually short lived creating a sense of hopelessness for those supporting the family. It is critical that practitioners recognise the **'time element'** in neglect cases – they are not 'one-off' incidents of abuse but a pattern of abuse over time. As such there will be a need for some families to be supported for a sustained period of time.

**As with any form of child abuse should practitioners at any point believe that a child is at risk of harm, they should make a referral to Children's Social Work (see TSCB Safeguarding Children Framework for more information about referrals)**

### **3. The impact of neglect**

Although the personal impact of neglect for each child will be different, there are some very well documented consequences of both chronic and episodic neglect both to children's physical, emotional and cognitive development. These are set out in **Appendix 1**.

In a recent study of Serious Case Reviews<sup>1</sup> neglect was highlighted as one of the key themes prevalent in all the cases reviewed. Researchers found that:-

- neglect was often seen in isolation, without the whole picture being taken into account
- A failure by practitioners to explore and understand the significance of the family history of dealing with similar situations

Researchers also found that even when there was concern, and advice given or action taken by practitioners; this was rarely monitored or reviewed. As a result, the cumulative impact of long term neglect was not understood and a comprehensive picture was not shared by the agencies involved.

While neglect is often thought of as a failure to meet a child's physical needs for food, shelter and safety, neglect can also be a failure to meet a child's cognitive emotional or social needs. If stimulation, encouragement and opportunities are lacking during a child's early years the weak neuronal pathways in the brain that had been developed in expectation of these experiences may wither and die, and children won't achieve their development milestones.

Researchers believe that the first years of life are the prime time for learning. What a child experiences in the first few years of life largely determine how their brain will develop.

During this phase of life synapses are being formed at an intense pace offering limitless opportunities for learning. If certain synapses and neuronal

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<sup>1</sup> Improving Safeguarding Practice – Study of Serious Case Review 2001-2003, Julie Barnes & Wendy Rose, Research Report DCSF-RR022, 2008

pathways are not repeatedly activated (through love, care, stimulation) they may be discarded and an infant's capabilities diminished.

For example all infants have the genetic predisposition to form strong attachments to their caregivers. But if these caregivers are unresponsive or threatening, the attachment process will be disrupted and the child's ability to form any healthy relationships during his or her life may be impaired (Perry 2001).

Malnutrition, before and during the first few years of life has been shown to result in stunted brain growth linked to cognitive, social and behavioural deficits, possibly with long term consequences. (Karr-Morse and Wiley 1997). For example iron deficiency can result in cognitive and motor delay; anxiety, depression, attention and social problems. Even if the malnutrition problems are corrected the social and behavioural difficulties which have resulted may be difficult to repair.

Literature reviews highlight a significant and enduring connection between neglect and a child's cognitive ability and educational performance. Neglected children not only do less well in terms of performance but also have more discipline problems in school, school exclusions and repeat years. These difficulties may begin in primary school, but persist and deteriorate in secondary education settings.

The internal world of the child, which underpins emotional development, identity and relationships, is also rendered vulnerable by neglect. Parental apathy and lack of stimulus can lead to the child feeling powerless and to them developing insecure and inappropriate attachments.

#### **4. Assessing neglect**

Assessment of neglect should be multi-agency, co-ordinated and include examination of family histories and chronologies, as neglect often spans generations. Assessment should identify strengths as well as difficulties and include direct observation of child and carer as self-reports are not always accurate.

Research on neglect<sup>2</sup> has found that there a number of principles that are of significance in assessing risk of neglect, namely:

- Holistic approach
- Child-centred
- Culturally sensitive
- Multi-disciplinary

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<sup>2</sup> *Neglect: research evidence to inform practice*  
Dr Patricia Moran, Action for Children Consultancy Services, 2009

- Well recorded

It is essential that children are interviewed individually to obtain detailed information to help practitioners understand what life is really like for them on a daily basis.

Practitioners need to be creative in gathering the information, using the framework of 'A Day in the Life Of ...' – details of the framework can be found in Appendix 2.

All of the information gathered should be thoroughly analysed taking into consideration:-

- Vulnerability and risk
- Resilience and protective factors

Intervention strategies need to be congruent with the findings of the assessment and analysis, matching planning and intervention with the identified need.

The concept of childhood resilience - achieving normal development despite difficult conditions - as offering some protection is well established. While it is true that some children will survive and thrive despite a neglectful upbringing and make the successful transition into adulthood, the vast majority do not. Childhood resilience does not necessarily mean that children are less prone to danger or harm.

For some children their very resilience means that they are placed or place themselves in potential danger without appropriate parental or other adult oversight. Research also indicates that those children who were considered resilient in their early years, as they grow older and more independent are more likely to stay out late, get into fights with peers or adults, injured in accidents, or develop violent, anti-social or erratic behaviour.

Therefore practitioners need to be very clear about how they evidence 'resilience' as a safeguarding factor. The key question for practitioners is whether and in what ways it can be harnessed and developed.

This can be achieved by:-

- Pinpointing individual child traits – the child's distinctiveness and 'sparkle' which characterises them - what positive aspects are there in the child/young person's personality and presentation? Some of the factors which enhance resilience include: sense of humour, intelligence, pleasing physical appearance, etc.
- Reviewing a child's early life experiences – resilient infants tend to have predictable temperamental characteristics, prompting positive responses from others
- Considering if the child has established a healthy, safe bond with at least one person in their first year of life

- Identifying if there is a close relationships with alternative care givers, e.g. could be an aunt, grandparents, family friends etc
- Identifying if the child/young person has a positive relationship with at least **one** responsible adult. This could be a teacher, youth practitioner, social practitioner, neighbour, etc
- Exploring sibling relationships – is there a mutually supportive relationship, does the older child provide support and care for a younger sibling? Etc
- Assessing the quality of the child/young person’s peer relationships and whether they feel valued and respected by their friends

The Graded Care Profile (GCP) is one model that aims to achieve a consistent and systematic approach to assessing and responding to neglect across all organisations. The GCP scale was developed as a practical tool to give an objective measure of the quality of a child’s care across all areas of need. Instead of compartmentalising care into neglectful and non-neglectful, this scale draws on the concept of continuum.

This model has not been comprehensively adopted in every area, including Tameside, but further work under the auspices of the TSCB is progressing to evaluate its use. In the meantime further information about the model can be found at <http://www.salford.gov.uk/graded-care-profile.htm>.

## **5. Factors which impact on parent’s capacity to care**

When assessing and responding to emotional and/or physical neglect, it will be important to consider how the potential presence of the following factors may impact on a parent’s ability to provide ‘good enough’ parenting:-

### **Domestic Abuse**

- Neglect may occur when the mother and children are deprived of food, money and material goods
- The cumulative impact of the domestic abuse on the child and the non-abusive parent
- The expectation of agencies/practitioners that mothers are always able to care for and protect their children
- Expectations of mothers to deal with crisis in the adult relationships and sustain levels of care
- In such situations, adults involved may be preoccupied with their relationship
- Little engagement and direct work with the perpetrator of the domestic abuse

- In the majority of cases where a child has died and abuse and neglect have been a factor in the child's death domestic abuse is identified as being present within the family

### **Adult Mental Health Issues**

- Differing impact of chronic or acute illness on the parents capacity to care
- Effects of 'diagnostic combinations' – e.g. Mental health difficulties, alcohol/drug misuse, learning difficulties
- Impact of medication upon parental capacity to care
- Joint working between adult mental health practitioners and children's social care requires knowledge, respect and understanding of each others roles. It requires staff to work jointly to assess the needs of the child and to support the adult. Where concerns exist that a child is at risk of or suffering significant harm the needs of the child must be paramount.

### **Alcohol or Substance Misuse**

- Parental denial, minimisation, secrecy, manipulation etc
- Adverse effect of dependency on alcohol and/or drugs, and the availability
- Safety and supervision issues
- Professional disagreement/uncertainty re: level of risk
- Possible conflict between practitioners in terms of belief systems and values
- Possible conflict between practitioners re; confidentiality

### **Parents with Learning Disabilities or Learning Difficulties**

- Different professional groups may use differing definitions in relation to the severity of the difficulty/disability
- Learning disabilities or difficulties may be present in those with an above average IQ but associated with specific conditions such as autism or Asperger's syndrome
- Parents may appear to understand professionals concerns but are unable to retain the information ; these families are more likely to need long term support.

### **Motivation to Change**

Assessments can often focus on information gathering but fail to consider and understand motivation and change and to engage parents in that process.

Capacity to change is made up of motivation and ability, and if either of these is missing, the parent in question will lack the ability to change. DiClemente's model of change (1991) may be helpful. This model can be used with parents, especially when their engagement with practitioners is involuntary.

The basic premises of the model are:-

- Change is a matter of balance. If the motivational forces are greater than the status quo forces, change will be likely to happen
- For the process to work, professionals need to assess and work with parents in terms of their readiness to accept or deny the need for change

Appendix 3 contains more information about this model.

## **6. Barriers to recognising neglect**

When working with situations where some form of neglect may be an issue, practitioners should be aware of some of the potential pitfalls to fully identifying the impact of the situation, these include:-

- A failure to observe and listen to children
- A belief that neglect can be addressed solely by relieving poverty
- Taking a collective view of children in the same family, i.e. all children in the family share the same experience, when what is required is an individual assessment of each child taking into account their position within the family, their development, their relationships etc
- A belief that parenting is innate and natural and therefore parental behaviours must be right
- A fear of imposing professional and class values on others
- Making assumptions about race and culture that could under or over state the risks
- Viewing neglect as inevitable as the parents are unable to change their own lifestyle/behaviour
- Developing pervasive beliefs that as long as the children seem happy, other omissions of care are of less importance – the 'dirty but well-loved syndrome'
- A lack of knowledge of the impact and long term consequences of neglect on children
- An adherence to a belief in the adults rights to 'self determination' which may deny or be in conflict with the rights and/or best interests of the child

- Over identification with vulnerable parents, leading to denial of children's needs
- A belief that nothing better can be offered to children
- Resist placing all new significant events or incidents within the context of what is currently known and understood about a family; rather the significance of individual events should be assessed and examined independently, with practitioners considering the risks and implications to the child's safety and well-being as a consequence
- 'Rule of optimism' – a belief that parents can change despite evidence to the contrary and the family support model of intervention in difficult households makes it psychologically challenging for practitioners to switch over to a strategy of putting child protection first

**Studies have shown that once the 'rule of optimism' develops, it is then difficult for practitioners to change their views about the family. This may be in spite of compelling evidence of neglect and significant harm.**

## **7. Successful responses to neglect**

There is a growing consensus that no one single method of intervention is likely to be sufficient. The chronic and multiple nature of the problems experienced by some neglectful families necessitates an integrated approach in which a blend of practical and therapeutic services are delivered to all family members, including male carers. There should also be an understanding that for some families this may be over a long period of time.

What is clear is that intervention should be preceded by thorough assessment and a clear understanding of the specific nature and source of the difficulties and strengths. Any work that is undertaken should be sustained, focused and targeted – especially when it is clear that the level and complexity of need indicates a sustained period of support. It is essential that practitioners avoid the 'revolving-door syndrome' in which families return to agencies with the same unresolved difficulties.

The following points are key to an effective response:-

- Neglect is an issue in its own right – practitioners need to respond to concerns about the standard or quality of care that a child is receiving
- Quality assessment that clearly identifies the risks and actions to reduce the level of risk – a move away from reacting to symptoms towards an analysis of and work with the root causes of neglect
- Develop clear plans in respect of the parents/carers and the child for responding with identified timescales and pro-active

monitoring – issues arising from review should be actioned immediately to avoid drift and plans amended

- Identify realistic timescales for supporting families – recognising that for some long-term support will be required – drift can be avoided by developing clear focused and purposeful actions with clear outcomes for all family members, especially the child
- Understanding of the parental childhood experience and their family history and how that may impact on their parental style and capacity
- Maintain the child's development as the focus, working towards outcomes that are in hers/his best interest
- Establish and maintain effective interagency communication, ensuring that there is a shared understanding of the problem and of the intervention plans and that roles and responsibilities are clarified, acknowledged and agreed. Wherever possible, promote opportunities for reflective discussion rather than simply passing on information
- Ensure that the up to date information on the child is accurate and readily available
- Identify those who have best knowledge of the family and who can be asked for up to date information
- Identify those aspects of the child's welfare and parenting capacity which gives you most concern, and focus observation and intervention on these, and promote those aspects of parenting which are positive
- See the child in his/her home environment. If you cannot gain access for whatever reason, take this seriously and reflect with other practitioners and managers on what you should do
- Build a professional, honest, and positive relationship with parents and the child
- Provide practical material support where required
- Maintain clear, concise and accurate chronologies
- Interventions need to be multi-faceted, i.e. addressing all the issues within the family, e.g. mental health, housing, income, parenting, etc – however a balance should be struck to avoid overwhelming the family and prevent confusion
- Recognise the uniqueness of each family and their needs
- Cultural sensitivity
- Neglectful parents are often immature - avoid "dysfunctional dependence"
- Reviews are not only a forum for sharing information – they are an opportunity to critically analyse all of the available information, challenge progress towards outcomes for the child and their family and should be a catalyst for re-assessment

## 8. Levels of Intervention

Moran (2009) says that it is possible to set out the characteristics of interventions that are most likely to succeed from evidence of what appears to be at the very least 'promising'.

- Long term
- Multi-faceted
- Early as well as late – neglect can occur at any time from infancy to teenage years
- Consider protective factors as well as risk factors
- Parent/carer friendly
- Involve fathers as well as mothers
- Include a focus on attachment

*Neglect Matters – A multi-agency guide for professionals working together on behalf of teenagers*<sup>3</sup>, the government publication identifies 3 levels of intervention; Primary, Secondary and Tertiary.

### Primary prevention

Primary prevention is about preventing neglect before it occurs. At the most general level it includes the provision of a range of universal services that have an important role to play in engaging and promoting the health and well-being of children and young people.

As regards parenting, what is most relevant to neglected children and young people is the research on the outcomes of parenting for children, and in particular, the work on *parenting styles* which underpins the *parenting capacity* domain of the Assessment Framework.

It is the 'authoritative' parenting approach, combining love, emotional warmth, basic physical care, safety, stability, guidance and boundaries as well as stimulation that is most likely to contribute to young people's all round well-being. The central idea within this framework is the combined effect of two aspects of parenting – control and acceptance/warmth.

Based on these two dimensions, a typology of parenting has been developed consisting of four broad categories:

- Authoritative – high control, high warmth
- Authoritarian – high control, low warmth
- Permissive – low control, high warmth
- Neglectful – low control, low warmth.

*(Baumrind, 1968, developed further by Maccoby and Martin, 1983)*

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<sup>3</sup> Neglect Matters – A Multi-agency Guide for Professionals working together on behalf of teenagers – Lesley Hicks and Mike Stein, DCSF 2010

## Secondary Intervention

The focus of secondary intervention is when problems arise – or early intervention in the history of a difficulty. For example, a practitioner may notice a sudden deterioration in the appearance or cleanliness of a young person which is very much out of character.

If this cannot be addressed by informal measures, such as discussions with the young person and parents, and offers of assistance are declined, and the concerns persist, then it is important that an early assessment takes place to determine the appropriate level and types of intervention. The Common Assessment Framework provides a tool for working in partnership with children and families in achieving effective early intervention.

Depending on the extent and severity of a young person's needs, a referral to children's social care may be appropriate in which case the *Assessment Framework* would be used.

## Tertiary Interventions

Tertiary interventions aim to prevent the recurrence of problems that have already come to light, and have usually persisted beyond, or have not responded to, early interventions.

Literature from the United States includes a categorisation of interventions in terms of ecological (concrete); ecological (social support); developmental; cognitive-behavioural; individual; and family systems (DePanfilis, 2006).

The author emphasises the importance of collaboration across welfare systems and communities both to prevent and to reduce the effect of neglect.

- Ecological (concrete) interventions link to basic resources such as housing, clothing and the like
- Ecological (social support) links to networks – these may help reduce social isolation and increase parenting abilities
- Developmental interventions relate to help with young people's role achievement, with the involvement of mentors and peer groups
- Cognitive-behavioural approaches include social skills training and education, for example in some aspect of parenting or economic life
- Individual interventions relate to alcohol counselling, mental health counselling or stress management
- Family system interventions link, for example, to family-functioning, counselling or family therapy.

This intervention approach is consistent with the ecological approach represented by the 'Child's developmental needs', 'Parenting capacity' and 'Family and environmental factors' domains of the Assessment Framework.

## 9. Promoting resilience

An approach featured in Neglect Matters and which practitioners find very helpful arises out of the research findings on the resilience of children and young people in the context of adversity.

As Masten (2006) notes, there has been a 'remarkable consistency' in what contributes to good outcomes among vulnerable children and young people in studies of resilience carried out during the last 30 years. Masten summarises these as factors associated with behavioural resilience in children and youth as follows:

### Relationships and parenting

- Strong connections with one or more effective parents
- Parenting quality (providing affection, rules, monitoring, expectations, socialisation)
- Bonds with other pro-social adults (kinship networks, mentors, elders, teachers)
- Connections to pro-social and competent peers.

### Individual differences

- Learning and problem solving skills
- Self-regulation skills (self-control of attention, emotional and arousal, impulses)
- Positive views of the self and ones capabilities (self-efficacy and self-worth)
- Positive outlook on life (beliefs that life has meaning, faith, hopefulness)
- Appealing qualities (social academic, athletic, attractive: engaging personality; talents)

### Community context

- Effective schools
- Opportunity to develop valued skills and talents
- Community quality (safety, collective supervision, positive organisations)
- Connections to prosocial organisations (clubs, faith groups)
- Socioeconomic advantages.

## Implications for Practice

*Neglect Matters* sets out the following implications for practice with adolescents.

Primary prevention	Issues for practice
<i>Schools and communities</i>	Raising awareness of neglect by inclusion of neglect/adolescent neglect in PSHE curriculum. Providing opportunities for young people's involvement and participation. Range of extra-curricular activities and leisure opportunities
<i>Parenting</i>	The promotion of 'authoritative parenting', with a focus on supporting teenage development, e.g. through local parent groups
Secondary Intervention	Issues for practice
<i>Early recognition of teenage neglect</i>	Informal response, for example, meet and discuss with young person and parents (if appropriate). Seek early resolution to problems
<i>If problems not resolved</i>	Apply Common Assessment Framework – involve young person, meeting of staff from different agencies, identify lead professional and agree action
<i>If problems persist or more severe</i>	Application of Assessment Framework to understand impact of neglect on young person's health and development, decide on course of action, methods on intervention by which staff from respective agencies
Tertiary Intervention	
<i>Ecological perspective</i>	The research literature supports the use of multi-faceted interventions. Promoting the resilience of neglected young people by working with young people, parents, involving schools – and these can be reinforcing of each other
<i>Specific evaluated interventions</i>	These include Cognitive Behavioural Therapy (CBT) and Multi-systemic Therapy (MST) approaches – but generic programmes will need to be developed focusing on the specific developmental needs of neglected adolescents

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## Impact of Neglect

### 1. The results and long term consequences of poor standards of home hygiene

ISSUE	CONSEQUENCES
<p>Persistent dirty carpets, bedding, chairs and clothing child smells Infestation, itching and scratching, infected bites, skin infections.</p>	<p>Itching and scratching leads to loss of sleep; irritable and crying; raises family stress levels. Skin lesions become infected; spread of infection, may need repeated antibiotics over a long period. Others reluctant to interact with child; affects social, emotional and developmental progress.</p>
<p>Persistent inhalation of polluted air in the home; accumulated dust, cigarette smoke, animal hair. Damp atmosphere, moulds and fungus growing on walls, etc. Stagnant air through lack of ventilation.</p>	<p>Repeated chest infections, asthma attacks, inhalation of second hand cigarette smoke; chronic lung disease. Repeated chest infections; debilitating. Babies may require frequent hospital admission.</p>
<p>Eating food from the floor which is contaminated with dirt and/or animal faeces. Food left on the floor that becomes mouldy. Eating food that is past sell by date. Keeping food at incorrect temperature (bacterial growth). Using dirty/contaminated crockery and utensils. Inadequate cleaning particularly of feeding bottles and other equipment.</p>	<p>Toxoplasmosis and Toxicara cause widespread damage to all tissues can result in impaired vision. Recurrent gastro-enteritis. Salmonella, Botulism. Frequent gastro-enteritis can cause damage to gastro-intestinal tract reducing effectiveness of function.</p>

**2. The long-term results and consequences of failure to provide an appropriate diet for children**

ISSUE	CONSEQUENCES	
Insufficient food intake for growth needs	Deficiencies of essential nutritional elements. If severe in under 2 yrs impaired brain growth. Poor growth, thin older female. Reduced energy levels. Miserable and lethargic.	Anaemia; poor bone growth (rickets/severe) poor absorption of essential vitamins Learning difficulties, developmental delay, poor concentration, delayed neurological development. Psychological effects of being small and thin. Poor participation in social activities; social isolation. Poor academic achievement.
Restricted/rigid diets/foods	Imbalanced diet i.e. too much fats, protein vitamins, minerals, and carbohydrates dependent type of diet. Poor growth, mineral and vitamin deficiencies	
Early introduction of inappropriate solid foods to babies	Imbalanced diet; insufficient levels of nutrition for growth. Immature digestive system cannot cope; constipation, kidneys overloaded.	
Low nutritional value food	High carbohydrates and fats. Poor growth but may be very overweight. Need to differentiate between a well-nourished child/baby and overweight or child/baby through fat carbohydrate e.g. snacks.	Poor nutrition can result in behavioural difficulties, e.g. hyper -activity, which in tern impact on the child's education and level of achievement.

### 3. The result and consequence of failure to supervise and provide a safe environment

ISSUE	CONSEQUENCES	
<p>Examples:            Inside/outside home -            Falls            Scalds/burns            Ingestion of poisons and toxic substances            Fires in the home            House fire            Suffocation (plastic bags; baby left alone propped on cushions)            Road traffic accidents            Abduction            Abuse by risky adults</p>	<p>Death            Permanent brain damage            One or more damage to vital organs            Permanent scarring            Loss of function of limbs            Repeated surgical interventions            Chronic lung damage            Accumulative effects of long term Medication</p>	<p>Loss of family and home; Chronic illness/disability; permanent residential care; poor school attendance; impact on academic achievement; inability to participate in childhood pursuits; social exclusion; poor self esteem and worth. Repeated hospitalisation; Stigmatisation; Reduced opportunities in adulthood; Risk of mental health problems.</p>
<p>Unsupervised meal times/prop feeding            Unsupervised bathing, baby left in bath</p>	<p>Death through suffocation, choking, and nutritional intake may be inadequate.            Death through drowning, hypothermia and burns/scalds.            Near drowning incident.</p>	<p>Weight loss.            Irreversible brain and lung damage.</p>
<p>Left with unsuitable or dangerous carers            Left with young children            Left alone            Exposure to violent or pornographic images            Exposure to domestic violence</p>	<p>Significant harm through all forms of abuse. Acute life threatening neglect. Sibling abuse/bullying. Obvious dangers of being left alone, including emotional trauma.            Death/abduction.            Emotional and sexual abuse.</p>	<p>Consequences self evident.</p>

**4. The results and long term consequences of failure to obtain appropriate health care**

ISSUE	CONSEQUENCES
Failure to obtain appropriate vaccinations > risk of contracting potentially serious childhood illness - Measles, Mumps Rubella, Meningitis, Polio, Whooping Cough.	Death Irreversible brain damage Damage to major organs Chronic lung conditions Reproductive prospects Source of infection in the community
Failure or delay in obtaining medical treatment when the child is ill > illness and suffering prolonged unnecessarily; illness, condition more difficult to treat; increased risk of having more, potentially toxic medication; hospitalisation; source of infection in community.	Death Chronic ill health; impairment of major organs dependent on infection / condition Prolonged medical intervention Repeated hospital clinic attendance
Failure to enable child to access developmental/health promotion opportunities; delayed or failure to detect treatable conditions > squints; hearing loss; congenital dislocation of the hips; un-descended testicles; heart abnormalities; delayed development and growth.	Visual and hearing impairment; impairment of mobility; delay in providing appropriate resources to maximise potential learning disabilities; poor academic achievement; chronic heart and lung conditions; low self-worth/esteem.

**5. The result and long-term consequences of failure to provide personal hygiene for the child**

ISSUE	CONSEQUENCES
<p>Examples:            Persistent failure to adequately wash/change nappy            Nappy area in babies quickly becomes red and sore leading to pain and discomfort &gt; area becomes infected, septic spots and/or fungal infection &gt; ammonia dermatitis, has appearance of 2nd degree burns.            Poor toilet hygiene, soreness around anus, may develop fissure &gt; reluctance to open bowels &gt; constipation.            In females spread of infection to genitalia and can cause urinary tract infection. Skin folds become moist, ideal of bacterial growth &gt;infected.</p>	<p>Pain and discomfort cause irritable crying baby &gt;recognised source of increased stress levels.            Infection may be difficult to clear and require local and systemic treatment.            Pain associated with constipation may cause behaviour difficulties in toddlers and children and may have dietary problems. Particular consideration needs to be to the implications for disabled, incontinent children/young people. Social contact may be reduced, people reluctant to interact as baby/child smells. Impacts on self-esteem and social interactive skills.</p>
<p>Hands and nails, babies put hands in mouth &gt; source of transmission of threadworms. Handling contaminated food on floor, or animal faeces if home hygiene poor. &gt;Gastro-enteritis, * toxoplasmosis, * toxocariasis.            Sharp and broken nails cause damage to skin, nails tear causing pain/infection.</p>	<p>Can be major health hazard in young children, causing widespread damage to all tissues and damage to retina of eye.</p>
<p>Hair, daily grooming essential for detection of head lice.            Washing hair would be part of grooming. Head lice can lead to excessive scratching &gt; skin is broken, becomes infected/infectious. Hair tangled and knotted and smells, gives general unkempt appearance.</p>	<p>As child grows, they become more aware of their personal appearance and its impact on others, and can be victimised by both children and adults. They become marginalized within their communities and may face academic and social exclusion. They may not have developed skills to care for themselves, which may impact on future relationships and role as parents. The effects of exclusion may be far reaching</p>

**6. The result and long-term consequences of failure to provide personal / environmental warmth**

ISSUE	CONSEQUENCES
<p>Examples:            This commonly is due to a poorly heated environment and inappropriate clothing. Particularly dangerous in young babies &gt; absence of shivering - a protective reflex &gt; death.            Premature babies in particular may have difficulty retaining their body heat. Hypothermia is compounded if the baby is lying in wet bed or cot.</p>	<p>Death can also result from pneumonia and untreated chest infection.</p>
<p>May develop cold injury, hands and feet are swollen/red.            May be apathetic, babies may be reluctant to feed.</p>	<p>Loss of function of limbs affected.            Dehydration and weight loss            Malnutrition as reluctant to feed &gt; weight loss body fat</p>
<p>May develop hypostatic pneumonia, repeated chest infections.</p>	<p>Repeated hospital admissions if no improvement in circumstances.            Potentially life threatening.</p>
<p>Clothing is inadequate for weather conditions, may 'stand out' from their peers; children may present at school with pallor and blueness of extremities, may be lethargic and disinterested in interaction with peers.</p>	<p>Poor participation in school activities.            Poor academic achievement if repeated illnesses.            May elicit pity or derision from peers regarding appearance.            Low self-esteem.</p>
<p>In extreme cases of frostbite, the child may lose part of their toes.</p>	<p>Pain, surgical intervention. Loss of mobility/function.</p>

## Establishing a Day in the Life of a School Age Child

Question	Factors to Consider
Do you get yourself up in the morning?	<p>Is the child expected to get themselves up?</p> <p>Is there a regular routine or does it depend on the motivation of the carer?</p> <p>Does the child have to take responsibility for carers and /or siblings in the morning?</p> <p>Is an alarm clock /mobile phone used to make sure child is up in time for school /play school etc?</p>
Do you have anything to eat?	<p>Is there usually food in the house?</p> <p>What is available to the child?</p> <p>Does an adult/sibling or child themselves take responsibility for preparing breakfast?</p> <p>Is the child given money to buy something on way to school?</p> <p>If so, what do they tend to buy?</p>
What happens about getting dressed?	<p>Are clothes readily available, clean and in a good state of repair?</p> <p>Does the child have to find their own clothes?</p> <p>Do they have their own clothing?</p> <p>What happens about washing, etc?</p> <p>Does the child wash and brush their teeth in the morning?</p> <p>Is this appropriately supervised?</p> <p>Are there facilities available, e.g. tooth brush?</p>

## Establishing a Day in the Life of a School Age Child

<p>What happens if you are going to school?</p>	<p>How does the child get to school?          Who is responsible for getting the child to school?          Is the child responsible for other children?</p>
<p>What happens at school?</p>	<p>What is the nature of the child's relationships with their peers, teachers and support staff?          What do they enjoy at school?          What do they find difficult?          What makes them happy and sad at school?          Do they have friends?          Are they bullied?          What do they do at playtime?</p>
<p>What happens if it's the weekend or school holidays?</p>	<p>Is the child expected to look after other children and/or the carer?          Are they expected to do errands, etc. for the carer?          How do they spend their time?          Do they have any friends?          Are they left unsupervised or allowed to undertake inappropriate activities?          What happens about food? (Consider areas below)</p>
<p>What happens after school?</p>	<p>Are they collected from school and, if so, on time?          Do they stay for after school activities?          Are they responsible for other children?          Do they have friends that they see?          What is the journey home from school like? (Consider opportunities for bullying etc)          Is there anyone at home when they arrive back?          What happens when they get home?          Do they have any caring responsibilities?          Is food available when the child gets home from school?</p>

## Establishing a Day in the Life of a School Age Child

<p>What happened in the evening?</p>	<p>Is there food available?          What kind of food does the child eat in the evening?          What does the child enjoy eating best? How often do they have this?          Does anyone prepare an evening meal? If so does the family eat together?          If not, does the child get their own food and/or get food for others?          When does the child usually have their last meal/snack?          What happens if the child says they are hungry?          Does the child spend their time watching TV? Do they go out - where and with whom?          Does the child enjoy games and toys; which ones? Do they have toys?          What do the carers do in the evening? What does the child think about their activities?          Does anyone talk to the child or give them any attention?          Is the child left alone or expected to supervise other children in the evenings?</p>
<p>What happens at bed time?</p>	<p>Does the child have a bedtime?          Who decides when the child goes to bed?          Where does the child sleep?          Do they change their clothes before bed?          Do they have a wash and brush their teeth?          Does the child get disturbed? E.g. carers making a noise, child sleeping on settee.          Is the child left alone at night and/or expected to look after other children?</p>

## Model of Change

### The assessment of each of the stages

#### Pre-contemplation

Most parents are at this stage at the start of contact with the agencies. They may have a vague notion of wanting change, but not that they need to change. Parents at this stage are unable to make a full psychological commitment, as they have not yet come to terms with the need to change. The implications for this are that early contracts need to be reviewed as (if) the parents move into the change cycle.

#### Contemplation

At this stage, the parents consider that there is a problem, and can explore how to tackle it. Effective intervention will depend on whether external motivation can be transformed into internal motivation. This means that practitioners need to be able to combine external sanctions with engagement with parents in order to effect change.

Parents may need time to:-

- Look at themselves and come to terms with what they see
- Appreciate the child's needs
- Count the cost of change
- Identify the benefit of change
- Identify goals which are meaningful to them

The practitioner's task is to assess sources of motivation and:-

- Recognise the parents' ambivalence, compliance, genuine commitment and capacity to change
- Recognise that each parent may be at a different stage of the change process
- Understand that different changes may be required from each parent
- Assess the motivational/status quo sources in the extended family

7 stages of contemplation are identified as follows:-

1. Accept that there is a problem
2. Accept some responsibility for the problem
3. Have some discomfort about the problem
4. Believe things must change

5. See yourself as part of the problem
6. Make a choice to change
7. See the next steps towards change

### **Determination**

At this stage, parents should be able to express:-

- Real problems and their effect on the child
- Changes they wish/should make
- Specific goals to achieve
- How parents and practitioners will cooperate to achieve the goals
- The rewards of meeting the goals
- Consequences if change is not achieved

Professionals need to be clear about agreed plans, and plans should be detailed and specific. Plans should be for incremental change, as motivation to change is more likely if there is early support and clear expectations.

### **Action**

This is the point of change, where parents use themselves and services. There can be a danger of confusion and parents feeling overwhelmed (and consequently disengaging) at this stage, so clarity of aims and objectives is essential. Any agreement which was made at the pre-contemplation stage needs to be reviewed to see if it is still valid.

### **Maintenance**

This stage is about consolidating changes made, rehearsal and testing of new skills and coping strategies over time and in different conditions. Professionals need to pay attention to relapse prevention, essentially work to anticipating stresses and triggers which might arise.

This can be the stage where on parent is able to change, and the other not thus causing stress in their relationship. If this is due to professionals concentrating their efforts on one parent, this sets up failure, so including both parents is important. The assessment task is to ascertain if parents are able to internalise changes if external motivators are relaxed.

### **Lapse and Relapse**

Change is cyclical, and most of us do not succeed first time. "Change comes from repeated efforts, re-evaluation, renewal of commitments and incremental successes" (p 105). A lapse can usually be dealt with, but a relapse, such as a return of the abusive behaviour is not so easy to deal with.

Overall, the task for professionals is to increase the weight of the factors which promote change, whilst decreasing the forces for the status quo.

Motivation is interactional, so look to the wider network (partners/professionals/family/friends and community) for sources of motivation, stresses and weaknesses.

### **Managing ambivalence**

Ambivalence is an ordinary response to change, so the assessment of parent's real commitment. The response to change model is useful. It identifies four possible types of response to change, depending on effort and commitment to change:-

- Dissent and/or avoidance
- Tokenism
- Genuine commitment
- Compliance

The practitioners task is to be aware of ambivalence, and assess how parents manage ambivalence.