Thriving Communities

A framework for preventing and intervening early in child neglect

Alice Haynes, Chris Cuthbert, Ruth Gardner, Paula Telford and Dawn Hodson
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Table 1. Levels of neglect 14
Why should you be concerned about preventing child neglect?

Child neglect is the most prevalent form of child maltreatment in the UK, and many believe that neglect will always happen, no matter what we do. Yet, mounting evidence shows us that prevention is better than cure, and that we can prevent and intervene effectively in child neglect. Findings ways to put this learning into practice, and to keep testing and developing new learning about what works, demands our urgent attention. At the moment, we are missing an opportunity to stop child neglect in its tracks – not only protecting this generation of children but, in turn, helping those children to become the best possible parents for the generation to come.

What does this report offer you?

This report is for national and local decision-makers and commissioners. It sets out a range of concrete actions across five different levels of society – children, parents, communities, universal services and local government – that we believe will help prevent child neglect and tackle it at the earliest opportunity. We focus specifically on actions that can prevent or tackle neglect before the need for intervention from children’s social care at a Child in Need or Child Protection level.

What will make a difference and how do we get there?

Below, we set out actions that we believe will make a difference in preventing and tackling child neglect, and concrete ways to achieve them.

These are underpinned by three key building blocks:

1. Relationships matter
Child neglect happens when relationships do not form or when they break down. The most important relationship is the relationship between the child and their parents. Supporting and improving this should be the goal of all our work to end child neglect. However, the relationships that surround the parent–child relationship are also key to preventing neglect, including the presence and quality of relationships between parents and practitioners, parents and their local communities and support networks, children and practitioners, and between different practitioners working with children and families.

2. Knowledge and awareness matters
Knowing what children need for healthy development, what child neglect looks like, why it happens and what to do about it is essential in stopping it from happening. We need to make sure everyone in a community – from parents and children to practitioners and the general public – understands these issues and knows how best to respond.

3. Evidence-based responses matter
Evidence shifts practice from what we think works to what we know works. It should underpin everything we do to help children and families at risk of or experiencing neglect – from preventative programmes and early help provision through to statutory interventions. To effectively prevent and tackle neglect, we therefore need to draw on the evidence-based approaches, tools and services that we know work. Where we do not yet know what works, we need to continue testing and evaluating the support being provided.

Our vision

A concerted shift to prevention where everyone – children, parents, communities, universal services and local government – works together to help children thrive, preventing neglect before it happens and nipping early problems in the bud.
Thriving communities: our vision

**Children**
- Recognise the signs of neglect
- Feel safe to tell

**Parents**
- Understand their child’s needs and how to meet them
- Feel safe to ask for help
- Can access high-quality support when they need it

**Universal services**
- Understand children’s needs
- Recognise the signs of neglect
- Know what they can do to help
- Feel confident and supported to do it

**Communities**
- Understand children’s needs
- Recognise the signs of neglect and understand why it happens
- Know what they can do to help
- Feel confident and supported to do it
### Actions for preventing and intervening early in neglect

#### Children and young people

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<th>What will make a difference?</th>
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<tr>
<td>Increasing children and young people’s knowledge and awareness of healthy child development and neglect</td>
<td>The PHSE curriculum should include specific content on healthy child development, healthy relationships, parenting and child neglect.</td>
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| Enabling the development of positive and trusting relationships between children and the practitioners who work with them | • Schools should take advantage of the opportunity provided by non-teaching activities for staff to develop relationships with the children and young people in their care.  
• In health services, children and young people should see the same health professional at each contact, through models of case allocation that facilitate the continuity of care.  
• The role of school nurses should be promoted within schools to pupils so that they know where and when they can visit them, and that they recognise school nurses as people who can provide emotional as well as physical help.  
• GPs should use core skills of general practice to develop and maintain a strong doctor–child relationship. |

#### Parents

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<tr>
<td>Increasing parents’ knowledge and awareness of healthy child development</td>
<td>Local authorities and Clinical Commissioning Groups (CCGs) should ensure that there is universal provision of high-quality, evidence-based perinatal parent education classes that foster an understanding of child development, attachment and the care that children need.</td>
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<td>Using evidence-based tools to support practitioners to assess care and identify neglect earlier</td>
<td>Local authorities and Local Safeguarding Children’s Boards (LSCBs) should promote the use of evidence-based assessment tools, such as the Graded Care Profile and NCFAS, across universal and early help services to assist professionals to identify and articulate concerns about neglect.</td>
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<td>Using evidence-based services for preventing and addressing neglect</td>
<td>Local commissioners should ensure that there are accessible, high-quality, evidence-based, targeted support services for parents with additional needs.</td>
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<td>Enabling the development of positive, trusting and challenging relationships between parents and professionals</td>
<td>Local authorities, LSCBs and management in individual organisations across universal services and targeted services should ensure that practitioners are equipped with parental engagement skills and have access to reflective supervision.</td>
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## Community

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<tr>
<td>Increasing the community’s knowledge and awareness of healthy child development, neglect and help seeking</td>
<td>National or local government should work with local partners to pilot public education campaigns with two components: the promotion of understanding about healthy child development and positive parenting; and the promotion of help-seeking behaviour for emerging parenting difficulties. Campaigns should be rigorously evaluated.</td>
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<tr>
<td>Promotion and fostering of community support for parents</td>
<td>Local partners should invest in and evaluate initiatives and services that nurture social networks between parents in communities. This should include developing and testing new models to harness the power of volunteers to help prevent child neglect.</td>
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## Universal services

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<td>Clear understanding of staff in universal services about the actions they can take to provide early help</td>
<td>Government, National Institute for Health and Care Excellence (NICE) and professional membership bodies, such as the Royal College of Midwives, Royal College of GPs, Royal College of Nursing, Royal College of Paediatrics and Child Health, should clarify the role of universal services practitioners in providing early help for neglect. They should set out these role requirements clearly in statutory, professional guidance and professional job descriptions. More explicit guidance should be developed on how practitioners can provide direct support to children and parents.</td>
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<td>Increasing staff in universal services’ knowledge of how to provide early help to parents and children</td>
<td>LSCBs and safeguarding practitioners should ensure that all staff in universal services who work with children and families receive, during their pre-qualification training and at least every three years while practising, specific training on:</td>
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<td>• child development;</td>
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<td>• the risk factors for, signs and impact of neglect;</td>
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<td>• building relationships and conveying concerns to parents;</td>
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<td>• building relationships with children to enable them to speak out;</td>
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<td>• being receptive to a child’s disclosure about neglect; and</td>
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<td>• how to provide early help.</td>
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<td>Increasing universal services’ capacity for early help through pastoral support</td>
<td>Education and health services should recognise and draw on the role that family support workers and other pastoral workers can play in preventing neglect. Family support workers and other pastoral workers should be given adequate training and supervision to reflect the skill required to take on this role.</td>
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<td>Enabling effective multidisciplinary team meetings</td>
<td>LSCBs should ensure that all agencies working with children and families hold regular multidisciplinary meetings to discuss early concerns about children and their parents in the local area.</td>
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<td>Developing accessible and effective LSCB threshold documents</td>
<td>The Department for Education should undertake research into the quality and consistency of LSCB threshold documents, and should develop prototypes and pilot them.</td>
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How can local government help communities thrive?

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<th>How do we get there?</th>
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<tr>
<td>Sizing the problem</td>
<td>Local government should regularly collect data on the number of children classed as ‘in need’ because of neglect and on parental risk factors for neglect.</td>
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<tr>
<td>Drawing from and developing learning on the most promising ways of preventing and tackling neglect</td>
<td>Local government should commission evidence-based services to prevent and tackle neglect, and should rigorously evaluate strategic approaches, such as early help hubs and early help strategies.</td>
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<tr>
<td>Redirection of funding to prevention</td>
<td>National and local governments should reduce the £17 billion ‘late intervention’ spending by 10 per cent by 2020 through better and smarter investment in early help.</td>
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Introduction

Why should you be concerned about preventing child neglect?

Child neglect is the most prevalent form of child maltreatment in the UK, with an estimated one in 10 young adults having been severely neglected by parents or guardians during childhood (Radford et al, 2011). The human and economic costs are vast, far-reaching and long-lasting. Despite our ever-growing understanding of child neglect (Brandon et al, 2014; Burgess et al, 2013; Farmer & Lutman, 2014; Gardner, 2008; Hicks & Stein, 2013; NSPCC, 2015a), and the mounting evidence that the benefits of prevention are better than cure (Allen, 2011; Davies & Ward, 2011; Easton et al, 2013; Field, 2010; Knapp et al, 2011; Munro, 2011), we have not yet put in place an effective way to prevent child neglect from happening, or to tackle it as soon as it starts happening. At the moment we respond too late, focusing limited resources on ‘late intervention’, which responds to a child and family’s needs once harm has been done. We are missing an opportunity to stop child neglect in its tracks – not only protecting this generation of children but, in turn, helping those children to become the best possible parents for the generation to come.

What does this report offer you?

This report is for national and local decision-makers and commissioners. We are in a challenging political and economic climate; preventative and early help provision has borne the brunt of austerity and cuts to public services, and with a greater reduction in public spending on the horizon, we face the challenge of doing more with less. Many believe that child neglect will always happen, no matter what we do (Lindland & Kendall-Taylor, 2013). This report challenges head on this fatalistic view of child neglect, proposing a range of concrete actions that we believe will achieve a more preventative system.

Our vision

A concerted shift to prevention where everyone – children, parents, communities, universal services and local government – works together to help children thrive, preventing neglect before it happens and nipping early problems in the bud.

Our actions are based on this ecological framework (children and young people; parents and carers; communities; and universal services) because it is only through concerted action at all those levels that we will be able to deliver the step-change to a truly preventative approach. We focus specifically on actions that can prevent or tackle neglect before the need for intervention from children’s social care at a Child in Need or Child Protection level. This is a report about child protection that is not just about those working in the formal child protection system, but that calls on the whole community to work together to make change happen. To make these ideas a reality, it will require national and local decision-makers and commissioners to lead the way, investing in and championing prevention and early help as the most logical and effective way forward.
A whole system approach challenges us to consider how and where safeguarding risk is held. Currently, risk is held mainly by local authority children’s services; if there is any doubt whatsoever about the safety of a child, the expectation is that the concern is immediately escalated to local authority children’s social care. However, when the child protection system is under such pressure and thresholds for interventions are so high, we need to challenge ourselves to think about whether, in some cases, risk can be held further upstream, and how this might be achieved.

What level of responsibility lies with the community, with friends, family, neighbours, and community and religious organisations, to prevent neglect and to get help to parents as early as possible? We will not be successful in ending child neglect if we rely solely on professionals and on the state to respond.

The community holds untapped resources and assets, which if supported by professionals, and backed by knowledge and evidence, could be the key to making a substantial difference to the lives of the thousands of children and families affected.

Universal services make up a large and skilled workforce, all of whom are trained to work with children and families. What would it take to ensure greater confidence to hold risk in these services? Who in universal services would be best placed to hold the risk, and how do we ensure that they get the support they need to do so? It is clear we would need to invest more heavily in high quality training, so that practitioners are equipped with the skills to hold this risk without putting the child in danger, and ensure that practitioners have access to high quality advice and support from those with specialist child protection knowledge.
Figure 3. The size of the workforce: children’s social workers and universal services practitioners*

* All figures relate to autumn 2014 (unless stated) and are rounded to the nearest 10. FTE children’s social workers in English local authorities (Department for Education, 2015a); teachers in state-funded schools (Department for Education, 2015b); early years practitioners (Department for Education, 2014) (NB: figure is for 2013 and refers to paid staff working in full day care settings); GPs (Centre for Workforce Intelligence, 2014) (NB: figure is for 2013); midwives (HSCIC, 2015); health visitors (HSCIC, 2015); school nurses (HSCIC, 2015)
What is child neglect?

Neglect is the most common reason for a child to be on a child protection plan in England (Department for Education, 2015c) and features in 60 per cent of serious case reviews (Brandon et al, 2013). Neglect is the most common concern about which adults contact the NSPCC helpline (Turnball, 2015).

In England, the statutory safeguarding guidance defines child 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 as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:
>
> - provide adequate food, clothing and shelter (including exclusion from home or abandonment);
> - protect a child from physical and emotional harm or danger;
> - ensure adequate supervision (including the use of inadequate care-givers) or ensure access to appropriate medical care or treatment.
> - It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs” (Department for Education, 2015d).

The neglect of a child’s emotional needs has historically received less attention than physical neglect. We have only recently begun to understand the nature of emotional neglect and the impact it can have on a child (CORE INFO, 2012, 2014; Glaser, 2002), following a number of follow-up and longitudinal studies in the late 1980s and 1990s on emotional abuse and neglect (Erickson et al, 1989; Herrenkohl et al, 1991; Briere & Runtz, 1990). Physical neglect tends to be easier to recognise than emotional neglect, and can appear to need a swifter response than emotional neglect, although this is not the case. In some academic literature and practitioner guidance, emotional neglect is paired with emotional abuse, and this can add to the complex task of defining emotional neglect (Brandon et al, 2014). Whereas emotional abuse is an active form of maltreatment, such as deliberately trying to scare or humiliate a child, emotional neglect is the omission of the provision of emotional or psychological care. Again, while emotional neglect may seem more benign than emotional abuse, emotional neglect can have serious and long-lasting effects (Gardner, 2008; Glaser, 2002).

Child neglect happens at different levels of severity. Table 1 illustrates one way of assessing the seriousness of neglect. Because neglect is very difficult to quantify, practitioners should consider these categorisations alongside their own professional judgement and observations of the child and family. We know that, for example, ‘mild’ or ‘low-level’ neglect can be deeply damaging to a child if it occurs over a long period of time, and failure to provide care in just one area can be fatal for a child.
### Table 1. Levels of neglect

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<tr>
<th>Level of neglect</th>
<th>Description</th>
<th>Response</th>
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<tr>
<td>No neglectful parenting</td>
<td>Consistent good quality parenting where the child’s needs are always paramount or a priority.</td>
<td>Normal universal services access.</td>
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<tr>
<td>Mild or low-level neglect</td>
<td>Failure to provide care in one or two areas* of basic needs, but most of the time a good quality of care is provided across the majority of the domains.</td>
<td>Likely to require a single agency targeted short-term intervention until resolved, or a referral to local authority children’s services if deteriorates or remains unchanged.</td>
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<tr>
<td>Moderate neglect</td>
<td>Failure to provide good quality care across several areas, some of the time. May occur when less intrusive measures, such as community or single agency interventions, have failed, or some moderate harm to the child has or is likely to occur; for example the child is consistently inappropriately dressed for the weather, such as being in shorts and sandals in the middle of winter.</td>
<td>Requires a formal targeted single or multi-agency intervention (for example, a Common Assessment Framework). This would coordinate support where needed. All cases will need a formal monitoring for referral to children’s social care if there is no improvement. However, if there is already evidence of no improvement, and associated with domestic abuse, mental health, substance misuse, learning difficulties or other parental risk factors, a referral to local authority children’s services should be made from the outset.</td>
</tr>
<tr>
<td>Severe neglect</td>
<td>Failure to provide good quality care across most of the domains most of the time. Occurs when severe or long-term harm has been or is likely to be done to the child, or the parents are unwilling or unable to engage multi-agency support.</td>
<td>Referral to local authority children’s services will be required. If the child is already know to statutory services, child protection procedures should be instigated followed by legal planning if further no improvement.</td>
</tr>
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* ’Area’ refers to four basic domains of care: physical care, safety, love and esteem.

(Amended from DePanfilis, 2006)
The impact of neglect on children

The impact of neglect on a child can start before they are born. A mother can self-neglect during pregnancy – for example, as a result of mental health problems, substance misuse or domestic abuse – and this can damage the way a baby develops in the womb (Valdez-Santiago & Sanin-Aguirre, 1996; Schei et al, 1991; Fischer et al, 2006; NICE, 2015). Once a baby is born, physical and emotional neglect during the early years of life can also have a profound impact on the development of the brain and body (Glaser, 2000). These early years are the time when a baby’s brain develops fastest, and the physical and emotional care they receive at this time will shape the way their brain develops (Center on the Developing Child, 2013a).

If a baby is malnourished, brain cells can become weak or damaged. For a baby’s thought processes and ways of thinking to develop in a healthy way, a baby needs sensitive, attuned and loving care from his/her caregivers. This sensitive care, characterised by a secure attachment relationship, supports a baby to manage everyday stress. When babies do not get this care, it can disrupt the architecture and chemistry of the brain (Center on the Developing Child, 2013b).

As a child grows older, both their physical and psychological development can be affected by neglect. Poor diet can impede continued brain growth and physical development, and can lead to obesity (Horwath, 2013). Children who are not kept clean can develop skin conditions and dental problems, and a lack of supervision can result in injuries or death (Brandon, et al, 2013; Coohey, 2003). Optimal physical development also requires a child to be stimulated and encouraged to develop gross motor skills, which may not occur when a parent or carer is neglectful (Horwath, 2013). Children who have been neglected are more likely to experience mental health problems, including depression and post-traumatic stress disorder (Lazenbatt, 2010). As children go into their teenage years, feelings of being unloved and unwanted may lead to suicidal feelings, running away, anti-social behaviour and offending (Hicks & Stein, 2013; Weatherburn & Lind, 1997). They may find it difficult to maintain healthy and loving relationships with others later in life (Hicks et al, 1999) and may be at more risk of sexual abuse and exploitation (Hicks & Stein, 2013).

For children who experience neglect and who go on to be parents themselves, there is a risk of the intergenerational transmission of neglect (Crittenden, 2008; Howe, 2005). This is by no means the case for all those who experience child neglect but for some, this past trauma can impact upon the relationship they have with their own children.

"In most cases maltreatment boils down to the actions and behaviours of carers, and these are driven by minds and what goes on inside them... In time, young minds become old minds, which in their turn become the minds of future caregivers who have to deal with the stresses and strains of their world. Thus, a new generation of carers creates the social environment with which their children have to interact, and in which their young minds form, and so on." (Howe, 2005, p7)

The impact of child neglect on society and resources

The prevalence of child neglect and our collective failure to respond early impacts not only on the child and family, but also has a profound impact on wider society and resources.

When a child experiences neglect, and when they experience mental health difficulties, poor physical health or engage in anti-social behaviour or offending as a result, it is costly to intervene. Rather than directing money into ways to prevent these difficulties occurring in the first place, we spend public money on ‘late intervention’. The Early Intervention Foundation has estimated that nearly £17 billion per year is spent in England and Wales...
by the state on ‘late intervention’, defined as the "fiscal cost of acute, statutory and essential benefits and services that are required when children and young people experience severe difficulties in life" (Chowdry & Oppenheim, 2015, p5). This includes the cost of crime and anti-social behaviour, school absence and exclusion, child injuries and mental health problems, youth substance misuse, youth economic inactivity, and child protection and safeguarding (which account for over a third of that total cost).

Infancy is a time of particular vulnerability, and evidence tells us that encountering adversities and stresses like neglect during this time significantly increases the risk of a number of mental and physical health outcomes in adulthood. Experiencing adversities can alter the way an infant’s brain develops and functions (Shonkoff, 2007), and this can lead to depression, anxiety, behavioural disorders, substance misuse (Kessler et al, 2010), cardiovascular diseases and cancers (Johnson et al, 2013) in later life. Managing these problems requires significant resources from our healthcare system. As well as being a burden on resources, the impact of child neglect can also make it difficult for children to grow up to be productive members of society, and we risk losing the potential benefits to our society that they might otherwise provide.

**Risk and protective factors: an ecological perspective**

The causes of child neglect are multifaceted and complex. Ecological theory provides a compelling lens through which to consider risk and protective factors for neglect (Bronfenbrenner, 1979).

> “Child maltreatment is multiply determined by forces at work in the individual, in the family, and in the community and culture, and that these determinants are nested within one another.” (Sidebotham & Heron, 2006, p498)

Belsky (1980; 1993) identified four areas of influence that can increase the risk of child neglect happening: parental background, socio-economic environment, family structure and children themselves. Factors in parents’ backgrounds that are associated with child maltreatment include mental health difficulties, substance misuse, young parenthood, learning difficulties and adverse childhood experiences (particularly abuse or neglect in their own childhoods). In relation to socio-economic factors, child neglect is more prevalent in families affected by poverty and social isolation (Slack et al, 2003), although it is important to note that neglect can also occur in affluent families (Action for Children, 2014). Domestic abuse is a key factor in the family environment that is associated with neglect. Characteristics of the child that are risk factors for neglect include disability (Stalker & McArthur, 2012) and babies born before term, with low birth weight, or with complex health needs (Strathearn et al, 2001).
Why focus on prevention and early help?

There is growing consensus, backed by a wide body of research, that providing children and families with help before a problem emerges or at an early stage prevents children from suffering unnecessary harm, improves their long-term outcomes and is more cost effective than reactive services (Allen, 2011; Davies & Ward, 2011; Easton et al, 2013; Field, 2010; Knapp et al, 2011; Munro, 2011).

This report looks both at preventative and early help actions (defined below). It focuses specifically on actions that can tackle neglect before the need for intervention from children’s social care at a Child in Need or Child Protection level.

Throughout this report, we use the terms ‘prevention’ and ‘early help’:

Prevention is about intervening before something becomes a problem.

Early help is providing support as soon as a problem emerges at any point in a child’s life.

(Department for Education, 2015d)

Neglect can be prevented, and it can be stopped once it starts (Churchill, 2015a, 2015b; Johnson & Cotmore, 2015; Whalley, 2015a, 2015b; Williams, 2015). At one time or another, all parents face difficulties in their lives that can make parenting hard but providing timely and high quality advice, support and interventions for parents can in many cases prevent these difficulties leading to neglectful parenting and children experiencing harm as a result.
This is a time of particular pressure on the child protection system, both as a result of a reduction in funding and increased demand for services. There has been a 27 per cent reduction in local authority budgets since 2010 (Hastings et al, 2015). At the same time (between March 2010 and March 2014) the number of referrals to children’s services increased by 9 per cent, the number of child protection enquiries by 60 per cent, the number of children subject to a child protection plan by 24 per cent and the number of children in need by 6 per cent (Ofsted, 2015). Cuts to public spending are continuing – in June this year, the Department for Education announced that it would cut £450 million from its non-schools budget in 2015–2016.

In response to this pressure, thresholds for statutory intervention have risen, with children’s social care being increasingly required to act as an emergency service (Jütte et al, 2014). Therefore, the vast majority of neglect is occurring in the community, where many children experience a suboptimal level of parenting but do not meet the threshold for statutory intervention at a child in need or child protection level (Barlow & Calam, 2011). Research from the NSPCC estimates that for every child on a child protection plan or the child protection register, there are likely to be another eight children who have suffered maltreatment (Harker et al, 2013).

Given this context – a perfect storm of increased need and decreased funding for children’s services – we need to take a whole system approach that focuses on preventing neglect. Preventative and early help provision can stop problems when they first emerge, reducing the harm experienced by a child and the need for a referral to children’s social care in the first place. At the same time, we need to keep building the evidence base for work with children and families. There has been a woeful lack of research on social care interventions with children and families, and this must be addressed to ensure that the ‘help’ we are giving children and families to prevent and address neglect does actually help. We urgently need more research into which families can benefit most from which interventions.

Finally, it is important to emphasise that prevention and early help are part of a continuum of support. Children and families do not stay at one level of need but may move between the need for intervention at an early help level, Child in Need level or Child Protection level, and, therefore, these levels of response are equally as important to get right.

Structure of the report

We begin by setting out our three key building blocks for change, which underpin all of our actions for change. Then, at each level – children, parents, communities and universal services – we consider:

- What is the opportunity to prevent neglect?
- What stops this happening?
- What will make a difference?
- How do we get there?

We end by setting out how local government can enable communities to thrive.
1. Relationships matter

Child neglect happens when relationships do not form or when they break down.

The most important relationship is the relationship between the child and their parents, and supporting and improving this should be the goal of all our work to end child neglect. Children need attuned, sensitive and loving care throughout their lives, and when this does not happen, it can be deeply damaging for their physical and psychological development, their happiness and their overall wellbeing.

To prevent and tackle neglect, the relationship between parents and the other adults around them is also key. Parenting poses challenges for most of us as parents, and we need support from friends, family and our local community to manage those challenges. Parents also benefit from help from professionals, whether that be support that is provided to all new parents from universal services like midwives and health visitors, or help for specific challenges that some parents face, like mental health problems or substance misuse. Relationships are vital for this help to be effective.

Figure 5. Thriving communities: what will make a difference?

Knowledge and awareness matters
Increasing knowledge and awareness of healthy child development, neglect and help-seeking in children and young people, parents, community members and practitioners.
Increasing staff in universal services’ knowledge of how to provide early help to parents and children.

Evidence-based responses matter
Evidence-based tools to support earlier identification and assessment of neglect.
Evidence-based services for preventing and addressing neglect.
Understanding unmet need.
Evidence-based strategic, multi-agency early help provision.
Accessible and effective LSCB threshold documents.

Relationships matter
Positive and trusting relationships between children and practitioners.
Positive, trusting and challenging relationships between parents and professionals.
Community support for parents.
Increasing universal services capacity through pastoral support.
Multidisciplinary team meetings.
And it is not only parents who need support from practitioners, but also children and young people. A positive relationship between a child and their teacher or GP, for example, might be the difference between a child telling about neglect at home or suffering in silence. Children and young people also need supportive friends and adults they can trust around them, who they can turn to if there are problems at home.

Finally, the quality of the relationship between different practitioners working with children and families is important to preventing neglect. Practitioners need to be able to reflect on and discuss concerns together, to get advice, to challenge one another and find the right solutions for the children and families they work with.

‘Attunement’ is an important part of developing healthy and collaborative relationships (Kennedy et al, 2011). It is about reciprocal communication, meaning being responsive to another person’s feelings and thoughts. Attunement requires us to be self-aware and able reflect on and understand our own behaviour. Parents and professionals need help and support to achieve and maintain attunement under stress.

2. Knowledge and awareness matters

Understanding what child neglect looks like, why it happens and what to do about it is essential in tackling it. Yet research tells us that people – local decision-makers, practitioners, the general public, and children and young people – are not equipped with this knowledge and awareness.

Most parents want to do the best for their children. This can be harder if they lack knowledge about what children need, if they are struggling with their own problems, or if they do not have positive examples of parenting from their own childhood. If people understand about healthy child development, they are more likely to notice earlier when parenting (both their own and others’) is not meeting the needs of a child. If people understand why neglect happens, that it is often the result of parents being under significant pressure, they are likely to want to offer support. If people know how and where they can get help, whether that be children or parents themselves or community members and practitioners, we have a better chance of getting that help to families at the earliest possible point. If practitioners working with families have the knowledge and skills to help parents engage with sources of support, we have a better chance of that help being effective. And if local decision-makers understand the urgency of the problem of child neglect, and they are equipped with evidence-based approaches to tackling it, they can make sure that prevention and early help is supported and enabled at a strategic, area-wide level.

3. Evidence-based responses matter

Developing and using an evidence-base for social care work with families, employed alongside professional judgement, means better outcomes for children and families. Evidence shifts practice from what we think works to what we know works.

“Knowledge = evidence + practice wisdom + service user and carer experiences and wishes.” (Lewis, 2001)

In order to prevent and tackle neglect, evidence-based practice should run through the spectrum of provision for parents, children and families, from preventative programmes and early help provision through to statutory interventions. Shockingly, however, we do not know how many children and families need our help or whether most of the interventions that are carried out with children and families in social care actually work.

Our challenge, therefore, is two-fold: to know what the needs are in our local areas, and then to use tried and tested means of meeting those needs. We already have some evidence to tell us what works for tackling neglect, but we urgently need to build on this knowledge base, testing our early help provision for neglect to find out more about what works, with which families and why, and whether improvements can be sustained over time.

Building an evidence base takes time and requires funding. While the use of interventions backed by robust methods of evaluation, such as randomised controlled trials (RCTs), is recommended (Chaffin & Friedrich, 2004), this level of rigour is not always possible and we need to strike a careful balance between the requirement for evidence and the pressing need to provide services to families.
Level 1: Children and young people

The opportunity to prevent neglect

Helping and supporting children and young people to speak out is an important part of a multi-faceted approach to preventing neglect. We must embrace and nurture any opportunity to hear from children and young people about issues that impact their lives. If they are able to do so, it increases the chances of getting help to families at the earliest possible stage. However, we should not, and cannot, rely on children and young people being able to tell us when they are not being well enough cared for at home. We should not because of a fundamental recognition that it is our duty as adults to protect children. We cannot because evidence shows us that children and young people might not understand that what is happening is harmful to them, and if and when they do, they face significant and sometimes dangerous barriers to telling others.

What stops children and young people from speaking out?

Research and practice experience suggests that children and young people do not readily tell others when they are being maltreated (Cossar et al, 2013) and in particular when they are experiencing neglect (Vincent & Daniel, 2004). For example, analysis of data from ChildLine, a 24-hour helpline for children and young people, shows that children and young people do not often contact the helpline about neglect (Turnball, 2015). Children and young people do not readily tell others about neglect because, first, they may not recognise a situation as neglectful and, second, because if they do, they can face a range of barriers that prevent them from telling others (Action for Children, 2014; Allnock & Miller, 2013; Cossar et al, 2013; Haynes, 2015). In addition, babies and very young children, are not physically able to tell.

Recognition

Cossar et al (2013) identified a number of factors that may mean that a child or young person is not able to recognise when a situation is neglectful:

- A child living in a neglectful situation may consider their experience to be the ‘norm’ or feel that they deserve to be maltreated, especially if emotional neglect is combined with emotional abuse.
- They may struggle to believe that their parent or carer could, as someone they expect to care for them, be abusive to them.
- If a child or young person experiences neglect from time to time, they may focus on periods when their relationship with their parents or carers was good.

Cossar et al (2013) also found that children may be more likely to be able to recognise that they are being neglected once they reach the age of 11 or 12. At this age, they are more likely to enter other families’ homes or witness other children’s relationships with their parents or carers, and compare it with their own.

Telling

If a child or young person is able to recognise when a situation is neglectful, who do they tell? Children and young people might tell others that they are experiencing neglect in a number of ways, including talking to relatives, friends or professionals, or calling helplines or seeking advice via online forums. However, research suggests that young people turn first either to parents, carers or family members, or to their peers (Action for Children, 2014; Jobe & Gorin, 2013). They are less likely to ask professionals for help (Action for Children, 2014; Jobe & Gorin, 2013; Haynes, 2015), and when children and young people do talk to professionals, it tends to be social workers, teachers or youth workers1 to whom they turn (Cossar et al, 2013; Jobe & Gorin, 2013; Haynes, 2015; Turnball, 2015).

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1 However, funding for youth services has been in decline in recent years (UNISON, 2014) - see chapter How can local government help communities thrive?
There are a number of reasons why a child or young person might not feel able to talk about experiencing neglect:

• They might want to protect their parents or carers from the possible consequences of a disclosure about neglect, they may fear being removed from their parents’ care, or they might wish to protect their wider family more generally from the impact of a disclosure (Allnock & Miller, 2013; Cossar et al, 2013; Haynes, 2015; Jobe & Gorin, 2013).

• They might be too frightened of their parent or carer to tell about problems at home (Action for Children, 2014; Haynes, 2015; Cossar et al, 2013).

• They might be uncertain about whether the adult has time to listen, whether that adult has the training or authority to help, and what their reaction will be to what they are told (Action for Children, 2014; Haynes, 2015). Haynes (2015) found, for example, that young people may not attempt to speak to GPs or school nurses about difficulties at home because they perceive them to have a strictly physical health-based remit.

• Children and young people may also be concerned that other children will find out, resulting in teasing or bullying (Cossar et al, 2013)

• Children and young people experiencing neglect can feel isolated (Allnock & Miller, 2013), and they may not feel that they can trust any adults, regardless of who they are (Action for Children, 2014; Cossar et al, 2013; Jobe & Gorin, 2013; Haynes, 2015).

Relationships are the key to telling

“Young people value practitioners they can trust, who are effective, knowledgeable and available.” (Cossar et al, 2013, pii)

Underpinning much of the research about why children and young people do not disclose abuse and neglect to professionals in particular is the need for, but often absence of, safe and trusting relationships (Mortimer et al, 2012). All children come into contact with staff in universal services, for example teachers and GPs, creating an opportunity to build and nurture such relationships.

Yet there are many barriers that can get in the way, including significant time and workload pressures on professionals, the opportunity for reflective supervision, low levels of professional contact with children (for example, school nurses) and the often challenging behaviour of children and young people experiencing neglect.

What will make a difference?

Children and young people’s understanding of healthy child development and neglect

For children and young people to be able to recognise that they are experiencing neglect, they need readily available, age-appropriate information on healthy child development, healthy relationships, parenting and neglect (Allnock & Miller, 2013). This could be delivered in PHSE lessons in schools. PSHE education is a “planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives” (PHSE Association, 2015).

• Content on healthy child development should look at children’s development and needs across the lifespan, from pregnancy to the teenage years, and the influence of parents/carers on a child’s wellbeing and development.

• Content on healthy relationships should include education on attachment theory, parent/carer–child relationships, and the importance of respect, love and care.

• Content on neglect should include what different types of neglect look like, why neglect occurs, what impact it can have on children, and where to seek help.

• The potential effects of stressors, such as poverty, domestic abuse, mental ill health and substance misuse on parenting, and sources of advice and help.

The PHSE Association sets out ten principles of good PHSE education, which may be useful in developing the content for these sessions (PHSE Association, 2015).
Children and young people can also be helped to understand these issues through other forms of communication, such as assemblies, animations and leaflets. The NSPCC Schools Service, run in primary schools, aims to ensure that children have an understanding of abuse in all its forms, including bullying, and an ability to recognise the signs of abuse; to ensure children know how to protect themselves from all forms of abuse; and to make them aware of how to get help and sources of help (including ChildLine). The service plans to visit every primary school in the UK at least once every two years. The NSPCC is currently undertaking an evaluation of the service, which is due to be published later in 2015. In 2010, the University of York, The Children’s Society, the NSPCC and the Department for Children, Schools and Families worked with young people to develop a guide, Neglect Matters, for young people about neglect (NSPCC, 2010).

Positive and trusting relationships between children and practitioners

If and when children and young people do recognise that the care they are receiving is neglectful, they need to feel able to confide in others. Children and young people may understandably be more inclined to disclose problems at home to family or friends, rather than to professionals.

We look in detail about actions at a community level in section 3.

If we can support children and young people to feel able to confide more in professionals, such as their teacher or GP too, we increase the opportunity to get help to a family as soon as possible. We know that children and young people are more likely to tell a professional about neglect when they have sustained and trusting relationships with them; therefore, services should be designed to maximise the potential to build such relationships between practitioners and young people (Cossar et al, 2013).

“Long-term relationships are the best cure I’d say. For someone to speak to, the ideal person is someone that has built up a long-term relationship and is friendly and stuff like that. Because if you’re chopping and changing every time, like get a different social worker or you get a different teacher, a different someone, you’re never going to...” (Young person, quoted in Haynes, 2015)

Because teachers have daily contact with children and young people, they are particularly well placed to foster relationships. Capitalising on non-teaching activities, such as school trips or break times, is one way to develop relationships with young people, as suggested in this comment from a young person:

“If you saw school staff as more human... I remember when I was at school I never thought of school staff as normal people; I don’t know what they did, I just didn’t see them as normal. I think the best chance I would have had is like on a school trip or something like that when you see them, a residential or something like that, that informal chance when you’re not in a classroom.” (Young person, quoted in Haynes, 2015)

Health professionals like GPs and school nurses are also in a good position to develop and maintain a strong relationship with children and provide early help. GPs often treat families over many years and see multiple members of the same families (providing a holistic view of a family), particularly when a family has long standing health needs (Woodman et al, 2014). They often command respect from patients and have the skills to coach and provide advice (Tompsett et al, 2009; Woodman et al, 2014; Woodman et al, 2012). Woodman et al (2014) suggest that “reconceptualising the GP’s role to include direct responses to certain children and families would play to the existing strengths of general practice” (p9), but highlight the need for more research in this area. As part of the government’s Healthy Child Programme, school nurses have responsibility for children aged between 5 and 19. They are tasked with a range of activities that support relationship-building, such as giving advice, education and support, as well as medical treatments (Royal College of Nursing, 2014).

Relationship-building between health practitioners and children and young people is likely to be best developed through case continuity, where children and young people see the same practitioners at each contact. In some settings, this may be difficult to achieve. School nurses are a small workforce, consisting of approximately 1,200 practitioners (HSCIC, 2015), which is around one for every 7,000
children and young people, and GPs are also facing a capacity crisis (Royal College of GPs, 2015). In instances where case continuity is difficult to achieve, effective change could still be realised through a shift in the ethos of a GP practice or school setting, where there is a clear focus on developing practice that supports relationship building and is child and family centred. For GPs, advice on how to develop relationships and facilitate communication with children of all ages is set out in the RCGP and NSPCC Safeguarding Children Toolkit for General Practice. This includes ensuring the waiting room and practice environment is welcoming and friendly, using drawing and play to communicate, advice on how to phrase questions, and advice on how to develop trust through openness and honesty (Royal College of GPs, 2014).

For teachers, the Children’s Commissioner’s reports on outstanding safeguarding practice in schools (2012; 2013) are useful sources of advice. Ideas include ‘Worry Boxes’, ‘circle time’ and nurture groups for younger children (2012), and opportunities for informal contact with older children, such as teachers sitting with students at lunchtime, headteachers or other staff having an open door policy, and counsellor drop-in arrangements (2013). School nurses are a fantastic resource for children and young people, but children and young people may not know how to make contact with them or how they can help (Haynes, 2015). Where possible, schools and school nursing teams should promote the role of the school nurse within the school.

Alongside the opportunity to build relationships with young people, practitioners need a range of skills to provide effective early help for children and young people. These include the skills to build those relationships, and skills to identify neglect and provide early help. This is picked up in Section 2 on universal services.

Summary

Helping children and young people to understand when they are experiencing neglect, and ensuring that they feel safe to tell their story and feel confident that they will be heard and believed is a crucial part of a multi-faceted approach to preventing neglect. We must embrace and nurture any opportunity to hear from children and young people about issues that impact their lives. If they are able to do so, it increases the chances of getting help to families at the earliest possible stage.

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<th>What will make a difference?</th>
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<tr>
<td>Increasing children and young people’s knowledge and awareness of healthy child development and neglect</td>
<td>The PHSE curriculum should include specific content on healthy child development, healthy relationships, parenting and child neglect.</td>
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| Enabling the development of positive and trusting relationships between children and the practitioners who work with them | • Schools should take advantage of the opportunity provided by non-teaching activities for staff to develop relationships with the children and young people in their care.  
• In health services, children and young people should see the same health professional at each contact, through models of case allocation that facilitate the continuity of care.  
• The role of school nurses should be promoted within schools to pupils so that they know where and when they can visit them, and can recognise school nurses as people who can provide emotional as well as physical help.  
• GPs should use core skills of general practice to develop and maintain a strong doctor–child relationship. |
The opportunity to prevent neglect

A child’s primary caregivers, whether they are parents, foster carers, grandparents or other family members, construct and shape the environment in which he or she develops. This in turn shapes the way that children interact with the world around them. For example, a child’s ability to have rewarding relationships, their ability to learn and the extent to which they can be functioning and contributing members of society are all deeply impacted by the care they receive (Shonkoff & Phillips, 2000). For optimum development and wellbeing, children require sensitive, responsive, loving parenting driven by an understanding of their emotional, physical, safety and stimulation needs, from pregnancy through their childhood and adolescence.

The influence of parents on their child’s development begins during pregnancy. A woman’s mental and physical health, behaviour, relationships and environment all influence the baby’s development in the womb (Shonkoff, 2007). Research has shown that maternal stress during pregnancy is linked with poorer physical, emotional and cognitive outcomes for infants (Bergman et al, 2007). Once born, babies and very young children are particularly vulnerable to poor care. In the first two years of life, a baby’s brain is developing rapidly, with 700 new neural connections forming every second (Center on the Developing Child, 2015). In order for healthy brain and physical development, babies need care that is responsive, sensitive and attuned (Cuthbert et al, 2011). ‘Serve and return’ interactions shape brain architecture:

“When an infant or young child babbles, gestures, or cries, and an adult responds appropriately with eye contact, words or a hug, neural connections are built and strengthened in the child’s brain that support the development of communication and social skills… When caregivers are sensitive and responsive to a young child’s signal and needs, they provide an environment rich in serve and return experiences.” (Center on the Developing Child, 2015)

Engaging people at times of major life transitions can be an effective way of bringing about change. Pregnancy and the first years of a child’s life are a particular window of opportunity because parents can be especially open to offers of advice and support, and expect to have contact with professionals (Cuthbert et al, 2011).

Why we are failing parents

Inadequate perinatal parenting support

Antenatal and postnatal classes (termed perinatal) can be an effective way of reaching all new parents with information and support about healthy child development and the importance of the parent–infant relationship. However, while NICE clinical guidance (2014) states that “Pregnant women should be offered opportunities to attend participant-led antenatal classes”, there are a significant number of women who are not accessing antenatal education classes. A Healthcare Commission survey (2007) found that 36 per cent of women were not offered antenatal classes by their NHS trust (with variation within trusts ranging from 11 per cent to 67 per cent of women not being offered classes). A survey by the National Perinatal Epidemiology Unit (NPEU) of a random sample of 10,000 women reported similar findings, with 31 per cent of women reporting that they were not offered a class or workshop (Redshaw & Heikkila, 2010).

In the NPEU survey, of those attending classes, less than half felt that there were enough classes in the course (42 per cent) and that the classes covered the topics women wanted (45 per cent). Classes tend to focus on promoting physical health and preparations for labour and birth (NHS, 2014) and while this information is extremely important, parents-to-be also need to be prepared for the emotional and social aspects of having a baby.

Classes also tend to be targeted at mothers, yet we know that fathers also have a significant impact on the development and wellbeing of their children (Lamb, 1997) and, therefore, need support during the perinatal period as much as mothers. Fathers’ positive involvement in high-quality perinatal education classes is likely to help them manage the stress of the perinatal period, prepare them for childbirth and fatherhood, and help them support their partner, and this supportive role goes well beyond pregnancy (Royal College of Midwives, 2011).
Families also benefit from support in the postnatal period. However, the survey by The National Perinatal Epidemiology Unit found postnatal support to be wanting. While two-thirds of women reported that regular baby clinics (68 per cent) and open drop-in clinics (71 per cent) were available to them, only around half were aware of children’s centres (52 per cent), a third (34 per cent) knew that parent-to-parent groups were available and a quarter or more that postnatal classes (29 per cent) and a baby café (25 per cent) were available (Redshaw & Heikkila, 2010).

The Harvard Centre on the Developing Child has produced a series of accessible videos explaining early brain development and the impact of neglect (for information, go to www.developingchild.harvard.edu). There are also two apps for mobile phones that parents might find useful. Getting to Know Your Baby (www.your-baby.org.uk) is a website and free mobile phone app developed by the Warwick Infant and Family Wellbeing Unit to help parents and health professionals learn about how the emotional wellbeing of babies develops within close relationships. Baby Buddy is a free mobile phone app for parents and parents-to-be (www.bestbeginnings.org.uk/babybuddy). The content is personalised and has been approved by doctors and midwives, and spans from pregnancy to the first six months after birth.

The need for support with parenting does not end after the postnatal period. Children’s centres can provide such support for families with children under the age of five. However, since the economic recession, there has been a substantial reduction in government funding in universal services, such as children’s centres, leading to cuts in services provided despite a reported increase in the need for such services (4Children, 2014).

Targeted parenting support for parents with additional needs

Some parents will need help additional to that which is universally provided. Targeted parenting programmes provide interventions for specific problems experienced by parents that can affect their capacity to care for their children, such as mental health difficulties, substance misuse, domestic abuse, or support to overcome unresolved adverse experiences and trauma.

Assessing and identifying need

It is vital that neglect is identified as early as possible and that parents who may be struggling are helped to understand the concerns and to change their parenting behaviour. Using a standardised tool to assess child neglect can help practitioners across universal and targeted services to quantify and categorise parental behaviours about which they have concerns, grade their level of concern, assess the experience of the child and ensure that the help a family is offered is appropriate and effective. Tools can also be helpful in measuring motivation and parents’ capacity for change. However, tested tools for identifying child neglect are not widely available and are infrequently used by professionals outside social care. Many existing tools lack a robust evidence base.

Problems engaging parents in universal and targeted services

Engagement is the purposeful, productive interaction between two parties towards an agreed outcome. In the context of preventing child neglect, we are talking about the engagement of parents with the help they are being offered, both in terms of universal parenting support and more targeted services. Getting some parents to engage in support can be a complex and challenging task. This is the case both for early help, which is voluntary, and for statutory interventions. A parent’s engagement with support can be affected by a range of factors, including ambivalence, denial and unwillingness to change, as well as difficulties understanding the concern presented by professionals (Ward et al, 2014).

The voluntary nature of early help presents both challenges and opportunities. On the one hand, some parents may be less likely to engage with support if it is optional. On the other hand, some parents may prefer being involved with services when they are given a choice. Effective early help requires both aptitude and skilful practice, with practitioners needing to reach a delicate balance between ensuring the wellbeing of a child,
maintaining a trusting and positive relationship with parents and preventing over-reliance on services. This in turn requires regular training and support for practitioners. Research tells us that staff in universal services can find it difficult to engage parents in early help (Burgess et al, 2013; Haynes, 2015). Staff in universal services do not tend to get training on parental engagement or to receive reflective supervision that can support them in this work.

We are, therefore, missing an opportunity to equip universal services to effectively engage parents in early help, when they may be more open to receiving help. This would save money and effort later on when problems are more entrenched and people can be more resistant to help.

What will make a difference?

Parenting programmes
Evidence suggests that parenting programmes can reduce child maltreatment and parental risk factors, and enhance parental protective factors (Chen & Chan, 2015). A comprehensive, quantitative meta-analysis of the evidence (Chen & Chan, 2015) found in particular that strengths-based approaches are effective in preventing child maltreatment (Holzer et al, 2006), as are programmes that start on or before the prenatal period.

Unique opportunity in the perinatal period
All parents should have access to high-quality, evidence-based perinatal parent education classes that focus on social and emotional as well as physical health. Providing perinatal education classes to all parents should be a priority for Clinical Commissioning Groups (CCGs), and drives to increase the availability of and access to classes should target both mothers and fathers.

There has been a welcome increase recently in perinatal classes focused on the transition to parenthood (Barlow et al, 2008), in which parents are helped to understand the importance of the attachment relationship with their baby, the importance of this life stage for their child’s future healthy development and wellbeing, and more general parenting skills (Department of Health, 2011). Evidence suggests that more research is required but that such programmes “have the potential to improve a range of outcomes such as dyadic adjustment, maternal psychological well-being, parental confidence, and satisfaction with the couple and parent–infant relationship in the postnatal period” (Barlow et al, 2008, p44). Parents are also likely to benefit from postnatal classes, in which bonding is promoted via information about the sensory and perceptual capabilities of infants and about infant massage, and where support with any emerging difficulties can be provided (Barlow et al, 2008).

Enhancing parental sensitivity and responsiveness should be a key focus of perinatal education classes, with the aim of classes being to support parents to understand and put into practice the principles of ‘serve and return’ (Center on the Developing Child, 2013a). Parents should be taught about and helped (where necessary) with observational skills so that they can understand their baby’s signals and see the value of prompt, sensitive and contingent responses. High quality perinatal education classes should be delivered by practitioners who have a good knowledge of infant mental health and attachment theory, have good parent engagement skills, are reflective, and are able to identify parents with additional needs.

There is an emerging evidence base for the effectiveness of couple-based interventions with expectant and new parents (Pinquart & Teubert, 2010). Antenatal and postnatal classes that involve both mothers and fathers can support parents with changes in their relationship. Couple’s relationships can be strained after the birth of a baby because parents are tired and stressed, and experiencing changes to their roles and identities (Barlow et al, 2008).

Tools for assessing care and identifying neglect
While a number of standardised tools for assessing parental care and identifying child neglect are in use, only the Graded Care Profile (GCP) (Johnson & Cotmore, 2015), the North Carolina Family Assessment Scale (NCFAS-G) (Williams, 2015), the Safeguarding Assessment and Analysis Framework (SAAF) (Macdonald et al, 2014) and the Signs of Safety risk assessment approach (Turnell & Edwards, 1999) have or are being evaluated for effectiveness.
The GCP and GCP2, revised from the original model and also tested by the NSPCC, is an assessment tool designed to help practitioners identify when a child is at risk of neglect and to improve consistency. It can be used as part of the early help process, as well as at a child in need and child protection level. Our evaluation of the GCP (Johnson & Cotmore, 2015) found that it can help practitioners to specify the type and seriousness of neglect, thus making it more ‘visible’ to all involved. It helped to disentangle the effects of neglect on the child from all the other issues. GCP can help pinpoint the strengths that parents have to build on, what changes they need to make and what support is needed. This can make things clearer for families and save unnecessary intervention. Most practitioners found the GCP to be a useful tool for assessing the child’s needs, across a range of case types and child age groups. GCP is seen to improve practitioner skills and practice in recording and reporting neglect, and their communication both with parents and professionals.

NCFAS-G is another assessment tool for neglect and is used to progress difficult cases. We know that professionals need support to take the right decision at the right time to reverse or to forestall serious neglect, and this approach can assist them and reduce delay. The tool has been evaluated in the UK by the NSPCC in the context of families where there are longstanding, complex issues and, therefore, used by social workers, but it has a research base for its use across the full spectrum of need. NCFAS-G calls for a score of strength or difficulty across seven crucial areas of family functioning, as well as a judgement as to whether intervention is needed in any of these areas. Our qualitative evaluation (Williams, 2015) tells us that the family functioning review often helped improve the evidence that social workers had access to and joint working helped improve the quality of evidence and understanding. Aspects of the review that helped and that were not always found in assessment practice, including:

- a focus on aspects of family functioning that cannot be readily observed (for example, whether a parent administers medication regularly);
- a requirement to score the family on each area of family functioning; and
- a requirement to demonstrate how the evidence available meets the criteria provided for each score.

Positive, trusting and challenging relationships between parents and professionals

Helping parents engage with early help is critical to its success. As such, engagement skills should be seen as part of the core skill set for all professionals working with families. Engagement is fundamentally about the quality of the relationship between parents and professionals and is an ongoing and iterative process (Roose et al, 2013). It is an attitude, rather than a technique, which lets the family know that the professional understands them and is working with and for them (Minuchin & Fishman, 1981). Good engagement involves trust, honesty and compassion, requiring a practitioner to maintain a productive relationship with parents to get to the desired outcome, without compromising the need to address the concern at hand.

Practitioners need to understand how behaviour change takes place, so that they can both support the parent to make changes and can judge a parent’s readiness to engage in assessments and interventions. The model dominating the health and child protection fields is the trans-theoretical model (TTM) of behaviour change (Ward et al, 2014), which can be used for early help as well as engagement with statutory services. The TTM (Prochaska et al, 1992) sets out six stages of change over time. They include a parent’s contemplation before they change their behaviour, preparation for that change, behaviour change itself and, importantly, ‘relapse’, used to highlight that the process of parental engagement is not likely to be straightforward (Prochaska et al, 1992). Motivation to change plays a big part in whether parents are able to improve their caregiving, and motivation comes when a parent views the gains of engaging with help as outweighing the losses (Prochaska et al, 1994; Ward et al, 2014). Motivational Interviewing (MI) is another technique that can help improve parents’ engagement with services. MI is a client-centred approach that focuses on ‘guiding’ parents to resolve ambivalence, developed as an alternative to more confrontational and advice-giving methods of engagement (Miller & Rollnick, 2002).
Reflective supervision may have the potential to play an important role in helping practitioners provide early help for neglect. Deciding on the best course of action for a child can be “complex and ambiguous as a result of professional and inter-agency anxiety, fear of getting it wrong and the difficulties of accessing information from anxious and sometimes reluctant service users. It is the task of practitioners, supervisors and multi-disciplinary planning meetings to share, sift, search for and weigh the significance of their information” (Morrison, 2010, p11). Good supervision is already an essential part of effective social work practice, facilitating the provision of high quality services by encouraging social workers to continuously develop professional judgement and skills, and by supporting and motivating professionals undertaking demanding and at times distressing work (CWDC/Skills4Care, 2007). An effective supervisor is able to understand a practitioner’s perspective, history and current circumstances, to notice and facilitate discussion around a practitioner’s anxieties, concerns, skills and weakness, and develop that practitioner’s knowledge, skills and confidence (Morrison & Wonnacott, 2010).

The potential benefits for children of building practitioners’ parental engagement skills and providing the opportunity for reflective supervision are substantial. Therefore, while we recognise that services are under pressure at the moment, managers should think about how they can ensure that practitioners receive training in parental engagement and some form of reflective supervision for when they are working with cases of neglect. There may be a role here for group supervision or peer support, provided by key practitioners trained in reflective practice.

Evidence-based services for preventing and addressing neglect

Evidence shows that, with the right help, it is possible to prevent and tackle child neglect. We need to make the most of this knowledge by increasing the availability of evidence-based services through local commissioning. We also need to keep building the evidence base, testing our early help provision for neglect to find out more about what works, with which families and why, and whether improvements can be sustained over time.

In Appendix A, we provide details of a range of programmes that target individual parental risk factors for neglect, and these are:

- Parents Under Pressure
- Family Environment: Drug Using Parents (FEDUP)
- Baby Steps
- Minding the Baby
- Family Nurse Partnership
- Parent–Infant Psychotherapy
- Domestic Abuse, Recovering Together (DART)
- Family SMILES
- Mellow parenting
- Solution Focused Brief Therapy (SFBT)

There are also a number of services that have been evaluated and have been found to be effective in tackling neglect specifically in the UK context, which are described below.

Evidence-based services for neglect

Video Interaction Guidance

What is it?

Video Interaction Guidance (VIG) is a supportive programme of parent counselling that uses video to help parents become more attuned and responsive to their child’s communications (both verbal and non-verbal).

What makes it special?

With practitioner support, the videos can show families the steps they need to take to start to achieve or restore a strong parent–child bond. Some parents have described this as “a light-bulb moment” that can shift “stuck” family relationships. We have evaluated the programme in use with families where there are concerns about neglect and, more specifically, about emotional neglect.
**How does it work?**

VIG UK (Kennedy, Landor & Todd, 2011) has supported and trained NSPCC practitioners in the principles and use of VIG. Parents decide on what they want to change and on specific goals, for example wanting to spend time with the child and talk about what is important to them. With permission, interactions between parent and child are then filmed and edited by the practitioners to focus on positive moments; for instance smiling, making eye contact and taking turns in conversation. Work is done to replicate and build on these moments. Parents are encouraged to celebrate success and build a stronger bond with the child.

**What have we learnt?**

The evaluation (Whalley, 2015a) tells us that parents report statistically significant improvements. These include their relationship with the child, their own parenting strategies and communications, and in the child’s emotional and behavioural difficulties. The commitment and flexibility of the VIG practitioner is crucial.

Video Interaction Guidance can give parents confidence to try new approaches with their child when things seem difficult. Parents felt that they were more aware of their child and, importantly, not only aware of the negatives so that activities with them are no longer dreaded:

- **Mother on the VIG programme:** 100% better, happy, we are communicating as a family. We talk to each other when we have a problem.
- **Evaluator:** What do you think has made the programme work well for you?
- **Parent:** “The video, to see the smiles you don’t normally see.”

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**SafeCare®**

**What is it?**

SafeCare® is a structured, preventative programme for use with parents of children aged from birth to six who are at risk of experiencing significant harm through neglect.

**What makes it special?**

SafeCare® has robust evidence of effectiveness in preventing and forestalling child neglect (Chaffin et al, 2012) as well as a strong cost-benefit analysis (Edvald, 2012). We have tested it for the first time in the UK and have trained practitioners in SafeCare® (called home visitors) as well as trainers.

**How does it work?**

SafeCare® focuses help on three key areas that are known to be associated with child neglect: parental interaction with the child or infant; home safety; and child health. The programme is delivered within the family home, providing natural opportunities to train parents in practical skills to use with their children. The programme is delivered by trained practitioners, called home visitors, over 18 to 20 sessions. There is an integral assessment designed to encourage progress at each stage.

**What have we learnt?**

The evaluation tells us that SafeCare® can be effective in the UK (Churchill, 2015a; 2015b). SafeCare® was beneficial for the majority of families who took part in the evaluation:

- 80 per cent of parents completing the health module showed improvement in child health care skills
- 97 per cent of parents who completed the home safety module reduced the number of health and safety hazards in their homes
- 98 per cent of parents who completed the parent–child interaction module demonstrated improved communication skills with their child/ren.

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3 All quoted figures are based on outcome data from a sample of service users. Improvements were statistically significant. Further information on SafeCare® success criteria figures is available in the full report.
Of the families with the most difficulties – those that SafeCare® practitioners considered significant enough to warrant a statutory intervention for neglect – 66 per cent improved to a point where no such intervention was considered necessary by the end of the programme.

Parents said the establishment of a trusting relationship between parents and the practitioner, and the perceived partnership approach to working, played a vital role in their engagement with SafeCare® and the success of the programme.4

SafeCare® was valued by referrers – 91 per cent of referrers said that they would refer similar families to SafeCare® in the future.5

Standard and Pathways Triple P®

What is it?
Triple P® is a widely known and researched parenting programme originating in Australia. Standard and Pathways Triple P are elements of the Positive Parenting Programme (PPP), a multi-level public health system of family interventions for parents of children who have (or are at risk of developing) behaviour problems.

What makes it special?
The programme aims to make the critical task of child-rearing more straightforward for parents (Markie-Dadds et al, 2000). The NSPCC has for the first time used and evaluated the programme where there are specific concerns about child neglect in families of children aged between two and 12 years.

How does it work?
In this context, Triple P is delivered for families in their home on an individual rather than a group work context. Standard Triple P typically includes sessions for assessment of the issues and on positive parenting skills, including practice and planned activity sessions. Pathways Triple P offers three modules to coach and support parents in ‘Avoiding Parent Traps’, ‘Coping with Anger’ and on ‘Maintaining Changes’. The early qualitative and quantitative evaluation shows promising results.

What have we learnt?
The evaluation (Whalley, 2015b) tells us that parents report statistically significant improvements in their relationship with the child, including communication and giving appropriate autonomy; in their own parenting strategies and over-reaction to the child; and in the child’s behaviour. Parents value practitioners who are flexible with new ideas and suggestions, non-judgemental in their approach and reliable in their time-keeping. The practitioner’s commitment builds up trust.

Pathways Triple P can give parents practical ideas for things to try with their children when the situation appears to be ‘stuck’ in difficulty:

“...I’m more confident... Not resolved but I am able to deal with situations differently without feeling stressed.” (Mother on the PTP programme)

“Me and my son get along better and the techniques have worked.” (Mother on the PTP programme)

“...It’s a lot better. I’m able to see the triggers.” (Mother on the PTP programme)

Thriving Families

What is it?
Thriving Families is a specialist integrated model for delivering services for children and families where neglect is a concern. It consists of two distinct elements: the Bespoke Assessment Approach, which is a holistic assessment for neglect, and three services described above (SafeCare®, Triple P and Video Interaction Guidance).

What makes it special?
Thriving Families provides a coordinated and concentrated local response to child neglect which aims to be flexible enough to fit the needs of families and referring agencies locally. The approach responds to clinical observations that where we have services, we should offer robust and engaging assessments, and vice versa. Thriving Families is being implemented in five sites in England and Wales, and will be evaluated over the next five years. The evaluation will test whether we are successful in matching families’ particular needs with the best fitting service and whether this happens in a more timely way.

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4 Parents’ views are based on interviews with 15 parents who completed the programme.
5 Twenty-three surveys were received, representing a response rate of 39 per cent.
How does it work?

Families where neglect is an issue frequently struggle with problems like family relationships, ill-health or substance misuse. Help can be delayed by numerous assessments and referrals. By integrating our assessments and our core offer of services, Thriving Families aims to work closely with local providers to deliver the right help earlier to both children and parents, and thus prevent neglect from harming children or escalating.

Bespoke is a framework for the assessment of child neglect that draws from insights and techniques, such as Structured Family Therapy, Motivational Interviewing, Appreciative Inquiry, Reflective Functioning and Solution Focused Brief Therapy. Bespoke is designed to inform and to support professional judgement and to engage families as fully as possible in the assessment process, while at the same time considering parents’ capacity to change. It is based on the principle that “what you do in the beginning determines what is possible in the end”.

The Bespoke Framework challenges practitioners to ask themselves four questions in relation to neglect: “What do I know about the scale of the neglect, its type, its impact on the child and the reasons for the neglect?” Standardised tools and measures are provided to help practitioners answer these four questions. Practitioners have built-in reflection and analysis time while keeping focused on the core issues. The aims are to ensure that parents receive the correct intervention as early as possible, that the safety of the child is enhanced and that the underlying reasons for neglect are addressed. Bespoke will be evaluated as part of Thriving Families.

Summary

The child–parent relationship is central to tackling neglect. Parents and primary carers are the most important people in a child’s life and they influence, for better or worse, their child’s wellbeing and development. For healthy development, parents need to give their children sensitive, attuned and loving care. The vast majority of parents want to do the best for their children but parenting well can present challenges to all of us as parents. Some parents will face more challenges than others, whether that be because of mental health difficulties, domestic violence, substance misuse or past trauma, and we know that neglect can occur when parents are under these sorts of pressures. Evidence shows that with the right help, we can prevent and tackle neglect.

<table>
<thead>
<tr>
<th>What will make a difference?</th>
<th>How do we get there?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing parents’ knowledge and awareness of healthy child development</td>
<td>Local authorities and Clinical Commissioning Groups (CCGs) should ensure that there is universal provision of high-quality, evidence-based perinatal parent education classes that foster an understanding of child development, attachment and the care that children need.</td>
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<tr>
<td>Using evidence-based tools to support practitioners to assess care and identify neglect earlier</td>
<td>Local authorities and LSCBs should promote the use of evidence-based assessment tools, such as the Graded Care Profile and NCFAS, across universal and early help services to assist professionals to identify and articulate concerns about neglect.</td>
</tr>
<tr>
<td>Using evidence-based services for preventing and addressing neglect</td>
<td>Local commissioners should ensure that there are accessible, high-quality, evidence-based, targeted support services for parents with additional needs.</td>
</tr>
<tr>
<td>Enabling the development of positive, trusting and challenging relationships between parents and professionals</td>
<td>Local authorities, LSCBs and management in individual organisations across universal services and targeted services should ensure that practitioners are equipped with parental engagement skills and have access to reflective supervision.</td>
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The opportunity to prevent neglect

While undoubtedly in some areas social support for parents occurs as part of the natural make up of a community, there is nonetheless “inadequate recognition, promotion and use of children and families’ wider networks to promote well-being and help sustain positive change over the long-term” (Aked et al, 2009, p60). Most of us are likely to come into contact with families in our local communities and social networks where we have concerns about the care children are receiving. We may witness seemingly aggressive or unresponsive parenting, children being poorly supervised or not wearing appropriate clothes, or we may be concerned about a parent’s mental health, substance misuse or abuse in a relationship. If a member of the community believes that a child is at risk of or experiencing significant harm, they are advised to contact the police immediately or use the NSPCC Helpline. But can communities help parents much earlier on? And what would this look like in practice?

Definitions: Community and social capital

When we talk about community-level early help for neglect, we are talking about the network of people in our lives made up by friends, extended family members or neighbours, colleagues, or more casual acquaintances who we regularly see for example on public transport, at the school gate, in our local shops, at swimming pools and leisure centres, in parks and playgrounds, doctors’ surgeries, restaurants and places of worship. It also includes those we come in contact with for the first time.

At the same time, the concept of ‘community’ as a value applies here too, meaning solidarity, commitment, mutuality and trust.

Social capital refers to “social connections and the attendant norms and trust” (Putnam, 1995). It describes the pattern and intensity of networks among people and the shared values that arise from those networks.

The fundamental basis for a community-based approach to preventing neglect is creating the opportunity for parents and carers to share problems and to work towards managing those problems at an early stage. A community-level response to early signs of neglect might start with simply asking if everything is OK or an offer of help in that moment. Asking parents how they are and if they need help may increase their sense of connectedness to the community. Community members may be able to provide parents who are struggling with simple practical help, someone to talk to, or give advice on where to seek help. This relies on us being ‘open’ to others; seeming approachable, smiling, looking around and engaging with those around us.

How will this prevent neglect? Social isolation is a risk factor for neglect (Horwath, 2013). Supportive social networks have been found to reduce stress by serving as a buffer against threatening events, influencing the coping strategies of parents, and providing emotional support (Crockenberg, 1987; Osofsky & Dewana-Thompson, 2000). Social isolation can mean that parents have minimal social interaction, meaning less help with the daily tasks of parenting (Brandon et al, 2014), and is associated with mental health problems, including depression, anxiety and low self-esteem (Pierson, 2009), which are likewise associated with neglectful parenting. Mental health problems, as well as other risk factors for neglect, such as substance misuse and domestic abuse, can also lead to further isolation, exacerbating these difficulties. Support from social networks in the perinatal period is associated with maternal mental health, babies’ health at birth, and breastfeeding initiation and duration (Collins et al, 1993; Dennis, 2002). Building relationships, even at a relatively surface level, can, therefore, act as a protective factor against neglect.

Through community members, there is also a potential opportunity to get help from professionals and services to parents earlier than we currently do. Family, friends, neighbours and colleagues may see that a parent needs support before professionals do. Parents struggling with adverse experiences and/or problems with parenting may find it less
stigmatising to be offered help from the community rather than professionals. Showing concern for the parent, offering emotional or practical help and encouraging parents to seek help from professionals are all ways in which the community can help parents receive help faster.

Support from the community for parents at risk of neglecting their children should be considered as part of a wider spectrum of universal and targeted support from professionals. For this model to be successful and safe, community members need to be able to judge if there is concern about significant harm to a child and professionals may need to be contacted without the parent’s consent. In addition, we know that, in some cases, communities can act as a negative influence on parenting capabilities. Because we create social networks by associating with people like ourselves – those who are likely to share the same access to information, ties and resources as us (Fisher & Gruescu, 2011; Rowson et al, 2010) – social networks may perpetuate poor parenting practices.

What stops communities doing more?

Social norms around offering and accepting help

A society in which it is common for parents to ask others for help, for help to be given and for parents to accept that help, requires cohesive, trusting positive social networks. Yet, evidence suggests that social capital (see page 26 for definition) has declined over the past four decades (Dorling et al, 2008; Fisher & Gruescu, 2011). This is for a number of reasons. There is a greater tendency now for families to move from their local area and, therefore, from their extended family and community (Sheppard, 2009). This has meant that children are less likely to be raised collectively, within a network of family and friends. The public are using outside space less (including for play by children), reducing in turn the opportunity for social interaction and development of support networks in communities (Clements, 2004; Department of Health, 2013a; Fisher & Gruescu, 2011).

In addition, the dominance of individualistic cultural norms in the UK impacts on the way we give and receive help. Very broadly speaking, in individualistic cultures, people are encouraged to maintain independence and take responsibility for their own actions, whereas in more interdependent cultures, there is a greater emphasis on relationships and community (Triandis, 1989). Anderson, Brownlie and Milne (2015) argue that there is a tension in British society between two powerful moral frameworks: the desire and moral impetus to be kind and helpful to others on the one hand, and the desire to be independent and self-sufficient on the other. Alongside this is the fear that asking for help with parenting will result in intervention from children’s social care.

Public perceptions of child neglect and early help

There is little research on the general public’s understanding and views of child maltreatment and, in particular, child neglect. In addition, most of the research is based on self-report, which means we need to acknowledge the possibility of self-report bias, where research participants want to respond in a way that makes them look as good as possible.

Are the public aware of the prevalence of neglect?

Some data suggests that there is good public awareness of the prevalence of child abuse and neglect. In a survey of 690 people, 60 per cent agreed that child abuse and neglect was common, and 74 per cent agreed that it was “probably happening close to my area right now” (Jutte et al, 2015). However, a survey of 402 adults members of the public in Birmingham by YouGov found that 70 per cent said that they had not been concerned about a child being neglected (NSPCC, 2014). This raises questions about whether the public are able to recognise neglect and/or are willing to acknowledge its presence.
What do the public see as risk factors for neglect?

The evidence suggests that the public have a good understanding of some risk factors for child maltreatment but not about others. The Frameworks Institute conducted a research study into how the UK public views child maltreatment. It drew from a sample of 20 members of the public, selected to represent variation across domains of ethnicity, gender, age, location, educational background, family situation (married, single, with children, without children and age of children), and a sample of 23 child maltreatment experts, designed to reflect the diversity of the child maltreatment field. The research found that the public had a good understanding that maltreatment could be passed from one generation to another and that interventions could prevent that from occurring (Lindland & Kendall-Taylor, 2013). They recognised that breakdowns in social networks could be a risk factor for child maltreatment, such as high divorce rates, the corrosion of close local communities, more young parents and an increased dependency on digital technologies for entertainment. For neglect specifically, they recognised that poverty could be a contributory factor.

However, the research by the Frameworks Institute also found misperceptions in the public’s view of child maltreatment. For example, while the public made the link between drug and alcohol abuse and maltreatment, they spoke about maltreatment occurring because parents are selfish and unable to control their behaviour in order to meet their children’s needs, rather than taking into account their struggle with addiction. A social class stereotype was also used; physical abuse and neglect were seen to be more likely to occur in “lower class” families, due to a lack of parenting competency, ambition and self-control. In addition, respondents thought that emotional neglect was more frequently seen in “upper-class” families.

What is the public’s understanding of the impact of neglect on children?

Research suggests that neglect is not perceived to be as damaging to children as physical and sexual abuse, and people “struggle to even conceptualise how being neglected can lead to negative developmental outcomes for children” (Lindland & Kendall-Taylor, 2013). There is a lack of understanding about the wider societal effects of maltreatment, for example on disease prevalence, employment and educational attainment, suggesting that the public underestimate the wider costs of maltreatment.

Do the public think we can prevent neglect?

There is a prevailing fatalistic view of child abuse and neglect (Lindland & Kendall-Taylor, 2013). A survey of 2,001 adults found that almost three-quarters (72 per cent) agreed that “child abuse and neglect in the UK will always be around” (NSPCC, 2015). When asked to identify from a range of actions which ones were potential solutions to tackling child abuse and neglect, the most common response, from 34 per cent of participants, was “Removing children at risk of being abused from their families/carers” (Jutte et al, 2015). However, in the same survey, more than half (52 per cent) agreed that “child abuse and neglect can be prevented in the UK”, and this is the perception on which we need to build. Thirty per cent of those in this survey felt that “Training or education to improve parents/carers parenting skills and relationship with their child” was a potential solution to tackling child abuse and neglect.

Do the public think they can recognise child neglect?

The YouGov poll in Birmingham (NSPCC, 2014) found that 75 per cent either agreed or strongly agreed that they knew what neglect was. More people said that they felt confident about identifying physical neglect than emotional neglect, with 69 per cent either agreeing or strongly agreeing that they would feel confident in recognising the signs of physical neglect, and only 54 per cent either agreeing or strongly agreeing that they would feel confident in recognising the signs of emotional neglect.
Do the public know what to do when they recognise child neglect?
The public do not seem to feel confident to raise a concern with professionals about a child or family when they have an initial concern. The YouGov poll in Birmingham found that the majority of respondents (50 per cent) said that they would speak to a professional only when they were "fairly certain" that a child was being neglected. Twenty-four per cent said that they would speak to a professional when they had a "rough idea", while 17 per cent said that they would have to feel "completely certain". The most common reasons for not contacting a professional as soon as concerns emerged were fear of making a mistake (50 per cent) and worry about not having substantial proof or enough information (40 per cent).

In a poll of 3,263 adults by Action for Children (Burgess et al, 2013), 25 per cent reported feeling very or quite worried about the safety of a child living in their area, but only a third of these respondents chose to tell anyone about that concern. The majority of those polled in the YouGov survey said that they knew who to contact if they were worried about a child being neglected (62 per cent), and for most of those, that was children’s social care or a social worker (45 per cent). This may be the most appropriate course of action for some children and is indeed better than inaction, but we should challenge ourselves to think how we encourage the public to also draw on the skills and expertise of other professionals, like teachers, GPs or health visitors for example, when they have a worry about a child.

What will make a difference?
How can we foster the kinds of community relationships that might make a difference to the prevalence of child neglect?

Community education: a two-pronged campaign approach
Public education campaigns can be an effective way of improving public knowledge and changing behaviours (Hornik, 2002; Wakefield et al, 2010). Research suggests that they are likely to be more effective when combined with other approaches that actively involve the participation of parents in support programmes and community activities, and when they are embedded in a sound theoretical framework and aligned with support services at a community level (Horsfall et al, 2010). However, there is also a clear need for further research into the effectiveness of education campaigns around child maltreatment.

Both campaign strands described below would target both parents and adults without children. They could be run at a national or local level.

Strand 1: Healthy child development and positive parenting
The specific aims of campaigns on healthy child development and positive parenting should be to:

• Increase awareness and understanding of what children need for healthy development, including sensitive and attuned caregiving, focusing on the early years and infant mental health;

• Increase awareness and understanding of emotional neglect, so that it can be identified more quickly.

Strand 2: Help-seeking
Encouraging parents to seek help when problems first emerge is crucial to preventing neglect. The specific aims of campaigns on help-seeking should be to:

• De-stigmatise help-seeking behaviour and encourage parents who are struggling to seek help (tackling the assumption that seeking help with parenting will automatically prompt a response from children’s social care);

• Tackle the widespread fatalistic view of child neglect by making people aware of the range of professionals and services that can offer effective help;

• Increase awareness and understanding of the context in which neglect can happen, in particular the link between substance misuse, domestic abuse and mental health problems and child neglect, and communicate that the risk factors for neglect can occur in any family, regardless of class, affluence or personality characteristics;
• Provide the public with a ‘toolkit’ of responses to help tackle neglect, including promoting helplines, information sources, encouraging peer-to-peer support, promoting the role of staff in universal services like teachers and GP as sources of help and advice, and where necessary, reporting concerns to children’s social care.

As well as the community then being better equipped to help parents when they need it, they would also be better equipped to help children and young people, who we know are more likely to go to their family or friends when they need help (Action for Children, 2014; Jobe and Gorin, 2013).

**Examples of education campaigns**

**Birmingham Safeguarding Children Board (BSCB) and NSPCC neglect campaign**

Birmingham Safeguarding Children Board (BSCB) and the NSPCC launched the Help campaign in 2014 with the aim of encouraging people to seek help and advice straight away if they have concerns about a child being neglected (BSCB, 2014). The campaign aims to raise awareness of the signs and symptoms of neglect in order to help people recognise when they or others might need help. The campaign includes the ‘Neglect Matters’ guide to spotting the signs of neglect, alongside posters with the phrase: “Help: a four letter word you shouldn’t be afraid of. Being a parent isn’t always easy. If you’re struggling, the NSPCC can help. Friendly advice and support is just a phone call away. Call 0808 800 5000. We’re here 24/7.”

**Australian Childhood Foundation’s Invisible campaign**

For their campaign Invisible, the Australian Childhood Foundation used life-sized mannequins of children to raise awareness of child neglect (Australian Childhood Foundation, 2009). They placed the mannequins against walls in locations across Melbourne and pasted over them with their campaign poster, which read “Neglected children are made to feel invisible”. They then removed the mannequins, leaving ripped paper and an empty space that read “Thank you for seeing me”. The campaign was not evaluated.

**Developing an evidence base**

As with all preventative or early help provision, the content and methodology of campaigns should be carefully considered, and we recommend that campaigns are piloted and evaluated before being scaled up. Very few attempts have been made to use social marketing campaigns to prevent or reduce child maltreatment, and, as such, there is relatively little evidence regarding their effectiveness (Horsfall et al, 2010). There are a range of theories for generating individual or community-level change through campaigns and, likewise, a number of models that can be used to guide the implementation of a campaign (for more information, see Horsfall et al, 2010). A systematic literature review found 36 publications about child maltreatment campaigns released between 1995 and 2009 and a total of 21 campaigns. Only half of the 21 campaigns were identified as having published evidence of impact and/or outcomes evaluation. However, these evaluations did demonstrate some capacity to positively affect people’s awareness, knowledge, attitudes and behaviour.

There is some evidence to suggest, for example, that Level 1 of Triple P is an example of an effective campaign. Level 1 of Triple P is a universal parent information strategy providing “all interested parents with access to useful information about parenting through a coordinated media and promotional campaign using print and electronic media” (Sanders, 1999, p72). It includes the use of radio, local newspapers, newsletters at schools, mass mailings to family households, presence at community events, and website information (Prinz et al, 2009). The US Triple-P System Population Trial, which included a media strategy relating to positive parenting, found strong evidence for changes in relation to actual prevalence of child maltreatment (Horsfall et al, 2010; Prinz et al, 2009). A trial in Ireland found that “significant reductions in the population percentages reporting a high level of parenting need may well translate into reduced risk of child maltreatment, but such a claim would require to be explicitly tested in the Irish context” (Fives et al, 2014, p159). However, an evaluation of Triple P in Glasgow by the University of Glasgow was less positive, finding that the programme was ineffective in changing in social and emotional functioning among the child population (Marryat et al, 2014).
Community support for parents

Alongside equipping communities with the knowledge they need to play an active role in preventing neglect, we also need to bring communities together more, draw on existing assets and the power of volunteers to enable supportive relationships and social support networks to develop. Peer-to-peer support is a potentially highly cost effective approach, which when supported appropriately by professionals, could help to prevent neglect by building a sense of agency, community and interconnectedness for parents.

Some important principles in developing community support

The Asset Based Community Development (ABCD) model recognises and draws on the individual skills of local residents, alongside existing formal and informal networks and the physical assets of a local area, like its land and buildings (Kretzmann & McKnight, 1993). ABCD relies on local people being committed to investing themselves and their resources to bring about change within a community. Relationships lie at the heart of this approach: successful ABCD requires asset-based community developers “to constantly build and rebuild the relationships between and among local residents, local associations and local institutions” (Kretzmann & McKnight, 1993).

How does it work in practice? Methods might include: interviews or workshops with local residents to learn about successful community initiatives, promising practice and crucially hidden or unrecognised skills and assets in the community; bringing together of a core group of community organisers from local organisations and the community; and the setting up of community activity (Mathie & Cunningham, 2005).

Where services are delivered by professionals, the benefits of the co-production of services with parents and communities should be considered. Co-production means “delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours” (Boyle & Harris, 2009, p11). There is some evidence to suggest that co-production can lead to the delivery of better outcomes, develop social networks to support resilience, and improve wellbeing (Boyle & Harris, 2009). However, further piloting and evaluation is required to determine whether co-production of services is an effective aspect of services to prevent neglect.

In research by Anderson et al. (2015) on people’s experiences of everyday help and support, the participants put forward a range of ways they felt might increase the likelihood that help is accepted, and these ideas may be helpful to consider when developing community-led services. They included downplaying the significance of the help given, minimising the demands on the helper (for example, incorporating help giving alongside a task that would otherwise still take place), offering help before it is asked for, active reframing of help giving as reciprocal, and giving people the option of not accepting the help.

When devising or implementing volunteer-led parenting support, it is vital that there is a clear protocol in place for when professional input is required.

Evidence-based community support for parents

What does community support for parents look like in practice? Below, we give examples of existing approaches to community support for parents provided by volunteers. The strength of the evidence of the programmes vary. The programme Empowering Parents, Empowering Communities (EPEC) has a particularly high standard of evidence (Day et al, 2012), which may be useful to consider for those designing and commissioning services.

Empowering Parents, Empowering communities (EPEC)

Empowering Parents, Empowering Communities is a community-based programme in Southwark that trains local parents to run parenting groups in schools and children's centres. Parent facilitators are given a 10-week training course on parenting, and then run an eight-week manualised training course for interested parents in their community (The Centre for Parent and Child Support, n.d.).
A randomised controlled trial was conducted by the Institute of Psychiatry/Kings College London between 2009 and 2011 to evaluate the clinical effectiveness of the programme (Day et al, 2012). The evaluation found that EPEC appears to be effective in reducing problem child behaviour, increasing positive parenting and engaging parents. The programme did not appear to have an impact on parental stress (including parental distress, difficult child, and parent–child dysfunctional interaction). The authors recommend further research to ascertain the long-term effects and cost effectiveness of the programme.

**Sure Start Children's Centres**

Sure Start centres sit at the heart of communities across England and provide universal service provision for families. Sure Start was set up to help families in the most disadvantaged areas of England (Rutter, 2006), with the aim to "transform education, health and family support services for children under five and their families, increase the availability of high quality childcare for all age groups whose parents need it, and meet the needs of the most disadvantaged" (Sure Start, 2004, p 5).

Volunteers from the community work in Sure Start centres to support activities, such as outreach work with families, organising events and delivering open access activity sessions (All Party Parliamentary Sure Start Group, 2013), and findings from the Children's Centre Census suggest that their numbers are increasing (4Children, 2012). Evidence gathered by the All Party Parliamentary Sure Start Group (2013) found that volunteer engagement improved the reach of services, improved the sustainability of services because it allowed professional staff to focus on more targeted work, and crucially, helped centres build stronger relationships with communities (All Party Parliamentary Sure Start Group, 2013). More research on the effectiveness of volunteers working in Sure Start centres is needed to ensure that families receive the best support possible. This is particularly the case with the proposal by the Centre for Social Justice of expanding the reach of Sure Start to ‘Family Hubs’ (Centre for Social Justice, 2014). If implemented, this model would mean co-locating and coordinating all services for families with children aged 0–18 in children’s centres.

**‘Instructions Not Included’ programme, Family Lives**

*Instructions Not Included* (INI) was a befriending volunteer pilot programme providing parenting and family support to vulnerable families. It was funded by the Department for Education (DfE) and delivered by Family Lives (Marden et al, 2013). The programme aimed to build capacity in family support provision through volunteering and peer support, and to build capacity for parents to help themselves and others. The volunteer team was recruited from existing volunteers already active in the local area and new volunteers, and consisted mainly of parents. They received a 16-hour training course and were matched with one parent. Volunteers received supervision throughout their relationship with the parent. Referrals to the service came from a range of professionals across family support, health, education and social work.

The pilot was independently evaluated using a mixed methods approach, including volunteer and parent questionnaires, validated clinical tools to assess parenting self-efficacy and child behaviour, and case studies (Marden et al, 2013). The findings were promising; INI was found to be successful in reaching parents more at risk of family pressures, such as lone parents, those with more than two children and those with children with behavioural problems. Children's behaviour scores and parenting self-efficacy scores showed statistically significant improvement following the intervention. There were strong referral relationships developed with children's centres, schools, and family-oriented health services but limited engagement from GPs.

**Home Start**

Home Start is a national family support charity that employs volunteers to provide support and friendship via home visits to families with complex and multiple risk factors with children under five. Home Start is based on the following theory of change: "The wellbeing of the parents is improved in families provided with social support [a protective factor] in a structured supervised way. This leads to increased feelings of parental self-competence. As a result parental behaviour becomes more adaptive and child behaviour improves" (Kenkre & Young, 2013, p6–7). Home Start accepts referrals from professionals working in social care, health, education, mental health, probation, early years and from families themselves.
An independent evaluation of Home Start by the University of South Wales drew from an administrative dataset of 33,000 families supported by Home Start and 15,000 Home Start volunteers. It found that the majority of families were referred to Home Start by their health visitor or another professional due to a range of risk factors, including lone parenting, substance abuse, domestic abuse, mental health difficulties, young parents and learning difficulties (Kenkre & Young, 2013). The evaluation explored outcomes (parenting skills; parental wellbeing; child wellbeing; and household management) and found that the families had higher coping scores following Home Start support, although no standardised measures were used.

Summary
Communities have an important role to play in preventing child neglect. However, there is an urgent need to address the persistent and pervasive social norms that see parenting as a private matter and that equate offering, asking for or accepting help with intrusion or weakness. To fully realise this potential, communities need more education on the signs, impact and drivers of neglect and how to seek help. We also need to promote and foster community support networks for parents, alongside adequate support from professionals.

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<th>What will make a difference?</th>
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<td>Increasing the community’s knowledge and awareness of healthy child development, neglect and help seeking</td>
<td>National or local government should work with local partners to pilot public education campaigns with two components: the promotion of understanding about healthy child development and positive parenting; and the promotion of help-seeking behaviour for emerging parenting difficulties. Campaigns should be rigorously evaluated.</td>
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<td>Promotion and fostering of community support for parents</td>
<td>Local partners should invest in and evaluate initiatives and services that nurture social networks between parents in communities. This should include developing and testing new models to harness the power of volunteers to help prevent child neglect.</td>
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The opportunity to prevent neglect
Since the death of Victoria Climbié in 2000, there has been increasing recognition of the need for universal services to play a greater role in providing early help, and that this can actually safeguard children from harm. People working in universal services, like teachers, health visitors, GPs and early years practitioners, may see children and parents regularly, which provides the opportunity to build relationships with families. Practitioners will also work with many different children and families at the same time, and, therefore, have the opportunity to compare the development and wellbeing of a child with other children (Burgess et al, 2013; Munro, 2011). Parents might be more inclined to admit to needing help to staff in universal services than those working in children’s social care, because of stigma and the fear of having a child forcibly removed from their care (Katz et al, 2007); although they may also not want to discuss their difficulties with someone from within their community.

It is our belief that all universal services practitioners, whether they have a specific safeguarding responsibility or not, can and should be supported to provide some form of early help for neglect.

What gets in the way of universal services providing early help?
The NSPCC conducted research to look at early help provision with around 900 universal services practitioners working across six professional groups (teachers, early years practitioners, school nurses, GPs, midwives, health visitors) and 18 young people (Haynes, 2015). We found differences in the types of early help provision the groups were providing, and while some groups were doing a lot of early help work, there were also some significant gaps in provision (even taking into account that some roles lend themselves more or less to early help).

We asked the practitioners about their everyday practice in providing early help for low-level neglect. Understanding what early help is being provided in universal services had a two-fold purpose: to identify what good practice can be built on, and to identify what provision is missing.

Ways in which practitioners can provide early help for neglect include:

- Identifying parental risk factors for neglect or neglect itself;
- Understanding the child’s unmet need by talking to the child, their parents and other practitioners;
- Contacting other practitioners to gather information about the child and family;
- Assessing the child’s and parents’ needs and developing a plan to meet them – identifying which services might be best placed to help a child or family, within or external to universal services;
- Addressing the child’s needs through directly providing practical and/or emotional support where possible, and/or through signposting to other services or agencies if more targeted and/or specialist services are required;
- Monitoring the child and/or parents throughout the period of concern, to assess whether problems escalate further or improve; and
- Reviewing and reflecting on progress, considering whether the support offered is making a positive difference to the child within their timeframe?

Relationships are crucial; for early help to be successful, practitioners need to have the opportunity and ability to develop relationship with children and parents.
This figure, developed from the discussion group data and literature review, sets out a model for the provision of early help for neglect within health and education services/teams. Effective early help requires practitioners to have the opportunity and ability to develop relationships with children and/or parents. ‘Provision of direct support to the child and/or parents’ includes practical and/or emotional support. This runs throughout the process, alongside monitoring the child and/or parents. At each stage, practitioners should refer to their LSCB threshold document. This process is time-limited and the time frame given for change to be evident will depend on the child’s age and their specific needs. A referral to children’s social care is positioned at the end point on the pathway, when early help has not been successful. However, if a concern escalates at any point, a referral should be made to children’s social care. The early help activities that individual practitioners are able to carry out will depend on their role, the age of the child, and the particular context of the child and family.
We asked them to tell us, from the following list of responses, which they would normally do if they were concerned that a child they were working with might be experiencing low-level neglect and may benefit from early help:

- We don’t have many neglected children in this area, so this is an issue I rarely face.
- I would normally contact other practitioners to gather information about the family.
- I would normally provide direct support to the child by giving them emotional and practical support.
- I would normally provide direct support to the parents/carers by giving them emotional and practical support.
- I would normally ensure a Common Assessment Framework was completed.
- I would normally signpost the family to other agencies or practitioners for help.
- I would normally talk to the child about my concern.
- I would normally talk to the parent about my concern.
- I would normally start formally monitoring the child.
- I would normally escalate my concern to another person in my team.
- I would normally make a referral to social services.

The most common way the practitioners provided early help was signposting families to other agencies. While signposting is an important component of early help provision, it needs be done alongside other aspects of early help, like taking time to understand a child and family’s needs, and developing a relationship with them that supports them to engage with other services. Other findings from this research show that this is not always the case, which raises concerns that signposting can sometimes be about ‘passing the buck’.

The practice of routinely monitoring a child in response to early concerns about neglect was more commonly done in education settings than in health settings, with 84 per cent of early years practitioners and 76 per cent of teachers saying that they routinely monitor children, compared with only 20 per cent of midwives, 37 per cent of GPs, 52 per cent of school nurses and 66 per cent of health visitors. The higher rate in education settings is likely to be because monitoring is facilitated by the regular daily contact they have with children, but, nonetheless, health practitioners also need to be monitoring children if they have concerns about neglect.

There were differences between the groups on whether they spoke with and gave direct support to children and parents when they had a concern. The importance of talking to a child or young person about a concern is set out in Working Together To Safeguard Children 2015, which states that “for services to be effective they should be based on a clear understanding of the needs and views of children” (p9). Our research found strikingly low percentages of practitioners who said they would normally talk to a child about an early concern of neglect, raising concerns about how child-centred practice is. Of particular concern were the 69 per cent of teachers, 67 per cent of school nurses, 88 per cent of early years practitioners and 63 per cent of GPs who said that they would not normally talk to a child about an early concern. Talking to a parent about a concern, however, was relatively common practice, which is a promising finding.

Providing practical and emotional support to parents was very common for health visitors and early years practitioners, of whom 96 per cent and 79 per cent respectively said that they would do so. It was less common for GPs (67 per cent), school nurses (66 per cent), midwives (59 per cent) and teachers (53 per cent). The percentages for GPs and midwives seem particularly pertinent given their frequent contact with parents.

The research also found that a high number of practitioners said that they would refer a low-level, early concern about child neglect to children’s social care. When a concern is low-level, a referral to children’s social care should only be made when early help has not been successful within the child’s timeframe or the concern escalates. However, 75 per cent of midwives, 47 per cent of school nurses, 35 per cent of GPs, 32 per cent of health visitors, 31 per cent of early years practitioners and 29 per cent of teachers said that they would refer an early concern about neglect to children’s social care.
The key barriers to early help provision

There are a range of reasons why early help is not being consistently and comprehensively undertaken across universal services.

Capacity crisis and the impact on relationships

Preventing neglect requires the nurturing of relationships at a range of levels. In the context of universal services, we need to move towards developing ‘relational’ services (Mulgan, 2012; Muir & Parker, 2014). This means a greater focus on the quality of relationships between service users and service providers, fostered through personalised care (Muir & Parker, 2014). However, like children’s social care, most universal services are facing funding cuts and a capacity crisis. High caseloads, staff shortages and an increased focus on target-driven practice, can mean that practitioners feel that they do not have enough time to spend with parents and children, and on reflecting on their practice to identify and provide an effective response to neglect (Burgess et al, 2012; Easton et al, 2013; Haynes, 2015). These capacity issues can also mean that practitioners feel undervalued and, therefore, less inclined to take on work that they may see as ‘outside’ their remit.

Fit-for purpose professional guidance on how to give early help

There is an absence of fit-for-purpose guidance on the role of universal services in undertaking early help (Haynes, 2015). Statutory and non-statutory guidance for universal services practitioners gives them a role in providing early help for neglect, but the extent to which this role is explicitly and clearly set out, however, varies. In addition, much of the guidance focuses on the role of practitioners to identify neglect, share information and signpost to other services; more explicit guidance should be developed on how practitioners can directly respond to concerns, for example through developing and maintaining relationships with a child and/or parent, and providing practical and emotional support. A lack of clear guidance for staff in universal services on responsibilities to provide early help and how to do it in practice may prevent practitioners from responding to concerns early or effectively, meaning that children continue to suffer and problems can escalate.

Lack of support to determine what action is appropriate

Staff can refer to their LSCB threshold document for guidance on what action to take for different levels of concern about a child. Working Together requires LSCBs to publish a threshold document, developed in collaboration with children’s social care and other partners, which includes:

“...the process for the early help assessment and the type and level of early help services to be provided; ...and the criteria, including the level of need, for when a case should be referred to local authority children’s social care for assessment and for statutory services.” (Department for Education, 2015d, p15)

However, while some threshold documents may provide practitioners with a robust framework for considering and responding to concerns about a child’s wellbeing and safety, many are opaque and confusing for practitioners, particularly in relation to concerns about neglect. An informal review of 10 threshold documents by the NSPCC found that threshold documents generally downplay the severity and potential long term impact on the child. The threshold documents were found to be potentially confusing for practitioners, giving no guidance in relation to scaling the level of neglect. Neglect was seen as a single homogenous issue, which is either identified as an early help issue or requiring statutory intervention, with little guidance on how to differentiate between the two or to explore greater granularity. In addition to the poor quality of threshold documents, Haynes (2015) found a worrying lack of familiarity of universal services practitioners with their LSCB’s threshold document (Haynes, 2015). Haynes (2015) also found that a substantial proportion – between 20 per cent and 55 per cent – of practitioners with a safeguarding responsibility had not read their LSCB threshold document.
As set out in the Working Together guidance (Department for Education, 2015d, p.14), universal services practitioners and those working in specialist services should always have the opportunity to discuss safeguarding concerns about children and families with a local authority social worker, and it is up to children’s social care to set out the way in which practitioners can access this advice. However, research suggests that staff in universal services find it difficult to contact children’s social care or to speak to a social worker regarding a concern about a child or family (Haynes, 2015).

Without robust and embedded threshold documents and advice from social care, practitioners may decide to refer to children’s social care for any level of concern because this feels like the safest option for children. This can lead to a backlog of referrals and high numbers of referrals being bounced back, meaning wasted resources and longer waits for help to reach children. Without support to complete referrals, they may also be poorly evidenced, increasingly the likelihood that they will not meet thresholds for intervention.

**Working Together?**

Problems with multi-agency working and information sharing about safeguarding concerns between services are longstanding (Laming, 2009). Staff in universal services have reported not being able to speak to other practitioners on the telephone, and of practitioners failing to attend meetings about a particular child (Haynes, 2015). Professional disagreements about the best course of action for children can also present a barrier to early help. Haynes (2015) found that poor multi-agency working was felt to be more of a barrier to early help provision for neglect by schools and early years providers than by health services.

**Knowledge base and skills**

To provide effective early help for neglect, practitioners benefit from having a good understanding of neglect and how to identify it, and from having the skills to engage parents in help. However, research suggests that not all practitioners feel equipped with this knowledge and these skills.

Practitioners can find it hard to identify neglect, particularly emotional neglect, and the lack of clarity around what constitutes acceptable standards of care (DePanfilis, 2006; Easton et al, 2013; Gardner, 2008; Haynes, 2015). Research also suggests that there is a lack of understanding about what services are available to families within the local area, or a lack of services to which families can be signposted (Easton et al, 2013; Baginsky, 2008). Practitioners need access to regularly updated information on what services are available locally to provide early help to families and how those services can be contacted. Engaging parents can also be challenging for practitioners. Haynes (2015) found that practitioners may be worried that raising an issue with a parent might result in them withdrawing from the service, or in the relationship between the parent and the professional being “destabilised”. Disguised compliance and dishonesty could also present a barrier to providing early help, where parents who “talk a good job” are able to persuade other practitioners that they do not require help. Participants were also anxious about hostile or aggressive responses to their concerns, making them reluctant to raise them.

What role does safeguarding training play in equipping practitioners with this knowledge and these skills? Haynes (2015) found that 12 per cent of the 900 practitioner participants in the research had not received training on neglect during the past three years within that time period. Many spoke about desiring further in-depth training specifically on neglect, with some noting that despite the prevalence of neglect, the emphasis of training is often placed on other types of abuse. They felt that training on neglect could be too broad, without attention being played to the specific context within which the practitioners were working, or could seem out of date. Some commented that statutory training for practitioners was sometimes completed only to satisfy requirements, without practitioners being given the time and space to unpick and consider the implications of the training for them as a professional.
What will make a difference?

Increasing capacity through pastoral support

The current workload pressures on staff in universal services provides an opportunity to think more about the role of family support workers and other pastoral workers in undertaking more of this early help work. Research by the NSPCC (Haynes, 2015) identified promising practice around the use of pastoral workers to provide parenting support in schools, and this provision could be extended beyond education services to health services. To be effective and safe, however, pastoral workers must be sufficiently trained to work with vulnerable children, parents and families.

Clarity of guidance on how universal services practitioners can provide early help

To support universal services practitioners in playing a greater role in providing early help, there must be an explicit articulation of expectations for the provision of early help for each group of practitioners. Clearer role expectations for universal services practitioners may also alleviate some of the reported tension between universal services and children’s social care by setting out more clearly who is responsible for what provision. More explicit guidance should be developed on how practitioners can provide direct support to children and parents.

Clear and embedded threshold documents

Urgent research is required into the quality and consistency of LSCB threshold documents and their effectiveness in supporting practitioners to respond to neglect. A prototype for an LSCB threshold document should be developed and piloted. Research should also be undertaken to explore how best to embed threshold documents into local services.

Supporting the relationship between universal services and social work

Further research is also needed on how to improve the provision of support from social workers to other practitioners. This could include family support work teams, advice lines without the need for a referral, no name consultations, multi-agency screening teams (MAST) and Single Point of Access referral procedures (Haynes, 2015). Locality social workers, who work directly with a group of schools, can help develop a robust and trusting relationship (Haynes, 2015). However, this system can encounter difficulties if there continues to be ongoing points of tension in the relationship between social workers and education practitioners. Employing non-social work staff in this position, for example the Local Authority Designated Officer or Designated Safeguarding Nurse, may overcome this issue.

Upskilling universal services to provide early help

There is a range of training requirements that must be met in order to ensure that universal services can provide effective early help for neglect. All practitioners working with children receive specific training on neglect during their pre-qualification training and at least every three years while practising, which equips them to:

- Feel confident in identifying all forms of neglect at the earliest possible stage;
- Understand and communicate the impact of neglect on a child’s development;
- Approach the concern from the child’s point of view;
- Articulate concerns about neglect to other practitioners;
- Convey concerns to parents;
- Develop relationships to understand and address early concerns with parents, applying principles of good parental engagement;
- Develop relationships to understand and address early concerns with children and young people.

Improving information sharing

In order to encourage inter-agency working and information sharing, there should be an explicit expectation that multidisciplinary meetings between practitioners across universal services are regularly held. Practitioners should feel able to challenge one another and reflect on cases in order to reach a consensus about appropriate responses. This would be facilitated through reflective supervision. Multi-agency training across health, education and children’s social care may also be a useful way of encouraging better multi-agency working (Atkinson et al, 2002).
**Summary**

Universal services practitioners make up a large and skilled workforce, many of whom work closely with children and parents on a regular basis. With the right ingredients of clear role expectations, access to quality training and supervision, and adequate resources, there is huge potential for these practitioners to play a leading part in preventing child neglect. Much of the work that constitutes early help for neglect is already a core part of the role of many staff in universal services, and, indeed, many are already carrying out aspects of this work. However, we are currently missing an important opportunity to fully realise the potential of this workforce to help prevent child neglect.

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<tr>
<td>Clear understanding of staff in universal services about the actions they can take to provide early help</td>
<td>Government, NICE and professional membership bodies, such as the Royal College of Midwives, Royal College of GPs, Royal College of Nursing, Royal College of Paediatrics and Child Health, should clarify the role of universal services practitioners in providing early help for neglect and set out these role requirements clearly in statutory, professional guidance and professional job descriptions. More explicit guidance should be developed on how practitioners can provide direct support to children and parents.</td>
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| Increasing staff in universal services’ knowledge of how to provide early help to parents and children | LSCBs and safeguarding practitioners should ensure that all staff in universal services who work with children and families receive, during their pre-qualification training and at least every three years while practising, specific training on:  
- child development  
- the risk factors for, signs and impact of neglect;  
- building relationships and conveying concerns to parents;  
- building relationships with children to enable them to speak out;  
- being receptive to a child’s disclosure about neglect  
- how to provide early help. |
| Increasing universal services’ capacity for early help through pastoral support | Both education and health services should recognise and draw on the role that family support workers and other pastoral workers can play in preventing neglect. Family support workers and other pastoral workers should be given adequate training and supervision to reflect the skill required to take on this role. |
| Enabling effective multidisciplinary team meetings | LSCBs should ensure that all agencies working with children and families hold regular multidisciplinary meetings to discuss early concerns about children and their parents in the local area. |
| Developing accessible and effective LSCB threshold documents | The Department for Education should undertake research into the quality and consistency of LSCB threshold documents, and should develop prototypes and pilot them. |
How can local government help communities thrive?

Local government and other local commissioners can play a key role in enabling communities to come together to prevent and tackle neglect. The role of local government is two-fold: to scope the level of need in the local population and to put in place an effective, evidence-based strategy to meet those needs.

What’s stopping local government from playing its part in preventing neglect?

Not knowing the scale of the problem

Local areas do not know the level of need at a population-level, and without this information, it is difficult to meet that need.

Accurate data is not collected about the scope and scale of child neglect (Action for Children, 2014). Currently, data specifically on child neglect is only collected in the context of Child Protection Plans (CPP). For children classed as ‘in need’, data is only collected on whether their primary need is ‘abuse or neglect’. Action for Children issued a Freedom of Information (FOI) request asking 118 local authorities in England what mechanisms were used locally to determine how many children are at risk of or are experiencing neglect, beyond those on CPPs. Of the 80 responses received, 60 per cent did not have a system in place (Action for Children, 2014).

There is also an absence of data on parents who are at risk of neglecting their children. For example, research by the NSPCC has indicated that in many local areas data is not collected on the most vulnerable groups of babies and their parents, including on families where there is parental drug and alcohol misuse (Rayns et al, 2013), parental mental illness (Hogg, 2013), domestic abuse, homelessness (Hogg et al, 2015) and parental involvement in the criminal justice system (Galloway et al, 2015).

Are strategic responses based on evidence?

Local government must recognise the importance of using evidence to inform their response to child neglect. As well as commissioning evidence-based services, local government should consider the evidence behind their strategic responses to child neglect. Local authorities across the country have developed a range of ways to support practitioners and services to provide early help, including the development of ‘Strategies’ for early help or neglect, and ‘early help hubs’, ‘early help services’ and ‘early intervention services’. The development of these approaches is welcome and represents commitment to tackling neglect early; however, they often lack the necessary evidence-base that tells us that they are effective.

There is also a lack of evidence about what works in ‘early help hubs’, ‘early help services’ and ‘early intervention services’, and there is a lack of uniformity in what each of these terms mean and what support they provide. They can be a tool for signposting practitioners to local services, either through an online database of services (for example, Wandsworth Council, 2015) or through tailored advice from early help workers (Worcestershire, 2015). They can provide a forum for information-sharing among practitioners (for example Lewisham Council, 2015), and early help training for local practitioners (for example, Southwark Council, 2015). They also provide early help and specialist services to children and families, both within the local authority team and across local partner agencies, including practical advice on difficulties like debt or housing problems and parenting support (for example, Tameside, 2015). Many combine a variety of these functions (for example, South Norfolk, 2015).
Example: North East Lincolnshire LSCB neglect strategy

The neglect strategy developed by North East Lincolnshire LSCB is a promising example (North East Lincolnshire council, n.d.). The neglect strategy consists of:

• Introducing a neglect assessment tool, which is an adaptation of the Graded Care Profile;
• Aligning the assessment tool to the Child concern model to achieve clearer thresholds for early help and support;
• The neglect identification and intervention pathway;
• Professional’s capabilities framework for neglect aimed at universal providers, identifiers, assessors and interveners;
• The development of practice guidance and multi-agency protocols;
• A public/community awareness-raising campaign that is ongoing and being embedded.

The neglect pathway and child concern model aim to help practitioners to identify the best agency to support a particular family in respect of a particular element of neglect. They also seek to facilitate multi-agency working by mapping where each service fits into the neglect pathway. Particular attempts have been made to ensure the use of simplistic language in the documents, and events were held when the strategy was launched in an effort to embed the strategy by informing and involving practitioners. North East Lincolnshire LSCB’s strategy also aims to join up local agencies who lead on early help, including the Health and Wellbeing board, the Children and Young Person’s Partnership Board, the Youth and Crime Board, the Strategic Partnership Board and the LSCB. This is to ensure an economy of scale in the face of financial cuts, for example through a single assessment and planning process. Future plans also include exploring the extent to which children’s centres can be transformed into family hubs to enable them to support children and young people of all ages.

The impact of cuts to local government funding

Local government is operating in a challenging financial climate, and rising demands and increased numbers of referrals to children’s social care have meant that available resources have been focused on reactive rather than preventative services for child neglect. From 2011 to 2015, substantial cuts to local government spending were made, leading to a 27 per cent reduction in their spending power (Hastings et al, 2015). In social care between 2009–10 and 2014–15, net spending per capita was cut by 16.7 per cent (Innes & Tetlow, 2015). Councils were spared further cuts in the July budget, but in the upcoming spending review in November 2015 it is expected that funding for local authorities will be decreased further.

Funding for early intervention has been hit hard. Under the coalition government, there was a reduction of 55 per cent in central government grant funding for early intervention work (Children and Young People Now, 2015). The Early Intervention Grant was cut by £150 million in the period 2013–2015. There have been and continue to be cuts to adult services that address key risk factors for neglect, including mental health (HSCIC, 2014; Community Care, 2015), domestic abuse (Towers & Walby, 2012), drug and alcohol services (Public Health England, 2014), and cuts to services for children like youth services (UNISON, 2014) and children’s centres. Added to this context are the complexities of a system based on one to four year spending reviews (Action for Children, 2013). This means that it can be difficult for local areas to work towards a long-term strategy for preventing neglect (or indeed other forms of maltreatment) when contracts are managed on a short-term basis.
What will make a difference?

Sizing the problem

Local authorities and inter-agency forums, such as LSCBs and Health and Wellbeing Boards, have responsibility for the wellbeing of a local population, their needs and the services they require. Local government is uniquely placed to collect data on the scope and scale of child neglect in England and Joint Strategic Needs Assessments (JSNAs) provide a way of bringing together the data and making it available to local service providers.

We need a much clearer picture of the level of need in each local area for early help services for neglect. Local government should regularly collect data on the number of children classed as ‘in need’ because of neglect and collect data on parental risk factors for neglect. Local government should publish this data in JSNAs, so that it is accessible to other local commissioners and service providers.

Drawing from and developing learning on the most promising ways of preventing and tackling neglect

Once the pattern of local need has been established, local government needs to bring together that evidence with the research evidence on effective responses to child neglect to put in place an effective strategy.

We have an emerging evidence base for services that are effective in preventing and tackling neglect, and local government should be commissioning those services in their local area. At a population-level, we know that parenting programmes that start during the prenatal period are effective in preventing child maltreatment (Chen & Chan, 2015). Local government should ensure that high-quality, evidence-based perinatal parent education classes are universally available. In addition, we have evidence about services that work to tackle risk factors for neglect (including services like Parents Under Pressure, the Family Nurse Partnership, Baby Steps and Minding the Baby – see Appendix A for other services and more detail). We also have evidence about what works in tackling neglect, such as Safe Care, Video Interactive Guidance and Triple P (Churchill, 2015a, 2015b; Whalley, 2015a, 2015b). Joined up service provision between children and adult services is essential, so that when a need in an adult is identified, the impact of that need is recognised in relation to the child. Local government also need to develop understanding of ‘what works’ at a strategic level, evaluating Neglect Strategies, Early Help strategies and area-based early help hubs and services.

Redirection of funding

There is no doubt that, alongside a focus on improving the evidence base around prevention and early help, there needs to be financial commitment to the provision of prevention and early help for neglect in universal services and targeted early help services. But where should this come from? The Early Intervention Foundation has calculated that ‘late intervention’ currently costs us £17 billion a year (Chowdry & Oppenheim, 2015, p5). We recommend that national and local governments should reduce this £17 billion ‘late intervention’ spending by 10 per cent by 2020 through better and smarter investment in early help (Chowdry & Oppenheim, 2015). The redirection of 10 per cent of funding would first require the government to measure the exact expenditure on universal services, early intervention and ‘late intervention’, and then transfer of an estimated £1.7 billion over the course of the next Parliament from ‘late intervention’ to early intervention. This spending on early intervention should be tracked and evaluated for effectiveness. Alongside this redirection of funding, funding should be decentralised to budgets at a local level, and build on pioneering work around ‘pooling’ the budgets of individual services to support greater interconnectivity.
An evidence-based approach to responding to local need: Blackpool Better Start

Blackpool Better Start is funded by The Big Lottery Fund and aims to deliver lasting change by improving services for 0–3-year-olds and their families over the next 10 years. The programme uses a tiered model of provision, using evidence- and science-based interventions spanning all levels of need for children. It will expand evidence-based services already being used in the local area (such as FNP and Baby Steps) and would introduce other services that have been successfully developed elsewhere (like programmes to support parents with additional needs and provide pathways to support for parents who have or are experiencing substance misuse, trauma, and mental ill health). The programme will also develop new interventions designed to address critical gaps in current support, such as our work on domestic abuse in pregnancy and infancy, and alcohol abuse in pregnancy.

Longer term planning for spending on early help would also support more efficient and relationship-focused service provision (Chowdry & Oppenheim, 2015). One to four year spending reviews result in short-term planning, meaning that often a “service has barely enough time to be set up and begin to deliver support before its staff have to plan for reconfiguration or even closure” (Action for Children, 2014, p4). Five or even ten year plans for funding for children’s services and early help services would enable longer term visions, the time to embed services and would increase the opportunity for children, young people and families to develop relationships with practitioners (Action for Children, 2013; Early Action Task Force, 2012). Any shift in spending would need to be tracked and the impact on families measured.

Summary

Local government can enable communities to come together to prevent and tackle neglect. To do so, they need to understand local levels of need and use evidence to inform their strategy to meet those needs.

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<th>What will make a difference?</th>
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<td>Sizing the problem</td>
<td>Local government should regularly collect data on the number of children classed as ‘in need’ because of neglect and on parental risk factors for neglect.</td>
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<tr>
<td>Drawing from and developing learning on the most promising ways of preventing and tackling neglect</td>
<td>Local government should commission evidence-based services to prevent and tackle neglect, and should rigorously evaluate strategic approaches such as early help hubs and early help strategies.</td>
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Appendix A: Programmes that target parental risk factors for neglect

Family Nurse Partnership

The Family Nurse Partnership (FNP) is a voluntary home visiting programme for first time young mothers, aged 19 or under (and fathers). A specially trained family nurse visits the young mother regularly, from early in pregnancy until the child is two, to achieve three main aims:

- To improve their pregnancy outcomes, so that their baby has the best start in life
- To improve their child’s health and development by developing their parenting knowledge and skills
- To improve parents’ economic self-sufficiency, by helping them to achieve their aspirations (such as employment or returning to education) (FNP, 2015a).

The programme also works with mothers and fathers to build positive relationships with their baby and understand their baby’s needs, and build positive relationships with others, modelled by building a positive relationship with the family nurse. The FNP was developed in the United States (known as the Nurse-Family Partnership) and is based on evidence from extensive US research, including three randomised controlled trials (RCTs). In the US, the programme effects were found to be: improved prenatal health, fewer childhood injuries; fewer subsequent pregnancies; greater intervals between births, increased maternal employment; and improved school readiness (FNP National Unit, 2011). An RCT is currently underway to explore the effectiveness and cost-effectiveness of the FNP in England (Owen-Jones et al, 2013).

In March 2015, the FNP was being delivered in 135 local authorities in England (FNP, 2015b). The Government has committed to increasing the number of Family Nurse Partnership places to 16,000 by April 2015. Commissioning for the FNP will transfer to local authorities in 2015 (Department of Health, 2013b).

Parents Under Pressure

Parents Under Pressure (PUP) is a service working with parents of children under the age of five who are on a drug or alcohol treatment programme. By working closely with the parents over a number of months, Parents Under Pressure aims to:

- help parents develop their parenting skills
- develop safe, caring relationships between parents and their children.

Parents Under Pressure takes a strengths-based approach. It focuses on things parents are good at to help them:

- increase their understanding of child development
- be aware of and respond to their child’s emotional needs
- improve interactions with their child.

PUP was developed in Australia for parents with a child aged two to eight years old. The NSPCC and the University of Warwick are evaluating PUP in the UK context, using a randomised controlled trial to measure service impact on families with a child under the age of two and a half (NSPCC, 2015b). An evaluation of Parents Under Pressure in Australia found the service reduces the potential for child abuse, rigid parenting attitudes and child behaviour problems (Dawe & Harnett 2007).
Family Environment: Drug Using Parents (FEDUP)

Family Environment: Drug Using Parents (FEDUP) is a service developed by the NSPCC that works with children and families where one or both parents misuse drugs or alcohol (NSPCC, 2015c). FEDUP combines 10 weekly group sessions for children aged between five and 12 years old and one-to-one sessions with parents over eight weeks. It begins with a four-week assessment period with the parent/s and the child so as to learn more about the family and the support that they need.

The session with children (made up of five young people) includes structured discussions, games and activities, and aims to provide children with drug or alcohol misusing parents with:

- a safe space;
- mutual support from other young people to build self-esteem;
- a better understanding of drug and alcohol problems;
- the opportunity to develop life skills to improve their ability to deal with difficult circumstances.

One-to-one sessions with parents explore:

- how substance misuse affects the parent, their child and their family;
- the parent’s own history and experiences;
- how to keep their child safe;
- their child’s life history;
- child development;
- support networks.

The NSPCC is evaluating FEDUP and has published an interim evaluation based on self-report data (Cass & Fernandes, 2014b). It found that, at the end of the programme, children and young people reported a decrease in their emotional and behavioural problems, and that parents felt more confident about their parenting and reported having a greater knowledge about children’s needs at the end of the programme.

Baby Steps

Baby Steps is an evidence-based, nine-session perinatal programme co-developed by the NSPCC and Professor Angela Underdown from Warwick University (Coster et al, 2015). Following a home visit, parents attend weekly group sessions in the six weeks leading up to the birth, and a further three sessions after the baby is born. The programme is delivered by a health professional (for example, a midwife or health visitor) and a children’s services practitioner (for example, a nursery nurse, family support worker or social worker). This brings a crucial combination of skills to address the emotional, social and physical needs of expectant, parents.

Baby Steps has a number of key underlying themes that contribute to its theory of change:

- Parent–infant relationships – it seeks to strengthen the parent–infant relationship by encouraging the development of sensitive, reflective interactions.
- Co-parenting relationships – it aims to strengthen the couple relationship by encouraging listening, developing conflict resolution skills, and helping parents to manage relationship changes.
- Parental wellbeing – it aims to improve parental levels of stress, anxiety and depression as well as their self-confidence by supporting mothers and fathers to negotiate the emotional and physical transition to parenthood, and helping them to keep healthy and relaxed.
- Reaching disadvantaged groups – the programme was designed with the needs of such parents in mind – for example: learning disabilities; social care involvement; drug and alcohol problems; mood difficulties; relationship conflict; and those from minority ethnic backgrounds. As these parents can be less likely to attend appointments, Baby Steps facilitators make home visits before the programme to engage parents who might not otherwise attend. The programme has been designed to be accessible for parents with additional needs, be delivered in other languages and to engage those who are disaffected from education.
Minding the Baby

Minding the Baby uses pioneering infant mental health approaches to help young mums and mums who are struggling emotionally to develop a positive relationship with their baby, and gives practical support like feeding tips, help with housing and financial advice. The service is based on attachment theory and aims to develop maternal reflective capabilities (the ability of a mother to recognise and respond to their baby’s feelings and needs). Mothers are supported over a two-year period through home visits.

Minding the Baby was developed by Yale University in the United States. An evaluation conducted there found that the programme has a positive effect both on the health of the baby and on the parent–infant relationship (Sadler et al, 2013). University College London and the University of Reading are undertaking a randomised controlled trial commissioned by the NSPCC to evaluate the impact of the programme in the UK context (NSPCC, 2015d).

Parent–infant psychotherapy

Parent–infant psychotherapy (PIP) is increasingly being used to address a wide range of problems that can occur in the perinatal period (Barlow et al, 2015). PIP works with the parent and the infant, focusing on the relationship between the two with a view to promoting optimal child development. It aims to address infant regulatory disturbances (such as excessive crying or sleeping problems) and problems in the attachment relationship between an infant and their parent (Fraiberg, 1980; Lieberman et al, 2000). Examples of PIP include Watch, Wait and Wonder, in which a parent is encouraged to be more directly involved with their child by engaging in playful interaction that follows the lead of the child and then to explore the feelings that were evoked.

A systematic review of parent–infant psychotherapy found that “although PIP appears to be a promising method of improving infant attachment security, there is no evidence about its benefits in terms of other outcomes, and no evidence to show that it is more effective than other types of treatment for parents and infants” (Barlow et al, 2015, p11). The review recommended further rigorous research to fully establish the impact of PIP.

Domestic Abuse, Recovering Together (DART)

Domestic Abuse, Recovering Together (DART) is a service that works with mothers and children who have experienced domestic abuse. It works to support the mother–child relationship by helping them to talk about their experiences with each other, and to rebuild their relationship where difficulties have occurred following the abuse. The service consists of weekly group sessions with children aged between seven and 14 and their mothers over a 10-week period.

DART is commissioned by the NSPCC and based on University of Warwick research, Talking to my Mum (Humphreys et al, 2006) and previous Working Together guidance (HM Government, 2010), which states that children’s outcomes are improved if the non-abusing parent is supported to take an active part in the child’s recovery from abuse. It also builds on work undertaken by the Community Group Treatment Programme in Sutton, which focused on working with children but found that sessions where the mothers attended were the most successful (Audit Commission, 2007). It is currently being evaluated by the NSPCC.
**Family SMILES**

Family SMILES works with families where parents experience mental health difficulties (NSPCC, 2105e). The service aims to improve children’s self-esteem, resilience and life skills, help parents understand the impact of their mental health problems on their child, and improve protective parenting skills. The service consists of weekly group sessions with children of a similar age and six one-to-one session for parents.

Over eight sessions, the children take part in creative activities, discussion and play, aimed at giving them a better understanding of their parents’ mental health problems. Sessions with parents aim to support them in developing parenting skills and good relationships with their children, and make a safety plan so that they are cared for safely in the event of the parent suffering a relapse.

Family SMILES is based on the Australian Simplifying Mental Illness plus Life Enhancement Skills (SMILES) programme (Pitman & Matthey, 2004). The Australian SMILES programme originally involved group work with young carers with a parent or sibling with a mental health problem. It has been used in other countries, including Canada, and positively evaluated in a number of reports (Pitman and Matthey, 2004; Baldwin and Glogovic, 2010).

The NSPCC interim findings, based on changes for children and parents based on the standardised measures they completed before the start of the programme and then again at the end, found that children and young people reported an increase in their self-esteem and a decrease in their emotional and behavioural problems. Parents reported a decrease in their level of distress and unhappiness, and an increase in their self-esteem (Cass & Fernandes, 2014a).

**Solution Focused Brief Therapy (SFBT)**

Solution Focused Brief Therapy (SFBT) is defined by a focus on “constructing solutions rather than resolving problems” (Gingerich, & Eisengart, 2000). SFBT is a competency-based model that assumes that the desired behaviours are already happening within an individual, and aims to increase the frequency with which they occur. The process, which is usually short (around six weeks) requires those receiving the therapy to imagine preferred ways of being and to set goals to achieve change (Trepper et al, 2013).