

Childhood Neglect: Improving Outcomes for Children

Learning Outcomes

To meet a child's developmental needs and support strengths.

Audience Groups 1-8 (Working Together 2010)

Time 30 minutes

Key Reading

Daniel, B., Taylor, J. and Scott, J. (2011) Recognizing and Helping the Neglected Child. London: Jessica Kingsley Publishers (Chapter five).

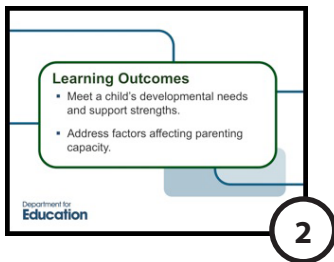
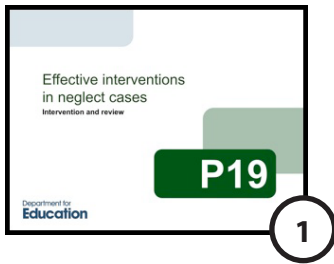
Davies, C. and Ward, H. (2012) Safeguarding Children Across Services: Messages from Research. London: Jessica Kingsley Publishers.

Farmer, E. and Lutman, E. (2010) Case Management and Outcomes for Neglected Children Returned to their Parents: A Five Year Follow-Up Study (Research Brief). London: Department of Children, Schools and Families.

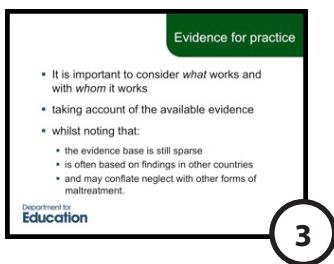
Moran, P. (2009) Neglect: Research Evidence to Inform Practice. London: Action for Children.

Links to Common Core

Common Core 1 Effective communication and engagement with children, young people, their families and carers (skills: consultation and negotiation). Identify what each party hopes to achieve in order to reach the best possible and fair conclusion for the child or young person.

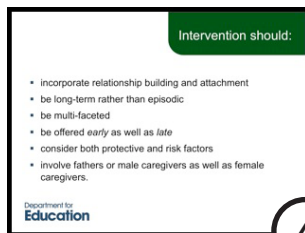


Learning outcomes.



Thoburn's review (2009) of effective practice of working with children and families at risk of significant harm concluded that no single service approach or method had yet been identified to be effective with families where the concerns of harm were significant and complex. Instead, such interventions were likely to represent one part of an overall package required to support children or families experiencing difficulties.

It is important to preface the presentation with the observation that there has been very little research into routine intervention as provided by a multi-disciplinary network. Most of the research has been undertaken in relation to specialised and manualised approaches and programmes. This does not mean that the participants are not undertaking effective interventions using a range of mixed approaches although it is always helpful to consider the findings of the available evidence. The key point is that there is still far more research required into effective intervention with neglect. Overall, it is important to make the very best of the information we do have, even if the research we have is not always specific for neglect.



Relationships need to be built with all family members – children and adults; as well as between all the professionals and para-professionals involved in the protective network. Parents of children who are neglected may themselves have poor experiences of relationships, but can develop different understandings of relationships via good therapeutic relationships. Links can be made here with attachment theory, both as a theory to help with understanding what has contributed to the development of neglect, and also as a basis for intervention.

All the available evidence points to the need for long-term, sustained intervention, rather than short-term and / or episodic periods of support. It can be very unhelpful for cases to be closed as soon as there are some initial signs of improvement because the improvements are often not sustained, leading to re-referral, re-assessment and changes of worker.

Neglect is usually multi-faceted and therefore intervention also needs to be multi-faceted. There is a need to consider each ecological level – i.e. consider intervention at the levels of the child, the parent/s, extended family, school and community. Intervention also has to take account of the past history of all involved and the entrenched patterns of behaviour. Intervention also needs to draw on the range of knowledge, skills and expertise of all the professionals involved.

Interventions can be 'early' or 'late' in relation to both a child's age and stage in the development of the problem. Stein et al.'s (2009) work on neglected teenagers, for example, alerts us to the importance of noticing neglect occurring later in children's lives.

The assessment process in neglect cases usually provides a comprehensive overview of the range and extent of problems and risk factors having a negative impact on a child's wellbeing. It can be easy to overlook protective factors. The presence of protective factors does not 'cancel out' the adverse factors, but they can be built upon and enhanced for the child's benefit. The research on resilience, pointing to the benefits of protective factors for children such as secure attachment relationships, support from extended family, good school experiences, access to hobbies and activities, can be drawn on when planning intervention. Intervention should both aim to reduce the adverse factors that increase the likelihood of harm and enhance protective factors that improve wellbeing.

Father and father figures are often overlooked in assessment, planning and intervention plans. A full presentation on assessing the role of fathers is also available (presentation 16).

Managed dependency

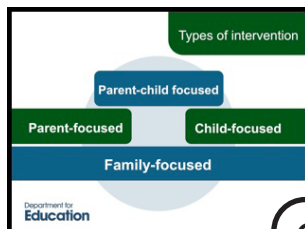
- The vast majority of parents rely on the assistance of others.
- Parents whose children are neglected tend to have no-one to turn to for support.
- Practitioner fears about parents becoming 'too dependent' can lead to episodic patterns of support.
- Therefore, instead, plan to provide long-term support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

Department for Education (Tanner & Turney 2003)

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Practitioners can often struggle with the anxiety associated with the provision of long-term support and with fears that parents are becoming 'over-dependent'. 'Managed dependence', a term coined by Tanner and Turney (2003), describes the need for sustained approaches to support for parents.

Rather than trying to 'move people to independence' it can be more effective to assume that the children will benefit most from long term support and that parents will need, to some extent, to be dependent upon formal services for some years. This is different from 'drifting' packages of care where many resources are piled into a family situation but without appreciable improvements for the child. In many cases parents can provide sufficient care for their children as long as they know they can rely on consistent additional support that will not be withdrawn the moment there are small signs of improvement. The fear, or actual previous experience, of removal of services can act as a disincentive to change.



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Interventions do not always neatly fit into one type or another – but this is a helpful typology for conceptualising the different approaches.

Who works

'There is considerable research evidence to support the claim that relationship skills are important in helping people to change, whatever intervention method is being used.'

(Munro 2011 p.88)

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Before moving into the detail of different types of intervention this is an opportunity to pause and re-iterate the importance of establishing a therapeutic relationship.

Munro (2011) also quotes Barlow with Scott (2010)

'...a recent overview of the evidence about effective interventions for complex families where there were concerns about (or evidence of) a child suffering significant harm, showed the importance of providing 'a dependable professional relationship' for parents and children, in particular with those families who conceal or minimise their difficulties' (p24).

Factors involved in the change process

Four factors account for the change process in work with vulnerable families:

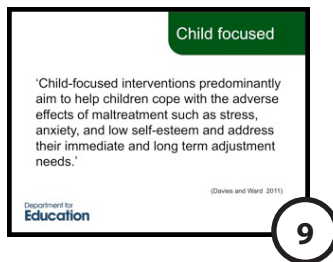
| | | |
|-----|--|--|
| 40% | characteristic of the user | history, social support, socio-economic status |
| 30% | relationship between worker and client | empathy and clear plans |
| 15% | method of intervention | family therapy, cognitive-behavioural therapy |
| 15% | verbal hope expressed by client | |

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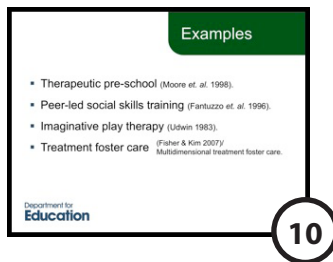
This slide, again, demonstrates the centrality of the quality of the working relationship.

Discussion point: Participants can be asked to discuss the characteristics of practitioners that support the development of good working relationships with children and adults. Ask them to consider the most challenging situations – for example, working with threatening and violent people; or working with very withdrawn people – and to explore in concrete terms the factors that promote good relationships. This can include core issues of respect such as arriving on time, remaining courteous, sticking to agreements, remembering details about preferred names, ages, likes and dislikes and so on.



The slides now return to looking at some of the evidence about intervention.

Children can be overlooked because of the focus upon parents' needs. However, the provision of direct support for children is vital. As shown in the presentation on the effects of neglect upon children, children are likely to need support in any, or all, of the areas of their developmental needs. They will need help to ensure that their physical, emotional and cognitive development is not compromised.



It is beyond the scope of the presentation to cover all interventions in depth – so a few selected ones are mentioned. Much of the evidence has been drawn from studies of physical abuse or a combination of forms of maltreatment, so it is important to be cautious about how findings are generalised across to neglect. Again, it must be stressed that interventions must be tailored to the needs of individual children and families, and based upon comprehensive assessment of what is required. Examples here are drawn from overviews by Davies and Ward (2011), Daniel et al. (2011), Montgomery et al. (2009) or Moran (2009):

- **Therapeutic pre-school - provision of direct medical, developmental, psychological and educational services to children in the context of pre-school day care settings (Moore et al. 1998).**
- **Peer-led social skills training – where withdrawn children are paired with more resilient children for regular play sessions, can lead to increased social skills (Fantuzzo et al. 1996).**
- **Imaginative play therapy – where children are involved in imaginative play to increase imagination, co-operation with peers and = less aggressive play (Udwin 1983).**
- **Treatment foster care (Fisher and Kim 2007) / Multidimensional treatment foster care.**

More information about Multidimensional Treatment Foster Care can be found at www.mtfce.org, a brief extract is given below (accessed 17/5/11):

MTFCE works by having highly trained foster carers who are supported by a specially trained clinical team. Together they deliver individualised treatment programmes to children and young people.

Each foster family works with one child at a time for between six and twelve months. Foster carers and clinical staff are trained in behaviour management systems for the age group with which they will work. These systems involve giving lots of encouragement and celebrating children and young people's achievements. Children and young people learn and practise new skills in a supportive environment.

When the children and young people move on to a permanent placement, the team helps their permanent carers to continue this work.

School based support

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

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The pack contains a presentation and exercise to focus in detail on what schools can offer neglected children, but it is very important, when discussing intervention, to give consideration to the role of school, teachers and education.

Discussion point: Participants from all disciplines can be asked to share ideas and practice experience of ways in which schools, teachers, and other adults within school settings (for example, school nurses) can provide practical and emotional support for neglected children.

Parent-focused interventions

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

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Research on different approaches has tended to concentrate on cognitive behavioural programs; psychotherapeutic interventions, and home visiting programmes. This does not mean, however, that other types of approach may not be effective.

Farmer and Lutman's study (2010) (briefing in the pack for background reading) starkly points to the fact that frequently when children are removed from home as a result of neglect very little work is undertaken with the parents to address the issues that lead to neglect in the first place. Children are then returned home to a situation that has not improved. The following is taken from their briefing:

'The parents of the older children received significantly less support than those with younger children, even though many were struggling with their adolescent children's serious emotional and behavioural problems. The older children received more types of help than younger ones but were also more likely to be receiving insufficient support. Lack of specialist help for parents was linked to poorer outcomes for children. In a fifth of cases little or no support was provided. Even when some services were delivered, they were often not at a sufficiently intensive level to meet the severity of parents' and children's needs in order to make and sustain change' (p2).

Addressing issues affecting parenting capacity

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

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There is a presentation in the pack and background reading that cover more detail about effective intervention with substance misuse, so here there is only a brief summary.

'Strengthening Families' was devised for parents who misuse substances and their 3 to 17 year old children. It aims to reduce family environmental risk factors and enhance protective factors, thus increasing personal resilience and fostering resistance to substance misuse. It focuses on family environments and helping parents develop their parenting skills (Kumpfer and Tait 2000).

'Parents under pressure' (see also www.pupprogram.net.au) has been effective with parents on methadone programmes (Dawe and Harnett 2007). It is a manualised approach with 10 modules undertaken in the family home delivered by accredited trained therapists. It is based on an ecological model and targets psychological functioning of individuals, parent-child relationships and social contextual factors. It supports parents to develop 'mindfulness' where they are aware of their emotional responses and how substance misuse can affect their parenting capacity.

Relational Psychotherapy Mothers Group (RPMG) has been shown to reduce mothers' self-reported likelihood of maltreating their children, although changes were not sustained (Luthar et al. 2007). It is a group-based psychotherapeutic programme, coupled with home-visits, for mothers addicted to heroin. There are 24 sessions - the first 12 address mothers' emotional issues and the second 12 focus on parenting and helping women to develop insight.

Examples

- Project 12-ways (Lutzker et al. 1998).
- Triple-P (Sanders et al. 2004).
- Cognitive-behavioural therapy (see Barlow and Schrader-Macmillan 2009).

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There is little research on programmes to reduce the levels of neglect associated with mental health problems - perhaps because 'mental health problems' can encompass a large number of very different diagnosed and undiagnosed conditions and experiences. Practitioners need to be reminded of the importance of working closely with colleagues in psychology and psychiatry in order to obtain clear diagnoses and to develop treatment plans for the mental health issue, combined with attention to the specific issues of neglect. See also Cleaver et al. (2011)

In relation to domestic violence research shows promise in working with mothers and children in parallel to explore these relationships (Humphreys et al. 2006). The NSPCC are delivering and testing a model called DART (Domestic Abuse: Recovering Together) that uses groupwork with mothers and children together throughout the programme and initial findings suggest that focusing on the mother-child relationship appears most helpful. The Post-Shelter Advocacy Programme (Sullivan and Bybee 1999) is a 10 week programme designed to support women, who have moved on from a shelter, by devising safety plans and improving self-esteem.

These studies address the issue of repairing relationships post-separation – there is a range of research on treatment for men who are violent to their partners but it tends not to focus on issues of child neglect.

Child-Parent focused interventions

- Parent-Infant/child Psychotherapy Intervention (Tish et al. 2008)
- Interaction Guidance (Berouti 2001)
- Parent Child Interaction Therapy (Chaffin et al. 2004)

Family focused interventions

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

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Project 12-ways has twelve core services - parent-child training, stress reduction for parents, basic skill training for children, money management training, social support, home safety training, multiple-setting behaviour management in situ, health and nutrition, problem solving, couples counselling, alcohol abuse referral, and single mother services. The programme has been associated with a reduction in child abuse and neglect but this may not be sustained over the long-term without additional 'booster' services (Macdonald 2001; 2005).

Triple-P is group-based parent-training using cognitive behavioural therapy (Sanders et al. 2004). Triple-P (Positive Parenting Programme) has been shown to improve the parenting of young children (aged two to seven years) in parents, some of whom had been referred to a statutory authority for potential abuse or neglect and/or parents having difficulty expressing their anger (Barlow and Schrader-MacMillan 2009).

Cognitive behavior therapy (CBT) aims to help people change their thoughts, beliefs and behavior and has been used in relation to emotional abuse (see Barlow and Schrader-Macmillan 2009 for more discussion on CBT approaches). Davies and Ward summarise an evaluation that suggests that CBT provided individually in the home can be effective, and is enhanced if coupled with additional group-based training.

Guard against

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

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Parent-Infant/child Psychotherapy Intervention Toth et al. (2006) is a psychotherapeutic approach focusing on improving parent-child attachment relationships and drawing on social support and promoting positive parenting. It helps mothers to consider how their past affects their representations of the child and parenting.

Interaction Guidance (Benoit 2001) is again, attachment-based, and uses video guidance to improve the quality of parent-child interactions. A number of video-interactive guidance programmes are being used across the UK and participants may have direct experience of its use to share.

Parent-Child Interaction Therapy (Chaffin et al. 2004) uses a cognitive behavioural approach to treat both parents and children and has been evaluated in the context of physical abuse to show reduction in re-abuse. The programme for physical abuse covers the negative consequences of severe physical discipline and building self-efficacy and self-confidence.

There are some promising findings for the effectiveness of Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) (for example, Swenson et al. 2010). MST-CAN is delivered in home and community locations, each stakeholder (family and practitioner) interviewed to establish their views on desired outcomes which become the overarching goals. The typical period of intervention is 4-6 months, but in higher risk situations can be extended. More details can be found at <http://www.mstcan.com/about.htm>, an extract from this site follows (accessed 17/5/11):

MST-CAN is delivered by a team of 3 therapists, one case manager, and a full-time supervisor. In addition, a psychiatrist who can treat youth and parents provides 20% dedicated time. Therapists provide treatment a minimum of 3 times per week for roughly 6-8 months. Great emphasis is placed on engaging and retaining families in treatment.

MST-CAN is delivered in the community (the families home, schools, neighborhoods) and incorporates treatment interventions that are supported and informed by research. All families develop a safety plan and conduct a functional assessment of physical or verbal conflicts to promote problem solving. Other treatments in MST-CAN commonly include cognitive-behavioral, behavioral, and family interventions for anger management, PTSD symptoms, family communication and problem solving, substance misuse (parent and/or youth), and abuse clarification. MST-CAN is not a one-size-fits-all treatment. Only strategies that are warranted are used.

4 patterns of case management identified:

- proactive throughout
- proactive case management that later became passive
- passive that later became more proactive
- passive throughout.

(Farmer and Lutman, 2010 p.1)

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The 'start-again' syndrome, coined by Brandon et al. (2008) in relation to serious case reviews, describes the tendency, despite the removal of one or more previous children, to see the birth of a new child as a fresh start and an opportunity for parents to try again, despite little or no evidence of any improvement in parenting capacity.

Frequent oscillations between removal from home and reunification is identified by Farmer and Lutman (2010) as a damaging feature of many neglect cases. They also describe different types of case management as elaborated on the next slide.

Principles for effective intervention

- Proactive intervention with older children and adolescents is required.
- Intensive services need to be provided.
- Clear cases for legal proceedings should be built.
- Practitioners need skills in working effectively with 'non-compliant' parents.
- It can be helpful to bring in a 'second pair of eyes' to counteract common errors.

(Farmer and Lutman, 2010)

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Farmer and Lutman's briefing from their study of reunification of children previously removed from home because of neglect is available as background reading, an extract follows:

'Four broad patterns of case management emerged. Encouragingly, case management was proactive throughout in a quarter (25%) of the cases. In all of these cases, once concerns about the children's welfare had been recognised children's social care services moved to protect children and plan for their future. The parents were still given the chance to show that they could care for their children safely but action was taken if they could not.

In many of these cases care proceedings or child protection plans were used effectively either to safeguard children, bring about increased cooperation from the parents or if this was not forthcoming to plan for permanence outside the family. The case management for 25% of the families was initially proactive but later became passive where children's social care services took appropriate action early on to safeguard the child and plan for the future but, as time wore on, management became passive.

Cases that were passively managed initially but management later became proactive included those which were managed as family support cases for too long in spite of a build up of concerns that would have made earlier child protection intervention more appropriate (26%). When case management was passive throughout (24%) children were left to suffer harm without adequate intervention, sometimes over long periods. The cases were treated as family support when they were open, and abuse, neglect and parental rejection of the children were minimized. Parental problems such as alcohol and drugs misuse or mental health difficulties received little attention. Overall there was a lack of direction in these cases and little permanence planning.'

(Farmer and Lutman 2010, p3)

Discussion point: This would be a good opportunity to encourage participants to discuss the dangers of the 'start-again' syndrome, oscillation and drift. They can be asked whether they recognise these tendencies and what can be done to guard against them.

Principles (continued)

- When children are removed there needs to be clarity about what has to change before their return home.
- Parents should be supported to address the factors affecting parenting capacity.
- Regular and detailed reviews are required.
- Effective permanence planning is needed so that children can experience stability.

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Farmer and Lutman describe some 'inevitable errors' associated with human characteristics that include:

'normalising and minimising abuse and neglect, downgrading the importance of referrals from neighbours or relatives, viewing each incident of neglect or abuse in isolation and not recognising their cumulative impact, lack of awareness of children's histories, not being able to maintain an accurate perspective on the extent of children's difficulties and developing a fixed view of cases which is not affected by contrary information' (p5).

Notes