Bury Safeguarding Children Partnership

Neglect Strategy – Toolkit and Practice Guidance

The purpose of the Bury Safeguarding Children Partnership suite of Practice Guidance is to support all Bury practitioners and partners who work with those children and families in Bury who are 'in need' of help and support. There is a focus on guidance on working with children experiencing neglect.

The documents provide information, advice on best practice and on common barriers and pitfalls, advice on 'Poverty Aware' Practice and tools to aid recognition and identification of child neglect, as well as guidance on a strength-based approach to engaging with resistant families.

CONTENTS

Practice Guidance 1. The Impact of Child Neglect

Child neglect can have a serious impact on a child, particularly if long term. It often co-exists with abuse and is often a precondition allowing abuse to take place. The persistent failure to meet children's needs undermines their resilience, leading to avoidable health and developmental problems, distress, unhappiness, harm, and poorer life chances.

A baby who is neglected in their first year can have impaired brain development. Child neglect can alter the way in which a brain functions leading to an increased risk of depression, dissociative disorders, and memory impairment in later life. There are also links with panic disorders, post-traumatic stress, and ADHD.

- Poor nutrition, hygiene and lack of parental supervision can result in, faltering growth, skin conditions, infections, anaemia, more injuries, dental problems, and poor educational outcomes.
- Emotional damage caused by the absence of love and care can alter how children behave and achieve at school, how they interact with peers and adults, and how they have relationships in their adult life.
- Children who feel unloved or unwanted can be at increased risk of going missing, self-harm, anti-social behaviour, sexual exploitation, and sexual abuse.[1]

The possibility that in a very small minority of cases neglect will be fatal, or cause grave harm, should be part of the practitioners' mind-set. (Brandon et al 2014).

The Brandon et al study concluded that:

- Neglect can be life threatening and needs to be treated with the same level of urgency as other forms of maltreatment and
- Neglect with the most serious and fatal outcomes is not confined to just young children but includes all ages - including adolescents (see neglect of older children guidance).

[1] Indicators of neglect missed opportunities 2014 DfE Brandon et al.

Recognition of Child Neglect

The response by professionals to child neglect is inconsistent and poor. Ofsted's Thematic inspection in 2014[2] presented a mixed picture in respect of the quality of professional responses to neglect. Almost half of the assessments reviewed either did not take sufficient account of family history or did not sufficiently convey or consider the impact of neglect on the child.

- Research (Davies and Ward 2011)[3] and (Turnbull)[4] confirmed that children suffering from neglect are unlikely to receive the help they need from agencies sufficiently quickly - many professionals lack confidence in identifying and responding to child neglect compared with other types of abuse and then there can be drift and delay in the interventions put in place to address it yet the longer a child experiences neglect the more damaging it is. Even when professionals have concerns about neglect, research indicates that they may be unlikely to consider how they can help or intervene, apart from referring to Children's Social Care.

The difficulty professionals experience in recognising indicators of child neglect and appreciating its severity may be because of characteristics that distinguish it from other forms of child maltreatment which make it harder for professionals to recognise that a threshold for action has been reached.

- Child neglect is usually – but not always - persistent, cumulative and occurs over time. It can continue without a critical event adversely impacting upon a child's development. It rarely produces a crisis that demands immediate proactive, authoritative action.
- Child neglect can be challenging to identify because of the need to look beyond individual parenting episodes and consider the persistence, frequency and pervasiveness of parenting behaviours which may make them harmful.
- Determining what constitutes a 'persistent failure', or 'adequate clothing' or 'adequate supervision' remains a matter of professional judgement.

[2] Professional Responses to Neglect: In the child's time: 2014, Ofsted: Manchester.

[3] Safeguarding Children Across Services: Messages from Research 2012

[4] Tackling child neglect key messages Scott and Turnbull 2018

There are two important concepts in recognising child neglect: Risk Factors and Risk indicators[5].

Risk Factors are elements specific to the individual child associated with increased likelihood of neglectful circumstances. Risk factors should not be used as predictors of neglect, as in longitudinal studies most children with risk factors are never neglected. Risk factors although should be interpreted cautiously can help to prioritise limited resources and better understand a child's circumstances.

Risk factors can be divided into those that are related to the child, those related to the family and those which are societal/environmental [6] (See Bury Continuum of Need)

1. Child related: younger age (especially children less than 12 months old, low birth weight, premature), children with disabilities, young carers, children vulnerable to exploitation, both sexual and criminal.
2. Family related: presence of domestic abuse, poor parental emotional well-being, poor parental mental health, parental substance misuse, parent learning disabilities, parent's adverse childhood experiences,
3. Society related: poverty, deprivation, unemployment, low income, poor community resources and social support, asylum seeking children, poor living conditions (e.g., overcrowding, unsafe home, instability).

Risk Indicators of neglect are symptoms and signs of actual neglect. It is essential to consider behavioural and developmental indicators alongside physical indicators[7]. No single indicator is specific to neglect alone, and so quality assessment is essential to identify whether there are additional indicators and/or alternative causes. [8]

Indicators of neglect are usually described in terms of the parent-child relationship according to the age band of the child, child functioning, the level of parental supervision and the extent to which health and educational needs are met. There are numerous tools to assist identification of children experiencing neglect. Professor J. Horwath's assessment framework 'Experiences of neglect by Age and Stage' is part of Bury's Neglect Toolkit and is available at Appendix 1. The National Institute for Health and Care Excellence (NICE) also provide extensive guidance[9].

[5] Brandon, M., et al., Missed opportunities: indicators of neglect–DfE what is ignored, why, and what can be done? 2014

[6] Rachel Akehurst, R., Child neglect identification: the health visitor's role. Community Practitioner, 2015. 88(11): p. 38.

[7] Maguire, S., et al., A systematic review of the emotional, behavioural and cognitive features exhibited by school-aged children experiencing neglect or emotional abuse. Child: care, health and development, 2015.

[8] Brandon, M., et al., Missed opportunities: indicators of neglect–what is ignored, why, and what can be done? 2014.

[9] www.nice.org.uk Child abuse and neglect, N.I.f.C.E. (NICE), 2017 and BASW

Recognising Child Neglect - Age and Developmental Stage [10]

Prenatal.

The status of the unborn is different to their status once born. Whilst in the mother's womb the unborn is recipient of whatever mother chooses to ingest. Prenatal neglect is more likely to be the result of acts of commission than omission and is identified from observation of the experiences of the expectant mother and her family context.

• Drug use during pregnancy – which has been linked to low birth weight, premature birth, increased risk of sudden infant death syndrome (SIDS), damage to the central nervous system and physical abnormalities. Babies may also experience neonatal abstinence syndrome at birth, which can cause irritability, tremors, respiratory distress and fluctuations in temperature.

• Alcohol consumption during pregnancy – this can lead to foetal alcohol syndrome, which is an umbrella term to describe a spectrum of conditions caused by maternal alcohol use, including learning difficulties and an inability to connect emotionally with peers.

• Failure to attend prenatal appointments and / or follow medical advice – prenatal support and monitoring sessions offer opportunities for problems to be identified early, and the health of mother and baby to be monitored. Parents can be supported to make appropriate arrangements for the birth, learn about how to care for their newborn and ultrasounds offer early opportunities for bonding with their baby. Drug use and alcohol use have both been linked with failure to keep prenatal appointments and failure to seek medical attention should any concerns arise during the pregnancy.

• Smoking during pregnancy - restricts the baby's supply of oxygen and is linked to increased risks of premature birth and low birth weight.

• Experiencing Domestic violence during pregnancy – effects of domestic violence are not limited to the consequences of physical injuries sustained through assault. Exposure to prenatal maternal stress or anxiety can affect the baby's development, as heightened maternal cortisol levels are shared through the placenta which can influence foetal brain development and have implications for the emotional, behavioural, cognitive, and social functioning of children.

• **Infancy (birth to two years) –** babies' growth and development are linked to their interaction with the world and their caregivers. Emotional and cognitive development can come through play, e.g., games like 'peek-a-boo' where actions are repeated for social and emotional reinforcement from the reactions of caregivers, and neural connections are 'fixed' through stimulation. Disinterest or indifference to such actions and/ or failing to offer stimulation will limit the child's development and growth, and damage infant attachments.

• **Pre-school (two to four years)** – most children of this age are mobile and curious but lack understanding of danger; they need close supervision for their physical protection, which neglected children may not experience. Children may not be appropriately toilet trained if they are in neglectful families, as this process requires patient and persistent interaction and encouragement. Children's language development may be delayed if their caregivers are not interacting with them sufficiently, and physical care may be inadequate, e.g., dental decay.

• **Primary age (five to eleven) –** for some neglected children, school can be a place of sanctuary. However, if their cognitive development has been delayed and they are behind their peers at school, it can also be a source of frustration and distress. Signs of neglect, e.g., dirty, or ill-fitting clothing, will be apparent to peers, teachers and to the children themselves, and may cause embarrassment and difficulties in their social interactions. Children without clear and consistent boundaries at home can

[10] Child Neglect: Identification and Assessment (2007) Professor J. Horwath

struggle to follow school rules and get into trouble. Educational neglect can include failing to ensure that children attend school, and high levels of absence can further impair their academic achievement.

• **Adolescence (twelve to eighteen)** – neglect is likely to have an impact on the young person's ability to form and maintain friendships and pro-social relationships, though the young person may be more reluctant to disclose their situation if they fear becoming looked after or being split up from their siblings. Whilst adolescents can find sufficient food for themselves, they are likely to be drawn to the availability of high-fat, high-sugar convenience foods if they have never learned to prepare meals. Adolescent risk-taking behaviour may be associated with, attributed to or exacerbated by a lack of parental supervision, which can expose neglected young people to the risk of harm through, for example, alcohol and substance misuse, risky sexual behaviour or criminal activity. Resilience to neglectful situations does not increase with age, and can have significant consequences for young people's emotional wellbeing; in a study of Serious Case Reviews, Brandon et al (2012) noted that 'past neglect was a factor in eleven out of fourteen reviews conducted after a young person was believed to have committed suicide'

It is important to remember that neglect should be seen in the context of an individual's experiences, and consideration should be given to whether the neglect began in this age group or has, in fact, been ongoing for several years.

A useful summary of the impact of neglect at the different ages and stages of a child/young person's life is provided by Prof J. Horwath's framework [11] and is available at Appendix 1.

[11] Child neglect: Identification and Assessment (2007) Prof. Jan Horwath

Vulnerable Children.

'It is important to note that some children may be more vulnerable to experiencing neglect - each child is unique, and their needs must be understood in the context not only of their age, educational circumstances, disability and health - but also in the wider context in which they live'. (Department for Education, 2016).

These particularly vulnerable include, but are not limited to:

- Premature babies
- Children with disabilities.
- Children vulnerable to exploitation, both sexual and criminal,
- Asylum seeking children,
- Children living with parents where there are concerns about poor mental health, domestic violence/abuse and substance misuse
- Children experiencing high levels of poverty and deprivation – likely to include lone parents – nearly half live of whom live in poverty (Research in Practice)
- Children living in Bangladeshi and Pakistani households are more likely to be living in poverty than other ethnicities (Research in Practice)
- Children whose parents have experienced Adverse Childhood Experiences (ACEs) in childhood.

Neglect of Children with Disabilities[12]

Those with special educational needs and/or disabilities are one of the most vulnerable groups in terms of safeguarding because they trust and rely on their caregivers to be sensitive to their personal care needs, their health, their emotional well-being, and their safety.

They may be especially vulnerable consequent on having fewer outside contacts than other children and may have communication difficulties which make it difficult to tell others what is happening and/or may be inhibited about complaining through fear of losing services.

- 4.1% of children in Bury have special educational needs by comparison with 3.8% across the Northwest Region, 3.4% in Statistical Neighbours and 3.7% Nationally. (LAIT 2021)

Research evidence indicates that disabled children are nearly 4x more likely to suffer neglect than their peers - but are less likely to be subject to Child Protection Plans under the category of neglect.

A parent or carer with a child with disabilities, may experience additional challenges or stresses which can exacerbate the potential for neglect and abuse.

As a professional recognition of neglect is challenging due to the complex needs of the child when working with disabled children practitioners need to be mindful of the following:

- Developmental delay or behaviour which challenges should not automatically be attributed to the child's disability; it may be a result of neglect and poor parenting.
- Neglect for disabled children can be life threatening; if, for instance, they do not have access to the correct medical treatment.
- Disabled children have the right to the same standard of parenting and relationship of care that other children have. Parents "doing their best" may not be the same as providing an acceptable standard of parenting.

[12] SEND – Safeguarding Network – Confidence in Safeguarding

- Disabled children have the same emotional, social, and cognitive needs as other children. These can often be subsumed by the high level of physical care and supervision that they require.
- Just because a child has a learning disability or does not communicate verbally this does not mean that the impact of neglect is less significant. A child's behavioural distress or difficulties may be their way of communicating that they do not feel safe at home.
- Parents of disabled children often experience financial and practical difficulties, for example through reduced opportunities to work. Assessments of parenting capacity must differentiate between neglect due to systemic issues and neglect caused by a lack of parenting capacity.
- Views and experiences of the child must be central so that the needs of the family with a disabled child are not allowed to mask safeguarding and child protection concerns. Safeguarding concerns should be standard agenda item in multi-agency meetings about disabled children.
- Disabled children often have their care needs met by numerous adults so neglect and abuse may have a variety of sources. Families can be overwhelmed by the number of professionals working with them. Different information is shared with different professionals, resulting in no one agency having a complete picture of the family situation. It is important that this is addressed in core group meetings.
- Disabled children can be neglected in specialist placements as well as at home. It is important that professionals work proactively with family carers when disabled children are placed away from home to ensure they know how to recognise and report on concerns.

Case Study 1

Lenny is a young person with complex needs. He is nonverbal with autism and dependent on his parents for all their care needs.

Lenny expresses himself through his behaviour which at times can be aggressive. His parents struggle to manage his challenging behaviours.

Disabled children have the right to the same standard of parenting and relationship of care that other children have. Parents "doing their best" may not be the same as providing an acceptable standard of parenting.

A nonverbal child's behavioural distress or difficulties may be their way of communicating that they do not feel safe at home.

Just because a child has a learning disability and does not communicate verbally does not mean that the impact of neglect is less significant.

Disabled children have the same emotional, social, and cognitive needs as other children. These can be subsumed by the high level of physical care and supervision they require.

Lenny is clinically obese which poses a serious risk to his physical health, his parents have not followed the advice of a dietician.

Lenny's parents have increased his medications in the last year to help keep him calm and to manage his aggression, but he has not been seen by his GP for a significant period.

Neglect for disabled children can be life threatening; if, for instance, they do not have access to the correct medical treatment.

Lenny is experiencing neglect of his emotional and health needs.

A multi-agency response is now being developed, to support the family and better meet Lenny's needs.

Neglect of Older Children

Whilst persistent child neglect is most damaging in infants and young children, older children are also damaged by neglectful parenting. In 2016 Joint Targeted Area Inspections (JTAIs) brought together four inspectorates – Ofsted, Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMIP) to scrutinise multi-agency responses to older children experiencing neglect. Their key findings (JTAI 2018) included that social care often fails to identify or respond effectively to neglect of older children:

- Neglect of older children sometimes goes unseen,
- Work with parents to address the neglect of older children does not always happen,
- Adult services in most areas were not effective in identifying potential neglect of older children,
- The behaviour of older children should be understood in the context of trauma

and

- Tackling neglect of older children requires a coordinated strategic approach across all agencies.

Adolescents are often viewed as being more resilient than younger children but, as referenced by the Children Society[13], they still need dedicated care to meet their physical and emotional needs and to support their education and to keep them safe. A lack of attention to any, or all, types of care can be neglectful to adolescents and create a catalyst for poor well-being and risky behaviour that can jeopardise a young person's health and prospects. It is thus unsurprising that teenagers are the largest growing cohort in both child protection and care - when older children enter 'care' they are more likely to remain in care long term compared to the youngest entrants (Neil et al., 2019).

[13] 'Understanding Adolescent Neglect – Troubled Teens.' The Children's Society 2016

Case Study2

Belinda is a teenager who has ADHD. She does not take her medication regularly and over recent months her school performance and attendance has been increasingly inconsistent. There is increasing evidence that Belinda is misusing alcohol and illicit substances.

Teenagers continue to need dedicated care to meet their physical and emotional needs, to support their education and to keep them safe.

A lack of attention to any, or all, types of care can be neglectful to adolescents and create a catalyst for poor well-being and risky behaviour that can jeopardise their health and prospects.

During the assessment process Belinda has described to her social worker, that she has not contact with her father who left the family many years ago, she spoke about her mother's excessive alcohol consumption, her mother's many relationships and her increasing absence from the home.

A 'Learning Circle' reviewed and reflected on Belinda's circumstances and decided that her needs are being neglected – a multi-agency child protection conference will be convened, and a multi-agency plan developed to ensure Belinda's needs are better met and that she is protected from the risk of further harm.

Tackling Neglect of older children requires a co-ordinated strategic approach.

Practice Guidance 2

Potential Barriers to Working with Neglectful Families.[14]

Barriers	Mitigations
Neglectful parenting often occurs against a backdrop of poverty and disadvantage and parents may be experiencing a range of other stressors in their lives. Neglectful parents may feel vulnerable, stressed, and even desperate.	Practitioners need to understand how parental capacity is influenced by these daily challenges. 'If the constraints placed upon parents by poverty are not acknowledged or addressed, social work involvement may well be experienced by families as reinforcing feelings of powerlessness and stigma' (Hooper et al, 2007).
Families may have had longstanding interactions with child protection workers and be wary of talking to frontline practitioners.	Display and persist with relationship-based/ strength based and child centred practice. Be reliable and professional and aim to provide educative, supportive, and timely assistance which addresses the specific needs of each parent and the stressors in their lives.
Neglect may have been normalized in the parents' home and in their community. We need to work with parents to help them recognise the cumulative harm caused by neglect.	Talk with parents to help them recognise the cumulative harm caused by the neglect of their children. Talk about the impact of neglect on the child and where appropriate draw upon descriptions of the daily lived experience provided by the child themselves.
Neglectful parents may show 'disguised compliance' where they deceive professionals into believing that they co-operate and engage with services (e.g., short term or housing improvements or sporadic or sporadic hospital visits despite ongoing neglect. [15]	Where a parent is hostile, avoidant, or demonstrating signs of 'disguised compliance' (see practice guidance) and you are concerned the child is experiencing neglect, if there is no improvement in the way the child(ren) is/are parented, consult the Bury Continuum of Need and the Bury Threshold Guidance (Neglect) to determine whether to make a referral to Children's Services. If unsure talk to your safeguarding lead or supervisor or consult with EHASH. **Remember - it is the cumulative effect of neglect that leads to children being harmed and to impairment of their development.**
Practitioners sometimes find it difficult to determine the seriousness of their concerns and may only have a 'limited window' into the child's world and parenting behaviour.	**Note/record your concerns. Look at the concerns chronologically and in terms of frequency. Consider the strengths and protective factors and the child's health and development. Ask yourself – do you know the cause if the child has health/development issues? Do not rely on what parents tell you if you are concerned about a child's health and development.** **Use the Horwath 'Experience of Neglect by age and stage' (Appendix 1) and the 'Bury Threshold Guidance – Neglect' tool (Appendix 2) to assist your recognition of indicators of neglect, understanding of the quality of parenting and the level of need. Discuss your analysis with your supervisor or safeguarding lead.**

[14] Howarth

[15] Rachel Akehurst, R., Child neglect identification: the health visitor's role. Community Practitioner, 2015.

Practitioner Pitfalls in Working with Potentially Neglectful Families.[16]

Practitioner Pitfalls	Mitigations
Bias.	Be aware of your own values, how your experiences shape your thinking and your own parenting behaviour, your views about people with different background to your own. People from any background abuse and neglect children - focus on the child(ren) and their circumstances. Avoid generalisation. Challenge yourself and allow yourself to be challenged by others. Use supervision and opportunities for consultation with your safeguarding lead.
Failing to distinguish between unmet need due to family or environmental factors and neglectful parenting.	A clear understanding of the issues and of the quality of the parent/child relationship is essential to distinguishing between unmet need and neglect. One of the salient features of neglect is a breakdown in the parent-child relationship which becomes a barrier to care-giving (Tanner and Turney, 2000). The difference between a family living in poverty with a strong parent child relationship and one in which the relationship has broken down is important in deciding what to do next to improve the child's lived experience and to support parents to improve the quality of their parenting.
Rule of optimism – thinking things will change because of the work you and others are doing – thinking you can make a difference where others have failed.	Do not be over-optimistic about parental capacity in difficult circumstances. Practitioners must maintain the balance between offering support for parents and being realistic about their capacity to change - particularly relevant in relation to chronic neglect, where cases may have drifted with very little improvement or change over an extended period. The desire to change neglectful parenting does not mean that parents have the capacity to change. '**Think the Unthinkable'**. Challenge yourself - ask 'what is the evidence of progress?', 'what is the evidence that things can improve?' Is it possible that I am I being deceived, seduced, intimidated? Am I threatened? A parent's capacity to make sustainable change requires evidence of commitment and of consistently changed behaviour. **Changes in parenting may be incremental. Subtle changes are effectively measured through dynamic/repeated use of the Graded Care Profile 2.**
Holding fixed views – over relying on a 'snapshot' at a single point in time when the child was 'OK' – ignoring events or information that do not fit with the hypothesis or explanation of what is happening to or around the child.	Frequent opportunities to reflect with experienced colleagues on the child's needs, the parenting capacity, and protective and risk factors in the child's household. Consideration of the range of possible reasons for what is happening to the child, tested against the evidence including the views of others who know the child and family. Supervision with experienced colleagues. Consultation with agency safeguarding leads. All to correct bias and test practitioners' analysis of the situation.
Believing what you are told by parent/carers – not focusing on the child or whether anything has changed for the child.	Always ask yourself 'how do I know what I am being told is true?' – consider the possibility that you are being persuaded when there is no evidence to support what is being said. **Think the Unthinkable.** Do not rely on what parents tell you when you are worried about child's health and development. If a parent tells you a behaviour is cultural norm check it out with colleagues or research cultural child rearing practices. Consider the range of possible reasons for what is happening to the child – test them against the evidence and obtain views from others who know the family.
Practitioners can sometimes be wary of making value judgements about parenting behaviour. Raising issues about how someone is parenting can impact adversely impact on their sense of self and identity. Practitioners may worry about harming their relationship with the parent.	Good practice in neglect cases is characterised by the quality of the practitioner relationships with families – the quality of the relationship is the primary vehicle for supportive and protective practice. Practitioners must develop a collaborative relationship with the parents whilst staying **focused on the rights of the child** – it is our responsibility to act when a child's needs are not met, or they have unexplained health or development issues.
Focusing on individual incidents not on what the child is saying or demonstrating; not thinking about long term patterns of behaviour, the family history and track record of earlier efforts providing help and intervention	Use a chronology of events to evidence how the child has been affected over time. Think about the pattern of parenting behaviour- has anything changed? Have changes in parenting behaviour been sustained? Are younger children having the same adverse experiences as older children?
titioners become habituated to a child's presentation and so fail to question a lack of progress.	Professionals can become acclimatised to poor parenting and poor conditions in the home. Practitioners can also make judgements that neglect is somehow acceptable or the norm for children 'in this area' or with the kinds of problem families like that have'. Remind yourself what 'good parenting' looks like and ask whether it would be good enough for your child. Think about the child's daily experience – put yourself in the 'child's shoes. Use supervision, discussion with other practitioners and discussion with safeguarding leads to get a 'fresh pair of eyes'

[16] Howarth

Practice Guidance 3.

Good Practice with Children Experiencing Neglect and their Families [17]

> Where good practice in neglect cases was noted, the quality of relationships with families was apparent as the primary vehicle for supportive and protective practice. This is particularly so when it is rooted in a sound grasp of the family context and roles and relationships, as an effective way of managing the complexity of compound ad cumulative risks of harm over time.
>
> *(Brandon et al,2020)*

- 'A collaborative, authentic relationship' is key (Reimer, 2013; Scott and Daniel, 2018)[18] - parents need to feel that workers understand what they are experiencing and that they care - there must be a focus on identifying and building on the strengths of the parent. Work should be culturally sensitive, but guard against setting different standards for children from minority ethnic groups.

> *LEARNING POINT*
> A strength-based approach when practitioners raise concerns with parents provides parents the opportunity to think about what they do well and could do better and to talk about immediate stress or difficult experiences. It can also open dialogue about the child(ren), their needs and how best to meet them. It also enables practitioners to understand what some of the factors that may be impacting on the parent's capacity to meet their child's needs – whether these are short term or indicative of persistent neglect of the child(ren).

- Be reliable and professional, provide educative, supportive, and timely assistance addressing the specific needs of parents.

- Be child focused. A clear understanding of the issues and of the quality of the parent/child relationship is essential. Creating a sense of safety for the child should be an early goal to create a more predictable environment, in which the child will be better able to develop and start to learn from new experiences.

- Address how child neglect is experienced within the family. Each family member should be recognised (always consider the role of the father); draw on your knowledge and understanding of the 'lived experience' of each family member to talk to parents about how their behaviour may impact each individual child within the household differently. Support should then be thought through at each ecological level - individual, family and community.

[17] Howarth in 'Tackling Child Neglect Research, Policy and Evidence Based Practice' August 2016
[18] Tackling child neglect key messages Scott and Turnbull 2018

- Where children are experiencing neglectful parenting, there is need for accurate and comprehensive assessment. In the absence of a clear understanding of the problem, interventions are likely to be inappropriate or ineffective. Tools like the Graded Care Profile2 and Howarth 'Experience of Neglect by Age and Stage' whilst crucial to the consistent identification of neglectful parenting and the systematic recognition of the impact of neglect on children, are not designed to help practitioners explore the reasons behind a lack of parental care or consider how structural socio-economic factors affect family functioning (Johnson and Cotmore,2015).

- Good assessment will include gaining understanding the parents' history and how it affects their day-to-day functioning and parenting capacity. Neglectful parents have often experienced past trauma including their own child protection history (adverse childhood experiences - ACE). Particular attention should be paid to the accumulation of stressors in parents' lives. If parents are struggling with multiple stressors, they may need support to address each of them individually.

LEARNING POINT
Talking to parents about their experience of being parented improves practitioner understanding of how a parent understands the needs of their own children, talking to parents about what they believe their children need and how they meet their children's needs improves practitioner understanding of parenting behaviour.

Relationship-based social work seeks to understand and address the psychological and emotional impact of past traumatic events on people. Starting from the position that the relationship between the professional and service user can be a conduit for change, the models emphasise empathy, respect of people's dignity, allowing them to tell their stories, and recognising their inner strengths. Practicing within a relationship-based framework enables social workers to understand people's life histories and to hear their lived experiences, bringing together the wider societal analysis of the determinants of harm with individual support plans.

- Ensure the characteristics of the child or other children in the family (such as disability, medical concerns, or behavioural problems), which might make it hard for the parent to meet their needs are understood.

- Understand the parents' motivation and capacity to change how they care for their children.

- Practitioners should help parents recognise the cumulative harm caused by the neglect of their children. Talk about the impact of neglect on the child and where appropriate draw upon descriptions of the daily lived experience provided by the child themselves.

- Practitioners should support parents to understand what normal development for their child looks like. Providing clear and simple descriptions of normal development as well as of the developmental signs of neglect at their child's specific developmental stage.

- Link interventions to specific improvements in the lives of children. Help parents to see what improvement would look like in relation to changes in the daily lived experiences of their children. Practitioners should work with families to develop plans which provide parents with

examples of how changes in their behaviour will result in improvements in their child's lived experience.

- Link interventions to observable changes in outcomes for children (i.e., child has a bath every day, has a clean uniform to wear to school) - avoiding development of plans which measure success as the completion of tasks (i.e., cleaning up the house, purchasing a new washing machine).

- Develop plans which are focused on changes to the quality of life for the child, think about:

    - The aspects of the daily lived experience of the child which you are worried are unsafe or causing harm?

    - How the daily lived experience of the child will be different when the child is safe from harm.

    - The daily lived experience of the parent(s), parenting issues, family and environmental factors which are positively and negatively influencing the ability of the parent(s) to meet the needs of the child.

    - What the parent(s) need to do differently to ensure the child is protected from harm and the child's lived experience improves.

    - How can this change be achieved? What are the first steps? Who needs to do what? To what timescales?

LEARNING POINT
The features of successful intervention and prevention programmes are clear objectives, regular monitoring and modification of programmes based on the needs of the child and family.

- Practitioners must gain understanding of how parental capacity is influenced by daily challenges. 'If the constraints placed upon parents by poverty are not acknowledged or addressed, social work involvement may well be experienced by families as reinforcing feelings of powerlessness and stigma' (Hooper et al, 2007). Work with families should include interventions which address the causes of neglect including poverty.

Poverty aware practice can help empower people to obtain their entitled benefits and support, assist them to access the money and services that they are entitled e.g., welfare benefits and ensure they do not wrongly pay for services that they are entitled to for instance domiciliary care or family support services. The implication of this is that frontline practitioners should include conversations about income, money, and poverty in their work with families, and in assessments and care planning.

Practice Guidance 4

Poverty Aware Practice

This practice framework aims to support social workers and other frontline practitioners in Bury to recognise (Poverty Aware Practice) and respond to (Anti-Poverty Practice) the impact of poverty on individuals, families, and communities.

Why Should Social Workers and other frontline practitioners be concerned with Poverty?

Social work's purpose is to improve and safeguard social well-being. Tackling poverty is central to enhancing social well-being. Alleviating poverty is highly effective at improving outcomes for children and adults – but poverty aware and anti-poverty practice it is also a moral imperative for social workers. The Social Work Professional Values and Standards include[19] the requirement for social workers to:

- Value each person as an individual, recognising their strengths and abilities.
- Respect and promote the human rights, views, wishes and feelings of the people I work with, balancing rights and risks and enabling access to advice, advocacy, support, and services.
- Work in partnership with people to promote their well-being and achieve best outcomes, recognising them as experts in their own lives.
- Value the importance of family and community systems and work in partnership with people to identify and harness the assets of those systems.
- Promote social justice, helping to confront and resolve issues of inequality and inclusion.

Poverty has a disproportionate impact on many of the service area groups social workers and other practitioners work with and so social workers and other frontline practitioners should be aware of the causes and consequences of poverty and use this knowledge to tackle poverty by both prevention and intervention.

Definition of Poverty. The definition most used is: "Individuals, families, and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities, and have the living conditions and amenities which are customary, or at least widely encouraged or approved, in the societies to which they belong. Their resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary patterns, customs and activities" (Townsend, 1979: 31)

This definition is commonly used because it describes a wider understanding of poverty and shows that poverty isn't just about what you have, or what you don't have, it's about what you possess in comparison to what the society around you has.

[19] Professional Standards Social Work England 2019

Bury's 'Cost of Living and Poverty Strategy' uses the following terminology to understand and describe poverty and deprivation in Bury.

- An income below 60% of average income 2010/11 uprated for inflation is Absolute Income Poverty.
- An income below 60% of the current average income is Relative Income Poverty.
- People/families who lack two or more of a home, food, heating, clothes, shoes, and basic toiletries are Destitute.
- People/families unable to afford what is necessary to participate in society, beyond the basics to survive – for example transport, digital access, family celebrations and social events – are living below the Minimum Income Standard.

Although the Minimum Income Standard is not a poverty threshold almost all households officially defined as being in relative income poverty (below 60% of average income) are also below the Minimum Income Standard. Thus, households classified as being in relative income poverty are generally unable to reach an acceptable standard of living.[1]

It is useful for social workers and other frontline practitioners to understand the various definitions of poverty that are used, but it is not suggested they need to measure or define individual poverty levels before responding to need.

- Self-report and the observation and assessment skills of practitioners should be sufficient for practitioners to recognise poverty and prompt them to think how they can mitigate and alleviate the impact of poverty.

Poverty Aware practice should be embedded in all routine processes - all assessments must include consideration of socio-economic circumstance, the impact on the individuals concerned, on household functioning and on people's capacity to change. [20]

The Extent and Impact of Poverty

Anyone can experience poverty. It is not a character flaw. Someone may be born into poverty, grow up in poverty, live life in poverty and die in poverty. Some people may never experience poverty, and some people will live life going in and out of poverty. Some people may experience poverty just once but feel the impact for the rest of their life.

- There are some groups who are more vulnerable than others, such as those with special educational needs and disabilities, women, and people who are Black, Asian, or Minority Ethnic– these groups are overrepresented in poverty statics.

Child poverty has been rising since 2011 – whilst the actual number of children in England has increased by 3% - but the number of children living in poverty has risen by 15% - virtually all this rise being in working families[21].

[20] Anti-Poverty Guide BASW 2022

[21] Barnard et al 2018 in 'Neglect in the context of poverty and austerity: Frontline Briefing '(2019) www.researchinpractice.org.uk

Adults being out of work is often said to be the main cause of child poverty- however, across the UK, 70% of children who are in poverty were from a household where at least one person was in work in 2018.

- The average rate of childhood poverty in Bury (after housing costs) is 32.1%.
- In 2020 -2021 the number of children in England under 16yrs living in low-income families was the same as in 2012 -13 (18.5%) but since 2012 -13 there has been a 26% increase in the number of under 16yr old children in Bury living in low-income families.
- In 2020 -2021, 14.5% of the population of Bury (28,000 people) were classified as 'income-deprived'.

Deprivation is a contributory causal factor in child abuse and neglect and a growing body of research is strengthening the evidence of this relationship (Bywaters & Skinner, 2022; Bywaters et al., 2016). [22] [23] In addition to the increased likelihood of abuse and neglect of children who experience poverty they are more likely to face a wide range of difficulties now and in the future.

- There are strong links between experiencing poverty as a child and having worse mental and physical health, a shorter life, lower grades in education, poor financial health, and lower paid, insecure work. One of the huge impacts of having less than others around you is that you cannot access the same opportunities, resources, or activities as others, so you feel inadequate and ashamed. We know that being in poverty, being excluded and feeling ashamed can impact a child for the rest of their life.

Impact of Poverty on cognitive, social, and behavioural development - Cooper and Stewart (2013) reviewing experimental studies on the relationship between cognitive, social, and behavioural development estimate that increasing the annual household income for children in receipt of free school meals by £7,000 would be enough to close the attainment gap between children on free school meals and children not on free school meals at Key Stage 2. Education attainment, and the impact on future access to high wage jobs and opportunities, has been shown to correlate with childhood experiences of poverty – and to be a major factor in determining a person's risk of continued poverty through life.

Impact of Poverty on diet - The Food Foundation's (2019) Broken Plate Report found that the poorest 10 per cent of households would have to spend 74 per cent of their "disposable" income (income after rent) on food to meet the government's Eatwell guidelines. This leads to poorer families choosing less nutritious, but more filling food.

Impact of Poverty on Parental conflict - Fahmy, et al. (2016) report that in households with both low incomes and high levels of social and material deprivation nearly 6 per cent report recent physical abuse from a partner, compared to 1 per cent in non-poor households.

Impact on Stress and parental mental health - Stress and worry can be caused by not having access to basic materials, such as toiletries, clothes, shoes, medication, and food. Living in food insecure households can result in hunger, malnutrition, and obesity. Poverty negatively affects peoples' sense of their identity and worth and their relations with others (Gibson 2016). This may manifest itself in

[22] www.gov.uk Bywaters & Skinner in Independent Review of Children's Social Care 2022.
[23] www.gov.uk Bywaters et al in Independent Review of Children's Social Care 2022

mental illness or parental lack of confidence in their ability to offer appropriate parenting to their children.

- To avoid shame people living in poverty may not claim the benefits that they are entitled to or seek support from professionals (Shildrick et al. 2010). Research has also found that to escape shame, people may limit or stop social interaction because of the financial cost (Chase and Walker 2014). Shildrick and MacDonald (2013) use the phrase 'the normalisation of everyday hardship' to explain how people will deny that they are facing hardship because of poverty.

This can be difficult for social workers and other frontline practitioners because people may obscure their difficulties, making it hard to assess their level of need and hence the effect of poverty on them. The key is the development of trusting relationships which allows for assessments to properly consider the socio-economic circumstances of the family and the impact on the individuals and household functioning.

Poverty Aware Practice in Bury Children's Services.

The Bury Let's do it! strategy has the eradication of poverty at its heart.

> 'Amongst the stresses of living in poverty is the stigma faced by individuals and families in seeking to access support. Indeed, the word poverty is a loaded term that can add pressure and bias to describing a household and through which there is a danger of generalising, missing the detail of the individual lives of local people.'[24]

The strategy sets out to take 'a strength-based approach to improving the lives of local people and reducing inequality. This means an approach which is built around respect, empathy, compassion, and fairness; one in which people are empowered to live their best lives, direct their own destiny, and recognises for different people this will take a different form'.

This is the key to poverty aware practice.

The strategy identifies that challenging and addressing stigma and unconscious bias in relation to poverty, in council personnel and partners will be a key enabler in tackling the effects of poverty in the borough.

'There is the need for open and honest conversations on terminology which undermines or degrades individuals even when it is not set out to do so. The voice of those experiencing hardship is critical to this, so that collectively we can develop a shared understanding and language locally which is clear and respectful; understood and constructive'.

This implies that:

- Social workers and other frontline practitioners may need to challenge their own views and use of language for unintentional bias - for instance do they think that those experiencing poverty just need to work harder, or budget better, or waste less or reduce their expectations. Such views could lead to not hearing or understanding service user experience and to stigma and guilt.
- Social workers, and other frontline practitioners should form respectful relationships with service users who experience poverty which promotes their dignity, self-belief, and self-esteem.

[24] 'Let's Do It' Bury.

- Social work and Early Help responses to poverty should be co-produced with service users.
- Frontline Practitioners should recognise the resilience of many of those coping with poverty and use a strengths-based approach to mutually identify and agree necessary supports.

Poverty aware practice restores dignity. [25]

- Social workers and frontline practitioners should recognise that those who have experienced poverty understand it best – and should listen to and learn from that experience.

Case Study3[26]

Poverty-aware practice means working alongside parents to look for the root cause of a situation.

POVERTY IS NOT NEGLECT

'a mother in poverty once found herself in a meeting at her children's school where every professional in the room accused her of not caring about her daughters' education because they were often late or absent from school. Not one professional asked her about her situation. If they had, they would have discovered that her children had both lost the travel cards that allowed them free transportation to school. Because they didn't have the travel cards, they were often thrown off the bus and had to walk the rest of the way to school. But replacing lost travel cards is not easy. Applications must be done online, but mother didn't have a computer or email address. The mother also needed to replace the girls' birth certificates and to get passport-sized photos, none of which she could afford because she was in rent arrears and debt. But after ATD helped the mother to replace the travel cards, her daughters showed up at school on time every day'.

Poverty-aware practice would have been for the professionals not to assume they knew why the girls were arriving late but to ask the mother how they could support her.

This case study above is from 'Altogether in Dignity (ATD) – an international human rights anti-poverty based organisation. Between 2016 and 2019 in partnership with professional researchers from the University of Oxford, they carried out participatory research in the UK to better understand poverty in all its forms. This was a ground-breaking study because people with direct lived experience of poverty took part as co-researchers. They worked alongside co-researchers with professional experience of poverty from fields such as social work, journalism, and the NGO sector. More information about this work can be found at www.atd-uk.org.

Poverty aware practice requires that frontline practitioners always ask themselves:

- Do the demands of service users, perhaps in child protection plans or risk management plans create additional financial pressure in an already poor family?
- Do we demand such high standards of behaviour and household management that anyone would struggle let alone those in impoverished households?

[25] Altogether In Dignity (ATD) Poverty Aware and Anti-Poverty Social Work 2021.
[26] Altogether in Dignity (ATD) Poverty Aware and Anti-Poverty Social Work 2021

The Response to Poverty.

Practitioners should consider ways of alleviating material poverty for their service users. This is anti-poverty practice. Practitioners should:

- Ensure that the people they are supporting are receiving their maximum benefit entitlement.

While practitioners do not need to be expert in all aspects of the benefits system, they should know enough to be aware of possible entitlements and be able to give basic advice. Where more expertise is required, they should be aware of avenues of support for benefits claims and appeals such as the Citizen's Advice Bureau and local advice centres

- Be aware of all local advice services so they you can signpost service users. Areas to consider might be advice on heating, insulation, debt management, banking, loans, money management, housing cost arrears, landlord advice, rent deposit schemes etc.
- Be aware of and refer to local charities and support organisations which can offer support to those experiencing poverty. These might include food banks, faith groups, clothes banks, homeless shelters and homeless outreach services, luncheon clubs, home repair services and community transport services.
- Be aware of grant-making organisations which may provide support to individuals or groups experiencing poverty.
- Be willing to offer advice and support to service users wishing to take up employment

Many of those who experience poverty also experience marginalisation and exclusion. Many feel disempowered. Social workers and other frontline practitioners have a role in countering these experiences through advocacy, resource brokering and systems negotiation with and on behalf of service users. This might involve:

- Challenging a landlord about their duties to make repairs.
- Accompanying a service user to a benefits appeal hearing.
- Negotiating better repayment terms with a loans company.
- Writing a supporting letter for a grant application.

Whilst practitioners should seek to empower service users themselves, they should also recognise the inherent power of their own positions and use that to support betterment for their service users.

Social workers and other frontline practitioners should seek out options to counter lack of opportunities arising from poverty. This could include:

- Considering whether access to play, education, work, sport, travel, holidays, or social and leisure activities is affected and if so, whether they can support access to these opportunities in any way.

Practice Guidance 5 - Engaging Resistant Families

All helping interventions to support behavioural change, social work or otherwise need to be based on an understanding of resistance to change and the ability to work effectively with resistance to change. After all, if there was no 'resistance' to behavioural change then the intervention would be redundant. Research suggests that a person who recognizes s/he has a problem and has the desire, means and confidence to address it is likely to succeed regardless of professional help (Orford 2001).

Research carried out for the government in the early 1990s, found that parents who wanted help and who were open about their problems rarely received local authority social work input – such families tended to be referred to non-statutory family support services (Department of Health 1995).

Thus, statutory child social work finds itself working to a large extent with families resistant to or at least ambivalent about social work involvement. This guidance though particularly pertinent to social workers is for all practitioners working with children and families to assist their:

- Understanding of the possible causes of resistant or non-co-operative behaviour by parents/carers
- Understanding of the variety of ways in which parents/carers display resistance and non-cooperation.
- Understanding of the potential of a strength-based approach to reducing parental resistance and non-co-operation.

Potential causes of Resistant or Non-Co-operative behaviour.

Forrester, Westlake and Glynn[27] identify five principle causes of parental resistance to engagement with social work professionals.

- Social structure and disadvantage,
- The context of child protection work,
- Individual factors (Shame, Ambivalence, Confidence)
- Parental denial or minimization of abuse or neglect and
- The behaviour of the social worker.

Social structure and disadvantage - most social work clients will have experienced discrimination, oppression, and disadvantage and this could be a factor shaping their relationships with social workers and other professionals. Black clients who have experienced racism may be anxious about whether a white worker will understand them or even whether the worker may be racist; working class clients may be antipathetic to a middle-class worker and women may feel mistrustful or hostile about a male worker (particularly if they have experienced gender-related abuse or violence).

The Context of Child Protection - In most encounters between social workers and their clients there are important differences e.g., age, class, disability - but whatever the dynamics arising from these differences the nature of a meeting between parent and child protection social worker creates a context in which the social worker holds more power in the relationship (Rees 1975)[28]. Not only are social workers in a position of relative power, but they are tasked with making judgements about parenting capacity (Broadhurst 2003)[29].

Simply being a client of social services can lead to fear about the implications for the care of children. Taylor (1993)[30] followed injecting female drug users for 14 months – all feared the negative views social workers seemed to have of them. They felt social workers automatically assumed that because they were drug users, they were bad mothers. Taylor outlined that this affected their approach in anticipation of what the social worker could do, and they developed attitudes and behaviours in response to their powerlessness which confirmed the negative views held not only by social workers but by people in general. (Taylor 1993).

The context of child protection social work involvement is always likely to create resistance.

Individual factors contributing to parental resistance.

Being asked by a stranger to reveal a personal secret is likely to engender unease - even resistance - particularly if it is something of which an individual is ashamed. Probing in such a way is essentially how social workers and others embark on assessing risks to children.

[27] Parental resistance and social worker skills; towards a theory of motivational social work 2012
[28] Rees S (1975) How misunderstanding occurs - Radical Social Work.
[29] Broadhurst K (2003) Engaging parents and carers with family support services – Child and Family Social Work.
[30] Taylor 1993 Women Drug Users: An ethnography of a female injecting community.

The shame and negative feelings people may have about some of their behaviours might make you believe that they would be bound to want to change. A parent may hate their drinking and the effect it has on them and their family, yet also find that it eases their feelings of self-loathing, a mother may be aware that returning to live with her violent partner places her child at risk but nevertheless appreciates the financial security it provides her and her child.

Individuals experiencing powerful 'positives' and 'negatives' associated with 'problem behaviour' and the alternatives are described as **'ambivalent'**. Miller and Rollnick 2002[31] consider ambivalence to be at the heart of difficulties experienced by anyone trying to change their behaviour.

When working with ambivalent parents, practitioners are at risk of increasing parental resistance – voicing the arguments for change can elicit from the parents what to them are equally powerful arguments for not changing.

Even when individuals want to change, they may lack confidence in their ability to do so, particularly when problems are long term and entrenched to the point, they conclude that they are unlikely to succeed change. There is a difference between ambivalence about the need to change and ambivalence about one's ability to change. The two different reasons for resistance to change may result in very different responses to social work actions and interventions. Social workers and others may need to adjust their interventions depending on their understanding of the reasons for clients not changing.

Resistance created by the behaviour of social workers.

Resistance to behavioural change is not something that exists solely within the individual, nor even something that is simply produced by the context of child protection it is to some degree a product of the nature and quality of the interaction between the individual and the social worker.

Social work behaviour is both a potential cause of resistance and an important tool for reducing resistance. The evidence for this in relation to the use of Motivational Interviewing by social workers is provided by a variety of studies discussed in Miller & Rollnick (1991, 2002).

Barber (1991)[32] suggests that statutory social work should start by assuming the likelihood of resistance and encourages social workers to openness, being clear about authority and exploring reasons for resistance as key elements of an effective response. The core skills are those of good listening, such as positive non-verbal communication, empathic listening, the use of open questions, affirmation of positives and the use of reflections (statements by the listener that try to represent their understanding of the parent's views). Reflective statements can provide a bridge across the types of difference outlined above: cultural, gender, class and power differences that can distort understandings between worker and client are reduced if the worker systematically and regularly reflects their understanding of the client's point of view, thus allowing the client to correct or add to the worker's view.

[31] Miller and Rollnick 1991 and 2002 Motivational Interviewing: Preparing people for change
[32] Barber 1991 Beyond Casework

Workers who seem respectful and empathic, and who use open questions and reflective statements regularly to check their understanding seem to create less resistance; those who take the position of the expert, who try to argue or persuade the client to change, or who are explicitly confrontational tend to create greater resistance from clients and reduce the likelihood of behavioural change and positive outcomes.

Harm to Child.

In situations where a child is at risk of significant harm or who has suffered actual harm, either due to deliberate neglect or abuse or because serious difficulties impair the parent from providing effective care there are likely to be real reasons for parental resistance to the involvement of social workers and other professionals (Ferguson 2011)[33]. It is not uncommon in child protection social work for parents to mislead social workers and minimise the consequences or deny the impact of their behaviours on their children. Deliberate abuse that is consciously and systematically covered up by parents/carers is relatively rare, but is a feature of several high-profile child deaths, such as Victoria Climbié and Peter Connelly (Laming 2003, 2009). As it is often disguised by apparent cooperation it is the most challenging example of parental resistance – guidance on working with families displaying behaviours associated with disguised compliance is provided (Practice Guidance6)

> 'Disguised Compliance' involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and to delay or avoid professional intervention'. [34]

It is the subversive undermining of plans designed to protect and promote the welfare of children at the same time as presenting as engaged in the work and in an apparently cooperative relationship with the worker. The term can apply in any discipline when practitioners are trying to encourage and initiate change in parenting behaviour.

Examples of circumstances which may contribute to the resistance of families to engage with services

- Children previously removed or fear of child/ren being removed
- Previous experience of poor service/lack of trust.
- Cannot or does not recognise that there is problem (their norm)
- Learning Disability
- Sensory Impairment
- Parental mental health
- Domestic abuse
- Threat of violence
- Drug and/ or alcohol misuse
- Cultural differences
- Criminal activity
- Social Isolation
- Lack of financial resource/Poverty
- Childhood Trauma (Adverse Childhood Experiences).

[33] Ferguson 2011 Child Protection Practice
[34] NSPCC 2010

Good Practice when working with Resistant and Non-Compliant Families.

- Focus on the welfare of the child and possible harm - keep the child's needs central and paramount. Spend time with the children including on their own.

- Focus on engaging the parents/carers - adopt positive and anti-discriminatory approaches to maximise the potential for a productive working relationship.

- Treat families with respect, afford them dignity e.g., keep appointments, be punctual and be cognisant of the impact of cultural differences. Families may develop a resistance or hostility to involvement if they perceive the worker as disrespectful, unreliable, or dishonest, or if they believe confidentiality has been breached outside the agreed parameters.

- Be clear from the outset what is known about the family to assess potential strategies e.g., parents with learning difficulties or mental illness may need to have information, advice and expectations conveyed in an alternative way, possibly working with specialist colleagues.

- Try to establish trust through active engagement, acknowledging that the family may see things differently and demonstrating a respect for their views, whilst confronting inappropriate attitudes.

- Explore the parent's rationale or motivation; consider belief systems as they may help to understand how the parents meet the child's needs.

- Where you think cultural factors are a factor in a family's resistance to having practitioners involved, seek expert help and advice in gaining a better understanding of the culture involved. Ask for advice from local experts, who have links with the culture.

Some Serious Case Reviews have shown that families can use practitioners' anxieties about cultural sensitivity as a deterrent, by accusing them of racism or not understanding their culture. It is important to explore and understand a family's cultural belief systems, but it should never lead to toleration of abuse.

- Be aware - some families, including those recently arrived from abroad, may be unclear why they have been asked to attend a meeting or why you are visiting them at home. They may not be aware of the roles that different practitioners and agencies play or that the local authority and partner agencies have a statutory role in safeguarding children.

- Communicate clearly, to ensure that resistance or non-compliance is not caused by any misunderstanding. "Ask yourself: What were the reasons for the parents' behaviour? Are

there other possibilities besides the obvious? Could their behaviour have been a reaction to something I did or said?

- Recognise when the family is not engaging - early recognition of resistance and failure to achieve progress with plans and agreements for the child is critical. Be clear about the level of engagement.

- Always consider the 'so what?' for the child if the parent/ carer does not engage.

> Always consider the 'so what?' for the child if the parent/carer does not engage.

- Where there are child protection concerns explain to parents / carers that lack of co-operation is unacceptable.

- Be persistent; if one approach isn't working think of an alternative e.g., visit at a different time of day, arrange to meet in a neutral environment, remove your badge so it's not visible, encourage the parent to have someone with them for support, check with other professionals what has already been tried.

> Be persistent.

- When working as part of multi-agency team consider who is best placed to try to build a relationship with the parent/ carer to limit the number of people trying to make contact.

- Undertake joint visits with colleagues or other practitioners – 'fresh pair of eyes.

- Record and share all decisions early, regularly update services and share information of progress with engagement.

- Where cases are stuck or there is disagreement, agencies should meet with each other to consider what is happening in the case.

> "Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision". [Working Together 2015 p.16].
>
> Where non-compliance is an issue, sharing information across agencies can assist in forming a plan to address this.

In circumstances where there is evidence of extreme resistance to the extent of disguised compliance

- Be a curious practitioner - question the information being provided by families. Check the validity of information with other agencies, do not be overly optimistic over changes that have yet to be sustained - retain a clear focus on achieving outcomes for the child.

- Authoritative practice –respectful uncertainty and healthy scepticism. Establish the facts and gather evidence about what progress is being made.

Authoritative Practice – respectful uncertainty, healthy scepticism. Establish the facts and gather evidence about what progress is being made.

- Use supervision to explore the dynamics of non-compliance and to plan how best to address the situation including alternative strategies, possible specialist assessments and how the work impacts on the practitioner.

Practitioners should consult a manager if access to children is ever denied, or appointments repeatedly cancelled and/or 'forgotten'.

Practice Guidance6

Indicators and Examples of 'disguised compliance'

- Parents agree with professional concerns and the changes needed but put little effort into achieving them.

- No significant change at reviews despite significant input. Change does occur but because of external agencies/resources not the parental/carers efforts.

- Families have short periods of superficial co-operation drawing attention away from concerns.

- Parents/carers engaging with certain aspects of a plan - selective co-operation, focusing on some issues, engaging with only some services or professionals.

- Parents/carers manipulating and splitting professional relationships.

- Appointments made but then missed, often with plausible explanation.

- Attention diverted away from the child towards parent's problems.

- Parents avoid engagement, for example claiming not to receive voicemails or missed calls.

Case Study - Sam aged 12 years and her 2 younger siblings were the subject of multi-agency intervention due to prolonged concerns about neglectful parenting. Sam was also at risk of sexual exploitation.

Sam's grandmother died unexpectedly 4yrs ago. Sam's mother has experienced other significant trauma during her life requiring involvement of statutory agencies - she has not engaged effectively with professionals in respect of the care of her children for many years due to her high level of distrust. The strategies she has used to distract professionals from focusing effectively on the needs of her children have included:

- Agreeing but cancelling planned visits based on anniversaries related to bereavements – sometimes these anniversaries did not match up with the facts
- Referencing her own trauma and distrust of professionals having the effect that practitioners felt unable to challenge and their attention was diverted to supporting her rather than focussing on the children.
- Citing the difficulty of caring for a disabled child as a reason for poor home conditions and missed appointments, but refusing care packages when offered
- Making it difficult for practitioners to see the children by ensuring they were unavailable on scheduled visits
- Splitting professionals by telling them different things and only agreeing to see certain individuals
- Making complaints against professionals which led to them lacking confidence to challenge
- Professionals sometimes felt paralysed by the fear that she would harm herself if they upset her.

- Conflicting accounts received from children, family members and different practitioners.

- Parents/carers making complaints against professionals which lead to professionals lacking confidence to challenge.

Risks and Pitfalls – of working with 'disguised compliance'.

- Not suspecting 'disguised compliance' - parents can be very skilled at diversion.
- Failing to question or verify parent's claims, increasing the opportunity for disguised compliance.
- Being judgemental - making assumptions as to why the family are being resistant to engage.
- Poor recording and communication between practitioners making disguised compliance more difficult to detect.
- Practitioners having difficulty in understanding the lived experience of the child because of barriers to meaningful 'contact' with the child.
- The needs of the adults eclipsing the needs of the child. Removal of focus from the child/ren i.e., disguised, or superficial compliance leading to a focus on the adult's engagement with services rather than the safety and welfare of the children.
- Holding a fixed view of a case distorting the way information is interpreted.
- Over-optimism emphasising positive information while minimising or filtering out negative information makes it hard to be a 'curious practitioner' and challenge what is happening to the child or to make timely interventions(drift).
- Being insufficiently persistent in trying to contact the family.
- Feeling out of depth and unsure what to try next.
- Responding/rising to the behaviours e.g., by raising voice.
- Reducing or downgrading in concern on the part of the professional allowing cases to drift.
- Closing the case with no further action

Appendix 1[35]. **Experiences of neglect by age group**; the examples are intended to give an overview of what children may experience rather than provide an exhaustive list of ways in which neglect may present.

Age Group	Medical	Nutritional	Emotional	Educational	Physical	Lack of Supervision
0-2 years	Includes failure to notice that a baby is unwell, and failure to seek medical treatment. Not attending routine health screening appointments may be indicative.	Under-nourishment leads to restricted growth and brain development. There can be a link between neglect and obesity, e.g., if parents use sweets as 'pacifiers.'	Lack of stimulation can prevent babies from 'fixing' neural connections	Infant attachments are damaged by neglect, which makes learning skills more difficult Some parts of the brain, e.g., cortex, are dependent on experience and stimulation to develop. Language relies on reinforcement and feedback from carers.	Dirty home conditions may affect infant immune system; lack of changing and nappy rash; lack of encouragement may delay skill development.	Babies should always be supervised, particularly when lying on surfaces they could fall from or in the bath. If babies feel abandoned, this can affect the development of attachments.
Pre-School 2- 4 years	May include missed health and dental appointments, and failure to seek medical treatment following accidents or for routine conditions such as head lice or squints.	Not eating 1200 – 1500 calories per day, and/ or unregulated amounts of fat and sugar in the diet, which can lead to heart problems, obesity, and tooth decay.	Neglected children without a secure attachment may experience difficulties playing with their peers, sharing feelings and thoughts, coping with frustration, and developing empathy.	Neglect can be a significant factor in delaying a child's language development e.g., through the amount and quality of interactions with carers. This delay affects their education.	Child may present as dirty or malnourished, and living conditions may be poor. Child may not have been toilet trained, sleeping sufficiently or have adequate boundaries.	Home may lack safety devices e.g., stair gates, dangerous items such as drugs or knives may be within reach, child may not have appropriate car seat, child may be left home alone.
Primary; 5-11 years	Children may have more infections and illnesses than their peers due to poor treatment, or lack of prevention e.g., through hand washing, good diet, or adequate sleep.	Food is not provided consistently, leading to unregulated diets of biscuits and sweets. Concerns should not just focus on weight; children of normal weight could still have unhealthy diets.	Insecure attachment styles can lead to children having difficulties forming relationships and may express their frustration at not having friends through disruptive behaviour.	Neglected children can experience several disadvantages at school, including low educational aspirations, lack of encouragement for learning and language stimulation.	Ill-fitting, inadequate, or dirty clothing, poor personal hygiene, lack of sleep, lack of routines or boundaries which can lead to frustration with school rules and boundaries.	Primary school children may be left home alone after school or expected to supervise younger children. They may be left to play outside alone or to cook meals without supervision.
Adolescent; 12+ years	Poor self-esteem and recklessness can lead to ignoring or enduring health problems rather than accessing services. There may also be risk-taking behaviour e.g., in sexual activity.	Adolescents may be able to find food, but lack of nutritious food and limited cooking experience can lead them to unhealthy snacks, which affects both health and educational outcomes.	Peer groups and independence are important at this age; young people who are isolated by neglect (e.g., through poor hygiene) will struggle. Conflict with carers may also increase.	Likely to experience cognitive impairment e.g., in managing emotion, challenging behaviour in school. Low confidence and academic failure can reinforce negative self-image.	Adolescents' social development is likely to be affected by their living conditions, inadequate clothing, poor hygiene, and body odour. This can affect their self-esteem.	Neglected adolescents may stay out all night with carers not aware of their whereabouts, which can lead to opportunities for risk taking behaviours that can result in serious injury.

[35] Howarth

Appendix2

BURY THRESHOLD OF NEED - NEGLECT

Relationship between Graded Care Profile2[36] and the Bury Threshold Document – Neglect.

The Bury Threshold Neglect document is a simple observational tool informed by the theoretical model underpinning the Graded Care Profile2 (GCP2) and the work of Prof. Jan Howarth.

It can be used by any frontline practitioner to aid early recognition and identification of parental neglect and to give an indication of the seriousness of potential neglect.

It should not be used in place of a detailed assessment of quality of parental care as provided by application of GCP2 - nor to assess parental capacity to change.

The sole purpose of the 'Bury Threshold Document – Neglect' is promotion of *early* recognition and identification of child neglect. It describes the quality of parenting and complements the Horwath Framework which describes the risk factors indicative of neglect in the presentation of children.

[36] The Graded Care Profile2 - Drs Polnay and Srivastava.

Bury Threshold of Need – Neglect

	UNIVERSAL L1	UNIVERSAL PLUS L2	EARLY HELP (MULTI-AGENCY PARTNERSHIP) L3	FAMILY HELP SOCIAL WORK LED MULTI-AGENCY PARTNERSHIP L4	SPECIALIST AND SAFEGUARDING SERVICES L5
PHYSICAL CARE • **FOOD**	Parent/Carer provides high quality nutrition. Quantity appropriate for age/development of child. Special dietary requirements always met. Meals are well prepared and organised. Child always put first. Family routinely eats together, eat at regular times.	Parent/Carer provides reasonable quality nutrition, quantity appropriate for age/development of the child. Special dietary requirements usually met. Child's needs generally put first. Family sometimes eats together, eat at regular times.	Parent/Carer requires help to provide reasonable quality nutrition consistently. Most of the time there is adequate quantity. Parents require help to ensure special dietary requirements are met. Family rarely eats together, and mealtimes may be irregular.	Parent/carer mainly provides poor quality nutrition. Only occasionally is food of a reasonable standard. Quantity is variable – too little or too much. Special dietary requirements not met. Limited preparation or organisation of mealtimes - irregular mealtimes.	Parent/Carer does not consider the quality of nutrition provided to child. May lie about quality of food provided. Child regularly unfed or routinely overfed. Special dietary requirements not met /ignored. No preparation or effort made e.g., child lives off No organisation, children eat what and when they can.
• **HOUSING**	Essential facilities present and additional facilities available. Home exceptionally well maintained and always clean.	All essential facilities present. House reasonably well maintained and generally clean.	Most essential facilities are present. House adequately maintained but repairs and some redecoration required. Most of the time house is reasonably clean.	Most essential facilities not present. House in disrepair, even though parents/carers could fix it. Most of the house dirty – including child's bedroom. House in need of significant redecoration.	No essential facilities leaving child unsafe. House in state of dangerous disrepair The house is dirty, smelly and in need of complete redecoration.

	UNIVERSAL L1	UNIVERSAL PLUS L2	EARLY HELP (MULTI-AGENCY PARTNERSHIP) L3	FAMILY HELP SOCIAL WORK LED MULTI-AGENCY PARTNERSHIP L4	SPECIALIST AND SAFEGUARDING SERVICES L5
PHYSICAL CARE • **CLOTHING**	Child very well protected from weather conditions.	Child has weather protective clothing	Most of the time the child is adequately protected/dressed for the weather.	Clothes do not usually provide adequate protection from weather conditions.	No suitable clothing.
	Clothes fit well. Clothing exceptionally well cared for, clean and ironed.	Clothes fit well enough. Clothes usually cared for and usually clean.	Clothes do not always fit well. Clothes not always cared for and not always clean.	Clothes rarely well-fitting and are usually dirty, crumpled, and uncared for.	Clothes always poorly fitting, always dirty, crumpled and in disrepair.
• **HYGIENE**	0-4 yrs. Child always bathed, groomed and clean.	0-4 yrs. Child bathed regularly and usually clean.	0-4 yrs. Most of the time the child is clean.	0-4yrs. Most of the time child is unwashed, often 'smelly'.	0-4yrs. Child seldom bathed or washed, always dirty and smelly.
	5 – 10yrs. Parent/Carer takes active role in hygiene needs; child is supervised, encouraged and clean.	5 -10yrs. Parent/carer reminds child and provides all necessary items. Child usually clean.	5-10yrs. Most of the time child is clean, occasional lapses in parental involvement.	5-10yrs. Most of the time, little parental involvement in child's hygiene needs. Child dirty and smelly.	5 -10yrs. Parent/carer shows no concern or awareness. Child dirty and smelly.
	11yrs+. Parent/Carer reminds child about hygiene needs, checks. Provides all necessary toiletries.	11yrs+ Parent/Carer reminds child. Provides all necessary toiletries.	11yrs+ Parent/Carer inconsistently reminds child, provides basic toiletries.	11yrs+ Parent/Carer rarely reminds child, provides minimal toiletries.	11yrs+ Parent/Carer ignores child's needs/ doesn't remind child/unconcerned. Does not routinely provide toiletries.

	UNIVERSAL L1	UNIVERSAL PLUS L2	EARLY HELP MULTI-AGENCY PARTNERSHIP L3	FAMILY HELP SOCIAL WORK LED MULTI-AGENCY PARTNERSHIP L4	SPECIALIST AND SAFEGUARDING SERVICES L5
MEDICAL/HEALTH	All ante-natal appointments kept.	Some ante-natal appointments missed.	Many ante-natal appointments missed.	Majority of ante-natal visits missed. Lack of preparation for birth.	All or most ante-natal appointments missed. Lack of preparation for birth.
	Parent/Carer seeks medical advice when child is ill and follows medical advice. All health appointments kept including dentist and optician. Visits clinic regularly. Immunisations up to date. Parent/Carer seeks advice in addition to scheduled health and development checks.	Parent/Carer seeks suitable medical advice when child is ill - but advice not always followed. Parent/Carer may require reminding to register child with GP/Dentist. Usually up to date with health and developmental checks and dental, optician visits - most appointments kept, quickly rearranges if unable to attend.	Parent/Carer does not always seek medical advice when child is ill - may not always follow medical advice - may require reminding to register child with GP/Dentist. Often misses appointments, may delay rearranging. Needs to be reminded to keep child's health and development checks - including dentist and optician.	Parent/Carer does not register child with GP/Dentist even when reminded. Frequent inappropriate or delayed medical presentations. Frequent significant illness/infections/injuries Parent/Carer does not take child for follow up health appointments, or health and development checks, including dentist and optician. Needs constant reminders and to be checked to ensure attendance.	Persistent refusal by Parent/carer to register child with GP/Dentist/ Parent/Carer only seeks medical advice when child critically ill or not at all. Does not attend follow up appointments. Always needs reminding. May give misleading explanation. Home visits are not accepted by parents/carers or avoided.
	In the event of disability or chronic illness the parent/carer adheres to medical advice.	In the event of disability or chronic illness generally adheres to medical advice.	Mostly adheres to medical advice related to chronic illness or disability.	Most of the time poor adherence to medical advice related to chronic illness or disability.	No adherence to medical advice related to chronic illness or disability – or lies about adherence.

	UNIVERSAL L1	UNIVERSAL PLUS L2	Early Help (Multi-Agency Partnership) L3	FAMILY HELP SOCIAL WORK LED MULTI-AGENCY PARTNERSHIP L4	SPECIALIST AND SAFEGUARDING SERVICES L5
SUPERVISION/SAFETY **PRACTICAL SAFETY FEATURES IN HOME** **PARENT/CARERS SAFETY RELATED BEHAVIOUR.**	All necessary safety equipment and safety measures in place and always used.	Most safety equipment and safety measures in place and usually used.	Poor attention to supervision and safety issues – safety measures inconsistently used.	Insufficiently protective - minimal safety measures in place and rarely used. Supervision poor.	Careless disregard for safety. Child dangerously exposed to harm in and out of the home.
PRE-SCHOOL YEARS	Child protected from danger in and out of the home.	Child generally protected from danger in and out of the home.	Child inconsistently protected from danger in and out of the home.	Child not sufficiently protected in or out of the home	Child exposed to danger no protective measures in place.
PRIMARY SCHOOL	Always vigilant, effective measures against all perceived dangers.	Usually vigilant, effective measures against obvious imminent dangers.	Mostly vigilant - most of the time measures taken against obvious imminent dangers - but not always effective.	Not usually vigilant - most of the time few or ineffective measures – child inadvertently exposed to danger.	No supervision only intervenes after accident - no safety measures put in place subsequently.
SENIOR SCHOOL	Child always closely supervised.	Child not supervised if known to be in a safe place.	Some supervision most of the time only intervenes when there is obvious danger.	Most of the time minimal supervision - intervenes only after accident.	Parent/Carer not bothered despite knowledge of dangers or only bothered if child is out late at night or has not returned.
	Parent/Carer allows child out in safe surroundings within agreed timescales. Parent/Carer makes frequent checks.	Parent/Carer allows child out in unfamiliar surroundings if believed to be safe, checks at agreed times.	Most of time Parent/Carer aware of child's whereabouts. Does not always check.	Most of the time Parent/Carer not concerned about child being 'out' in the day, only concerned about late nights. Does not always check whereabouts.	

	UNIVERSAL L1	UNIVERSAL PLUS L2	EARLY HELP (MULTI-AGENCY PARTNERSHIP) L3	FAMILY HELP SOCIAL WORK LED MULTI-AGENCY PARTNERSHIP L4	SPECIALIST AND SAFEGUARDING SERVICES L5
SUPERVISION/SAFETY **ONLINE SAFETY**	All available measures in place, electronic updates. Parent/carer closely monitors child viewing.	Safety measures often in place. Parent/carer usually monitors electronic updates and child viewing.	Some safety measures in place, but parent/carer only inconsistently monitors what child is viewing.	Parent /carer has casual approach to online safety. Does not ensure safety measures in place and does not monitor child viewing.	Careless disregard, despite understanding the dangers of online safety by carer.
SAFETY IN ABSENCE OF PARENT/CARER	Parent/Carer only leaves child with suitable adult with whom child is familiar.	Parent/carer leaves child with suitable and able adult or older sibling.	Mostly suitable childcare arrangements are made. Some effort made to ensure potential alternative carers are suitable.	Mostly unsuitable childcare arrangements, parent/carer makes little effort to ensure suitability or ability of alternative carers.	Careless disregard for childcare arrangements. Parent/Carer makes no effort to ensure suitability of alternative carers or disregards known concerns or leaves child alone.

	UNIVERSAL L1	UNIVERSAL PLUS L2	EARLY HELP (MULTI-AGENCY PARTNERSHIP) L3	FAMILY HELP SOCIAL WORK LED MULTI-AGENCY PARTNERSHIP L4	SPECIALIST AND SAFEGUARDING SERVICES L5
EMOTIONAL **PARENT/CARERS RESPONSIVENESS**	Positive attachments between parents/carers and child. Parent/Carer anticipates all cues and responds promptly and warmly to child	Parent/Carer understands clear signals, responses warm and well timed.	Most of the time parent/carer has some sensitivity – cues from child may have to be obvious to have an effect. Most of the time parent/carer responses are timely but sometimes are delayed or absent.	Most of the time parent/carer is insensitive, signals need to be repeated or prolonged from child to get a response. Parent/carers responses are usually delayed. Carer is not usually warm or responsive – unless child is distressed.	Parent/Carer is insensitive to even sustained intense signals – or aversive. No responses from parent/carer even when child distressed. Parent/carer may be punitive even when child distressed.
MUTUAL ENGAGEMENT	Parent/carer and child initiate interaction – although usually more so parent – mutual enjoyment, parent putting in extra effort to ensure the child's happiness	Parent/carer and child equally initiate the interaction, mutual enjoyment, parents respond even if the child is being difficult.	Parent/ carer and child initiate the interactions — usually more so from child. Parent less responsive if child is being difficult. Sometimes parent/carer does not interact with child with enthusiasm.	Child instigates majority of interactions with parent/carer. The interaction is mostly only functional - little enjoyment from child or parent/carer; Parent can appear indifferent.	Child is avoidant, resigned, or apprehensive. Poor interaction between parent and child; parent/ carer is aversive or emotionally cold. No pleasure from interactions, for either parent/carer or child.

	Universal L1	Universal Plus L2	Early Help (Multi-Agency Partnership) L3	Family Help Social Work Led Multi-Agency Partnership L4	Specialist and Safeguarding Services L5
Education/ Learning	Child has excellent access to age-appropriate books and toys. Parent/carers provide consistent support to child to learn. Child engaged in education, employment, or training if left school Child regularly attends nursery/school or is in full time employment. All milestones for cognitive development are met. Child on track to achieve educational potential .	Child has access to stimulation and early developmental experiences. Parent/carers support child to learn. Child engaged in education, employment, or training if left school but some evidence of poor punctuality or early years/school attendance. Not all milestones for cognitive development are being met.	Child has limited access to appropriate stimulation and early developmental experiences. Parent/carers provide inconsistent and limited support to child to learn. Child has poor punctuality or early years/school attendance. Poor educational progress despite support. Parent/Carer not supporting child/YP to access appropriate leisure activities. Milestones for cognitive development not being met.	Parents/carers unable or unwilling to ensure child accesses early learning experiences - despite support. Parent/carers unable or unwilling to support child to learn or access appropriate leisure activities. Persistence of poor punctuality and/or school attendance of child despite support. Unexplained absence from school. Parents/Carers condone absence from school. Child tired in school. Milestones for cognitive development not being met despite support.	Parents/Carers denies child access to stimulation. Persistence of poor punctuality and/or school attendance despite support. Persistent parentally condoned absence from school. Child/YP NEET (for more than 6 weeks). Child always tired in school. Milestones for cognitive development not being met.