

**4 year Longitudinal
evaluation of the
Action for Children
UK Neglect Project**

**Outcomes for the
children, families,
Action for Children,
and the UK**



**FINAL
REPORT**
January 2012

**Four year longitudinal evaluation of the Action
for Children UK Neglect Project**

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**Tony Long
Michael Murphy
Debbie Fallon
Joan Livesley
Patric Devitt
Moira McLoughlin
Alison Cavanagh**

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THE PROJECT TEAM

Dr Tony Long is Professor of Child and Family Health. A Registered Child Health Nurse, his personal research programmes are in evaluation of early intervention in health and social care services for children and families, parental coping, and clinical research on quality of life outcomes for children and families after treatment for cancer.

Michael Murphy is Senior Lecturer in Social Work. A qualified social worker and counsellor, he has wide experience in dealing with substance misuse, looked after children, chaotic families, and safeguarding children, and has published widely in these areas. He acts as a training consultant to several training organisations, is Chair of Bolton Substance Misuse Research Group, and was an executive member of PIAT.

Dr Debbie Fallon is Senior Lecturer in Child Health and is the co-lead for CYP@salford taking the lead on research with young people. Her research interests span health (particularly sexual health) social care and education issues for young people, She is published in the field of teenage pregnancy and sexual health and is a Trustee at Brook (Manchester) and for The Association for Young People's Health.¹

Dr Joan Livesley is a Senior Lecturer in Children's and Young People's Nursing and is published in the field of children in hospital, multi-agency working for children's services and evidence-based practice. She undertakes research in partnership with children and young people. She has a clinical background in services for children in hospital and the community, she has professional links with community children's services.

Patric Devitt is Senior Lecturer in Child Health with a clinical background in children's nursing working particularly with children with cancer and their families. He is a member of the steering group of the Royal College of Nursing's Research in Child Health Group. He researches the quality and effectiveness of services for children and families, and also investigates safety issues for children.

Alison Cavanagh is Lecturer in Child Health. Alison is a Registered Nurse in Child Health and Counsellor in training. Alison has a clinical background as a school health advisor/ nurse and wide experience working in the community, particularly in safeguarding services.

Moira McLoughlin is a Senior Lecturer in Children and Young People's Nursing. A registered children's nurse for over twenty years she is currently undertaking a PhD in a specific aspect of safeguarding and has developed and published teaching resources for both students and qualified staff in this area of practice.

<http://www.salford.ac.uk/nmsw/research/children,-young-people-and-families>

¹ Now University of Manchester. debbie.fallon@manchester.ac.uk

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EXECUTIVE SUMMARY

BACKGROUND TO THE EVALUATION

During a 5-year intensive family support (IFS) programme to provide effective, lasting intervention for families and children most in need Action for Children created a redefined focus on neglect in a selection of sites across the UK: the UK Neglect Project. The intention was to improve outcomes for children whose developmental needs were being insufficiently met, placing them at risk of poor educational, emotional and social outcomes. An earlier evaluation² reported that IFS could “*make a positive difference to the lives of children and their families in even the most challenging circumstances*”. This evaluation was designed to establish the factors that made this possible. A four-year longitudinal evaluation was commissioned which would allow researchers to follow families from referral to closure, and to pursue the work of individual sites over a period of development of working practices.

EVALUATION OBJECTIVES

- 1) To gather detailed evidence on the circumstances in which families are referred for intervention and the wide-ranging assessment of family needs and problems; the interventions applied; and the outcomes for children.
- 2) To correlate key factors at a population-level identified at the assessment phase with eventual disposition on closure and outcomes for the child. (eAspire data)
- 3) To identify correlation between presenting factors, interventions, and outcomes from individual case file Action for Children Assessment Tool scores.
- 4) To secure illuminating detail from textual data in case files to explain findings from quantitative data.

² Tunstill J, Blewet J, Meadows P (2008) *Evaluating the delivery by Action for Children of targeted family support*. Synergy Research and Consulting Ltd.

- 5) To identify worthwhile hypotheses for further research.

METHOD

The evaluation was based on quantitative recording of the level of concern about neglect in 14 areas at least on referral and on closure; electronic recording of key characteristics of the child, the parents and the environment; and review of textual data in files for detail of issues on referral, specific interventions, and evidence of outcome for the child. Serial review of the files and scores allowed for the longitudinal recording of progress, or lack of it, in each case.

An integral part of the project was to work with Action for Children to enhance the quality of data through the introduction of a new assessment tool and development of additional elements of the standing in-house electronic database; and to improve practice and outcomes through shared learning.

The inclusion criteria were that children were under the age of eight years, and neglect had been identified explicitly by the referring agency or on assessment. The customised Action for Children Assessment Tool was employed with all cases. Eighty-five cases were included from seven sites across the UK.

OVERVIEW OF FINDINGS

The Action for Children Services that were included in this evaluation demonstrated their ability to intervene successfully in most cases of neglect, even when neglect was a most serious concern (to the level of child protection intervention). In cases where parents refused or were unable to respond positively, children benefited from an expedited move into care.

- Prevention of neglect or improvement in the level of concern about neglect was shown in 79% of cases. Only in 21% of cases was no improvement made.
- In 59% of cases, concern about neglect was removed completely.

- In a further 9% of cases, intervention to prevent the expected development of neglect was successful.
- In the remaining 32%, concern about neglect remained on closure of the case. Most of these resulted in children being taken into care, though even among these a small proportion showed some improvement. The remaining cases in which concern remained were returned to the referring agency for continued work on the Action for Children action plan.

The most common problems identified as serious causes for concern were chaotic family lifestyles with absence of routines and poor home conditions. Poor hygiene

and domestic violence were also common factors. A combination of parenting programmes and home-visiting was the mainstay of intervention. The ability and willingness on the part of parents to engage with services was a crucial factor in deciding whether progress would be made or children removed for accommodation.

The Action for Children Assessment Tool enabled practitioners to work with parents to establish a joint understanding of problematic aspects of parenting and to plan for staged improvements. It also provided a valuable source of evidence of objective assessment and review.

Further work is needed to investigate the impact (immediate and longer-term) on children.

1 INTRODUCTION

Public inquiries and other reviews repeatedly show that following early identification of neglect, some children and families fail to receive adequate services, sometimes with tragic consequences. Since neglect is the most common category for child protection registration in the United Kingdom (Department for Education (DFE) 2011a), it is vital that intervention is both timely and effective. However, successful intervention to improve parenting ability, to establish appropriate intra-family relationships, and to secure positive outcomes for children “is likely to be costly, requiring intensive, long-term, multi-faceted work by a highly skilled workforce” (Moran 2009). If these factors can be addressed, then positive outcomes are possible. There is recent evidence, too, that when neglect is entrenched and timely assessment shows that the family situation is unlikely to change, then intervening to take children into care earlier rather than later improves outcomes in later (young adult) life (Hannon et al 2010). Both in cases where neglect can be addressed successfully and in cases where there is no indication of likely improvement, skilled, early intervention is the vital factor.

However, there is sparse research evidence on the most effective means of preventing or reducing neglect and its adverse outcomes. Reliance on studies from the US risks basing practice on non-transferable evidence which may not necessarily relate well to the political, legal and socio-economic context of British services. Variation in the way in which neglect is defined, including the scope of what is included in the definition, causes additional difficulty in interpretation and implementation of findings (Stein et al 2009). Failure to distinguish between neglect and other aspects of abuse further confuses the issue. Reports of interventions with vulnerable families often fail to distinguish between cases where neglect is the concern and more generalised cases of abuse.

Such studies as have been completed have tended to be of short duration: snapshots of activity and outcomes. A literature review for the former Department for Children Schools and Families (DCSF) established that most research evidence was retrospective, focused on proxy measures of outcomes (rather than direct observation), and were small in scale (Daniel et al 2009).

During the course of this and other related studies, it has become clear to the research team that in working with families which operate in a multi-dimensional type of chaos, child care teams and whole systems can become drawn into “mirroring” parts of that family chaos. In the middle of this mirroring, it can become difficult to maintain focus, to measure progress, or to measure decline in functioning in the child or the family. This may help to account for the “bulging thresholds” phenomenon, where levels of intervention have not escalated despite significant deterioration in the child’s situation. This also has an impact on researching what works with neglectful families. The mirroring of chaos can lead to difficulty in obtaining clear and logical data to measure outcomes. In this study, the use of a problem-specific assessment instrument together with associated training and ongoing support both centrally and locally helped to counteract this effect.

Managing neglect is complex, and simple approaches to intervention are likely to be insufficient. The chronic and multi-faceted nature of the problem necessitates a holistic, joined-up approach with a blend of services tailored to individual needs, often over a long period of time. Since the nature of neglect often demands longer-term intervention for sustained improvement to be achieved, then a longitudinal approach to evaluation is also indicated.

2 REVIEW OF EXISTING EVIDENCE

DEFINING NEGLECT

In comparison with other forms of maltreatment of children, neglect is complex and challenging to define (Moran 2009). The working definition provided in “Working Together to Safeguard Children” is well known and had been retained and reaffirmed as central guidance for several years.

“The persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs” (Department of Health 1999).

This definition was adopted by the project and the evaluation as the basis for decision-making. A rough rule-of-thumb version was also agreed: *“Neglect occurs when the basic needs of children are not met, regardless of cause.”* In an important practical sense this was helpful to practitioners. It brought attention squarely onto the impact on the child and reinforced the issue of parental fault or intention not being necessary for the child to suffer neglect.

The definition of neglect was revised in 2010.

“Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance misuse. Once a child is born, neglect may involve a parent or carer failing to:

- *Provide adequate food, clothing and shelter (including exclusion from home or abandonment);*

- *Protect a child from physical and emotional harm or danger;*
- *Ensure adequate supervision (including the use of adequate care-givers); or*
- *Ensure access to appropriate medical care or treatment.*

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs” (DCSF 2010).

UNDERSTANDING SOME DIFFERING ASPECTS OF NEGLECT

Growing understanding of the complexity of neglect and its contributing factors has led to categorisation of types of neglect, though the implication of some classification has not always been clear. In a review of definitions of neglect, Horwarth (2007) identified the following domains.

- Medical neglect – minimising or denial of a child’s health needs
- Nutritional neglect – often associated with failure to thrive or, more recently, obesity and lack of exercise
- Emotional neglect – being unresponsive to the child’s basic need for emotional interaction and support, perhaps causing damage to the child’s self-esteem
- Educational neglect – lack of normal stimulation in early years, failing to ensure attendance at school and to support learning in middle childhood
- Physical neglect – failure to provide appropriate living conditions, food, and clothing.
- Lack of supervision and guidance – inadequate supervision to ensure the child’s safety, and in later childhood not providing essential information and guidance about common risks (for example, alcohol misuse).

These help to specify aspects of care that may be the focus of neglect, and all of these featured in the referral, assessment and intervention reported in the cases in the evaluation.

A different approach was taken by Crittenden (1999) in seminal work on the causes and response to neglect. She considered both the cause and the manifestation of neglect and offered the following three common presentations.

Disorganised neglect

Crittenden described this as occurring in multi-problem, disorganized, crisis-ridden families, a common problem faced by family intervention projects. She noted that parents often appear to recognise their need for help, and they welcome professional intervention. Evaluation of a raft of family intervention projects indicates that this welcome is dependent, however, upon a respectful approach from practitioners, showing value for the parents (Ravey et al 2008) and placing equal priority on family-identified problems (Livesley et al 2010). Parents' feelings dominate behaviour, leading to inconsistent and unpredictable care of children. In response, children become more demanding in order to gain their parents' attention, sometimes in increasingly dramatic behaviour.

Successful management of such cases relies upon developing trust and both introducing and modelling consistent, predictable care. Alternative strategies will be introduced to offer more effective and positive ways for parents to manage the children's behaviour, and intensive, often prolonged, coaching to set boundaries and to provide structure to the family's day.

Emotional neglect

In emotional neglect, families might be seen to be materially relatively advantaged but the children suffer from their parents' failure to connect with them emotionally. Children know their roles, respond to clear rules, and often do well at school. Their physical needs are usually met, but their emotional needs remain unfulfilled. In the absence of empathic responses from parents, children may appear falsely bright and self-reliant, but on closer examination

they demonstrate poor social relationships with peers and with adults. It is not uncommon, in due course, for children to become carers of their parents. In doing so they may become strongly resistant to what is perceived as interference from services seeking to intervene to improve the parenting ability.

Case management is directed at helping parents to learn to access other sources of support and to reassert an appropriate parent-child relationship when necessary. It is often necessary to teach and coach parents to engage with their children emotionally.

Depressed neglect

Clinical depression in parents, with many varied causes, can be disabling such that parents may become unable to perceive their children's needs or to believe that any positive change is possible. They may appear unable to understand what is required of them and clearly lack motivation. Parents may feed, change and move children but rarely respond to signals from them. In the absence of response to their prompts, children may themselves become silent, limp, dull and depressed.

Affected children benefit from access to responsive and stimulating environments, so placements in day care are part of the solution. Building resilience in this way is key to their longer-term wellbeing. Treatment of depression tends to take much time, and little improvement may be expected in the short term. Nevertheless, coaching to practice simple interactive strategies (smiling, soothing and so on) may be effective with persistence.

Categorisation can be deceptive

Evidence about parental characteristics associated with neglect has been found to be particularly complex, and the types identified above may appear deceptively clear-cut. Naturally, the diagnosis of depression is to be left to those qualified to undertake such a skilled activity, but health visitors have been found to be well-equipped to recognise both the parental characteristics associated with neglect and the signs in children of developmental problems (Daniel et al 2009).

EFFECTIVENESS OF RESPONSES TO NEGLECT

Although most families can go through periods of relative neglect (Department of Health (DH) 1995), it is usual that the families which come to the notice of safeguarding systems have shown signs of neglectful interaction between parents and children over a number of years. Although there is some evidence to indicate that cognitive or behavioural approaches can be helpful within some parenting programmes, there is little evidence to suppose that most short-term intensive approaches work in the field of neglect, thus longer-term interventions seem to be more productive. However, organising and resourcing longer-term interventions can be particularly challenging to child care systems as most interventions around physical and sexual abuse have a relatively short intervention period. Neglect is characterised by repeated need for intervention, and families require long-term support. If families need to be in receipt of continuous services, this involves significant demand on practitioner time, interagency collaborative effort and emotional energy.

In the face of families with complex, multi-faceted problems, child care systems have to develop multi-faceted plans, seeking to deal with more than one aspect of concern at a time. This leads to three different challenges. The first is that child care interventions of all kinds seem to be less productive in the face of numerous competing problems. The second is that these different problems interact with each other to amplify child care difficulties within families. The third is that the complexity of interwoven problems in families leads to great difficulty in measurement and response by child care systems

These complex series of relative judgements often lead to a lack of agreement on the threshold for intervention, particularly at safeguarding and care stages of intervention (Platt 2006, Stevenson 2007). The intent to harm is not always present, but neglect may overlap with other forms of maltreatment. The presence of physical or sexual violence may lead to a decision to

move to a higher threshold, but sometimes it is the day-to-day neglectful interactions that lead to the most harm to the child (Platt 2006).

WHY IS NEGLECT NEGLECTED?

Assessment

Assessing a family's private domain is always difficult. The British safeguarding system was originally established to measure acts of commission – particularly around physical or sexual violence. Assessing neglect involves measuring a complex series of acts of parental omission and their subsequent impact on the child's development and wellbeing. This assessment attempts to measure collectively three areas of parental omission – provision, protection and emotional availability.

As part of the assessment, the assessors must decide if the interaction they are dealing with involves neglect, and at what threshold the child care system should respond. As well as measuring parental omission, the assessment attempts to measure the impact of that level of parenting on the child's development, safety, attachment and self-esteem. The true impact of neglect may not be apparent immediately, but may take months to become clear. This demands an understanding of the concept of neglect in relation to child development and its evidence base. It also requires an appraisal of parenting capacity, and parental capacity to change in relation to the developmental timetable of the child. If the impact of neglect is slow to become apparent, and the system around neglect is relatively reluctant to become involved in early stage interventions, the child can be many months old before the system gets to grips with the family situation (Horwarth 2007, Platt 2006).

Analysis

The analysis of the assessment of a neglectful family can also be difficult, if analysis is taken to be the ability to apply a collective meaning to gathered data. Difficulties in definition, difficulties in making judgements about highly complex and chaotic family situations, and finally

the difficult task of making judgements against changeable thresholds (Macrory & Murphy 2011) can make the analysis and decision-making process especially complicated.

Neglect is not absolute. It is not scientifically measureable. It is always relative and relies on a series of complex interagency judgements about 'normal' or 'average' levels of parenting in families. The Children Act 1989 offers a wide band of definition with 'significant harm' and 'reasonable parenting', which are matched with the latest "*Working Together*" report (HM Government 2010) which offers 'persistent [parental] failure to meet a child's basic needs' and 'serious impairment' of health or development (p39). A series of extra tools, including the Home Inventory (Cox & Walker 2002) and the Graded Care Profile (Pollnay & Srivastava 2001) have been developed, based loosely on Maslow's hierarchy of need, to assist in this process. Action for Children has used a modified version of the Graded Care Profile in its approach. However, all these tools depend on the practitioner's ability to analyse what they see of the family's private domain and to translate that into complex decisions about what is and is not child neglect.

Action

If measuring and analysing a neglectful family situation is beset with practice difficulty, then the collective action required to help families to change is also potentially problematic. The safeguarding system is set up to deal with the collaborative 'short sprint' between child protection inquiry, conference, core group and review conference. Neglect involves an interagency 'marathon' where practitioners and systems have to act collectively and respond to families over a number of years. This poses ongoing challenges to child care systems (Hallett & Birchall 1992).

Involvement with a family over a number of years can frequently find the practice group 'frozen' into a pattern of response that is not productive. If action is delayed to the end of the marathon it becomes difficult to truly assess, analyse and respond in a different way: to believe that

the situation has really become much worse; to recognise whether or not anything has changed significantly; and whether there is sufficient evidence to respond differently. This phenomenon of 'bulging thresholds' is particularly pertinent to neglect.

The intergenerational nature of neglect in many cases can mean that parents currently subject to professional concern and supportive intervention can have experienced seriously impaired levels of parenting which, in the absence of better knowledge and experience, they then replicate with their own children. Reder and Duncan (2001) note that, for some parents, "care conflicts" can be played out with their own children in response to normal demands from the children for levels of care which would be considered no more than minimally acceptable. One perspective on this intergenerational distress is the failure of attachment between parent and child that is sustained and replicated from one generation to the next.

In just the same way that attachment difficulties between parents and children can be a significant consequence of neglect, there can also be attachment difficulties between practitioners and the family. Working over a period of years with chaotic, unresponsive families can put significant emotional strain on those in the field. With parents who are persistently neglectful, notably those with substance misuse or domestic violence problems, children and practitioners may be prone to feelings of disappointment and anger at the lack of progress and repeated relapses (Hart & Powell 2006). This can be seen to be a manifestation of the emotional labour of working with neglectful parents, and the sustained effort and commitment required to pursue matters to a satisfactory conclusion draws heavily upon professional emotional resilience (Social Work Reform Board 2010).

Adult-orientation

In terms of child care systems, an adult-oriented issue is a problem with the adult parent that significantly impacts on their ability to deliver a consistent parenting service to the child. Substance misuse,

parental mental ill-health, domestic violence and learning disability can often be present and significant in cases of neglect. In terms of the neglect itself these issues can make the parent less available and responsive to the child. These issues can also intrude into the neglect response in four ways.

1) Child care staff are not used to measuring these issues and calculating their impact on the child (Cleaver et al 2007, McCarthy & Galvani 2010).

2) The adult-oriented issue can become the prime focus of attention.

3) The family is often involved in the adult-oriented practice system (eg mental health or substance misuse system) which makes interagency collaboration more complex.

4) The adult-oriented issue can become an obstacle to significant parental change.

WHAT WORKS?

A previous review of evidence to inform practice for Action for Children has

identified promising aspects of intervention (Moran 2009). Home visiting, parent training, school-based social worker support and intervention, social network support and therapeutic approaches with parents and children are supported by various degrees of evidence, though often not so convincingly. The latest review of child neglect for Action for Children adds more strategic dimensions to this (Burgess et al 2012). In this report it is noted that the current structure of child protection systems in the UK can militate against effective action on neglect; that increasing financial pressures are impacting more severely on children's wellbeing; and that commitment by UK and devolved administrations to a longer-term approach to intervention in neglect is essential. Furthermore, improving clarity among professionals and the public over what constitutes neglect would help to ensure earlier and more effective intervention. It is clear that intervening in neglect is likely to be costly in resources, requiring intensive, long-term, multi-faceted work, employing a highly skilled workforce. The challenges to achieving these requirements, particularly in a persistently difficult financial context, are enormous.

“Provision of such services is likely to be hampered by the short-term nature of much funding available for new initiatives, and by a desire for quick results. Given that neglect is a problem characterised by multiple contributing factors at personal, interpersonal, social and societal levels, it is also important to remember the role of social policy in alleviating neglect.”

Moran P (2009) Neglect: research evidence to inform practice. Action for Children.

3 THE EVALUATION STUDY

THE STIMULUS FOR THE EVALUATION

The Intensive Family Support Programme

Action for Children embarked on a 5-year Intensive Family Support (IFS) programme in a determined effort to provide effective, lasting intervention with families and children most in need. As the lack of evidence to guide services in dealing with neglect became apparent a redefined focus was created to concentrate on neglect in a selection of sites across the UK: the UK Neglect Project. Involved projects adopted a whole-family approach and locally-appropriate resources to target the IFS approach on selected families where there was evidence of vulnerability and unmet need relating to neglect. The focus was on work to improve the outcomes for children whose developmental needs were being insufficiently met, placing them at risk of poor educational, emotional and social outcomes.

Early Evidence of Success

As this evaluation was being planned, an earlier evaluation was reported (Tunstall et al 2008). This provided clear indication that IFS could *“make a positive difference to the lives of children and their families in even the most challenging circumstances”*. Even as a short evaluation, this offered both evidence of potential impact and tantalising glimpses into the detail of the mechanisms by which success might be achieved. Action for Children then proceeded to set up a raft of further evaluations of specific elements of its portfolio, and this included the project reported here.

The Need for Longitudinal Evaluation

Already cognisant of the limited results achieved by short-term, snapshot reviews, the commissioners planned for a longitudinal approach which would allow researchers to follow families from referral to closure, and to pursue the work of individual centres over a period of development of working practices and improvement of data recording. Including time to set the evaluation up and to

conclude analysis and reporting, a four year evaluation was commissioned from November 2008 to July 2012.

EVALUATION OBJECTIVES

Evaluation Aim

The end-product of this evaluation was to be research evidence to guide practitioners in intervening in cases of neglect, establishing which interventions produce the best results in given sets of circumstances.

The ultimate goal for Action for Children was to deliver better outcomes for vulnerable children, to develop an improved service response that could be rolled out across the organisation, and to improve co-working relationships with Local Authority and other statutory agencies

Evaluation Objectives

- 1) To gather detailed evidence on the circumstances in which families are referred for intervention and the wide-ranging assessment of family needs and problems; the interventions applied; and the outcomes for children.
- 2) To correlate key factors at a population-level identified at the assessment phase with eventual disposition on closure and outcomes for the child. (eAspire data)
- 3) To identify correlation between presenting factors, interventions, and outcomes from individual case file Action for Children Assessment Tool scores.
- 4) To secure illuminating detail from textual data in case files to explain findings from quantitative data.
- 5) To identify worthwhile hypotheses for further research.

EVALUATION DESIGN

Overview

The evaluation was based on quantitative recording of the level of concern about neglect in 14 areas at least on referral and on closure; electronic recording of key characteristics of the child, the parents and the environment; and review of textual data in files for detail of issues on referral, specific interventions, and evidence of outcome for the child. Serial review of the files and scores allowed for the longitudinal recording of progress, or lack of it, in each case.

An integral part of the project was to work with Action for Children to enhance the quality of data through the introduction of a new assessment tool and development of additional elements of the standing in-house electronic database; and to improve practice and outcomes through shared learning.

Preparing and Supporting the Managers and Practitioners

Working closely with the Action for Children project managers, the project team planned to ensure thorough preparation by front-loading the project with careful preparation of sites, instruments and partnerships. This involved site visits, explanation of the evaluation objectives and required data, and relationship-building with project managers and practitioners.

A series of meetings for managers (six per year) and workshops for project workers (2 per year) was conducted to ensure effective communication, cross-site collaboration, and problem-solving as the project and the evaluation evolved. Much effort was exerted by Action for Children, the research team and project staff to develop appropriate and practical instruments for collecting and recording the necessary data.

SELECTION OF CASES

Inclusion Criteria

The inclusion criteria were that:

- The family included at least one child under the age of 8 years (in

order to focus on the effect of early intervention in reducing adverse outcomes for children)

- Neglect had been identified explicitly by a referring agency at the point of request for an Action for Children service for a named individual (an external referral) *OR*
- Neglect was identified as an emerging concern relating to a child attending one of the included projects (an internal referral).
- The Action for Children Assessment Tool (or previously the North East Lincolnshire Assessment Tool) would be used and summary scores recorded.
- From early 2010 it was also agreed that enhanced custom fields in eAspire (an Action for Children bespoke tracking system detailed below under "Data Collection") would be included as part of the study data.

Recruitment of Services

Identification, recruitment and preparation of selected sites for inclusion in the evaluation was the first step. Joint visits were made by the research team and the Action for Children manager to all sites. Staff at every site were enthusiastic and supportive, and plans for the evaluation were revised and improved as a result of observation, feedback and discussions. At each visit, where possible, a senior officer from the Local Authority was invited to meet the visitors and service managers to discuss the value of the research project to the Local Authority, and to elicit support in the form of continuance of data collection on outcomes for children after leaving Action for Children services. On every occasion this was agreed, and, while the exact mechanism for transference of this data was still to be confirmed, it seemed likely that at least some ongoing data of the sustained impact on the child would be made available. However, as a result of budget cuts, this arrangement has not proved possible. Indeed, several commissions have since been cut, amended or lost.

A UK-wide group of services was recruited (Figure 1). Initially (January 2009), these included sites in Scotland, Wales and England. It was found that cases from a site in the south of England would not meet the inclusion criteria, so this was replaced in March 2009 by a site in central England. Following the interim reporting at the midpoint in July 2010, where it was reported that the sample was heavily skewed towards cases of entrenched neglect, further adjustment was made.

Three of the initial sites were closed to further recruitment to the evaluation (though existing cases continued), and two new sites were added. These were selected on the basis of their dealing with cases where early intervention was more likely. An additional site in Derry was brought in, completing the UK-wide focus.

Figure 1: Location of centres



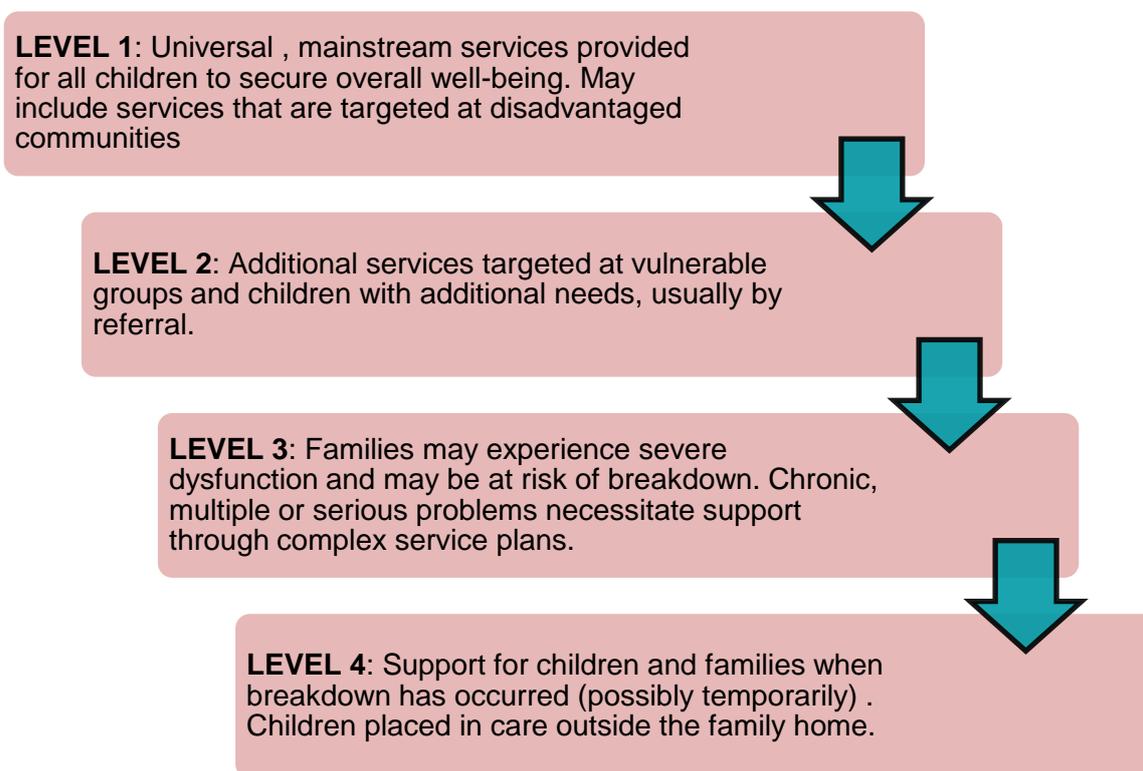
Overall, then, the constituency of the evaluation was in a state of flux, but the longitudinal nature of the project allowed for changes to be exploited positively rather than presenting limitations. The skewing of the sample was corrected, the spread of cases across the UK was widened, and additional explanatory factors were uncovered.

Five services focused mostly on high-level neglect cases assessed at Hardiker level 3 or 4 (Figure 2). Two sites also provided services at level 2, while one service focussed entirely on level 4 cases, undertaking intensive assessment for court reports. All seven services received direct referrals from the Local Authority, and two received self-referrals. Two sites

enjoyed particularly positive relationships with health professionals, receiving referrals from health visitors. Short-term contracts were common, often of around three months. A continuum of focus was

observed, from an entirely outreach-based service to regular group work in-house, but most services engaged with families with both approaches.

Figure 2: Levels of need and problems (Hardiker et al 1991)



DATA COLLECTION

Action for Children Assessment Tool

The North East Lincolnshire Assessment Tool, which was based on the Graded Care Profile Scale, was trialled for some time but a number of items were identified by practitioners as being problematic. These were reviewed internally by Action for Children and the NELAT was revised to such an extent that it seemed appropriate to present this as an Action for Children Assessment Tool. This was used for the rest of the project, and previous scores transferred into the new format by the research team. This instrument was held to be an objective, comprehensive, child-focused measure which promoted the use of common language and facilitated partnership assessments and planning with parents.

The instrument is divided into three general areas of concern: physical care,

safety and supervision, and emotional care, each populated by a number of specific elements (14 in total). The items are scored from 1 to 5, higher scores indicating increasing levels of a concern. A threshold was set at the boundary between 3 and 4. Scores below this line represented adequate care (though with some concern at scores of 2 or 3). Scores of 4 or 5 indicated inadequate care and serious concern. This threshold was an essential element as it provided practitioners with a means to gauge which aspects of care were unacceptable (rather than simply undesirable) and which to prioritise for intervention. Each item bore descriptors at each level to assist the practitioner further. Serial scoring of items allowed for clear indicators of overall progress and lowering of concern. Recording the number of scores of 4 or 5 offered the research team an additional index of the degree of concern and the direction of movement.

Table 1: Items in the Action For Children Assessment Tool

PHYSICAL CARE	AREA OF CARE & SAFETY	EMOTIONAL CARE
Nutrition Housing Clothing Hygiene Health	Awareness Practice Traffic Safety features	Carer behaviour Mutual engagement Stimulation

eAspire

Action for Children maintains an internal bespoke system which consists of four elements and tracks the child's progress through the service from referral through assessment, service plan and outcomes achieved at closure. It was recognised that elements of eAspire might serve to support and augment data collection. A number of custom fields were designed and added to the system to collect electronic data at referral stage pertaining to background characteristics of included children and their parents. Four areas were considered:

- Child's health characteristics
- Child's education and emotional wellbeing
- Parent/carer characteristics
- Environmental factors.

This was amended in detail and supplemented in 2010 by the addition of fields for *presenting needs & interventions*. The outputs from this data collection support the population-based conclusions, helping to show which factors were most common, which commonly presented in combination, and which were associated with eventual dispositions of children.

Outcome Measures

Further guidance was needed for workers to recognise and record observed outcomes robustly. In particular, the need to provide evidence of impact on the child was emphasised. A number of frameworks and sources of outcome indicators for aspects of the child's life were considered.

- The Action for Children Assessment Tool itself provided specific family-based indicators.
- The National Healthy Schools Programme³ offered school-focused indicators.

³ This site is no longer available following the dissolution of the DCSF

- The Strengths and Difficulties Questionnaire⁴ included specific behavioural indicators.
- The DCSF Child Well Being Group offered examples on the quality of relationships.³

Frameworks such as the Scottish GIRFEC (Getting It Right For Every Child)⁵ provided examples of how outcomes review might be structured. A workshop on these issues was held in July 2009 and followed up in October 2010. Accurate, valid observation of outcomes by project staff, with an acceptable degree of inter-rater reliability across and within projects was seen to be an essential precursor to similarly robust recording and presentation of the findings.

Data Collection Visits

Data from 1st April 2009 was collected. A first tranche of data collection was completed between June and December 2009. A second round of data collection visits was made in June 2010. Further data collection visits were made to individual centres until November 2011. A total of 85 cases made up the final sample.

Table 2: Cases taken from each centre

Centre	Cases included
1	23
2	14
3	7
4	23
5	9
6	3
7	6
TOTAL	85

⁴ www.sdqinfo.com/

⁵ www.scotland.gov.uk/Topics/People/Young-People/gettingitright

ETHICAL ISSUES

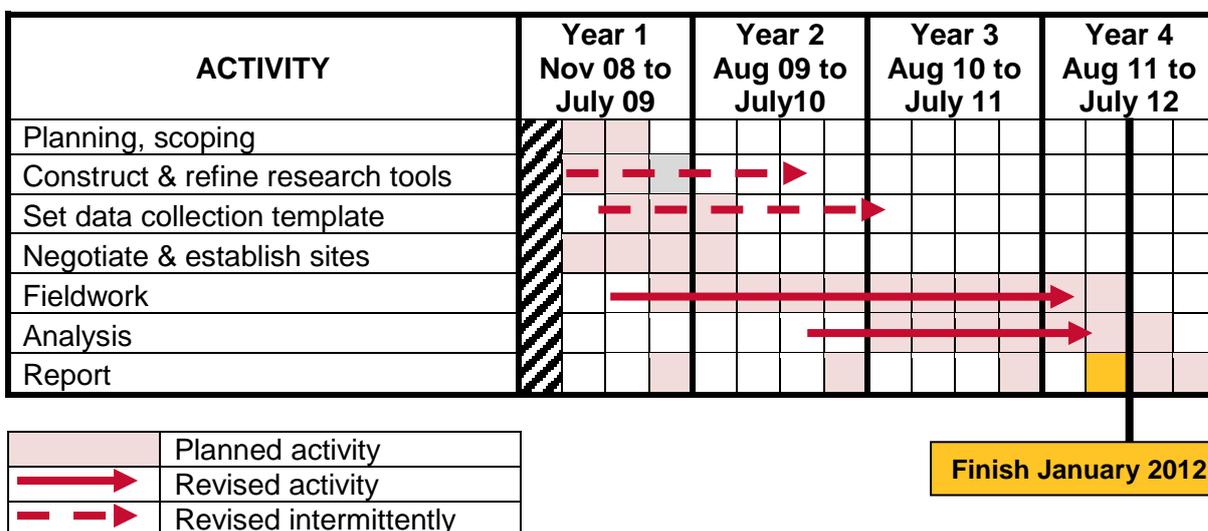
Information and Consent

As this was an evaluation of its own data, Action for Children already had authority and permission to review this data for the study. Information sheets and consent

forms were tailored to be locally specific for each project when required by the local manager. Formal approval was secured from the University of Salford Research Governance and Ethics Committee.

PROJECT TIMETABLE

Table 3: Evaluation timetable



ONGOING DISSEMINATION

A joint approach to publicising and disseminating the project and the evaluation has been pursued, the research team working closely with Maureen Nuttall and other Action for Children departments, and the university press and publicity department. In addition to updates and briefings, presentations were made at a number of specific events.

Specific events:

- February 2009: National neglect survey and associated media coverage.
- March 2009: Keynote presentation at Government Office North West conference *Understanding Neglect*
- June 2009: Keynote presentation at Merseyside Local Safeguarding Children's Boards (LSCBs) conference *Learning Together*.

- October 2009: Neglect appeal – Bauer Radio (Key 103) media coverage.
- November 2009: Walsall Safeguarding Children Board *Focus on neglect*.
- February 2010: North West Safeguarding Nurses Annual Conference: *Fit for Purpose*.
- February 2010: Wirral Council Children's Social Care Conference *Researching neglect: focusing on outcomes*.
- July 2010: Kirklees Safeguarding Children Board *Think Family Conference*.
- September 2010: British Association for Adoption and Fostering conference.
- November 2010: Action for Children national conference *Researching neglect: methods, problems and findings*.

- November 2010 Powys LSCB: *Outcomes of the UK neglect project and impact on compromised parenting* (Invited plenary).
- November 2011 Action for Children Northern Ireland and Western Health & Social Services Board: *Neglect and Outcomes from Research* (Invited keynote) Derry.

4 FINDINGS: eASPIRE CUSTOM FIELDS DATA

Action for Children follows a bespoke assessment and review system of practice known as Aspire and record outcomes from case on the database associated with this system are known as e-Aspire. eAspire was used with all cases. Each child would be assigned a PIN, and essential data was identified for each case. Flexibility in this system allowed for the addition of custom fields (specific to the sites engaged in the evaluation). These were developed for presenting needs on referral; child, parent and environmental factors on assessment; and interventions. The selected factors were known to exert an impact on the likelihood of neglect.

PRESENTING NEEDS

A wide range of factors which had stimulated referral (“presenting needs”) were identified. The frequency of each of these is displayed in Table 4 below. *Chaotic lifestyles* and *home conditions* were predominant in the presenting problems, and most often occurred together. *Poor hygiene* was also commonly associated with chaotic lifestyles and home conditions. This was certainly borne out in the textual data. However, other issues were also widespread, with a significant degree of *domestic violence* (known to exert a particularly negative impact on children’s wellbeing).

Table 4: Presenting needs – frequency of recording (n=85)

Alcohol abuse	8 (9%)
Attachments	8 (9%)
Behaviour management	25 (29%)
Chaotic lifestyle/no routines	44 (52%)
Domestic violence/abuse	29 (34%)
Emotional abuse	13 (15%)
Emotional development of child	22 (26%)
Fail to attend medical appointments	21 (25%)
Family dynamics	24 (28%)
Home conditions	35 (41%)
Lack of co-operation with services	11 (13%)
Learning disability/difficulty	17 (20%)
Mental health	15 (18%)
Neglect identified by referrer	35 (41%)
Parental supervision	29 (34%)
Physical, emotional assessments	2 (2%)
Poor hygiene	29 (34%)
Primary safety – supervision	23 (27%)
Relationship position	6 (7%)
Risk /integrated assessment	5 (6%)
School attendance	13 (15%)
Substance misuse	12 (14%)
Unmet health needs	19 (22%)

CHILD-RELATED FACTORS

Failure to attend for health appointments and *poor hygiene* were the most commonly reported factors in children's health characteristics. One of the projects appeared to have a particularly positive relationship with health professionals, especially health visitors, and this seems to have boosted efforts at that centre to address this issue. However, relatively little focus was placed on factors relating to the child: an issue that was mirrored in all aspects of the data. Those factors

which were more prevalent had already been identified on referral. The assessment process brought little more to light. The higher incidence of emotional and behavioural factors in the child reflects the level of need that was present in many cases. Multiple problems and complex needs are characteristic of families requiring support at levels 3 or 4. The problems identified in children could be either a contributing factor or a result of the chaotic family situation.

Table 5: Frequency of child health, education & emotional wellbeing indicators (n=85)

Child Health characteristics	
Complex health needs	10 (12%)
Chronic health needs	7 (8%)
Multiple hospital admissions	2 (2%)
Frequent infections	2 (2%)
Substance misuse	0 (0%)
Disability	1 (1%)
Injury due to poor supervision	8 (9%)
Not registered with a GP	0 (0%)
Failure to attend for health appointments	15 (18%)
Separation in SCBU	1 (1%)
Foetal alcohol syndrome	1 (1%)
Poor hygiene	17 (20%)
Child's Education & Emotional Wellbeing	
Emotional problems	24 (28%)
Behavioural problems	20 (24%)
School exclusions	6 (7%)
Special educational support	7 (8%)
Child is a carer	3 (4%)

PARENTAL FACTORS

The much greater prevalence of factors in parents was notable, and the bulk of efforts made by workers was focused on parental behaviour. However, the degree to which these interventions address

mental health, substance misuse or learning disability is not clear. The effect of domestic abuse on children is known to be significant (UNICEF 2006).

Table 6: Frequency of parent/carer indicators (n=85)

Mental health problems	23 (27%)
Learning disability	14 (16%)
Domestic abuse	35 (41%)
Substance abuse	23 (27%)
Offending behaviour	12 (14%)

ENVIRONMENTAL FACTORS

Little was recorded to indicate that the environmental factors considered in the literature to be most relevant and frequent were a particular influence in the cases in

this project. Child protection issues, either in the form of a child protection plan in operation or court proceedings were remarkably common (n=45, 53%).

Table 7: Frequency of environmental indicators (n=85)

Inconsistent residence	5 (6%)
Single parent household	19 (22%)
Living with relatives	5 (6%)
More than 2 children under 5	11 (13%)
Child protection multi-agency plan or Court proceedings	45 (53%)

INTERVENTIONS

The list of interventions commonly applied was compiled through consultation with practitioners and managers involved in the evaluation project. Some items were normally a required part of the service commissioned (especially *comprehensive assessment* and *parenting programme*).

However, there was a notable predominance of *home visiting* and associated focus on *routines and boundaries*. Review of case files demonstrated that this was drastically under-reported in the custom fields.

Table 8: Frequency of interventions applied (n=85)

Attachment 9	0 (0%)
Comprehensive assessments	24 (28%)
Counselling/mediating work	7 (8%)
Day care provided for child	3 (4%)
Domestic abuse (Freedom programme)	7 (8%)
Family group conferencing	4 (5%)
Multi-agency planning	32 (38%)
1-to-1 parent/child relationship	24 (28%)
One-to-one Webster Stratton	9 (11%)
Parenting programme (see list)	47 (55%)
Protective behaviours: ethnic minority	2 (2%)
Supervised contacts	9 (11%)
Home visiting/Outreach	47 (55%)
Routines and boundaries	51 (60%)

Commissioners would often specify a specific parenting programme as part of the commission. This would usually be the Positive Parenting Programme (PPP or Triple P), perhaps because of perceived rigour associated with this package. A recent independent evaluation of Triple P found no significant difference in parenting stress, positive interaction, family

functioning or child problem behaviours between this programme and other group-based programmes (McConnell et al 2011). A slightly smaller frequency was reported for use of the Webster Stratton (Incredible Years) programme. The effectiveness of this programme has been supported in Sure Start centres (Hutchings et al 2007).

Table 9: Frequency of parenting programmes applied (n=85)

Intervene parenting support group	0 (0%)
Triple P (PPP)	29 (34%)
Family Links	3 (4%)
Walter Barker: pictures	2 (2%)
Webster Stratton	22 (26%)
Parent line plus	4 (5%)
Teenage antenatal group	2 (2%)
Watch, wonder, wait	0 (0%)

SUMMARY

The eAspire data showed clearly that chaotic lifestyles and concern about home conditions were by far the most prevalent issues identified on referral that indicated neglectful parenting. Poor hygiene, emotional problems, and behavioural problems were the most commonly identified characteristics identified about the children during the intervention, and these obviously linked to issues identified on referral. Failure to take children to health appointments (mostly for immunisation, but also for ongoing care for enduring medical conditions) also caused concern in a significant number of cases.

Domestic abuse stood out as an indicator in parents of concern, though mental health and substance misuse were also important factors. Together, these provide a telling picture of the circumstances in which neglect occurred and the complexity of the challenge to practitioners.

The pattern of intervention was predominantly comprehensive assessment (usually an essential element of the commission), followed by a parenting programme and an intensive course of home visiting to establish routines and boundaries.

5 FINDINGS: THE ACTION FOR CHILDREN ASSESSMENT TOOL DATA

REMOVAL OF CONCERN ABOUT NEGLECT, REMAINING CONCERN ABOUT NEGLECT, OR PREVENTION OF NEGLECT

It is clear that Action for Children interventions were largely successful in addressing neglect. Success in this part of the analysis was gauged by the reduction of concern so that no areas of the Action for Children Assessment Tool were still scored at 4 or 5 (regardless of the number of areas scored at 4 or 5 on assessment). This was based on the notion of a threshold integral to the Action For Children Assessment Tool according to which a score of 1-3 indicates “good enough care” (even if not desirable care), and a child is considered to be subject to neglect if any aspect is scored at 4 or 5.

The reduction in all Action for Children Assessment Tool scores to below 4 was termed “**removal of concern about neglect**”.

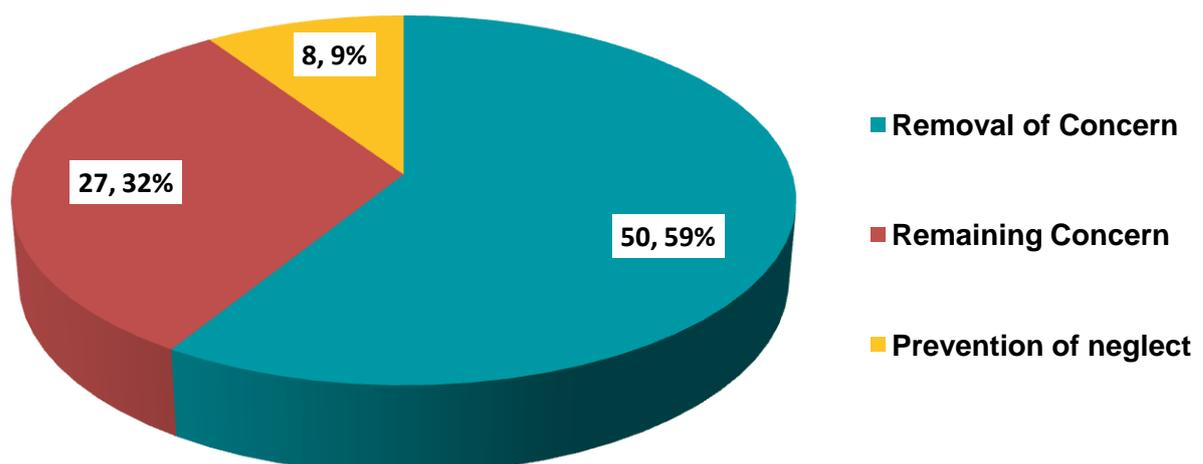
In some cases, the score in at least one area remained above the threshold for neglect – the boundary above the score of 3. This was termed “**remaining concern about neglect**”. This group was itself formed by two elements. The larger number of cases resulted in children being taken into care - “**Children removed**”,

while a smaller number were “**returned to other services**”. In some cases where children were taken into care (removed), no progress was made at all, but in some the degree of concern was at least reduced.

In a small number of cases, scores never reached the threshold of neglect. These were cases in which neglect was foreseeable and intervention was intended to prevent the otherwise inevitable occurrence of neglect. In all cases, the intervention was effective, and this was termed “**prevention of neglect**”.

In 50 (59%) cases the intervention was successful in that the cases were returned to lower-level concern and transitioned to other support (removal of concern). In 27 (32%) cases there was remaining concern about neglect (n=23, 27% of the total number of cases). A significant proportion of these resulted in children being taken into care. In the remaining 8 (9%) cases there was never a score above 3, though concern about the potential for neglect required intervention (prevention of neglect).

Figure 3: Removal of concern about neglect, remaining concern about neglect, or prevention of neglect

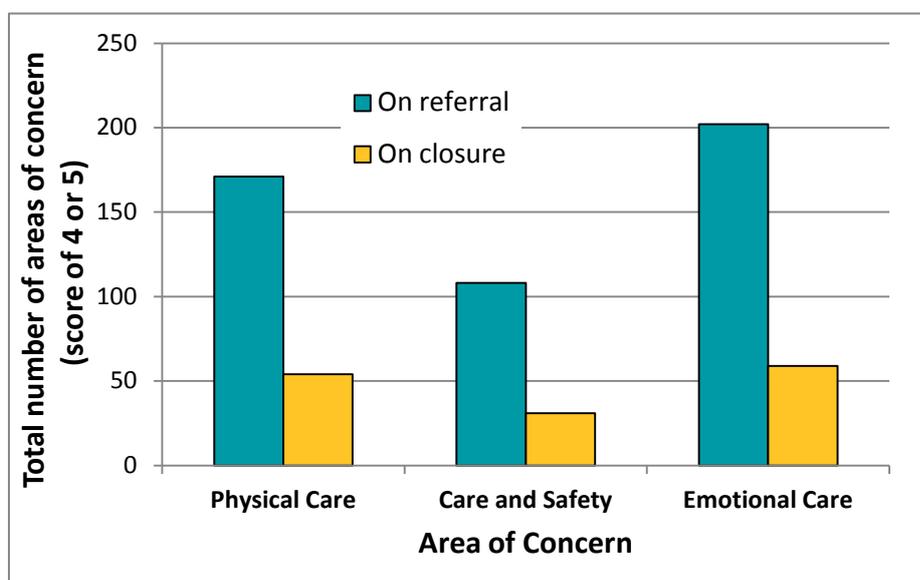


The areas of the Action for Children Assessment Tool in which serious concern was reported

All areas of the Action for Children Assessment Tool were implicated in practitioners' concern. Some cases showed only a single item of such

concern, but it was not uncommon for five or six items to be identified to be a serious concern (scored at 4 or 5 on the scale).

Figure 4: Change in total areas of serious concern (scores of 4 or 5) in the three major areas of the Action for Children Assessment Tool



REMOVAL OF CONCERN ABOUT NEGLECT

Fifty cases (59%) resulted in transition to mainstream services with no remaining concern about neglect on closure. Most cases transitioned into Child in Need or Targeted Services, though some were resolved to the extent that the families were handed back to universal services for ongoing support. In all cases a clear downward trajectory was recorded in reason for concern. Sometimes drastic changes were found, and even with no remaining areas for concern, there was still a range of problems which required intervention and support from other services.

When sequential records were kept over time of changes in the number of areas scoring 4 or 5, the pattern would often indicate something of the complexity of the cases in question. Some total scores would increase as major risks were successfully addressed but additional, less urgent items came to the fore. Not uncommonly, as the Action for Children

worker gained the trust of parents, the parents would divulge the presence of other problems, substance misuse, for example. Alternatively, despite a trend of improvement in parenting and a reduction in scores, an untoward event could prompt a sudden and significant increase in concern. Often this would be the result of the introduction of another adult into the household or crisis in relationship between parents. In some cases it would be the effect of violence or children getting into trouble. The worker would simply review the assessment, revise the plan and priorities, and demonstrate to parents how to react positively and effectively to the new problems.

Typically, parents would have learned to maintain a clean, tidy and hygienic house, and they would have established a more positive, stimulating relationship with the child by the time of the final review. Boundaries would have been set in place and maintained by the parents. Other

common indicators were better school attendance, more effective and appropriate communications between parents and children, and greater awareness of hazards to young children. The achievement of even a small change could take a great deal of intensive intervention, and frequently steps would

have to be retraced and learning fostered again before moving back to the timetable of progress. However, the persistence of the worker would tell, and parents would often comment on the positive effect of this persistence and stability on their own resolve to provide better parenting for their children.

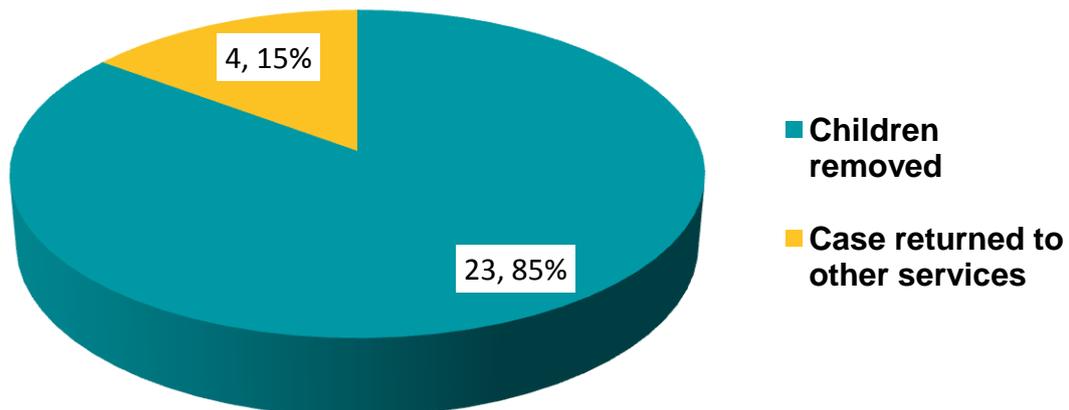
REMAINING CONCERN ABOUT NEGLECT

In 27 (32%) cases children remained subject to concern about neglect on closure of the case. This could range from a single lingering problem which would require longer intervention than was allowed in the commission to a complete absence of change or even worsening of the situation. However, most of the cases in this evaluation in which concern remained about neglect on closure of the case resulted in complete absence of improvement.

Twenty-three cases resulted in the child being taken into care on closure of the

case. These cases tended to relate to families in which neglect was already deeply embedded on referral. The cases were severe and complex. Cases which resulted in children proceeding into care would commonly show little or no change in the degree of concern about neglect, sometimes with concern increasing as additional issues came to light. The most common reason for closing a case was that the parent persistently failed to engage with intervention or was simply unable to make significant improvement in their care of the child.

Figure 5: Breakdown of cases where concern remained (n=27)



In such cases, the strength of evidence that the child was suffering neglect and that, despite intensive support and intervention, parenting was not improving was sufficiently convincing for the Local Authority to move directly into care proceedings. When Action for Children offered such an intensity of involvement, either families could change so that

parenting became acceptable or it became even more apparent that the case needed to be accepted as having crossed the threshold into level 6 - care proceedings. In this, Action for Children work ensured that when the situation was found to be irredeemable, children were taken into care more quickly. Hannon et al (2010) have demonstrated recently that children

who are taken into care sooner rather than later in such cases fare better in the long term.

Changes in total scores for those children who continued into care on closure of the case by Action for Children was also mostly non-existent or minimal, indicating

PREVENTION OF NEGLECT

Eight cases (9%) were found to have no scores of 4 or 5 yet were included in the project since it was agreed by a multi-professional team that neglect would be the inevitable outcome if preventive intervention were not provided. These were mostly cases of young parents, often referred antenatally, whose ability to provide adequate care was already of concern, and the intervention was aimed at keeping the baby safe while developing the essential skills in the parent. In each case the concern was underpinned by evidence from careful assessment and focused on specific deficiencies in preparedness for parenting.

The remaining cases related to holding actions in anticipation of a foreseeable improvement to the family circumstances.

OVERALL REDUCTION IN CONCERN ABOUT NEGLECT

Commissioners seek to achieve maximum service reach and avoidance of dependency by the support of time-limited periods of intervention, but the restriction caused by finite intervention periods sometimes resulted in workers being unable to pursue clear improvement to the potential conclusion of complete removal of concern about neglect. In addition to the 50 cases which improved to the point of **removal of concern** about neglect, a further nine which were counted as having **remaining concerns** showed improvement in scores and, therefore, reduction in concern. Of the latter, four were cases which were returned to other services, and five were cases in which the children were taken into care but some

lack of change in parenting behaviour. In some cases the total score worsened, often as additional, previously hidden problems came to light or, as in more than one case, as a known child offender returned to the house. In five cases where the children were removed, however, a small improvement had been made.

In one instance this related to the return of the children's father following his release from prison. The mother was unable to cope and her care of the children was deficient in both knowledge and skill. The commissioned brief for Action for Children with this family was to support the mother until the father's return to the household at which point an acceptable level of care was expected to resume. Indeed, the case file showed that on his return he was seen to be cooking for the children and enforcing reasonable morning and bedtime routines. In all cases, the potential neglect that was of concern was prevented, and in six of these eight cases there was improvement in caring ability rather than merely stability below the threshold of neglect.

improvement had been made, usually in one or two areas out of five or six which were of concern.

Moreover, of the eight cases in which intervention was aimed at **prevention of neglect**, six demonstrated reduction in actual scores and therefore lessening in the cause for concern of anticipated neglect.

Overall, the number of cases in which concern about neglect was prevented or reduced was 67 (79%). Even when no more serious concerns existed, a controlled transition to previous services was established.

Figure 6: Frequency of improvement in concern about neglect

	Removal of concern	Prevention of neglect	Remaining concern about neglect	
Improvement or prevention of concern about neglect	(n=50)	(n=8)	Returned to other services (n=4)	Total = 67 (79%)
			Children taken into care – some improvement (n=5)	
Absence of improvement in concern about neglect			Children taken into care – no improvement (n=18)	Total = 18 (21%)

SUMMARY

Neglect was prevented or the level of concern reduced in 67 (79%) cases. Of these, 50 resulted in removal of concern completely, nine had remaining concern, and eight were prevented from developing into neglect.

Of the 27 cases where concern remained, four were returned to other services for ongoing support while 23 resulted in the children being taken into care.

Eight cases were prevented from deteriorating into neglect.

The change in financial circumstances of local authorities during the evaluation meant that the eventual outcome remained unknown for many cases in which progress was being made but time

allowance prevented completion of the process. However, for some cases the file indicated that the plan was for mainstream services to continue with the planned work, and it was clear in others that referrals made by Action for Children to other specific agencies were to be maintained, too. In such circumstances it might be hoped that the improvement would be sustained.

In one centre, the commissioner was persuaded to extend funding for the Action for Children intervention in order to sustain adequate levels of parenting and safety for the children until the children became more able to be independent and to compensate for sub-optimal care by their mother who suffered from enduring mental health problems.

6 FINDINGS: TEXTUAL DATA FROM CASE NOTES

The following outline of the textual data taken from the case notes is presented in three sections – The Home, The Parents and The Child although it is acknowledged that the issues for each are overlapping. The narratives presented in these sections add to the quantitative data, providing further illustration of the various issues that indicated neglect as noted by the Action for Children workers. This includes data noted during the initial assessment and during follow up visits before determining the final outcome of the interventions. Data related to the final outcome indicated a mixed picture, with some success and some lack of progress.

It is notable that some of the issues have more qualitative commentary than others. For example, there is little commentary to reflect the outcomes of the section “living context”. In contrast, there are many

comments to indicate outcomes successful or otherwise in terms of the condition of the house in the “home conditions” section. Similarly, there are few comments present for outcomes related to the children’s personal hygiene but many comments in terms of outcomes about the relationship between the mother and the children. This may be because the workers feel compelled to rationalise their quantitative scores in areas that are potentially open to interpretation.

It was common during data collection that gross issues would be identified during assessment (including on-going assessment), but that these would often not be included in the comments on outcomes. A decision would have been made that objectives had been met and positive outcomes achieved, but the evidence for this was not recorded.

THE HOME

Living Context *On assessment*

Qualitative data available in the notes reflected the living context of the children and their families on assessment. Here, comments highlighted chaotic lifestyles in terms of housing, for example stating “currently in temporary accommodation” “impending eviction - housing issues” “Chaotic lifestyle – staying at multiple addresses” “Home conditions chaotic”. This included a lack of living space: “Overcrowding” “Overcrowded house”.

Chaotic lifestyles also included instability in terms of personal relationships or the many and varied individuals living in the home at any one time: “Makeup of household – negative impact on engagement” “Household deteriorated since mother’s boyfriend arrived” “Child with grandparents – mother living separately (associated with risky adults)” “Inconsistent family make-up”.

Instability within the home also included differences in parenting or care offered to individual children within the home, for example: “Pattern of mother leaving home with some children when relationship strained” “Younger children cared for at expense of neglect of older children”. Some of the children were looked after by the state, and comments related to this included “Other children in residential care” “Eldest daughter in residential care but disruptive when home”.

Workers also noted aspects of living context that included financial insecurity, for example “problems with debt”. Problematic relationships with others also raised issues that ranged from lack of support “Mother’s father and brother also in home but not supportive” “Limited sources of support – family/friends/neighbours” through to causes of conflict “conflict with neighbours” “difficulties with neighbours”.

Outcomes noted

"Chaotic household" was the only outcome recorded (though on many occasions).

Home Conditions

On assessment

The workers made notes related to the upkeep of the home that indicated either a lack of knowledge or lack of intent to provide a clean, safe and hygienic environment required for bringing up children. Some notes were general comments related to lack of cleanliness: "Home dirty / House not clean" "Poor hygiene" "Dirty, squalid environment" "House untidy and dirty". Other comments related to specific aspects of hygiene that were hazardous to the child's health: "Rubbish not removed" "Potty in hallway filled with stagnant urine". Many comments indicated that dogs also lived in the homes and that the parents did not ensure that the house was free of dog faeces, presenting health risks: "Dog faeces in living areas" "Faeces on floor in house" "Dog faeces in children's play area" "Hygiene problems – dog faeces in child's bedroom" "Faeces spread on walls and skirting board in child's bedroom" "House dirty with dog faeces". The workers noted the impact of the environment on the health of the child: "Child ill due to poor hygiene".

Outcomes noted

Successful outcome scores were supported by comments that reflected efforts made by the parents, including "Bedroom clean" "Home conditions maintained at satisfactory standard" "Home conditions good enough" "Some improvement in home conditions – cleaner and redecorated" "House clean and uncluttered" "Unplanned visit found house clean and child playing in doorframe bouncer properly supervised by mother" "Home condition improved. Smell of urine

THE CHILD

Physical Health

On assessment

Some of the comments highlighted non-specific concerns related to physical health: "Child's appearance suggests neglect". However, several comments

reduced" "Home conditions seen to be clean and clutter-free" "Home conditions now 'better than good enough". Other comments indicated that improvement had included more than cleaning, for example "Dirty carpets have been removed and decorating is in progress" "Children's bedrooms have been overhauled".

However, lack of success was noted by some workers, particularly reflecting lack of immediate personal attention to either the child or pets rather than a simple neglect of daily house cleaning, for example: "Faeces on windows, bedding and walls in boy's bedroom" "Dog faeces in child's bedroom again" "Child's bed sheets soiled" "House cold and untidy" "Some concern about dogs in the house".

Resources

On assessment

There were several comments related to general lack of resources, particularly a lack of basic furniture required for safe or comfortable sleeping arrangements: "Insufficient beds Child has no bed / no cot" "Insufficient beds" "Baby has no cot" "no bedclothes on children's beds". In addition to lack of furniture, some of the comments reflected lack of basic resources such as food or bedding, including "Lack of food, bedding and toys" "Little food in the house".

Outcomes noted

Successful outcomes made no mention of larger items such as furniture but did mention improvements on a smaller scale such as "Food in cupboards". Comments indicating lack of progress mentioned both lack of furniture "Despite provision of white goods, still no furniture in child's bedroom, and no heating in house" "Sparse bedroom furniture", and lack of improvement on a smaller scale "Fridge open, dirty and little food available".

highlighted health issues that had arisen for the child as a direct result of a lack of knowledge, ability or intent to perform basic age-appropriate child care in the home. For example, this included issues about nutrition and stimulation "Child

failing to thrive", inadequate attention to personal hygiene "*Child has genital sores from inadequate wiping after toilet*", and prolonged failure to intervene "*Worst ever nit infestation*".

The comments also made note of staff recognition of developmental delay in many of the children that may have resulted from an underlying physical problem but may also have resulted from a lack of cognitive or emotional stimulation of the child in the home environment. Such comments included "*Developmental delay*" "*Children all global developmental delay*".

Several staff noted that the parents had failed to take the children to scheduled health appointments for general health promotion or preventative health care, for example "*Immunisations outstanding and limited engagement with health services*" "*Missed health appointments*" "*Children not taken for health appointments*". This included preventative health care that is not automatically scheduled or monitored such as dental care "*Mother avoids dental care for self and children (anxiety)*" that can also have consequences for the child's future health "*Dentist reluctant to agree further appointments due to number missed*".

Failure of parents to act appropriately was also noted when the child exhibited signs of illness "*Appropriate health advice not sought for baby*" or when the child needed continued health support at home from parents, for example, "*Repeat prescriptions of asthma drugs not ordered and drug not available at home*" "*Child's health needs not being met – essential food supplements, control of fluid intake*" "*Mother ignoring health professional advice on bedwetting*".

On occasions where children had been admitted to hospital, staff noted that their parents had effectively abandoned them to the care of the institution: "*Child with medical problem (diaphragmatic hernia, O2 dependant, peg fed). Not been home from hospital*" "*Parents do not visit*" "*Becoming institutionalised*".

Outcomes noted

Nothing was noted about outcomes.

Clothing and children's personal hygiene

On assessment

In addition to the hygiene and cleanliness problems with the immediate environment, the workers noted issues related to lack of basic personal hygiene and care for the child. General comments included "*Personal hygiene of concern – not always clean clothing*" "*Child sometimes unkempt*" "*Children dirty and unkempt*". Other comments pointed to a lack of knowledge, ability or intent to perform basic age-appropriate child care in the home, for example, in terms of hygiene: "*Child left to manage toilet-wiping alone at 1 year*".

Comments were related to lack of clean or appropriate clothing both in and out of the home, for example, "*Children seen to be inappropriately dressed*" "*Child appears at school dishevelled and in stained clothes*" "*Child inappropriately dressed for weather conditions*". Sometimes it was noted that the children were not dressed at all: "*Children naked in house, mother asleep*" "*Children seen naked at bedroom window*".

Outcomes noted

Comments on outcomes were minimal, but included "Children presented well" "*Children's appearance unkempt*" "*Child sent to school in mouldy T-shirt*".

Attendance at school and nursery

On assessment

Impact on the child's education was noted, for example in terms of attendance: "*Attending school only for short periods / irregularly*" "*School attendance poor*" "*Removed from school by mother*" "*Child persuades mother to keep her off school*", or in terms of achievement "*Child's attendance good but achievement is low*". When children attended education services, comments were made if the parent failed to collect the child at appropriate times, for example "*Mother late picking up from nursery and not contactable*".

Outcomes noted

Success was noted here: "*No further problems with school attendance or punctuality*" "*No issues at school now*".

“Attending nursery regularly” “Attending cubs” “Attending nursery placement” “Mother managing relationship with school better – reported child’s illness”. In contrast, improvement was not always seen: *“Attendance at school sporadic” “Children still not attending school” “Still not attending all available nursery placement sessions”*.

Child Behaviour

On assessment

Comments were also made on assessment that highlighted inadequate parental management of the child’s behaviour: *“Ineffective management of children’s behaviour” “Mother unable to manage son’s aggressive behaviour”*. There were also many comments related to the children’s behaviour in the home that indicated a lack of adequate parenting including parental guidance or boundary setting. Some of the comments were non-specific: *“Child shows challenging behaviour at home” “Children’s behaviour not controlled”*. Other comments described problems that were associated with parenting problems or chaotic family situations such as aggressive behaviour towards other individuals including family members: *“Brothers fighting and hurting*

each other. Both hurting younger sibling” “Child kicking others, spitting and running off” “Aggressive to mother and sister. Kicking and biting” “Child physically aggressive to children, adults and pets”. Other comments indicated access to inappropriate equipment and associated aggression towards service providers: *“Child fired airgun at worker”*. There were also comments that potentially pointed to problems with mental wellbeing: *“Child soiling and smearing at home” “Child has threatened to self-harm” “Sexualised behaviour towards sibling”*.

Outcomes noted

Positive remarks were made about progress: *“Aggressive behaviour reduced” “Behaviour is calmer” “Reduced number of incidents” “Child interacts positively with siblings and other family members” “Using toilet to defecate” “Children happy and at ease” “Some evidence of less aggression from child”*.

Lack of progress was noted by a variety of behaviours exhibited by the children, for example *“Sexualised behaviour not resolved” “Child over-eating at nursery and hiding food” “Child hid from mother at home time at nursery”*.

THE PARENTS

The presence and health of the mother

On assessment

The health of the mother was commented upon, and sometimes this related to physical health and the impact that this may have exerted on parenting: *“Mother has slipped disc and is on anti-depressants” “Mother suspected to have learning difficulties. Unable to understand and undertake parenting”*. However, more often they related to mental health: *“Mother has suicidal thoughts” “Maternal depression” “Mother’s mental health unstable leading to inability to offer consistent and responsive care” “Mother diagnosed with personality disorder” “Mother has history of depression” “Mother exhibiting psychotic symptoms – but no medical risk to children” “Mother has history of depression”*.

Many comments were also related to substance abuse in the home: *“Cannabis and cocaine use” “Mother has chaotic lifestyle – crack-cocaine + methadone programme” “Mother staying with heroine-using parents” “History of alcohol abuse” “Smell of cannabis noted by worker”*.

Young parents and associated issues were also noted, for example *“Young mother, socially isolated” “Young mother” “Immature teenage mother – unborn child, needs support with general parenting skills” “Prenatal referral. Teenage mother and father residing together”*.

There were also comments that illustrated inappropriate communications between the mother and children that had the potential to cause the child distress: *“Mother tells children that they need to go into care because she is a bad mother”*.

Outcomes noted

Nothing was noted about outcomes of these issues.

The relationship between the children and the mother and the impact on the child's psychological or emotional health and bonding

On assessment

During the assessment the workers also noted aspects of the relationship between the mother and children that were likely to impact on the child's emotional wellbeing: *"Mother prioritises her own needs over those of her children"* *"Mother struggling to show emotional warmth"* *"Mother able to provide physical care but no emotional bond or warmth"* *"Little emotional warmth between mother and child"*. Lifestyle issues that were likely to have a negative impact on the child's emotional welfare were also noted, for example *"Over-use of social networking leading to emotional neglect of child"*.

Outcomes noted

A considerable amount of evidence was provided for outcomes in this area. *"Acceptance of child"* *"Acceptance of new baby"* *"Accepting of new baby. Uses baby's name and points baby out to visitors"* *"Child receives positive praise and attention from mother"* *"Mother spends quality time with child"* *"Seen to be playing, cuddling and interacting in a positive and enjoyable manner"* *"Improved emotional wellbeing"* *"Mother communicating with baby/children"* *"Improved emotional wellbeing – mother has quality time with children"* *"No professional concern identified. Baby breast-fed and consistent physical care on all visits"*.

When improvement was either slow or absent, a similar degree of detail was noted. This was mostly in cases where strong professional relationships were in evidence with health professionals. *"Medical advice not sought when children were ill"* *"Child's weight remains of great concern. >98th centile"* *"Immunisation undertaken – but only because HV made home visit"* *"Mother routinely placed her own needs above the welfare and safety of her child"* *"Child hides from mother at nursery"* *"Little opportunity to play and learn"* *"Parent aggressive towards*

children" *"Worker witnessed aggression and lack of warmth"* *"Little opportunity for child to play and learn"* *"Many missed appointments"* *"Mother failed to empathise with child's experience."* *"Persistent lack of emotional availability"*.

The presence and health of the father

Factors relating to fathers are often ignored or omitted from research into neglect and parenting capacity (Moran et al 2004). The positive or negative effects that can be exerted by fathers or father figures in neglectful households was made apparent by the workers in this evaluation. The notion of both risks and opportunities being attached to fathers and other male family figures has been recognised by Daniel and Taylor (2005). The need actively to seek fathers' involvement in parenting or simply to enable this has been reported, too (Long et al 2008).

On assessment

The role of the father in the child's life was noted, in particular whether the father was present in the home. This was mainly a comment related to custodial sentences: *"Father is in prison"* or *"Father in prison – then home on curfew. Support needed while he was in prison"*. The impact of the father's health, particularly mental ill health or substance abuse, was also commented upon *"Father diagnosed with bipolar disorder and ADHD"* *"Substance misuse by father (alcohol)"* including any impact on his behaviour: *"Child's father is alcohol abuser and violent"*. Violent behaviour exhibited by the father was also commented upon in the notes *"Child's father is unpredictable and violent"* *"Father had tried to strangle mother"* including the impact that this may have had on the care of the child: *"Mother scared of father and would not check his care of the child"*.

Outcomes noted

Success in this area was noted in terms of general improvement or mood: *"Return of mother's partner raised mother's mood"* *"Situation improved on father's release from prison"* *"Mother stated clearly that things would not revert to previous unsatisfactory state when children's father due to be released from prison"* *"Children are thriving in father's care (HV report)"*, and in terms of actions taken by the

parents to improve living standards: *"Parents decorating house together"* *"Couple working together on decorating house"*.

Commentary on lack of progress revolved around violence and abusive relationships rather than neglectful behaviour: *"Father of sibling under review for safety with child"* *"Inconsistent handling by father"* *"Mother had violent, abusive outburst at grandparents. Police involved"* *"Relationship between parents is volatile and non-trusting"*.

Parenting Ability

On assessment

Workers noted that some parents lacked basic skills necessary for maintaining a home environment or for provision of basic needs for children. Comments included *"Basic home-making skills lacking"* *"Needs help with organisational skills"* *"Needs help with nutrition. Does not cook"* *"Unable to maintain hygiene"*. Other comments pointed to a lack of knowledge, ability or intent to provide a basic diet or feeding conditions necessary for growth *"Inappropriate diet for toddler"* *"Prop-feeding"* *"Child eating ice lolly for breakfast"*.

Some comments made in the notes by workers identified problems with more specific parenting skills particularly in terms of developing routines or boundary setting for example *"Lacking routines and structure in home life"* *"Mother needs help with routines and boundaries"* *"Struggling with bedtime routines"* *"Routines with household inadequate"* *"Routines inadequate or absent"*.

Outcomes noted

Several comments highlighted success in terms of visible efforts by parents to apply the parenting techniques to which they had been exposed: *"Mother has changed parenting strategies"* *"Mother reports applying techniques to share time with child and offer praise"*, or a general change in attitude, for example *"Evidence of mother taking responsibility seriously"*.

There were many comments to indicate success in terms of boundary-setting following the intervention, for example

"Consistent boundaries in place and child feels secure" *"Routines established"* *"Mother has a routine for washing clothes"* *"Routines and home organisation learned and maintained"* *"Routines and boundaries much improved"* *"Mother reports that she has the kids in a bedtime routine"*.

Other qualitative data that indicated success related to more confident parenting: *"Mother is more confident"* *"Some evidence of greater parental confidence after parenting programme"*, while other comments pointed to increased parenting skills: *"Mother able to provide physical care without prompting"* *"Baby back in care of mother. Able to undertake care with support"* *"Observed to have coped with daughter's minor illness (pyrexia)"*.

However, comments also noted less success in terms of boundary setting for example *"Child allowed to play DVDs in early hours of the morning"* *"Children go to bed when they want to do. No routines"*. Other comments indicated a more general lack of improvement e.g. *"Mother has little insight into child's needs"* *"Home visits repeatedly showed lapses in care and inconsistent improvement"*

Parents' ability to keep the child safe

On Assessment

One of the most significant aspects of the qualitative commentary related to the safety of children in the home. Some of the comments related to hazardous situations through poor repair of the property: *"Cot unsafe – one side missing"* *"Exposed to hazards in the home"* *"Light switch hanging off and wires uncovered"*, or lack of parental insight or ability to maintain safety: *"Poor parental awareness of danger and risks"* *"Safety issues – fire in kitchen"*. Many of the entries related to lack of appropriate adult supervision which in some cases had resulted in injury to the child: *"Children left alone for extended periods"* *"Children left unattended"* *"Lack of supervision"* *"Little supervision indoors or outdoors"* *"Lack of supervision caused physical injury"* *"Children seen leaning out of windows"*. Some comments indicated that other dangerous actions were taken by parents in the place of appropriate supervision: *"Lock on child's bedroom*

door” *“Chair seen placed against child’s bedroom door handle”*.

Many of the comments related to the emotional wellbeing of the child with particular reference to witnessing or experiencing violence in the home: *“Child witnessed domestic violence” “Concerns about effect on children of parental domestic violence” “Child witnessed domestic violence between parents” “Children exposed to domestic violence” “History of serious domestic violence in grandparents. Same for child’s parents” “History of domestic violence and alcohol misuse with previous partner”*. Other comments highlighted safety issues related to danger posed by individuals who were not family members: *“Mother unable to protect child from inappropriate adults” “Unknown male arrived in house” “Subject to sexualised behaviour by another child (outside family)”*.

Outcomes noted

Successful outcomes reflected raised awareness of danger: *“Parent shows increased awareness of risks to safety” “Increased awareness of safety issues and risks to children”*, and that parents had taken action to remove dangers: *“Hazards have been removed” “Dangerous modelling tools put away” “Doors and windows locked to secure the house”*.

Lack of success was highlighted by recognition of lack of parental awareness: *“Father has poor awareness of immediate dangers”* or of parental failure to make the environment safe or secure: *“Electrical wires exposed – sockets and light switches” “Broken glass not repaired” “House still dirty and unsafe – planks of wood propped up against wardrobe”*. Lack of action in terms of adequate supervision of children was also noted in this section: *“Children play outside with no supervision” “Young children left to supervise younger siblings” “Allowed to go with strangers” “Children not supervised when playing outside” “Young children left to supervise even younger siblings outside” “Children playing in street unsupervised. Mother no insight into danger”*. Workers also made note here of dangerous, violent or potentially violent situations to which the child was exposed: *“Risky adults allowed*

in the house” “Child taken back to violent situation” “Child accompanying strangers on request.” “Child exposed to unsafe situations” “Mother return to house with child when violent father still there. Left child with him while she worked a double shift” “Mother denies knowledge of physical abuse but evidence was clear”.

Abuse

On assessment

In addition, workers noted abusive rather than neglectful situations in the home. This included verbal abuse by parents: *“Mother shouts at children” “Parents seen using abusive language to children and shouting at them”*, and by others: *“Other family members shout and swear at children”*. Physical abuse by parents and others was also noted: *“Father had punched one child in the face” “Mother swearing, shouting at and hitting children” “Physical abuse of child by father” “Inappropriate punishment” “Maternal uncle hit child with plastic spatula” “Marks of physical abuse found on skin by health professional” “Physical injuries to child on more than one occasion”*.

Outcomes noted

Outcome statements were sparse, however: *“Sexualised behaviour continues”*.

Attitude to Services

On assessment

Qualitative commentary highlighted the difficulties arising from reluctance of service users to engage with services, for example *“Distrust of social worker – reluctant to engage” “Mother failing to engage with housing and other services”*. This included attendance for scheduled appointments or availability for planned visits: *“Mother does not implement proffered advice” “Mother failing to engage with services or attend for appointments or admit workers for planned visits”*.

Outcomes noted

In terms of attitudes to services, workers noted an improvement in some parents’ attitudes: *“Mother and partner open to working with Action for Children” “Expressed appreciation for worker’s help with improvement in parenting”*.

However, lack of progress was noted particularly in terms of the worker's ability to access the home: "Access denied" "Access achieved only when not expected" "Refused entry to house". Parents' failure to engage with services was also noted: "Parent shows no interest or capacity to change".

"Mother persistently demonstrated no interest, capacity or willingness to work with agency to bring about change in neglectful parenting" "Mother not engaging purposefully with the service" "Only superficial engagement with services". These were often the summarising statement in cases where no progress was made and children were taken into care.

SUMMARY

In all three areas in which textual data was recorded, information about assessment was usually provided in detail. However, recording of outcomes was sometimes lacking, notably about children. With regard to issues about children's physical health (sometimes including serious medical problems), it might be understandable that workers would be

reluctant to express judgement in detail about outcomes. In contrast, issues of personal hygiene were central to many cases, yet comments on outcomes were minimal. The general focus on parental action rather than impact on children that is seen across both health and social care services may be a factor that contributed to this.

7 ANALYSIS AND DISCUSSION

OUTCOMES OF ACTION FOR CHILDREN INTERVENTION

Change in the level of concern about neglect

Overall, there was a significant improvement in the level of concern about neglect in the total of 85 cases considered. For most cases, discernible improvement was recorded, but two fairly distinct groups of cases were discerned.

Expediting the move into care

The first group was characterised by families in which no change was achieved and the children were subject to care proceedings. The complexity of this grouping requires further consideration.

The scores and narrative outcomes for some children showed that some parents were unwilling or unable to make the required changes to lifestyle and parenting behaviour, and the result was that the children were taken into care. These cases tended to be already on the threshold of care proceedings on referral to Action for Children, and successful transition to lower level services was predictably rare. However, Action for Children services clearly assisted statutory agencies to reach earlier conclusions about the need for children to enter alternative care whether with agreement of parents or through securing care orders.

This was most evident when Action for Children presented the results of comprehensive assessment to a multi-agency forum to enable that forum to make a clear decision about the well-being of the child or young person. The assessment from Action for Children in these cases was influential for two main reasons. First, the family was seen through “fresh eyes” and with a renewed chance of providing evidence of the family’s ability to change. Some families will engage more easily with staff from the voluntary sector than with those from the statutory sector, so one of the barriers to change may have been removed. The second strength was that if the families were shown to be unable to change even

with the intensive support that the Action for Children service was able to offer, the evidence of the poor likelihood of future change was seen to be compelling by commissioners and by the courts.

There was concern, however, among the research team and Action for Children managers that, while Action for Children had played a vital role in ensuring that these decisions were finally taken in confidence and with due evidence of need, such cases allowed for only limited evidence of the potential for early intervention in guiding families back from the threshold of proceedings and into targeted services.

Improvement in the level of concern about neglect

Once the sampling frame was altered to include project sites at which early intervention was possible, even though sometimes with families in which neglect was a particularly serious concern (sometimes scoring as many areas at 4 or 5 in the Action For Children Assessment Tool instrument as the cases above), it was noted that the possibility of returning some families to a much lower level of concern was realised.

Families in the second group showed engagement with project workers, made changes in carefully planned stages, often relapsed temporarily, and disclosed additional problems during engagement, but tended to transition successfully into targeted services. These families were not usually on the threshold of care (though this was not always the case), and “early intervention” more readily described the practice activity. The lowering of concern resulting from these early interventions prevented neglect deteriorating to the point where children would have to live with alternative carers. The importance of workers establishing effective, trusting relationships with families and gaining access to homes should not be understated. Similarly, the provision of

multi-faceted approaches which combined practical assistance with support for vulnerable parents to confront painful issues about their parenting were crucial to success.

Most of these transitioned to less intensive services with no remaining areas of concern. However, concern remained in other cases, often with a single lingering

area of concern which required extended intervention beyond the limit of the commission. Even in these cases where some concern remained on closure, huge improvements were often seen, with an obvious trajectory towards complete resolution. In these cases, families were transferred with well-developed action plans to the referring agency for completion of the work.

KEY FACTORS IN ACHIEVING POSITIVE CHANGE

Five factors proved to be essential to the success recognised by the evaluation. These related to early intervention, home visits and the relationship between parent and worker, explicit acknowledgement of neglect as a problem, addressing the complexity of the problem, and the utility of the Action for Children Assessment tool.

Early intervention

The notion of early intervention repeatedly requires clarification, particularly whether this refers to intervention at an early age of the child or intervention at an early stage of the descent into neglectful parenting.

Early age

Since neglect can become an issue at any stage of a child's life (Horwarth 2007), early age was not the prime factor in this evaluation. Neglect might develop because of multiple stimuli that start to affect parenting only when one child is in middle childhood. The birth of an additional child, changes in parental relationships, the admittance to the house of a 'risky' adult, the onset of substance misuse, and many other factors might tip the balance and transform what was previously acceptable parenting into clearly neglectful parenting. Neglect may occur in early infancy for one child but in middle-childhood for an older sibling. There were cases in the evaluation in which older children were neglected as attention was focused on young siblings. However, the neurodevelopmental evidence is clear that for infants who are subject to neglect in the early months, rapid intervention is vital (HM Government 2011, Howe 2005).

The age of children was not found to be an influence on whether or not the result was a return to targeted (or even universal) services or entry into care. In almost all cases in which neglect was so severe and improvement so inadequate as to require entry into care, all of the children were made subject to care proceedings. The whole family situation was the key, with the focus mostly on parental response and ability such that the risk to all of the children was too great to be managed at home. The context of family chaos and multiple gaps in parenting were clearly interwoven with this.

Early stage

Intervening when neglectful parenting is at an early stage was a key factor in the evaluation and became more vital as the preliminary analysis was completed. Early intervention was, in most cases, taken to mean intervention with the smallest possible delay after neglect had been identified as a concern. There may be a concern that early intervention could slide into intervention at such an early stage that neglect is neither present nor likely, yet the application of the Action for Children Assessment Tool was helpful in ensuring that there was actual concern about the level of parenting in cases recruited to the evaluation.

There was an exception to this which applied to eight cases. These related mostly to young, inexperienced parents, sometimes with a learning disability or with little other support, in which it was foreseen that neglectful parenting would be inevitable. This was sometimes recognised before the birth. In these cases, the target was to keep the baby

safe and appropriately cared-for while working with parents to increase skills and general parenting ability. In all cases this was seen to be successful and families were successfully transitioned to universal services.

Home visits and the relationship between parent and worker

Workers reported establishing effective relationships with parents and children, gaining trust and therefore access to challenge failings, offer guidance, and to provide reassurance and moral support. This was often accomplished with parents who were hostile or clinically depressed, or holding deep suspicion of agencies and their intentions. It was clear from letters and case conference minutes that workers gained access to houses and information which was sometimes not available to other workers and professionals. In this, Action for Children staff sometimes became the only workers with meaningful access, opportunity to observe the children and work with the parents.

To achieve this access and to sustain an effective working relationship the practitioners had to demonstrate persistence and determination to engage parents, to work through repeated rebuffs, and to retain the motivation to succeed. The notion of parents having had chances, missed them and therefore being considered impossible could not be accepted, so workers persisted and pestered until objectives were achieved.

The findings of the interim report of this evaluation prompted Action for Children to develop its Family Partners initiative, informed specifically by the experiences of Action for Children staff in the UK Neglect Project. The Family Partners project actively sought out early neglect and intervened in an informed manner, exploiting, in particular, the new learning about the importance of the practitioner-parent relationship. This Family Partners model is being delivered in several services in Action for Children and is being presented to commissioners as an effective and efficient way to engage families where there are early signs or emerging concerns and to achieve positive outcomes for children.

Explicit acknowledgement of neglect as a problem

Before being able to address inadequate and neglectful parenting effectively, it was vital to establish an explicit understanding with parents that the problem was neglect. Without this overt acknowledgement it would have been impossible to identify the improvements that were essential or to verify that the required changes had occurred. While in most cases the commissioner had already declared the concern about neglect to the parents, practitioners also spoke of many instances of parents being shocked to discover that their parenting was considered to be neglectful. The broaching of the subject was clearly a difficult matter for some. The research team engaged with managers from the sites to develop a template script for briefing staff on how to broach the subject of inclusion in the neglect project to parents when this was necessary. (Appendix A)

Addressing the complexity of the problem

Another aspect of successful home visiting was the workers' ability to identify (with parents) the wide range of problems that were stimulating or aggravating the neglect, to hold these and keep them all in mind, but then to prioritise those which needed to be addressed first, usually prioritising those that would immediately bring most benefit to the child. Often the pursuit of a single problem would involve a raft of activities, each of which might need to be taught and demonstrated, and then a sustained programme of coaching, reminding and motivating parents until a routine was established. For example, to achieve the outcome of children eating a nourishing evening meal, the practitioner might need to start with recognition of basic food groups and planning a meal, then shopping for the food, cooking the meal, supervising children in eating the meal, cleaning up after the meal, and so on. Practitioners talked of having to physically demonstrate *how* to clean a toilet such was the lack of experience of some parents. Consequently, while each individual aspect of care might require a detailed programme for progress to be achieved, the sum of these facets of care could be seemingly overwhelming – the

reaction experienced by many of the parents. Skill was needed to break this chaotic mass of difficulties down into manageable units of learning and then gradually building the whole picture back up again into the full skills set required for adequate parenting.

The utility of the Action for Children Assessment Tool

The use of the Action for Children assessment tool proved to be a key factor in enabling practitioners to measure and improve progress in each case. Practitioners reported that they used the instrument with parents (rather than applying it to them). They would use the items to score jointly with the parent according to the state of the situation. This might involve a tour round the house, including children's bedrooms. This access was often unprecedented and would uncover more evidence of problems.

Using the instrument allowed parents to come to their own understanding of what was lacking in their parenting: a powerful means to promote resolve to make the necessary improvements and changes. At this point, it would be hoped that the impact of this on the children would then be pointed out by the worker. The lack of recorded evidence means that this cannot be verified. Nonetheless, the joint agreement between parent and worker of deficiencies in parenting was a much more effective foundation for moving on to planning and action than the imposition of the view of an external agency.

The instrument was often completed sequentially in stages so as not to overwhelm the parent. As one prioritised issue was sent to be coming under control, another would be introduced, again often by agreement between worker and parent. Parents, then, were presented with challenging but manageable targets. The whole complexity of the case was held by the worker while the parent was encouraged to focus on improving selected aspects of care.

The Action For Children Assessment Tool was also found useful by practitioners in presenting the evidence of a case to multi-

professional groups and to commissioners. Its stable, objective nature and simple scoring system engendered confidence in the assessment of problems and evaluation of outcomes. The revised Action For Children Assessment Tool has been reviewed by the original author of the Graded Care Profile,⁶ and agreement has been secured for Action for Children to use the revised instrument. It now forms part of an Action for Children practitioners' toolkit. Care is taken to ensure that the instrument remains a supplement to judgement rather than a substitute for it (Munro 2010).

⁶ Dr Om Prakash Srivastava, Consultant Community Paediatrician, NHS Luton Community Services.

8 CONCLUSIONS

SUMMARY

There was little pattern to see in the characteristics of parents or children who were involved with the services in the evaluation. A number of different issues were present in most cases but the combination of specific issues differed from one case to another. However, the most common presenting problems were often linked: chaotic lifestyle with no routines, and home conditions which presented health, hygiene or safety hazards to children.

In 79% of cases, the Action for Children intervention succeeded in reducing the level of concern about neglectful parenting or preventing neglect from developing.

This reduction was sometimes minor when linked to a sustained overall high level of concern in cases which resulted in accommodation of children, but was most often indicative of major improvement at least to the point of moving the level of concern below the threshold of neglectful parenting.

In 50 cases (59%), concern about neglect was removed completely.

Twenty-three (27%) cases resulted in the children being taken into care, but the Action for Children service also achieved an improvement for the children concerned since this action was taken in a timely manner as a result of detailed and convincing evidence of intractable neglect.

In eight cases (9%) otherwise inevitable neglect was successfully averted by the intervention.

In six of these, the existing signs of potential for neglect were reduced to a point further from the threshold of concern.

Early intervention was vital.

While determined and persistent efforts by Action for Children staff often secured improvement in cases of entrenched neglect, though less commonly to the point

of removing concern to below the declared threshold, the best results were clearly to be seen when intervention began early in the family's decline in neglectful parenting. When cases were identified in a timely manner, and skilled, intensive intervention and support were instigated, significant success could usually be expected.

Establishing a positive relationship was crucial, as was home-visiting.

The most common responses to neglect involved a key worker forming a close working relationship with the parents and, commonly, coordinating interagency services. Home-visiting was almost universal across sites, usually focused on establishing routines and boundaries, and improving hygiene and safety in the home. Group-based parenting programmes, most commonly the Positive Parenting Programme or the Webster-Stratton Programme formed the second arm of intervention. For both elements of intervention, a crucial issue was the willingness and ability of parents to engage with the service on offer.

The Action for Children Assessment Tool was a successful innovation.

It proved to be useful both in identifying key areas of neglect together with example descriptors and in promoting shared identification of failings and routes to improvement with parents. Regular workshops for service staff and feedback from managers and researchers were designed in this project to promote this thoughtful use of the Action for Children Assessment Tool as a guide and an instrument rather than as a complete assessment in itself.

A high level of skill was required by practitioners.

Both the focus on home-visiting and the complexity of assessing, addressing and evaluating neglect demanded a high

degree of knowledge, skill, and experience of the practitioner.

Complex circumstances, vulnerable families, and the breadth of factors to include in decision-making provide a challenge to any worker. In this study, the best practice across all of the services was evidenced when the manager or lead practitioner engaged all the staff in

reflecting on what the assessment tool was indicating and then supporting them to share the findings with confidence with more qualified colleagues.

Many of the workers in the project acknowledged the role of this support in enhancing their confidence in assessment skills and presenting their findings to other colleagues and agencies.

KEY MESSAGES AND QUESTIONS FOR FURTHER RESEARCH

The Action for Children Services that were included in this evaluation demonstrated their ability to intervene successfully in most cases of neglect, even when neglect was a most serious concern (to the level of child protection intervention). In cases where parents refused or were unable to respond positively, children benefited from an expedited move into care.

The ability and willingness on the part of parents to engage with services was a crucial factor in deciding whether progress would be made or children removed for accommodation.

Specific contributing factors were identified, but mostly relating to the worker's approach and ability. Further research is needed to investigate the factors in parents that support or militate against a positive response to offers of help for efficiency in the approach to borderline cases to be enhanced.

The work undertaken in outreach or home-visiting by often unqualified support workers with especially difficult cases requires a high level of skill as well as experience.

Research is required to establish the means by which practitioners achieve this level of skill and expertise, and to isolate

the constituent elements in order to inform training and mentorship.

The Action for Children Assessment Tool enabled practitioners to work with parents to establish a joint understanding of problematic aspects of parenting and to plan for staged improvements. It also provided a valuable source of evidence of objective assessment and review.

The instrument, while valued, was too large and cumbersome. Further work is being undertaken by Action for Children to reduce the size of the instrument but without damaging its effectiveness. Testing for continued effectiveness and retention of both objectivity and specificity will be necessary.

Acknowledging that most neglected children remain in the care of their parents, it is vital that efforts are made to provide services directly to the child and not just to parents. Where a twin-track approach has been used in other services it has proved to be successful.

The degree to which the intervention impacted specifically on children's health and wellbeing could not be fully established in this evaluation. A focused effort to address this should be made with a moderate but carefully monitored sample using the methods developed in the evaluation.

9 REFERENCES

- Burgess C, Daniel B, Scott J (2012) *Child neglect in 2011. An annual review by Action for Children in partnership with the University of Stirling*. Action for Children
- Cleaver H, Nicholson D, Tarr S, Cleaver D (2007) *Child protection, domestic violence and parental substance misuse*. London: JKP.
- Cox A, Walker S (2002) *The Home Inventory*. Brighton: Pavilion.
- Crittenden P (1999) Child neglect: causes and contributors. in Dubowitz H (ed) *Neglected children: research, practice and policy*. Sage Publications, pp47-68.
- Daniel B, Taylor J (2005) Do they care? The role of fathers in cases of child neglect. In Taylor J, Daniel B (Eds) *Child neglect: practical issues for health and social care*. London: Jessica Kingsley.
- Daniel B, Taylor J, Scott J (2009) Noticing and helping the neglected child: literature review. London: DCSF.
- Department for Children, Schools and Families (2010) *Working together to safeguard children*. London: TSO
- Department for Education (2011) *Characteristics of Children in Need in England, 2010-11, Final*. Available at <http://www.education.gov.uk/rsgateway/D/B/STR/d001041/index.shtml>
- Department for Education (2011) *The Munro Review of Child Protection: Final Report. A child-centred system*. Cm8062. London: DfE. Available at <http://www.education.gov.uk/publications>
- Department of Health (1995) *Child protection: messages from research*. London: HMSO.
- Department of Health (1999) *Working together to safeguard children*. London: TSO.
- Hallett C, Birchall E (1992) *Coordination & child protection: a review of the literature*. London: HMSO
- Hannon C, Wood C, Bazalgette L (2010) *In loco parentis*. Demos/Barnardos. Available at http://www.demos.co.uk/files/In_Loco_Parentis_-_web.pdf?1277484312
- Hardiker P, Exton K, Barker M (1991) *Policies and practices in preventive child care*. Aldershot: Avebury.
- Hart D, Powell J (2006) *Adult drug problems, children's needs: assessing the impact of parental drug use - a toolkit for practitioners*. London: National Children's Bureau.
- HM Government (2010) *Working together to safeguard children*. London: DCSF.
- HM Government (2011) *Early intervention: the next steps. An independent report to Her Majesty's Government*. London: Cabinet Office.
- Horwath J (2007) *Child neglect: identification and assessment*. London: Palgrave/Macmillan.
- Howe D (2005) *Child abuse and neglect. Attachment, development and intervention*. Basingstoke: Palgrave Macmillan.
- Hutchings J, Bywater T, Daley D, Gardner F, Whitaker C, Jones K, Eames C, Edwards R (2007) Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial. *British Medical Journal*. 334(7595) 678. doi: 10.1136/bmj.39126.620799.55.
- Livesley J, Ravey M, Long T, Murphy M, Fallon D (2010) *Evaluation of the Blackpool Budget Holding Lead Practitioner Project*. University of Salford ISBN: 978-1-907842-03-0. Available at www.nursing.salford.ac.uk/research/n&m-research/childrenandyoungpeople/
- Long T, Fallon D, Devitt P, Oak E, Murphy M, Dugdill L (2008) A community health needs evaluation to improve uptake of services at a children's centre in a deprived and geographically isolated town. *Journal of Children's and Young People's Nursing* 2 (3) 108-114.
- Macrory F, Murphy M (2011) Management of the effects of prenatal drugs in children of drug-abusing parents. in Preece M, Riley E (Eds) *Alcohol, drugs and*

- medication in pregnancy*. London: MacKeith.
- McCarthy T, Galvani S (2010) *Alcohol and other drugs*. London: BASW.
- McConnell D, Breitzkreuz R, Savage A (2011) Independent evaluation of the Triple P Positive Parenting program in family support service settings. *Child and Family Social Work*
doi: 10.1111/j.1365-2206.2011.00771.x
- Moran P (2009) *Neglect: research evidence to inform practice*. Action for Children.
- Moran P, Ghate D, van der Merwe A (2004) *What works in parenting support? An international review of the literature*. London: DfES.
- Munro E (2010) *The Munro Review of child protection. Interim report: the child's journey*. London: DfE. Available at <http://www.education.gov.uk/publications>.
- Platt D (2006) Threshold decisions: how social workers prioritise referrals of child concern. *Child Abuse Review* 15: 4-18.
- Pollnay L, Srivastava O (2001) *The Graded Care Profile*. Luton: Bedfordshire and Luton PCT.
- Ravey M, Murphy M, Long T, Fallon D (2008) *Evaluation of the Blackpool Springboard Project*. University of Salford. ISBN: 978-1-905732-53-1. Available at www.nursing.salford.ac.uk/research/n&m-research/childrenandyoungpeople/
- Reder P, Duncan S (2001) Abusive relationships, care and control conflicts and insecure attachments. *Child Abuse Review* 10:411-427.
- Social Work Reform Board (2010) *Building a safe and confident future: One year on*. www.education.gov.uk/swrb
- Stein M, Rees G, Hicks L, Gorin S (2009) *Neglected adolescents - literature review*. London: DCSF.
- Stevenson O (2007) *Neglected children and their families*. Oxford: Blackwell.
- Tunstall J, Blewet J, Meadows P (2008) *Evaluating the delivery by Action for Children of targeted family support*. Synergy Research and Consulting Ltd.
- UNICEF (2008) *Behind closed doors. The impact of domestic violence on children*. New York: UNICEF. Available at <http://www.unicef.org/protection/files/BehindClosedDoors.pdf>
- www.actionforchildren.org.uk/media/143983/evaluating_targeted_family_support.pdf
- www.barnardos.org.uk/what_we_do/campaigns/campaigns_children_in_care.htm (accessed 12.7.10)
- www.childwelfare.gov/pubs/usermanuals/neglect/neglect.pdf
- www.education.gov.uk/rsgateway/DB/STR/d001041/index.shtml (Accessed 03.01.12).
- www.scotland.gov.uk/Topics/People/Young-People/gettingitright
- www.sdqinfo.com/

APPENDIX A: Introducing “level 2 parents” to the neglect research project

Key points

You have problems that are affecting your child(ren), and we want to help you with them.

(Indicate the impact on the child(ren) of struggling in these areas.)

The problems that I see now are the sort of thing that can lead to children receiving care that falls below government-defined standards.

If things got to that point, the level of care is defined as being neglect.

So, if things go on like this you will find people getting involved in your life to protect the children because they will be at risk of neglect. It can even end up in children being taken into care.

That's why Action for Children wants to help you now, while the problems can be fixed.

You can work with us now to tackle the problems and ensure that they don't escalate into needing more intrusive intervention. We can agree on what needs to be done differently, and I can help you to make the changes that are needed. You can stay in control and, hopefully, you will all see the benefits. (Examples from the specific case of what could be achieved for the family.)

So, there it is. It's not a demand: it's an offer to help you to help yourself.

(The research)

We are currently trying to find out what works best in the way that we help families with these sorts of problems. Some researchers from the University of Salford are working with us to do this.

They especially want to see if helping at an early stage like this is more effective than waiting until the problems have really taken over.

They are looking at family case files (but not collecting personal details like names or addresses) to see what works best in different circumstances.

If you agree they might want to see your case file and include some information anonymously along with other families like yours - and also some that are in much more difficulty. They may ask to interview you to ask how you found the service that we offer and if anything could be done better.

We would do this only if you agree, though your names or address or other details that might identify you wouldn't ever be recorded or divulged to anyone outside the Action for Children service.

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CYP@Salford

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