

# Section One Strategic Purpose and Vision

## Introduction and Background:

This Neglect Strategy has been developed by a multi-agency group (refer to [Appendix1](#)) and covers all children and young people aged < 9 months to 18 years. The work was commissioned from the Salford Safeguarding Children Board (SSCB), in line with SSCB business plan and Children and Young People's Plan, and is a key aim from the national outcomes framework for staying safe. The work in Salford to manage neglect has been underway for some time and this has influenced the need for the various strands of activity to be brought together in one strategy that defines the need, sets out the priorities and expected outcomes and promotes and supports best practice. The Framework for Assessment and expectations from [Every Child Matters](#) emphasises the importance of professionals working in partnership with children and their families and working in collaboration across a broad range of agencies. This strategy is designed around that commitment in the belief that this is the most effective way to approach and change the incidence of neglect for the children and young people of Salford, and to promote the best outcomes for those children who experience neglect.

From the research (refer to [Section2](#), of this strategy), we know that the severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress. Neglected children may also experience low self esteem, feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing'. (Working Together to Safeguard Children.2006). The likelihood is that a neglected child will fail to meet their potential across all 5 of the national outcomes for children and young people. The parents, the wider family, the local community and society share the responsibility with services for meeting the needs of children and preventing or ameliorating the impact of neglect.

## Purpose:

The purpose of the Strategy is to set out the priorities for developing and achieving a multi-agency co-ordinated approach to working with families where neglect is an issue. The Strategy is intended to be aspirational, inspirational and achievable. It covers the range of need across the continuum, including supporting families as early as possible to prevent significant harm to children and family breakdown. This strategy should be read in conjunction with the family support strategy.

By supporting these families appropriately we aim to maximise the chance that every child has the opportunity to fulfil their potential. The emphasis is on

support and prevention as well as safeguarding, in line with existing plans and preventative strategies such as:

- Children's Fund Delivery Plan
- Sure Start Local Programme
- Teenage Pregnancy Strategy
- Child and Adolescent Mental Health Strategy
- Behaviour Improvement Plan
- Anti Poverty Strategy
- Corporate Youth Strategy
- Family Support and Parenting Strategies
- Drugs – Protecting families and communities (2008)

The Strategy provides some analysis of what services are currently in place, what works, and suggested tools to ensure consistency, training, support and priorities for improvement and future developments.

### **Context:**

The strategy is set in the context of Salford Safeguarding Children Board, the Children Act 2004, Every Child Matters - Change for Children Agenda, the National Service Framework for Children, Young People and Maternity Services, and the Common Assessment Framework. The local authority has a general duty to take reasonable steps to prevent children within their area suffering ill treatment or neglect (Schedule 2 Para. 4-1) and in so doing should ensure that there is co-operation between the relevant agencies. Section 10 and 11 of the Children Act 2004 outlines the expectation on local authorities and their partner agencies and bodies to work together to improve the well being of all children in their area. The strategy sets out the priorities for family services in preventing and responding to neglect, which promote the five national outcomes for children from the Every Child Matters Outcomes Framework: be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being.

The strategy is underpinned by the requirement that services are planned and organised around the needs of children and make best use of the available resources.

### **The vision for the children of Salford:**

Salford Safeguarding Children's Board (SSCB) and Children and Young People's Partnership Board are committed to working towards improving outcomes for all children and young people in the City and this means aiming to ensure that every child and young person is able to achieve to their full potential. This aim is entirely consistent with Salford's Community Plan aspiration to create a safe city where children and young people are valued.

Salford Children and Young People's Partnership Board seek to achieve this aim through the provision of services that are integrated at whatever level, and to whatever degree is deemed most appropriate to ensure effective and

efficient service delivery, whilst working towards the creation of a fully integrated service.

The mission for Salford City Council to create the best possible quality of life for the people of Salford', is set out within the pledges of the Community Plan. Within this, the aspirations include being a city with an emphasis on young people, and a citywide priority to tackle the issues of neglect. The Salford Partnership, Partners IN Salford', comprising community, private, public and voluntary organisations, produced a revised community plan covering the period 2006-2016. Its vision is to create a city which is a superb place to live and work, seven themes set out what the partnership is seeking to achieve: a healthy city; a safe city; learning and creative city; a city where young people are valued; an inclusive city; an economically prosperous city; and a city that is good to live in. In order that this vision be achieved partnerships are creating joint strategies to address some of the problems faced by the city in particular those surrounding vulnerable children and young people.

In developing this strategy the intention is to ensure the delivery of services such that children and young people who experience neglect are identified and joint agency responses are provided at the earliest opportunity to prevent significant harm and promote each child achieving their potential. An emphasis on early intervention and support is intrinsic to the way integrated services will be delivered. This is represented through the development of the assessment triangle to a child centric triangle as represented through the following diagram, developed by the Scottish Executive:



## **Statement of Intent:**

In developing the strategy, the intention is:

To ensure the delivery of co-ordinated and effective Universal and Targeted Services based on assessed needs with the aim of supporting and promoting the wellbeing of children, young people and their families in Salford to impact on the levels of neglect they may experience. An emphasis on early intervention and support is integral to the way support services must be delivered.

## **Section Two National Context and Research**

### **Definitions of Neglect:**

.....the food would be cold and would be given to her on a piece of plastic while she was tied up in the bath .....she would eat it like a dog, pushing her face to the plate....'

Neil Garnham QC  
Counsel to the inquiry into the death of Victoria Climbié  
(Laming, 2003: 1)

(Neglect)....it is the most serious type of child maltreatment and the least understood....'

(Crittenden, 1999: 67)

Kieran O'Hagan argues that in order for the term neglect' to have meaning there must be a broader clarification of the type of the neglect. The expansion of the definition may be seen to be reflected in the expansion in the national increase in recognised neglect cases. The need is to view neglect not as a snapshot in time but as Jan Howarth suggests, as a video over time of the life of the child', which reflects the experience of the child. With this comes the requirement for skilled assessment and evaluation of the evidence.

The Department of Health defines neglect as, 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, for example, as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical and emotional harm or danger, failure to ensure adequate supervision including the use of inadequate care-takers, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs'.

It is suggested, that contemporary definitions of neglect should incorporate a holistic approach to the notion of parental responsibilities (Browne and Lynch,

1998; Dubowitz et al, 1993). A wider -ecological'- perspective on child neglect emphasizes that the responsibility for meeting the needs of children is shared by the parents, the wider family, the local community and society (Dubowitz et al, 1993).

Therefore, any definition of neglect needs to reflect both the physical and emotional components of it. The following definition was agreed by all agencies in the development of this strategy;

Neglect may be defined as occurring where the child's needs are not consistently at the centre of the carers thoughts, feelings and actions, such that this has an impact on the child's healthy development and this is known to be reflected within a video over the life of the child' rather than a snapshot of their experience.

### **Research Summary:**

It is important to acknowledge that as with most areas of research, that of neglect has limitations. There is an absence of a clear, consistent conceptual and operational definition of neglect and seldom differentiation between the subtypes. Similarly research has tended to draw from neglect cases defined through the child protection systems, introducing a significant level of bias. That said there has been a growing number of research projects designed to provide greater illumination regarding the aetiology, treatment, consequences and prevention factors for neglect. The key messages from them have influenced the drafting of this strategy and are briefly set out below

### **Aetiology:**

Socioeconomic factors are often cited as causes' of neglect (including perhaps societal neglect), but interventions to remedy this have not reduced the incidence. Culture, context and generational practice and norms are significant in evaluating the aetiology, and whilst sensitivity and knowledge of these are required, they and socioeconomic factors are neither necessary nor sufficient in themselves to cause childhood neglect.

### **Key messages:**

- Lack of social support and loneliness amongst carers are key factors in neglectful families, particularly where there are also poor social skills and parental history of neglect (Guardin, Polansky, Kilpatrick and Shilton 1993)
- The role of parental mental health and substance misuse have been identified as significant in the neglect of children, and this exacerbates the likelihood that carers will not access the community support that may be available to them (Tunnard 2002).
- Distortions and limits in the mental processing of information, most frequently displayed as poor interpersonal relationships, often endure across generations (in spite of improved economic success), and accounts for many of the consequences of child neglect. This has

enormous implications for the way in which interventions need to be shaped to be most effective (Crittendon 1985).

## **Impact:**

Many studies have concluded contrary to popular belief that the children who experience neglect emerge as the most severely adversely affected (English, 1995). Critical developmental needs can be met at different stages of development by a variety of sources; however, the quality of the parent-child interactions is pivotal for the child's healthy physical, cognitive and emotional development. It is important to be aware of both the short and long-term effects neglect has on a developing child. Developmental theory considers adaptive functioning specific to developmental stages and the dynamic interactions between the child's needs and environmental influences. This approach and understanding is useful to apply when addressing the effects of neglect. The existing research clearly indicates that children may experience short and/or longer-term cognitive, emotional and social problems, including deterioration in brain development, attachment disorders and developmental delay. The negative effects on children's cognitive development appear to begin in infancy and continue to impede their academic functioning in later years. The evidence for the effects of neglect on children's socio-emotional functioning is more ambiguous.

Some research has found a strong relationship between abuse and neglect in childhood and female depression in adulthood. Bifulco and Moran found that in each of the samples studied, neglect in childhood related to more than a doubling of rates of adult depression in females. This risk was increased where neglect was combined with types of emotional abuse including role-reversal and antipathy (Bifulco and Moran, 1998: 30, 44-45). The authors of this study have concluded that '...we can begin to assume that neglect and abuse in childhood is at least one of the causes of adult depression....' (Bifulco and Moran, 1998: 132). Evidence from this study also supports a link between childhood psychological abuse and female self-harming behavior during adolescence and early adulthood. There is therefore evidence of a strong relationship between childhood experiences of neglect and later significant mental health problems amongst females. There is a lack of empirical evidence concerning neglect and later mental health problems in young males, but it would seem likely that the longer-term outcomes of neglect may include depression, self-harm and substance misuse, irrespective of gender.

## **Key messages**

- Neglected children have worse delays in expressive and receptive language than from other forms of abuse (Allen and Oliver, 1982). This has an impact on comprehension and expression for these children, including the capacity for age appropriate play, impulse control and flexibility and creativity in problem solving.
- Some studies have indicated that neglected children are less able to form and develop social and peer relationships (George and Main, 1979).

- Failure to meet the basic nutritional and psychological nurturing needs of a child may impede physical growth as well as a range of other health effects. (Drotar, Eckerle, Satola, Palotta, and Wyatt, 1990).
- Evidence from a range of prospective and retrospective studies indicates that older children who have been neglected have cognitive and academic deficits that impair their development. These effects have been found to be greater and more enduring for neglect than for any other type of maltreatment (Eckenrode et al., 1994)
- There are clear social and behavioural effects for neglected children, although this has been characterised as passive, non-assertive or withdrawn characteristics, this is not always consistent (Wodarski et al, 1990)
- There has been little research on the connection between neglect and delinquency, but neglect has been shown to be a predictor of delinquency in association with poverty and lack of social support (Starr et al., 1991).
- Although the stereotype of neglectful families includes a cycle of intergenerational repetition, the evidence suggests that this applies to a minority of chronically neglectful families and those most likely therefore to be within the child protection system (Kaufman and Zigler, 1989).
- Neglected children are likely to require ongoing support throughout childhood and into adolescence. It is self-evident therefore that the potential impact for any individual child will be across all 5 outcomes, children also die from neglect.

## **Intervention**

Effective interventions for neglected children and their families must be based on a comprehensive assessment of the needs of individual children and their families. Within this process there is a primary responsibility to consider the type of neglect that may be apparent, the severity of the neglect, and the harm and risk of harm to the child. In addition, as DePanfilis indicates, attention should be given to the specific contributing causes of neglect, at the individual, family and community levels (DePanfilis, 1999: 214).

A child's basic needs may not be met in a range of ways, and there may be multiple pathways that lead to this. The importance of accurate assessment of risk and resilience, and evaluation of evidence is therefore crucial in ensuring effective interventions. The interventions should be directed across the range of influencing factors (individual, family, community /social context), as required. The goal of helping carers within their community to meet the needs of their child requires a mix of models, length and intensity and targeted resources. Thoburn and others suggest that the central questions for professionals are '....do families find the services helpful, and do they appear to be effective in preventing further impairment of children's health and development? ....' (Thoburn et al., 2000: 200).

The current framework for assessment emphasises the importance of professionals working in partnership with children and their families, as well as working in collaboration with a broad range of agencies (Department of Health

et al, 2000a: 56; see also Jowitt, 2002). This is particularly critical to the issue of child neglect in that neglectful families are highly likely to have multiple and complex problems that necessitate co-ordinated and multiple responses. The construction of a whole picture' of circumstances and events provides a strong foundation from which appropriate decisions about levels of risk can be formulated. It is further observed that .... in practice individual agencies may hold separate pieces of the jigsaw, but it is only by placing all the pieces together that the whole picture can eventually be seen ...' (Sanders et al., 1999).

### **Key messages**

- Social isolation and lack of access to support means that inclusive outreach and community interventions within the home and neighbourhood are essential (Anderson and Stewart, 1983).
- It is strongly recognised that neglected children may require individual intervention and support to help them overcome serious deficits in cognitive, academic and social skills (DePanfilis, 1999: 227)
- The concept of supplementary care can also be extended to include respite care in which neglected children can experience regular short-term placements away from home. Respite care has been found to be effective in supporting a wide range of families under stress' and children in need (Aldgate et al, 1996, cited in Stephenson, 1998a :118)
- Many families where there is risk of neglect may not have had positive experiences with formal systems; a key component therefore has to be the successful engagement and partnership with the family (Bean 1994).
- To decrease the risk of neglect, interventions need to help families learn to effectively manage and change the factors that have led to the risk. Practice needs to empower families to resolve these and avoid dependence on the system. (Lloyd and Sallee, 1994). This promotes an approach that builds on the families existing competencies and resources.
- The range of interventions that need to be drawn on and tailored to suit the carer and child circumstances need to include:
- Concrete resources i.e. safety equipment, budget management etc (Nelson et al, 1993).
- Social support interventions i.e. links to community groups, mentor involvement, recreation programmes etc (Whittaker and Garbarino, 1983).
- Developmental programmes i.e. health visiting, peer groups, mentors, therapeutic / developmental programmes (Miller and Whittaker, 1988).
- Cognitive behavioural interventions i.e. social skills training, parenting education, stress management, cognitive restructuring (Lutzker, 1990).
- Individual focus i.e. detox programmes, specialist child education programmes, crisis intervention (Azzi-Lessing and Olsen, 1996).
- Family focus interventions i.e. family centres, family counselling, home based family work (Daro, 1988).
- Intervention with neglectful families should address multiple dimensions of family life if lasting changes are to be expected and

need to be intensive and long term (Crittenden, 1999; Ethier et al, 2000).

- The most significant influences on outcomes for change are: client characteristics, the client worker relationship, with the method of intervention and degree of hips expressed by the client having significantly less influence. (McKeown.K, 2000)

## **Prevention:**

Primary prevention initiatives have been developed to provide broad-based and non-stigmatizing family support, administered at a local and community level. An important feature of primary prevention is that projects typically have a strong and positive emphasis on promoting child and family well-being and on working collaboratively, which it is observed ....perhaps accounts for their popularity among users who see them as sources of support and empowerment....'(Macdonald, 2001: 125, 126).

Prevention needs to relate to both universal (population based), and selective (directed to more vulnerable groups), activities that will both prevent neglect and ameliorate any effects.

## **Key messages**

- The most effective ways of promoting the well being of children often centre around the provision of effective social supports to parents, and their perceiving of this support as available, even if it is not called upon, is a strong protective factor for families (Brown and Harris 1978);
- Ecological theory provides an understanding of the ways in which stresses and supports may or may not balance and of how accumulated factors in a child's environment may be more damaging than individual events (Jack 2000);
- Ecological theory links closely with resilience theory so that programmes that benefit both individual children and communities can be identified. This has particular messages for children's centres and the extended schools agenda and services such as after school clubs and child mentor programmes in developing activities that can focus on the development of resilience. Theories of change are significant in thinking about service development. In general, change takes longer than was previously thought (Yoshikawa 1994);
- Time limited services will only be effective when preceded by a motivational or engagement phase of work, and linked to consolidation or maintenance activities. It is interesting to link these findings with the findings about the effectiveness of family centre work (Pithouse and Holland 1999) in which users did not appear to be aware of any impact of family functioning from their engagement with a family centre.
- All services and components of services require a built in' empowerment raising capacity so those parents can gradually achieve a greater level of self-efficacy and self-reliance, through community supports. A helpful description of empowerment oriented family support is that professionals are instruments of families, and intervene in ways that are individualised, flexible and responsive. Carers are viewed as

having existing capabilities as well as the capacity to become more competent, and practices should aim to strengthen functioning and optimally empower people as part of their involvement in these kinds of programmes (Trivette et al 1996). This is pertinent for all services, but has particular resonance for parenting programmes.

- Community involvement (including resources and role models) is particularly important because it may enhance the sustainability of prevention programmes if the community views the programmes as worthwhile and develops a sense of ownership and responsibility (Dubowitz 1999).

## **Conclusion**

The literature provides strong evidence that neglect is a serious form of child maltreatment that can have profound and long-term effects on children's lives. It should also be remembered that each year a number of young children die as a result of chronic and extreme neglect. It is broadly recognized that families who neglect their children have multiple and complex needs which may require intensive, multi-disciplinary and long-term intervention and support. There is a consensus that the most effective interventions are those which operate on multiple levels involving parents, children, the wider family and the community. Intervention and support that is based on a knowledge and understanding of protective factors can act to reduce neglect and promote resilience, enabling families to cope more effectively with complex and stressful situations. The primary aim of intervention is to reduce the risk of [significant harm](#) to children, and to protect children from continuing harm. This requires a comprehensive multi-agency assessment which evaluates the risk and resilience factors and targets the appropriate resources around the needs of the child and family. This requires creative tailor-made' interventions that mix models, duration and intensity to change enable the parents to manage and change the risks. There is a need for more empirical evidence to enhance understanding of the varying types of neglect that occur and to improve knowledge both of neglectful families and of the longer-term outcomes of neglect for both male and female victims. In addition, there needs to be more rigorous monitoring and evaluation of interventions so that knowledge about what works to reduce harm to children in which circumstances, can be accumulated and incorporated into good practice'. While the literature highlights the general lack of attention given to child neglect by academics, researchers and policy-makers, the issues of child neglect and prevention are becoming increasingly central to child-care policy and practice. In addition, within the context of preventing child neglect it is also critical that broader social policies aim to reduce levels of poverty and social exclusion.

## **Section Three Salford Community Context**

### **Community Profile**

A number of community factors impact on the prevalence and presentation of Neglect in Salford. A range of services have developed as a response to the demographics and community profile and it is important that this strategy also takes account of these characteristics if future suggested service development is going to be relevant and effective. A map of the extent of neglect cases on the child protection register at a moment in time across Salford is reflected in [Appendix 2](#)

## Deprivation and social exclusion in Salford:

Although neglect is not simply a matter of socio-economic context (see [Research summary, Section Two](#) previously), the circumstances within which children and families live their lives can nevertheless have a profound effect on the opportunities they have to achieve their potential and their capacity to access the support that may be available to overcome some of the hurdles they face.

- There are approximately 47,000 children and young people (under 17) living in Salford, and this forms approximately 22% of the over-all population.
- In 2000, the DoH estimated that from a total national child population of 11 million, 4 million are judged to be vulnerable. When this is applied to the child population of Salford, it could be estimated that there are 17,091 vulnerable children within the city. Given the high position of Salford in relation to the Index of Multiple Deprivation (see below), this figure is likely to be even higher.
- In the most recent report on the Indices of Deprivation in England, (2007), significant changes were made that allowed measurement of deprivation at a smaller spatial scale through the introduction of Lower Super Output Areas (LSOA), so the new Index of Multiple Deprivation provides a more detailed picture across the domains used. Below is a table illustrating Salford's ranking in respect of the country as a whole and within Greater Manchester.

District level measure	Salford position In relation to England	Salford position in relation to Greater Manchester
Local Concentration	7th	2nd
Extent	20th	2nd
Average score	15th	2nd
Average rank	24th	2nd
Income	40th	4th
Employment	28th	4th

- The Local Concentration measure shows the severity of multiple deprivation in the authority, measuring hot spots of deprivation
- The extent measure is the proportion of a district's population that lives in the most deprived LSOA's in England
- The average score and average rank measures are two ways of depicting the average level of deprivation across the entire district
- The income scale and employment scale measures show the number of people experiencing income and employment deprivation respectively.

From this index, based mostly on data from 2005, Salford is the second most deprived local authority area in Greater Manchester and the 15th most deprived in England, (from 150 English Local Authorities)

- The index divides the City into 144 Super Output Areas', 19 of these areas fall within the 3% most deprived areas across England.
- Areas such as Central Salford, Kersal, Irwell Riverside, Broughton, Langworthy, Ordsall, Winton and Little Hulton have a number of Super Output Areas'. In contrast, a smaller number of areas in Salford, notably Walkden South, Worsley and Boothstown are amongst some of the most affluent areas of the country.
- There are pockets of severe deprivation across the city with 15 out of 20 wards classified as amongst the 20% most deprived nationally.
- In addition to the overall level of deprivation in Salford, what marks Salford, as being different is the local concentration' of deprivation. Nationally Salford ranks 7th highest in this score; therefore not only does Salford have a large number of deprived areas but, compared to other areas, these contain some severe pockets of deprivation. The most deprived locality in Salford across all domains for measuring deprivation is that of Central locality. (Salford PCT Public Health Report 2004 -05).
- The average unemployment rate for Salford is 3.8%, which is approaching the national average 3.3%. However there are 7 wards where the unemployment rate is above 4.5% with Broughton, Langworthy and Little Hulton all exceeding 5%.
- There are 8,143 lone parents in Salford of whom 685 are male and 7,416 are female. This represents 8.7% of the population of Salford, significantly above the national average of 6.4%. As with unemployment, the figures are skewed, with Little Hulton, Broughton, Langworthy, Winton, Barton and Walkden North all have over 500 lone parents.
- Reliable statistics reflecting areas of low income are not readily available but the Indices of Deprivation Report from the Office of the Deputy Prime Minister rank Salford as 28th lowest borough in England in terms of income (where the lowest is 1).
- Salford also scores highly on the mental illness needs index, with 13 wards scoring above the national average and 7 of these falling into the highest category of need.
- Salford has a growing and significant non-white ethnic population (rising from 2.2 in 1991 to 3.9% in 2001); although this is lower than the

national (8.7%) and North West (5.6%) average. Economic migrancy is rapidly changing the city's demographics.

- At least 32 different languages are spoken within the city, and the 2004 school census would suggest a rise in the number of children from non-white ethnic backgrounds over the last 6 years, with a greater percentage currently in primary schools.
- There is an over representation of children and families with a non-white ethnicity forming referrals to social work teams (8.7%) when compared with the general BME population in the city, and the school population.
- Central locality has the highest percentage of the population from an ethnic minority background.
- Broughton is the most ethnically diverse electoral ward in Salford, having a percentage population from black or ethnic minority groups above the national average at 9.3%. Some parts of Salford, such as Irlam (1.9%) and Cadishead (1.8%), have very small recorded populations from black or ethnic minority groups.
- Salford also has a higher rate of the population identified as permanently sick or disabled, 9.5%, when compared with the national average, 5.5%.

## **Education**

There are clear disadvantages for children in not attending or being excluded from school and the neglect of their education socially excludes them and damages the likelihood that they will achieve their potential.

- Levels of attainment are improving and close to national levels.
- Levels of absence and levels of permanent exclusions have reduced significantly. Improving school attendance remains a priority for Salford. Whilst performance is similar to statistical neighbours, absence within the primary sector is comparable with the national average but levels of absence in the secondary sector are still above the national average. In 2005/06 Salford had 8 High schools identified as having high levels of absence. This reduced to 5 High schools in 2006/07 and is currently on track to reduce to 2 High schools at the end of this academic year.
- The numbers of permanent exclusions have started to decrease. In 2004/05 3 children looked after (who are some of the most vulnerable children in Salford), were permanently excluded from schools. In 2006/07 2 children looked after were permanently excluded from school.
- The numbers of days lost to fixed term exclusions has reduced from 9,156 in 2004/5 to 5,952 in 2006/07.
- The number of pupils with statements for special education needs has increased over recent years. In January 2006, 104 first time statements had been issued, in January 2007 this increased to 125 and in January 2008, 148. This may be an indication of better recognition and more efficient response, but none the less highlights the increase in the need for specialist resources.

- In September 2006 overall 27.32% of pupils were in receipt of free school meals. Within this, 29.02% of Primary pupils and 23.36% of Secondary pupils were deemed eligible.

## Health and Well-Being

The most significant source of harm to children and young people is ill health and the single highest cause of injury is road accidents and accidents in the home. The promotion of the physical and emotional health of children and young people is crucial in building their resilience and minimising the impact that neglect may have on their development. The patterns of healthy lifestyles for children and young people are established within families and are characteristically inter-generational, it is therefore important that measures to improve their health and well-being is reflected by a family approach that targets, supports and educates parents, carers and the wider community as well as the children and young people themselves.

- In Salford infant mortality under 1 year, is below that of the North West but remains higher than national average. Infant mortality under 28 days and under 7 days in Salford is lower than both the North West and the national average. Over the past three years pooled data has shown an improving trend in infant mortality, with a reduced gap between the Salford and England and Wales rates. Over 6 years, the gap has closed by 1.4 deaths of infants aged under 1 per 1000 live births. In 2004 – 06, the gap started to widen which is worrying as it indicates we may be slipping against the 2010 target. However due to the small numbers of deaths each year, annual figures can not pick up small changes (improvements or otherwise) in infant mortality, therefore progress is monitored through proxy measures on smoking in pregnancy and breast feeding initiation.
- Low birth weight is a close determination of infant mortality, and also influences health in later life and life expectancy. The percentage of low birth weights (<2500g) and very low birth weights (<1500g) remains relatively stable. Salford has a greater percentage of low birth weight babies (8.4%) compared to the national average of 7.9%. The percentage of very low birth weight babies is slightly less (1.4%) than the national average of 1.5%.
- Salford have some way to go to reducing teenage conceptions. Despite the under 18-conception rate being at its lowest in 20 years (41.1 per 1000 girls aged 15 – 17, 2005 (Source: Office for National Statistics, 2007)), the figures within Salford remain considerably higher than the national average. The latest figures for 2005 showing 61.2 conceptions per 1000 female population aged 15 – 17. Although the rate has fallen steadily from baseline there was a large increase in 2005 with 254 conceptions (1.4% reduction from baseline), which demonstrated that Salford are a long way from achieving the 50% targeted reduction by 2010. At ward level only 5 wards have a conception rate lower than the average for England (41.5/1000) (Cadishead, Kersal, Swinton South, Walkden South. Worsley and Boothstown). Hotspot wards (above 60/1000 rate of under 18 conception) have been identified as Barton,

Langworthy, Little Hulton, Blackfriars, Eccles, Ordsall, Pendlebury, Pendleton, and Walkden North.

- There is continued good uptake of primary vaccinations and MMR by children aged 0-4 in Salford, with the percentage uptake generally increasing year on year.
- Uptake of primary vaccinations by children aged 0-4 had exceeded the 95% target right through to the end of 2006/07, but has dipped slightly in 2007/08. MMR uptake still appears to be recovering with coverage of 87.9%, and demonstrates a year on year improvement in coverage.
- The major cause of child death is accidents. Hope A&E treated 12,000 children and young people from Salford in the previous year. This is in the context of a national increase in A&E attendance.
- More than half of all Salford children have had experience of decay by the time they are five years old and among those children with decay, each has approximately 2.5 decayed, filled or missing teeth (dmft) by 5 years old and many decayed permanent teeth have not been treated. The levels of dmft vary at ward level. Wards with the highest level of 5 year old children with dmft include Broughton, Irwell Riverside, Ordsall, and Walkden North
- A major national study suggested that 11% of boys and 8% of girls aged 5-15 had a mental disorder, with rates increasing with age. Currently 1500 children aged 5 to 17 were specialist CAMS users in 2004/05
- In 2007/08 150 young people were referred to SMART, the young person's drug and alcohol service for advice, support and treatment.
- 87 young people were referred to the SMART harm reductions nurse during 2007/8 as a result of a drug or alcohol presentation at the A&E department. Salford has the 6th highest drug and alcohol related admissions in England.
- 40 young people were supported by the substance misuse worker at Salford Youth Offending Service.
- During 2007/08 34% of young people worked with by SMART presented with Alcohol as a primary issue.
- During 2007/08 57 parents sought consultation from the SMART parent/carer service.

Further information on levels of deprivation and the state of the public health in Salford can be found in the Public Health Annual Report 2004-05 which can be accessed on: [www.salford-pct.nhs.uk](http://www.salford-pct.nhs.uk)

## **Social and Family Risk Factors**

Traditionally, performance measures in respect of child protection statistics are a reflection of the management of the system rather than an indication of good outcomes for children and young people. Historically, good performance in Salford of the child protection system was an indication of the priority that child protection always had, and a deliberate policy to ensure that the most vulnerable children in the city were protected. This has sometimes been at the expense of being able to respond to families needs at an earlier stage, and this setting of a high threshold for services was a significant issue in the report from the Joint review in 2003 and the JAR in 2006. Given the nature of

neglect, the evaluation of the implementation of this strategy will need to reflect outcome information across agencies, and have a longitudinal dimension.

- The total number of [initial child protection conferences](#) held over the past year (07/08) was 108. This represents an increase from the previous year, which was 75, and 99 for the year 05/06.
- The number of children subject of a [child protection plan](#) in Salford at 31.03.08 was 133, compared to 76 at 31st March 2007. In all years the highest category for registration was for neglect, forming 38% of the total number of children subject of a child protection plan as at 31.03.08. This mirrors the national picture for category of registration.
- At 31.03.08 Salford had 28 children on the register per 10,000 of the child population, this is a lower rate than most of our national comparator group for the previous year (figures for 2008 are not yet available), the average of which was 35.9 children as a rate per 10,000 of the child population. (England average, 25.4)
- For all children subject to a child protection plan during 07/08, 35% were affected by domestic abuse, 24% by parental substance misuse, and 8% by parental mental ill health.
- Between April 2007 and March 2008 there were 6910 domestic violence calls to Salford Police from this number 917 families were notified to Social Care because of the concerns about the children in the family, this represents 13.27% of the overall total of incidents reported. This does not account for families where the children were absent from the home on the occasion police were called out, nor the children and young people who have raised concerns with other professionals because of [domestic abuse](#).
- During the same period 210 cases were heard by Salford MARAC there is no data kept currently that identifies how many of those cases were families within which there were children. The number of IDAAS referrals during the 12 month period (April 2007 to March 2008) totalled 150 (45 from MARAC, 42 from DVU, and 63 from other).
- In 2007-08, 40 households with dependant children were accepted for re-housing after losing their NASS accommodation (National Asylum Support Service accommodation, i.e., accommodation provided under a national dispersal programme for asylum seekers whilst their application is being considered). Of these, 22 were female lone parents.
- A total of 1016 households presented as homeless. A statutory duty to re house was accepted for 626 households.
- Of the 626 households, 36 households were a couple with dependant children, 18 were male lone parents and 318 were female lone parents, 54 of the females have three or more children.
- The most common reason for presentation as homeless was domestic abuse with 130 women with dependant children.
- Of the 626 households accepted for re-housing, 42 with dependant children and/or pregnant women, were initially placed in a B & B.

## Children in Need and Looked After Children

- The Children in Need Census 2005 (a National Government organised Census conducted via Children's Social Services) reveals around 29 per 1,000 children in Salford of the 0-17 population, were [in need](#), and received a service from Social Care. This was the second highest figure for Greater Manchester authorities and North West metropolitan districts.
- At 31st March 2008, 531 children were in public care in Salford; this represents 113 children per 10,000 in the population. This is high when considered against the average for our comparator group of authorities where the figure in 2006 was 79 children per 10,000 in the population.
- Young people in public care are approximately 10 times more likely to have a [Statement of Special Educational Needs \(SEN\)](#). In Salford, at the end of the school year 06/07 (31.7.07) out of 420 [Looked After](#) Children of school age, 64 (15%) had a full Statement of Special Educational Needs, 3 were at stage 5 and 1 at stage 2. A further 9 were under assessment. There were also 50 (12%) children who are looked after receiving assistance under school action plus and 57 (14%) with intervention through school action.
- The ratio of the percentage of Children in Need from a minority ethnic group in Salford was given as 15%.

## Crime & Community Safety

Many of the young people who find themselves in contact with the criminal justice system in Salford live in areas of the city where there are high levels of deprivation.

- Deprivation is one of the main risk factors for engagement in criminal activity. In the last year (April 2007- March 2008) there were 619 young people involved with youth offending services. Not all were on court orders; some contacts were through preventative services and early intervention programmes.
- Many were already known to social care with long histories of family dysfunction, child protection issues or were actually cared for by the local authority. However many have slipped through the welfare net and have ended up in the youth justice system before preventative services have been able to act. In these cases there has been either a history of poor parenting and failure to meet the physical and emotional needs of the child or reluctance to engage with statutory services.
- Salford has the second highest incidence of youth offending (10-17yrs) of the 10 metropolitan boroughs in Greater Manchester at 81 offences per 1,000 population
- Anti social behaviour by young people adds to the stressors of family life and can be causally linked to placement breakdown when the young person resides in residential care units. In the city to date there have been 177 Anti social behaviour orders through the civil route and 130 on conviction. Many of these will lead to family eviction and are often connected to poor parental supervision.

Whilst the profile of Salford may suggest a City where there are significant problems that impact directly on its children, young people and parents, it is important to recognise that the vast majority of families in Salford do not experience the obstacles presented within this profile, or have resilience and support to over-come them without adverse effect. However the profile also serves to remind us that for some children and young people their vulnerabilities place them at significant risk not only in not achieving their potential but also of [significant harm](#).

## Section Four Evidence Gathering

### Service Mapping.

In the development of this strategy a number of evidence gathering exercises were undertaken to test assumptions and experiences of working with neglect in Salford. Whilst the findings have informed the strategy, it is important that the limitations of these are acknowledged. The 3 processes used were:

1. Survey of Services that are already available to respond to families where neglect may be an issue.
2. A study of some individual cases across the broader safeguarding continuum, and:
3. A review of children on the register for Neglect and a multi-agency audit of cases.

Detail of the methodology and evidence gathered can be found in [Appendices 3 to 5](#). The analysis from each of the exercises is provided below.

#### 1. Survey of Services:

During September 06 both voluntary and statutory agencies were asked to complete a pro-forma (Refer to [Appendix 5](#)), which asked a number of key questions about the nature of the service:

1. key eligibility
2. access
3. rationale for delivery
4. availability
5. age limitations
6. duration of services provision
7. permanency of service
8. evaluation process
9. threshold
10. Gaps in provision identified

The findings are collated in detail in [Appendix 5](#). The purpose of the analysis is to try and understand how the provision of services in Salford currently reflect the messages from research about the most effective means to work with families to tackle neglect across the range of needs on the continuum.

There were clear examples of services that were flexible and provided opportunities for families to access early family support in the area they lived that reflected partnership arrangements across statutory and voluntary services (e.g. Sure Start at Cornerstone, School nursing service). This will be further enhanced with the wider development of Children's Centres and as the Locality Teams become more embedded. There were also some good examples of services that promote resilience in children, e.g. after schools provision, funded nursery places, and those that provide ethnically sensitive services to minority groups who often feel excluded from mainstream provision, e.g. the Jewish Federation. Again the developments of the extended schools provision should maximise the opportunities that are available to families within their community to promote inclusion and diminish social isolation for those families who have some awareness and willingness to engage with services. There are a number of programmes that are aimed at working with parents and children together, particularly the under 5's e.g. parent survival and lifestart courses, and some examples of practical concrete resources being provided to families, e.g. Sure Start Home Safety scheme, but these were only available in Sure Start areas and inconsistently available within them. Many of the services accepted both self and professional referrals and this enhances the accessibility. All of the services that responded had national, local or service evaluation processes, many of which included services user evaluations as well as some limited outcomes based targets. However it was difficult to bring these together in an over-arching framework to either bench mark against the 5 key outcomes or compare communities or inform future development with comparisons of the relative success of different interventions. The interventions did reflect both individual and family provision. Many of the services that responded were mainstream funded although a significant number, particularly those offering services at threshold level 2 or 2/3 were short-term funded, e.g. YISP (Youth Inclusion Support panel) and CHAP (Community Health Action Partnership). For families in special circumstances, for example those with experience of severe mental health or substance misuse, services that were specific and /or targeted are available at a range of threshold levels. However it was recognised that the focus on the adult needing the service could result in the impact on the children within the family being less well assessed and opportunities for early referral being missed. Many of these adult based services could not identify for example how many adults they were working with who were also parents or living with children.

Overwhelmingly services reported high workloads, excessive demand for the services and a lack of capacity to respond to need. The reported impact of this was that many of the services have to target their resources, higher their thresholds for provision, withdraw from the more time consuming aspects of the work, e.g. home visiting or were faced with more complex work than their service was originally designed to meet. This has a significant impact on the knowledge base and skill mix of workers to recognise and meet the need effectively. There were examples of volunteers working with families where the level of neglect they were managing provided real challenges to their skills. Services also recognised that their provision was largely focused on meeting demands that come from individuals or families that were willing to engage or had the support of other professionals to facilitate engagement.

This left little or no capacity to pursue those that were deemed hard to reach' either for reasons of ethnicity or social exclusion or were less cooperative. This is particularly significant for families where neglect is an issue as research and experience informs us that services need to incorporate strong outreach provision to ensure that key services reach children whose parents may not seek out services. Families with multiple problems are often the least able (or willing) to navigate the complex web of support to which they are entitled. Consequently interventions can be least effective with some of the most vulnerable families' (Cabinet Office 2007. p. 42). Although not specifically reported to, anecdotally services are primarily shaped with female parents and carers in mind and specific service organisation to include male parents/carers are more rarely in evidence, although again there are pockets of good practice.

A further characteristic reported was the inconsistency of service provision, not simply in relation to postcode, but also in respect to the same service being disconnected from other areas of the same service and inconsistent in their provision. This difference is not always based on a clear understanding of the profile of needs of the community, nor does it reflect a joined up approach to managing neglect in the most effective way.

There were some gaps highlighted, specifically in respect of community mental health provision for young people, and social skills training for families with children over school age. Where the children in a family are experiencing neglect it is essential that symptoms exhibited in the child e.g. poor speech, decayed teeth, poor concentration, are viewed within the context of the child's whole experience, and that services are provided that seek to resolve the cause as well as the symptom. This demands a holistic assessment at the earliest opportunity and where needed a multi-agency plan to resolve the difficulties. The developments with the [CAF \(Common Assessment Framework\)](#), and Lead Professional should promote this approach, however it should be recognised that despite the introduction of FAM ([Family Action Meetings](#)) and the GCP ([Graded Care Profile](#)), for many years in Salford neither are yet embedded as standard practice (refer to case studies). There are many reasons for this, but of singular importance is the resource implication this has for services that already feel over-stretched. For many the limited capacity to initiate more comprehensive assessment and multi-agency meetings militates against taking early action in this integrated way. Particularly where there is residual doubt as to the outcomes that taking such action will have and services to manage the symptoms can be accessed more easily. This raises the need to identify and meet the level and nature of the support and training that is required for these services to engage with the processes that are envisaged as central to future service delivery.

It is worth mentioning here that there are services that are specifically designed around particularly vulnerable groups, e.g. children with a disability, asylum seeking children and many of these services are already multi-agency and have some degree of integration. However when the possible neglect of these children is reviewed it is true to say that they rarely feature in child protection statistics for neglect, at present (03.03,08) there are no asylum seeking children on the child protection register and one child with an

identified disability, and these groups are least likely to access the services that are designed to intervene with families to change neglectful parenting at an early stage. This is despite some research evidence that suggests that neglect was the most prevalent form of maltreatment for both disabled and non-disabled children, and that disabled children were 3.79 times more likely to be neglected than non-disabled children (Sullivan and Knutson 1988). This study also found that disabled children tended to be maltreated at earlier ages, and that pre-school disabled children suffered more abuse, including neglect, than the elementary, middle school and high school age groups. It is possible therefore that services need to address how they respond to the needs of families with a child with a disability and to recognise and assess neglect within this vulnerable group at an earlier stage.

In summary, this exercise appears to have revealed that there are already some areas of service provision that reflect the needs of families where neglect is an issue. The changes and developments envisaged for the future should further enhance this. However, capacity, training, assessment and skills mix for workers/integrated services are also crucial areas that need to be addressed if the services are going to have a significant long-term impact on outcomes for the children and young people at the centre of the difficulties.

## **2. Test Case Studies:**

Working with neglectful families does present significant challenges for practitioners in developing appropriate and effective interventions, and practitioners find child neglect a particularly difficult area of practice (Tanner and Turney, 2000). Neglectful families have a range of complex and multiple needs that require varied and intensive intervention and support: given the enormous heterogeneity of child neglect, varied interventions are needed, and should be tailored to individual needs' (Dubowitz et al, 1993). A primary consideration is to provide preventative intervention for neglected children, which should incorporate a development of practice that supports vulnerable parents while still maintaining the child's welfare as paramount (Jones and Gupta, 1998). More specifically, interventions with neglectful families should be underpinned by reflective, relationship-sensitive supervision and support (Howe et al, 1999: 295). It is further suggested that professionals need to provide a structured, predictable environment and to maintain an effective relationship with the parents based on expressing empathy, creating a protective context and developing feelings of trust (Crittenden, 1999: 56, 62).

The purpose of this exercise was to look in more detail at specific case examples across the agencies where some level of concern existed in relation to the possible neglect of children in a family. A template (refer to [Appendix 4](#)) was completed for each case and then some analysis and conclusions drawn about the issues the cases raised that could then be brought into the development of the strategy.

Not surprisingly, some of the issues that were identified within the Survey of Services were echoed within the data from the case studies as impacting on individual families and the outcomes for the children involved.

The multi-agency group tested out the provision for families where neglect is an issue in respect of 9 families. Questions were asked in each case to ascertain the strengths, weaknesses and concerns in respect of the current provision. For each case the following questions were applied:

- What were the needs that were being met
- What were the desired outcomes
- What services were available to meet those needs
- What factors affected delivery of the service (i.e. area, ethnicity)
- What assessment processes were used
- What were the gaps / barriers to service provision?

The 9 families considered included 35 children, and covered a range of interventions from across the neglect' spectrum, including lead agencies from Health, Sure Start, Housing, Drugs team, and Social Care.

In these 9 case studies analysed the spread of services involved was as follows;

Agency involved	Number of the cases	% of the cases
Health	9	100
Social Care	8	89
Education - schools	7	78
Education - nursery	2	22
Surestart	3	33
Housing	2	22
Substance Misuse Team	2	22
Family Support worker	2	22
Family Centre	1	11
Asfam	1	11
CAMHS	1	11
Welfare Rights	1	11
Open Door Project	1	11

It was apparent from the samples reviewed that workers recognised parents were struggling to care for their children and understood that this was impacting on their child/ren's health and development. As a result a variety of services were involved in an attempt to address the difficulties and ensure that the needs of the children were being met. Substantial information was available about families which demonstrated workers ongoing commitment in working with families to improve outcomes for children.

Whilst a policy for early intervention and prevention are effective in minimising the incident of neglect in the long term, it is important to recognise that working with early needs means working within not outside of the safeguarding continuum. Workers at all levels of intervention need to be acutely aware, skilled and confident of their wider safeguarding responsibilities. Particularly where they are working with uncooperative families. Often it was the change within a family from passive non-cooperation to active non-cooperation that led to workers taking more interventionist action, but with review it was clear the threshold for harm had been reached some time previously.

While there was evidence of a lot of involvement from a variety of professionals, information had not been effectively collated or co-ordinated. The risk in this is that professionals are not clear and specific in respect of what aspect(s) of the concerns they are asking services and families to change over what timescale and what they expect the outcomes to be. In the majority of cases there appeared to be no clear assessments or single or joint agency action plans including what to do when families didn't engage. This 'scatter gun' approach and lack of outcomes based analysis and evaluation is typical of the patterns in neglectful families where children end up on the child protection register and ultimately removed from home. Assessments were often static, they were not analytical, but were sometimes an accumulation of descriptions which were not neither interactive nor diagnostic in explaining vulnerability and risk, and resilience and protective factors. Nor were these hypotheses reviewed, evaluated and revised in a systematic way. Workers from all agencies often mistook activity for progress.

Meaningful descriptions of circumstances were absent and instead words were used which did not convey any real meaning. This may be a reflection of the workers own confusion, but prevents a picture over time being established which is so crucial in cases of neglect to enable workers to judge when to act and how.

There was some evidence that professionals focussed on the present and family strengths (particularly when concerns were being managed outside of formal child protection systems. Whilst an emphasis on behavioural approaches often used in parenting programmes, can be effective with families with low levels of need this approach can have serious drawbacks when used with families with deeper more entrenched problems. Referral onto short term programmes can also be a coping mechanism for practitioners and managers who feel overwhelmed by families. These programmes are unlikely, however, to produce the long term changes in families to protect children from the harmful impact of serious neglect. (Utting et al 2007).

There was little evidence of assessment of parental learning abilities. Given that this is a key feature for many families who are in need of additional support, and a crucial element in dictating the nature and likely success of any intervention, this was a serious gap and significant shortfall.

Given that parenting capacity does not operate in a vacuum but in communal, socio-economic and domestic contexts, assessments have crucially to

analyse the relationship between the parent/carer and child rather than the event or series of repeated events occurring within the child / parent relationship. The background context of a child's experience is essential to a dynamic understanding of risks and protective factors. It is important to recognise that a child's behaviour and psychological functioning offer powerful clues about their probable parenting experience.

Concerns about the cases reviewed appeared to have existed over a significant period of time without any change but without any indication that a target had been set with the family which outlined the process that would follow if circumstances remained the same. This restates the case for the need for effective supervision with neglectful families, and crucially for clinical review that is independent from the workers who are faced with supporting the family to ensure that the threshold for action is appropriately applied.

There were examples where the intervention with the family was coming at too late a stage to prevent [significant harm](#) to children. Confusion and misunderstanding of thresholds, but also a preoccupation among agencies with eligibility criteria for services rather than a primary concern about the child, dictated intervention. Referrals of neglect in some ways require a different approach to other child protection concerns. Agencies need to be clear and explicit about the thresholds that require intervention. In Salford, the [Graded Care Profile](#) as a tool can help with this.

There was at least one example in the study that revealed that there was a gap in culturally appropriate services. All the cases viewed had no information that expressed the views of the children involved or reflected their experience. An integrated process for the participation and consultation across services for children does not currently exist.

It is not unusual in families where children have been neglected over long periods of time for the family dynamics to be complex, confusing and at times overwhelming to the professionals involved with working with them. In some cases, crucially, workers would failed to take account of the significance of past history, and it's impact on current capacity of the parents/carers to care adequately for the child and instead adopted the start again syndrome'.

It is important to recognise the impact of this type of work on practitioners. The run down feeling that pervades passively neglectful families can affect the spirits of the professionals who work with them. Similarly, it has been well documented that worker fear can have a debilitating effect in promoting effective interventions with families, and hamper their ability to reflect and make accurate judgements and act clearly. Supervision is crucial to enable workers in critical thinking, analysis and review and to avoid drift with neglectful families.

The implications from the analysis are:

- Where professionals are confused or uncertain about the services that are available for supporting families this has a significant impact on the likely interventions that are employed.

- All practitioners need a holistic understanding of children and families and need training about the way in which separate factors might interact to cause increased stresses in a family and increased harm to a child.
- Inconsistent practice in assessing neglect leads to families receiving inappropriate services or gaps in meeting need
- Workers often mistake activity with and within a family for progress, and plans need to be more outcomes based with clear timescales that demonstrate sustained change.
- Poor plans that are not co-ordinated across agencies can lead to families not understanding the purpose of interventions, the expectations on them and how anyone will know when change has been achieved and the next steps if the situation continues.
- A lack of chronology without the experience of the child reflected can lead to drift' in cases and delay in taking pre-emptive action to prevent significant harm to the child.
- A lack of systematic evaluation of services matched to an understanding of what needs they are best designed to meet can have a detrimental effect on the family, for example the type of parenting class varies widely and has different success rates with different levels of need and parenting difficulties.
- Access barriers disadvantage some groups, in particular Black and Minority Ethnic groups, children with disabilities and complex needs, and a lack of culturally appropriate services further disadvantages minority groups.
- There are areas of duplication and gaps in services, which disadvantage some families.
- Research evidence shows that most families need two and a half years to achieve sustainable change through a programme of linked activities (Dr Anne Hallows, Sheffield University); there is little evidence of co-ordinated provision for families in Salford although there does appear to be a wide range of services.
- Supervision on a single and multi-agency level is the most effective mechanism for ensuring that practitioners receive the support they need to prevent them becoming overwhelmed and to help them think and act systematically in cases of neglect

It seems that in using available tools like the GCP ,CAF and having Family Action meetings concerns would be identified at an earlier stage and a way forward agreed with the family which would have better identified roles and responsibilities of all involved.

### **3. A review of children subject to a child protection plan due to Neglect and a multi-agency audit of cases.**

As part of the scoping exercise for the strategy, some evaluation of those children and young people subject of a child protection plan due to neglect was undertaken to ascertain the responses across agencies to those identified as the most vulnerable.

The register was scrutinised on 4th September 2006. At that time there were 125 children on the register of which 57, constituting 19 families were identified as having neglect as the primary cause for concern and intervention. This represented 46% of the children with a child protection plan, and this as a proportion has been fairly consistent over a number of years and has been stable as the numbers of children subject of a child protection plan have moved up and down since. This is also fairly consistent with the national figures and our regional comparators.

In addition to this a multi-agency audit of the children who had been subject of a child protection plan for 2 years or more (PAF 21) in 2006/7 was also scrutinised as all these children except 1 were registered because of primary concerns in respect of neglect. The audit tracked 21 children, which represented 7 families.

### Analysis

The analysis is restricted due to the limitations of the data examined and what could be extracted from the data base. The tables used for the analysis are contained in [Appendix 5](#).

The age group most represented within the figures were those of primary school age (44%). This is not particularly surprising given that neglect happens over a period of time and it is more likely that children of this age are more likely to start to show evidence of neglect. It is also significant that it is only at school and nursery that children are seen and monitored on a regular basis. Larger families can also be a feature of neglectful families and for these families it is likely that there will be at least one child at school. From the data obtained 23% of the families subject to a child protection plan for neglect had 5 or more children, although there were also 45% who had only 1 child. There was no significant difference in the gender of the children on the register for neglect.

One of the surprises in the data was the finding that the data also showed that there were a significant number (7%) of children who were aged between 15 and 17. This challenged agencies to consider what services were provided for this age group that would help these young people cope with the impact of the neglect they had experienced and alter negative beliefs and behaviours that may have developed. In its simplest form, what effective interventions are agencies able to employ with this group that will prevent them becoming the neglectful parents of the future? It is useful to reflect that children and young people in this age group identified for themselves that they are often viewed by professionals as able to manage their vulnerabilities for themselves because they are older, and sometimes feel neglected' by the agencies. (\*\*Source – Salford Best Value Review of Safeguarding 2005/6.)

Again, of little surprise was the finding that in 68% of the families' drug and alcohol misuse was the primary parental factor of concern. It is crucial that these services are confident about their wider safeguarding role in promoting and protecting the welfare of the children in the family at the earliest possible

stage. Domestic abuse was also a significant factor in many of the families (23%), but this is also reflected across a number of categories of registration.

At the point the data was obtained there was evidence that concerns about neglect had existed with agencies for a considerable length of time before referral was made to social care, the longest being 11 years, and the average being almost 2 years. This may be because neglect is not an incident' based form of harm to children in the way that physical and sexual abuse are, and it requires agencies to work with families to effect change over a longer period of time. The risk in this is that workers fail to remain objective in gathering and analysing the evidence of sustained and significant change within the family.

One of the tools that is highly effective in enabling professionals and families keep a track of change in neglectful families in an evidence based way is the [Graded Care Profile](#) (GCP). Again it was significant that this had been used with only 2 (9%) families both pre and post registration. This may be because professionals are still not familiar with or confident about using the tool, although it has been part of SSCB training for a considerable length of time. This was echoed in a recent Serious Case Review where the tool would have enabled workers to identify the areas of concern and reflect on the emerging picture at an earlier stage.

There were families (9%) who had become subject of a [child protection plan](#) for a second time. When these case details were examined in more detail it revealed that where previous registration did not have neglect as the primary category there were clear indications of neglect in the information shared by agencies at conference, but this had not been reflected in the plan that had been formulated at that time.

It is of relevance that apart from one case, the average length of time for families from being referred to social care to come to conference and for the children to be registered was 10 weeks. It is important to note that only 3 (13.6%) of these families had had a Family Action Meeting (FAM) prior to coming to conference, despite that fact that multiple agencies were involved and had had concerns about neglect for considerable lengths of time (as detailed previously). This suggests that the FAM process was not fully bedded down across agencies, or the system used by any agency prior to the time that they reached the threshold for the referral to social care. It also underpins the crucial role that the FAM's can play with families in effecting change, developing planned interventions and targeting resources on a multi-agency basis at an earlier stage for the child before significant harm is caused. All of which were identified as significant gaps in the case study work. More recent review of the use of FAM has suggested that as thresholds for referral into social care are perceived to have risen, families remain within the FAM process for too long, and after they have become a child protection concern.

The data also reveals that a significant number of agencies were involved with the families prior to conference, although the data is not able to indicate how long each of them had been working with the family. However the figures do suggest that there was little change in the numbers and type of agencies involved with the families after becoming subject of a child protection plan.

Not surprisingly the universal agencies (health visiting in particular), were most likely to be involved with a majority of the families both before and after the child had a formal child protection plan. Most of the families in the data were involved in the formal child protection system for between 7 months and 2 years (61%), with care proceedings having been initiated with 5 families (23%). There were 11% of families where children whom had been subject of a child protection plan for more than 2 years, which causes reflection as to what the plan might be achieving and that there may be, as the research suggests (see [appendix 5](#)), some families that will require long –term intensive support where it remains in the children’s best interests to do this. However these statistics do raise a couple of important questions:

- Are agencies being effective in their interventions with the family?
- Is a scatter gun’ approach being employed with these families with the risk of overwhelming them rather than targeting resources to effect change in specific areas?
- What purpose is registration serving with families, do child protection plans set out required areas for change with clear targets that parents can understand and what mechanisms for demonstrating this are used, how robust is the child protection review process in challenging and testing that evidence?

Some of these issues resurfaced in the audit of the cases where children had been subject of a child protection plan for 2 years or more during 06/07. The key findings were as follows

- All of the children reviewed within the cohort except 1, were on the register because of primary concerns about Neglect
- By the time of the audit (4 months after the figures were provided), all the children were or had been involved in court proceedings.
- These are some of the most complex cases that professionals are faced with working with to effect change
- All the children remained at home or with relatives as carers
- For the duration that the children were subject of a plan, many had experienced changes in key worker and other key professionals involved with the family with the resulting impact that new workers often approached entrenched problems with a new optimism about effecting sustained change, and existing workers developed a case familiarity’ that raised tolerance and threshold. Research demonstrates that this is a common phenomenon in cases of long term neglect. The potential is that workers can fail to quantify the impact the neglect is having on the children. In these situations there is a real risk that workers fail to take into account significant historical information and do not review the child’s experience as a video over time’.
- Core groups and child protection plans did not always challenge the evidence of change that was presented in a robust enough fashion the result being that there were peaks and troughs over time that were not picked up to effect intervention and were subsequently not always managed through the implementation of the protection plan.
- The Graded Care Profile had not been used consistently either within the working of individual cases or at all.

- The nature of long term neglect requires that a picture is built up over time that includes the perspective and experience of all the agencies that may be involved (refer to [Section 2 - Research](#)). In Salford each agency should maintain its own chronology of events, but these are not to a common template and understanding of what should be included, and they are rarely combined. It is common that when integrated chronologies are produced (for example in serious case reviews (SCR), after a child has died), that the patterns become obvious much earlier and indications that actions should have been taken earlier. This was true of a recent SCR in Salford presented to SSCB earlier in the year.
- Child protection reviews failed to look at the video over time' picture of the family but made recommendations on the basis of evidence presented at that time.
- There was sometimes an inconsistency within single cases in the approach of different Chairs of child protection reviews, which may have had an impact on the direction of the case.
- Child protection plans did not reflect the evidence of the effectiveness of multi-agency interventions with families over sustained periods to inform and target future actions. Actions tended to be general rather than being: specific, prescriptive and time limited with measurable targets and clear outcomes. Nor did the plans build on the evidence and patterns and trends of the many plans that had preceded them.
- There was little consistency in identifying the tipping point that would lead to the instigation of care proceedings.
- The shortage of experienced social workers to allocate families to caused delay in progressing the plan with some of the families, as did the transfer of cases from other authorities.
- There was a temptation for workers to lose focus on the experience of the child as parents own difficulties engaged sympathy.
- The numbers of professionals and services involved with these families over long periods of time (longest period on the register for one of the families is 3+ years) indicates that the cost across all the agencies is phenomenal, and the ultimate cost to the child involved is immeasurable.

## **Section Five Conclusions, Recommendations and Priority Objectives**

### **Conclusions**

There are some helpful findings from the data collected that have contributed to the priorities outlined below. Some of these and the operational gaps were reported to SSCB earlier in the year in order to allow agencies to start implementation as soon as possible. However, it is important to note that whilst many of these recommendations relate primarily to those children who have been identified as the most vulnerable in Salford in the experience they have at home, it is salutary to remember that there are many more children who remain hidden or that are causing concerns for agencies who are not yet subject to formal safeguarding arrangements. If the neglect strategy is to

achieve anything, it should be to ensure that all children receive the support they need to enable them to stay safe from neglect at the earliest opportunity.

## **Recommendations**

With neglect as with all safeguarding activity, it is critical that assessment, intervention and service provision should be based on joint-working and multi-agency partnerships. It is further suggested that .....’collaboration across organizational and agency boundaries should be established to ensure co-ordinated assessment, care planning and service delivery – by adult and children teams for individual families....’ (Cleaver et al, 1999: 100). The development of multi-agency partnerships and joint working practices are critical to providing multiple and coordinated interventions and services which meet the complex and multi-dimensional needs of neglected children and their families. Effective multi-agency practice should be underpinned by a rigorous application of continuous monitoring, reviewing and planning, with clear allocation of responsibilities and accountability between agencies. Furthermore, if services are to be coordinated effectively, training must be provided on a multi-disciplinary and cross-agency basis (Cleaver et al, 1999: 101-102).

### Strategic and service development recommendations

- The findings underline the appropriateness of government thinking in driving agencies to review the benefits of working in integrated teams. The review of the range of data clearly suggests that many of the issues that created difficulties in the management of the risk would have been better scrutinised and evaluated if they had been worked within the context of a multi-agency team. The recommendation therefore is that this is pursued in Salford.
- The neglect strategy needs to be linked to the other strategies for children and young people and adults, including the family support and parenting strategies for children, and the Hidden Harm’ action plan from the DAAT.
- Services should review how services collaborate to meet the needs of 15-18 year olds who have experienced neglect to minimise any negative impact it may have on both their progression to adulthood and their future potential role as parents themselves.
- There is a need for more creative and responsive services for young people who have been difficult to engage with. There is evidence elsewhere in the country that specialist adolescent support teams across agencies that work within the community are most effective in avoiding agency neglect of this group of vulnerable young people.
- Agencies should review the interventions they employ with families where neglect is a concern and consider if they are appropriately targeted, effective, evidenced and evaluated. An overarching framework for evaluating services in delivering against clear outcomes would allow better matching of need with provision. This needs to be combined with how the various elements of support provided for families work together to manage and reduce the risk.

- There needs to be an agreed multi-agency approach to supporting some families long term (e.g for up to 17 years), where this is assessed and agreed to be in the best interests of the child, in the same way that there is a corporate commitment for children who become looked after for the rest of their childhood.
- A clearer and more comprehensive provision for families on assessing, and affecting changes in attachment that covers children, young people and adult attachment work should be developed. The assessments need to reference the research as to what is effective in changing neglectful parenting, including Kieran McKeown's work on the importance of client characteristics and worker-client relationships as key influences on outcomes.
- Services need to consider how they promote resilience through their interventions
- The findings should feed into all agencies workforce reform programmes, so that the type of workers and the skills and support they are required to work with families across and within the safeguarding continuum are clearly identified in order to avoid inappropriate intervention.
- Creativity, flexibility and fluidity across all services needs to be enhanced at all levels, so that families who are hard to reach' or uncooperative may benefit from less traditional ways of working.
- All services need to review how they engage with fathers/male carers.
- The impact of high workloads needs to be addressed not only in relation to the delivery of the service, but also in respect of the impact on services who provide support further down the continuum as thresholds rise.
- There needs to be greater clarity about thresholds to avoid confusion and misunderstanding and the inevitable preoccupation with eligibility as the driver to intervention rather than the assessed need. For an effective response to neglect comprehensive multi-agency holistic assessment should allow for tailor made packages on intervention across the continuum.

### Systems, Policy and Training Recommendations

- Schools should be targeted for support in calling and holding FAM
- Workers in services for adults should be trained and skilled in recognising the impact of adult behaviours on the children in the family, and in using the CAF and GCP to inform them of when to refer to discuss their involvement with other agencies. This should specifically address the issue of confidentiality where the children are not yet requiring child protection enquiry /intervention.
- Agencies are trained and supported in the use of FAM and GCP at an early stage for all families where neglect is an issue, and that this is built into all relevant agency policy and procedures.
- There should be a trigger for the review of a case after an agreed number of FAM's in neglectful families that is independent of the service to ensure that the threshold and intervention is appropriate
- Agencies training strategy needs to ensure that the use of the GCP is embedded within and across all partners, this needs then to be

implemented and supported. This will be required to happen across a number of parallel strands that include multi-agency child protection training, multi-agency prevention and intervention training and single agency safeguarding training.

- A process for regular review, evaluation, scrutiny and audit that establishes the effectiveness of the implementation of the strategy at both the micro case level and macro outcomes in neglect level should be established.
- SSCB strategic training group need to
  - Review current core group training so that professionals are confident about their role within the core group, using the tools available and ensuring evidence based evaluation to inform plans
  - Ensure that all relevant LSCB training reflects the use of the graded care profile and enhances worker skills and confidence in its use.
  - Review the neglect training that includes managers so that complex neglect cases are effectively managed at all stages through the process.
- Policy and Procedures Sub group need to
  - Ensure that the policies and procedures that underpin the intervention in complex neglect cases reflect the requirement to use the Graded Care Profile, Integrated Chronologies, use of supervision/consultation and child protection plan templates that ensure evidence based evaluation over time.
- Safeguarding Children Unit need to
  - Review the practice and approach of chairs to include a view of the progress of cases over time
  - Challenge the child protection plans for evidence of change in a robust and consistent way.

#### Individual Case Management Recommendations

- The SSCB should support the development of integrated chronologies for all cases at key points in the process, namely at the point of a Family Action Meeting, Initial Child Protection Case Conference and at the Transfer in of a family on the register from another SSCB.
- There need to be better links for all agencies between the research findings in respect of neglect (including what interventions work best in which circumstances), and practice, and more developmentally informed analysis.
- Social Care must always consult with the Police where they are concerned about neglect, such that a joint decision can be made as to whether it is appropriate to pursue the criminal strand of any enquiry.
- Assessments need to reflect analysis, identify patterns, and accommodate social and relationship history. Recommendations for action following assessment need to ensure that they are explicit and SMART, with defined outcomes and timescales such that families are aware of what is expected and what the purpose of any intervention is. This needs to happen for all Families where neglect is an issue, and may benefit from a template to facilitate this.

- There should be effective independent supervision/consultation perhaps on a multi-agency basis (as well as that provided on a single agency basis) for all complex Neglect cases and this can form a recommendation from the child protection review.
- There should be an independent chair of complex neglect cases both at the level of Family Action Meetings and of Core groups
- [Child protection reviews](#) should consider making recommendations to the police for specific interventions they require if they are called out to the family in the few cases where the risk requires a more dynamic approach.
- In initial child protection conferences wherever evidence of potential neglect are identified, these are reflected and addressed in the child protection plan irrespective of the primary category of registration.
- At the point of any child no longer becoming the subject of a child protection plan, there should be FAM held to ensure that agency intervention remains coordinated and focused on the child.
- All agencies should review their responses to and provision for children with disability within the safeguarding framework, not outside of it.

## **SSCB Strategic Priority Objectives**

The information contained within the body of this strategy has implications across all agencies in relation to how we structure and deliver our services for children and families on an individual basis and across organisations. The development of this strategy identified some key principles that should apply to all services irrespective of the level of need they are targeted at, and these are outlined within Appendix 6, and there is an overarching recommendation that this is adopted by all agencies. In considering all the evidence both, national and local, broad and detailed, the following key areas for change have been identified:

1. Workforce issues - Improve knowledge, assessment skills, training within and across agencies on the impact of neglect, effective intervention, evidence gathering and evaluation, supervision. This includes ensuring that the appropriate skills mix of the workforce at all levels of intervention.
2. Thresholds – Review this document in line with the lessons from the evidence gathering exercises and research to ensure that there is a more seamless provision of services for children and young people who may be in need because of neglect. There also need to be robust systems in place for ensuring that there is a regular, and where required, independent, review of how the threshold is being applied across the continuum of need.
3. Move towards a more integrated structure across agencies in delivering services at all levels of need, and improve their coordination that allows the child to remain at the centre.
4. Develop more effective intervention models where neglect is recognised as having a significant impact on the child that provides a range of tailor-made' options that incorporates length, intensity and smart targets based on assessed need, this includes long term options

for supporting families and crucial areas of joint intervention with adult focused services.

The nature of a strategy is that it does not set out the detail of how to achieve the priorities. Whilst many of the detailed recommendations set out earlier in section 5 have already been taken to SSCB, it is suggested that a multi-agency group meet to set out how to take forward the priority areas outlined above and complete the action plan in [Appendix 7](#).

The completion of this strategy has taken time and a great deal of effort from the involved individuals representing their agencies. The overriding approach has been to share expertise and develop and challenge the way that we do things in Salford to improve the experience of its children and young people. If the success of the group in working together is replicated across the provision of services then there is every reason to be optimistic that the implementation of this strategy will result in the children and young people being better safeguarded across the continuum of need.

## Section Six Appendices

### Appendix 1

#### Members of the Neglect Strategy group:

Kate Rose (Chair)	Safeguarding Children Unit
Jackie Bell	Salford Substance Misuse Service
Mathew Benham	SMART
Jean Rollinson	Salford PCT
Jane Anderson	Homelessness & Housing Advice Team
Brenda Lee	Operational Manager, YOT
Carol Barlow	GMP
Julie Barnes / Jill Clarke	GMP
Roisin Rafferty	Allegations Manager
Jackie Price	Supervisor of Midwives
Tim Littlemore	Sure Start (Salford PCT)
Steve Canning	Children's Services (Inclusion)
Die Green / Fran Ball	New Prospect Housing
Jackie Price	New Prospect Housing

Denise Lynch	Locality Manager
Christine Blackshaw	Salford Families Project
Margaret Duthie	New Prospect
Michael Kemp	Head of Service Courts & Child Protection
Glen Mills	Adult Mental Health
Vicki Obi	Salford Drug Service
Jo Perruzza	Drug Service
Steve Simmons	Head of Service, Substance Misuse

## **Appendix 2**

[Please click here to view Appendix 2](#)

## **Appendix 3**

[Please click here to view Appendix 3](#)

## **Appendix 4**

[Please click here to view Appendix 4](#)

## **Appendix 5**

[Please click here to view Appendix 5](#)

## **Appendix 6**

[Please click here to view Appendix 6](#)

## **Appendix 7**

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## Section Seven

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