Barnsley Local Safeguarding Children Partnership: Keeping Children Safe

'Neglect Matters' strategy: ensuring Barnsley has effective arrangements for preventing and responding to neglect at the earliest stage.

2023 – 2026

Reviewed April 2023
Next Review Due April 2024
Neglect Sub-Group

This strategy is owned and overseen by the Barnsley Safeguarding Children Partnership (BSCP) and the impact of it will be scrutinised by the executive and the independent chair.

The BSCP will monitor progress against the strategic objectives on a quarterly basis. The effective delivery of the strategy will be reported to the partnership through highlight reports.

Contents:

What is neglect and what does research tell us?

There are many forms of neglect. Neglect can happen in any family situation, at any time during a child's or adolescent's development and is not exclusive to any class, race, or strata of society. It is a myth that neglect only occurs in low income or deprived families, therefore children and young people in Barnsley may experience neglect in every community across our borough.

There are many definitions of neglect. The Barnsley Safeguarding Children Partnership adopts the Working Together to Safeguard Children (2018) definition:

"The persistent failure to meet a child's basic physical, emotional and/or psychological needs, likely to result in the serious impairment of the child's health or development".

Neglect is characterised by the absence of a relationship of care between the parent/carer and the child and the failure of the parent/carer to prioritise the needs of their child. It can occur at any stage of childhood, including the teenage years (Working Together, 2018).

Horwath (2007) identifies the following types of neglect, which are now widely accepted and used in policy and practice related to neglect (see Appendix A):

Medical neglect: Carers minimise or deny a child's illness or health needs, or neglect to administer medication or treatments. It includes neglect of all aspects of health care including dental, optical, speech and language therapy, mental health, and physiotherapy. Consistently not taking children to medical appointments is a clear indicator of medical neglect.

Nutritional neglect: Usually associated with inadequate food for normal growth leading to "failure to thrive" or "faltering growth". Increasingly another form of nutritional neglect arises from an unhealthy diet and lack of exercise which can lead to obesity, increasing the risks to health in adolescence and adulthood.

Emotional neglect: Defined as the "hostile or indifferent parental behaviour which damages a child's self-esteem, degrades a sense of achievement, diminishes a sense of belonging and stands in the way of healthy, vigorous and happy development". It is the non-deliberate consequence of a carer's neglectful behaviour (Iwaniec, 1995). Whilst these parents appear to offer a good standard of physical care and meeting their child's cognitive needs, they are unable to offer warmth and a loving, caring environment – they may be withdrawn, unavailable, unresponsive and may have experienced a high criticism, low warmth childhood themselves. Therefore, they will struggle to relate at an emotional level with their child.

Educational neglect: Includes parents failing to comply with state requirements, but also includes the broader aspects of education such as supporting their learning, including that any special educational needs are met.

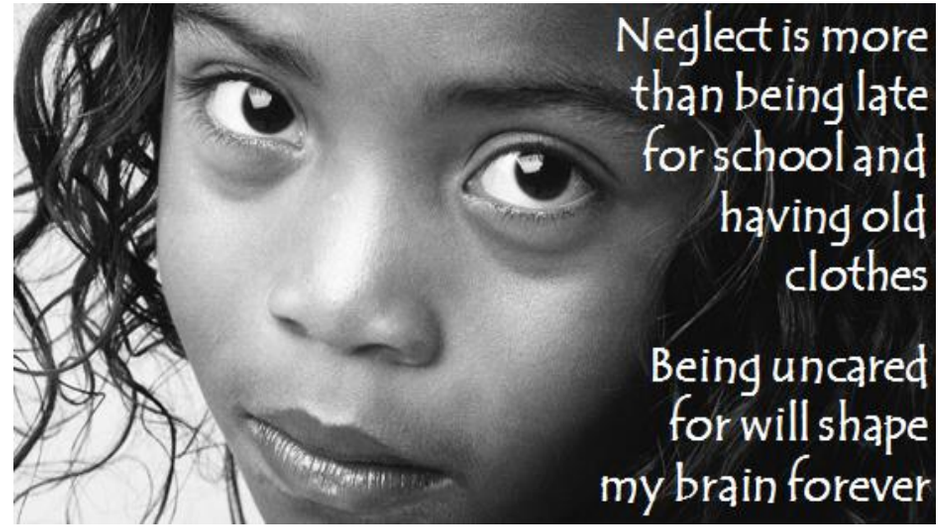
Physical neglect: Refers to the dirty state of the home, lack of hygiene, lack of heating, inadequate and/or broken furniture and bedding. It may include poor or inadequate clothing, which marks a child as different from their peers, resulting in isolation or bullying. It also refers to a lack of safety in the home, and exposure to substances.

Adolescent Neglect: Is different to neglect of younger children and is often overlooked as young people grow older. For teenagers, the boundaries between neglect and maltreatment are often more problematic: e.g., when a young person is forced to leave home through abuse and finds themselves 'neglected', hungry and homeless. Unrecognised neglect from childhood can manifest itself in adolescence. Research tells us there are links between neglect and harmful sexual behaviour and child sexual exploitation (Howarth and Platt, 2019). Young people impacted by neglect can display poor behaviour in the classroom or anti-social behaviour in the community and this can become the prominent emphasis of work, rather than connecting the behaviours to neglect. We should also be mindful about specific groups of neglected teenagers – disabled young people, young carers, young people from ethnic minorities, and others who may feel marginalised in their communities.

Child Neglect: Presents itself in many ways and is usually related to parental behaviour. Crittenden (1996) and Howe (2005) have studied this and linked it to attachment styles / categorised the ways in which neglect may manifest. These include:

Disorganised Neglect: Parents may be driven by their own feelings and unable to put their children's needs first. They often experienced unstable childhoods themselves and focus on meeting their own needs and when these are not met, they perceive this as rejection.

Depressed, Passive and Physical Neglect: Parents who exhibit this form of neglect are unavailable to their child to provide both emotional warmth and meet their developmental needs. The authors argue this is considered the most negative environment for children to grow up in.



Why do we need a Neglect Strategy?

The impact of neglect on children and young people is well documented. Neglect causes great distress to children. It can lead to poor health and poor educational and social outcomes. In some cases, it can lead to a child's death. Even where this is not the case, the effects can be serious and long lasting. Children's abilities to form relationships and to attend and do well at school may be affected. These things will influence their success in adulthood and their ability to parent in the future. The cumulative impact on children of both persistent and intermittent neglect is a central concern when considering the most effective ways of protecting them.

Neglect and cumulative harm

Child neglect usually occurs because of parent/carer behaviour and can be accompanied by either an inability or alternatively, a lack of capacity to change circumstances and behaviours that are impacting negatively on the child.

Cumulative harm is used to describe the ongoing incidence and impact of neglect over time and the harm that is caused to children as a result.

Neglect is a relationship issue

Neglect (headlice, poor hygiene, weight loss, lack of supervision, etc.) may signal a poor adult-child relationship.
All neglect stems from parents prioritising something else over the child's basic needs.
Workers sometimes become too tolerant of high levels of neglect and fail to spot risk.

Interaction is not the same as 'attachment'

Parents may overcompensate or put on a display for strangers. Don't assume that a child has a secure attachment style because they are smiling. Determining the quality of attachment is a skilled and sometimes prolonged task. Many children who are abused are compliant and eager to please. Often even very young children are torn between trying to protect their parents from detection by the authorities and protecting themselves (NSPCC).

Poverty, neglect, and cumulative harm

Whilst neglect and cumulative harm can be apparent in any family, evidence suggests that there is a strong correlation between a family's socio-economic situation and neglect. Material hardship and lack of money is a direct contributory factor to neglect and the added stress and pressure that this brings to parents/carers is an indirect, but important factor.

The way that poverty interacts with other factors that affect parenting is also important to consider, as poverty can interact with and influence:

- Parenting capacity: e.g., parents affected by mental ill health, physical illness, learning disabilities, lack of prior education, shame and stigma.
- Capacity for investment to secure improved home conditions, respite etc.
- Negative adult behaviours, substance misuse and/or domestic abuse.

An example of this is highlighted in evidence suggesting when parental substance misuse is accompanied by poverty, it is more likely to lead to an escalation to statutory services than substance misuse in a position of affluence (Joseph Rowntree Foundation, 2018).

Affluent neglect

Affluent neglect refers to the neglect experienced by children in wealthy families. Often, neglect in wealthier families can be more difficult to spot, as the type of neglect experienced by children and young people in these circumstances can be emotional. There are a huge number of risks that children from all walks of life face, and people often perceive children from affluent families as being protected from some of these risks. In reality, children from affluent families are not sheltered from neglect, as some would assume. It can be the case that parents work long hours and leave children in the care of paid carers; this can create feelings of loneliness in the child, and parents disconnected from their child's emotional needs. It is suggested that affluent parents may also put a high amount of pressure on their children to succeed academically, which can sometimes lead to psychological and emotional problems for children.

It can sometimes be the case that due to a lack of parental supervision and guidance, wealthy parents may have a more relaxed attitude to risks their children take, or in many cases aren't sufficiently present or available to know about what their children are doing. This can lead to increased risks for their children, who may have the financial means to facilitate drug misuse and the independence to engage in harmful sexual activity.

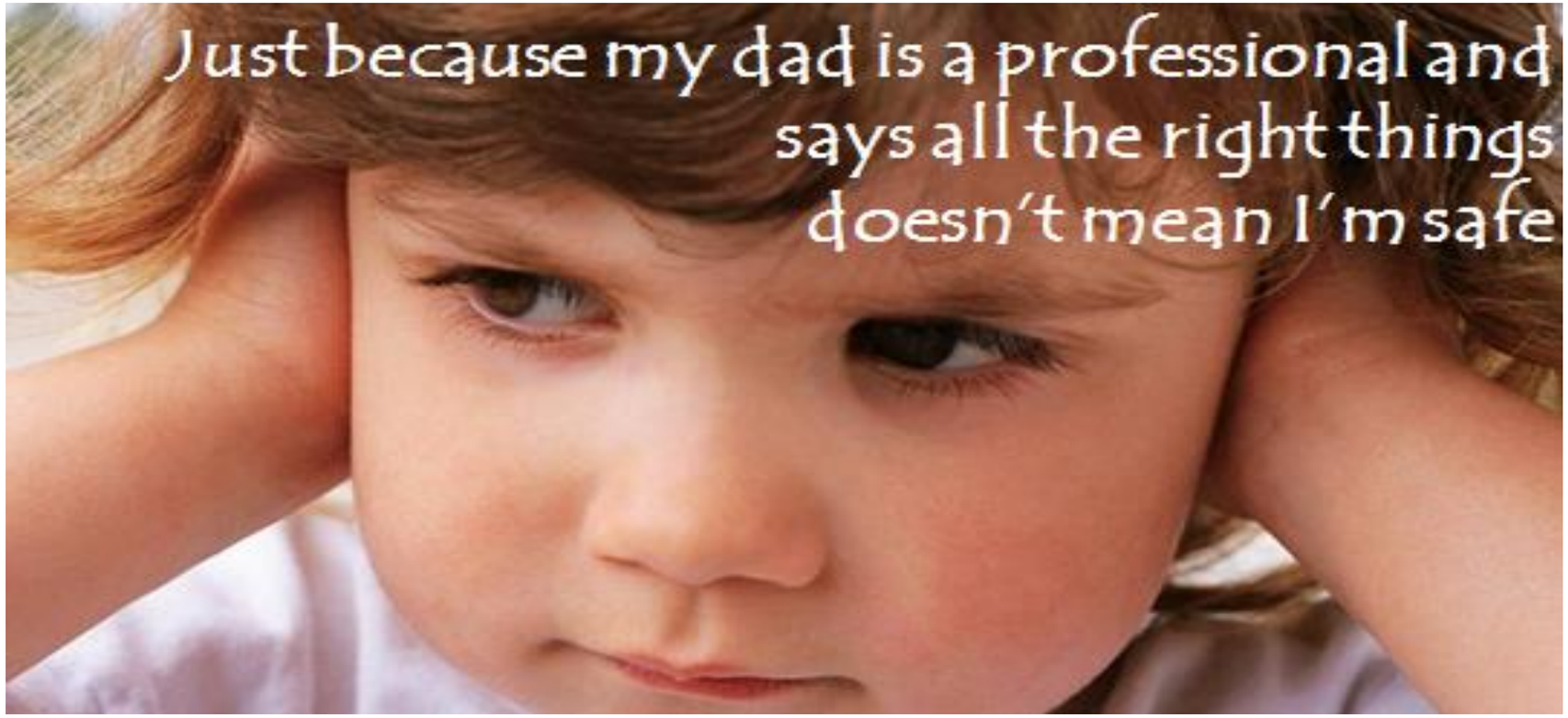
Parental alcohol and substance misuse, domestic abuse and parental mental ill health are often considered issues that only occur in poorer families; however, this is not the case. These same problems are found in affluent families and have lasting effects on the children in the home.

Why is affluent neglect so often overlooked?

There are several barriers that may prevent children from more affluent homes (who are experiencing these types of neglect) from accessing the support they need. Firstly, their symptoms of neglect may be harder to recognise. The nature of emotional neglect can make it much harder to identify than other types of neglect. For example, due to the family having hired people to care for their children, they may present as clean, well dressed and properly fed, when they are actually experiencing emotional neglect.

A lot of staff training often uses case studies that focus on children from poor or working-class families, so staff in educational and health settings may not be as adequately trained to identify and intervene with cases of neglect among wealthier families. Often it is the case that when working with poorer families, they are already known to social care services, so neglect is easier to suspect as a linked manifestation of family issues. The same cannot be said for wealthy families, as often they are not “on the radar” of protective services. There may also be increased hostility towards agencies such as social care from more affluent families, making it more difficult to improve outcomes for children in these circumstances.

There is also a case to be made for the role of unconscious bias when working with children from wealthier families. These children may have new clothes with designer labels, so not associated with the usual signs of parental neglect. It can be even harder to identify and intervene in neglect concerns when a child is attending boarding school, or their parents are living abroad or out of the area, making it even more challenging to not only identify neglect but also intervene to improve outcomes for the child.



The purpose of this strategy is to set out the ways in which we will enhance practice and continuously improve the outcomes for children, young people and families.

What do we know about neglect locally and nationally?

There continues to be a growing body of evidence which demonstrates the damage done to children and young people living in situations of neglect. All aspects of their development can be adversely affected, including their physical and cognitive development, emotional and social well-being, and their mental health and behaviour. For some, the consequences can be fatal. The need to take decisive and timely action is supported by a wide range of research. In addition, the cost of neglect in financial terms is high. When neglect is identified, a range of services are likely to be involved to reduce risk and need, and to address the issues that arise from it.

Much of the available information is focused on the prevalence and impact of neglect in Child Safeguarding Practice Reviews both locally and nationally, including children who are the subject of a child protection plan. There is less evidence available from research and practice about its effects in the wider population of children and young people. However, it is becoming clear that a greater focus is needed on the early identification of (and intervention in) neglect, and there is a greater awareness of the critical impact of neglect, particularly on early development in children less than three years of age.

Ofsted undertook a thematic review into neglect in 2014. They found that most safeguarding partnerships did not receive or collect specific data about neglect, except at the highest level - i.e., those subject to a child protection plan. Although information was provided on the quality of early help, this was generally not broken down by category of concern. The prevalence of neglect is therefore thought to be under-represented in any statistical analysis. It may not be picked up where there are numerous concerns (perhaps including other forms of abuse), and it is unlikely to be quantified in early help work. Additionally, Ofsted found that local authorities who had a neglect strategy and/or a systematic improvement program addressing policy, thresholds for action, and professional practice, were more likely to make a positive difference to children living in situations of neglect.

Research (including NSPCC Thriving Communities) also shows that little evidence is produced about the effectiveness of interventions to deal with neglect and that there is a tendency to allow cases to drift instead of taking decisive action. It shows that where tools exist to evaluate the effectiveness of interventions there is more timely and improved decision-making.

About Barnsley

Barnsley was ranked 38th most deprived district in England on the 2019 Indices of Deprivation. The key drivers of deprivation in Barnsley (top 10% most deprived) are Employment, Skills & Training, Health & Disability and Crime.

57.2% of households in Barnsley are deprived in one or more dimension (ONS, 2021).

Barnsley has 47,478 children aged 16 and under, which is representing 19.4% of the total population (ONS, 2021).

21.2% of children 16 and under live in low-income families (Stat-Xplore, 2021).

27.3% of pupils are eligible for Free School Meals (FSM entitlement) in Barnsley, this is above the national (22.5%) and regional (24.8%) average (DfE 2021/22).

5.1% of Barnsley's school age population is from a minority ethnic background - the national figure is 34.5% (Stat-Xplore 2021).

8% of Barnsley's population belong to ethnic groups other than White British (3.4% are from non-white groups) - well below the English average of 19%. It follows that 92% of Barnsley residents are White British (ONS 2021).

7.5% of people in Barnsley are in bad or very bad health, which is above the national average of 5.2%. This could be influenced by people's lifestyles and several other wider factors, such as deprivation and industrial legacy (ONS 2021).

What does the data tell us about neglect in Barnsley?

- In April 2023, Barnsley children's social care have 320 children subject to a child protection plan. Of this, 180 are due to neglect, which is 56.2% of all child protection plans in Barnsley.

- Of the children and young people subject to an instigated Early Help Assessment in the past 12 months (March 2022 - February 2023), only 1.4% had neglect as an area of need (out of a total of 930 Early Help Assessments that were completed). This does not include children and families that are being offered early support within the community without the need for an EHA.

- Between 1st April 2022 to 31st March 2023, South Yorkshire Police (for Barnsley) recorded 140 cases of Neglect/Cruelty to Children for police investigation.

What will we do in Barnsley to prevent neglect and to protect children?

The child's experiences, from the first intervention by professionals, must be clearly assessed, recorded, and understood, with a clear plan in place to address issues. Authoritative decisions made in good time will only be possible if there is effective oversight from managers through regular high-quality supervision. Assessments need to become an integral part of engaging directly with families to understand what life is like for the child or children living there. We need to recognise the reduced likelihood of reaching their potential for children who suffer neglect. This includes recognising that we may be "de-sensitised" to the living conditions of children which are "not good enough" and fail to identify "disguised compliance" in families we have worked with over a long period of time.

To effectively prevent and tackle neglect, we therefore need to draw on evidence-based approaches, tools and services that we know work.

Gain a better understanding of neglect in Barnsley. Although we have an understanding of the prevalence of neglect in Barnsley and of the way that agencies identify and work with families where there is neglect, we are keen to gain a more detailed and sophisticated understanding of the issue and communicate this to the workforce. We need to understand the importance of looking beyond single incidents of crisis when making threshold decisions, and place weighted emphasis on understanding cumulative harm and how this is impacting children. We will gain this by strengthening our Integrated Front Door, through our early help offer, multi-agency information sharing, recording and decision making.

Raise awareness and understanding of neglect and its impact on children. We will, through agency workforce development, provide multi-agency training, audit and supervision to ensure that staff are knowledgeable about neglect and its impact. We will increase the

community's knowledge and awareness of healthy child development, neglect and help-seeking through media campaigns. We will increase parents' knowledge and awareness of healthy child development by ensuring there is universal provision of high- quality, evidence-based perinatal parent education classes that foster an understanding of child development, attachment and the care children need. This includes an understanding by parents of the impact neglect can have on the outcomes and life chances of their children. We will increase children and young people's knowledge and awareness of healthy child development and neglect, and enable the development of positive and trusting relationships between children and the practitioners who work with them. We will ensure that the wider workforce is equipped to articulate cumulative harm and neglect, and that they understand the application of the right escalation process should this be required.

Ensure that staff from all agencies can spot the signs of neglect and assess the level of risk for the child. We will do this by promoting and endorsing the multi-agency use of the Graded Care Profile in all the work that we do with families and embed the Signs of Safety model of working across all partnerships in Barnsley. The Graded Care Profile is a validated, evidenced based tool and has been designed to help childcare professionals to understand the lived experience of the child and convey this to parents when working with cases of neglect. We believe that if all professionals consistently incorporate the use of this tool into everyday practice with families (to identify areas of strength and areas that need support and improvement), it will enable us to recognise early signs of neglect, be specific and clear about what needs to change, consistently measure the quality of the care given to the child over time and whether change is taking place. Within the Integrated Front Door we will ensure that, if neglect is identified by the referrer as a concern, the Graded Care Profile has been completed prior to the referral being accepted. Children's social care staff will have mandatory training as part of their induction and CSC will ensure there are Graded Care Profile check points within the child's social care journey. The 5-point check system (being at initial referral, completion of assessment, supervision, initial child protection plan and legal gate way presentation) will ensure that we are being specific and clear about what needs to change to stop us from being worried about a child, consistently measuring the quality of the care given to the child over time and whether change is taking place, and if that change can be sustained.

In addition to the Graded Care Profile training, we will continue to deliver multi-agency training in Barnsley that develops professionals' understanding of neglect and the impact of neglect on children through adverse childhood experiences. Topics will include the effects of trauma on the child, an Introduction to child development, introduction to working together to safeguard children and young people, understanding child attachment, child neglect, and compromised parenting – the effects of the trigger trio.

Promote early identification and response to neglect. We will ensure that there is clear understanding among staff in Universal Services about the actions they can take to provide early help when they identify the early warning signs of neglect. Education and health services, which are co-located across Barnsley schools and the local hospital, will recognise and draw on the role that family support workers and other pastoral workers can play in preventing neglect. All agencies working with children and families will hold regular Team Around the Family (TAF) meetings to discuss early concerns about children and their parents in the local area. We will ensure there are safe, welcoming, and warm family hubs available for families to visit within their own communities who need help and support. Within the Integrated Front Door, we will ensure that if neglect is identified by the referrer as a concern that the Graded Care Profile has been completed prior to the referral being accepted.

We will continue though the BSCP to audit, review and learn together as a partnership.

A seen child is not always a safe child

Almost every child who has been subject to a Child Safeguarding Practice review over the last 40 years was 'seen' by a professional within days (or hours) of their death.

Simply seeing a child is not protection against harm. Workers need to try to understand what the world looks and feels like for that child. Getting a narrative of the child's day-to-day experience is a good place to start rather than getting them to answer yes/no questions. Professional involvement is not the same as engagement.

Just because another professional is involved with a child does not mean that they are proactively engaged with protecting the child.

The danger is that we assume that, if a child has a social worker, they are being protected; or if a police officer visited the house after a domestic violence incident, the child is safe. The social worker may not know what you know; the police officer may not have had any cause for concern.

Never assume that someone else is doing something when you have cause for concern.

Barriers to professional curiosity

It is important to note that when a lack of professional curiosity is cited as a factor in a tragic incident, this does not automatically mean that blame should be apportioned. It is widely recognised that there are many barriers to being professionally curious. Some of the barriers to professionally curious practice are set out below:

- **Disguised compliance** (or more appropriately known as “apparent co-operation”)
  A family member or carer gives the appearance of co-operating with professionals to avoid raising suspicions, to allay professional concerns and ultimately to reduce professional involvement. We need to establish the facts and gather evidence about what is actually happening. We need to focus on outcomes rather than processes to ensure we remain focused on the child.

- **The ‘rule of optimism’**
  We use a strengths-based approach, but this does not mean that new or escalating risks should not be treated seriously. The ‘rule of optimism’ is a well-known dynamic in which professionals can tend to rationalise away new or escalating risks despite clear evidence to the contrary. Quite simply, hoping for the best - even when the information tells us otherwise.

- **Accumulating risk – seeing the whole picture**
  Reviews repeatedly demonstrate that professionals tend to respond to each situation or new risk as an isolated event, rather than assessing the new information within the context of the whole person or looking at the cumulative effect of a series of incidents and information.

- **Normalisation**
  This refers to social processes through which ideas and actions come to be seen as 'normal' and become taken-for-granted or 'natural' in everyday life. Because they are seen as ‘normal’ they cease to be questioned and are therefore not recognised as potential risks or assessed as such.

- **Professional deference**
  Workers who have most contact with the individual are in a good position to recognise when the risks to the person are escalating. However, there can be a tendency to defer to the opinion of a ‘higher status’ professional who has limited contact with the person, but who views the risk as less significant. Be confident in your own judgement and always outline your observations and concerns to other professionals; be courageous and challenge their opinion of risk if it varies from your own.

- **Confirmation bias**
  This is when we look for evidence that supports or confirms our pre-held views and ignores contrary information that refutes them. It occurs when we filter out potentially useful facts and opinions that don't coincide with our preconceived ideas.

- **‘Knowing but not knowing’**
  This is about having a sense that something is not right but not knowing exactly what, so it is difficult to grasp the problem and take action (commonly referred to as a ‘gut feeling’). A ‘gut feeling’ is not evidence, hence the need for professional curiosity.

- **Confidence in managing tension**
  Disagreement, disruption, and aggression from families or others can undermine confidence and divert meetings away from topics the practitioner wants to explore and back to the family’s (perhaps differing) agenda.

- **Dealing with uncertainty**
  Contested accounts, vague or retracted disclosures, deception and inconclusive medical evidence are common in safeguarding practice. Practitioners are often presented with concerns which are impossible to substantiate. In such situations 'there is a temptation to discount concern that cannot be proved' and concerns, therefore, go unrecorded.

Learning from local child safeguarding practice and other case reviews on cumulative harm/neglect

It is important that Barnsley's approach to neglect applies learning from practice that has led to serious incidents and subsequent Practice Reviews across the UK. Below are highlights and key learning points from a recent study into practice reviews over three years:

- Poverty was an issue within neglectful circumstances, but it was often overlooked by practitioners or addressed on an ad-hoc basis.
- There was an extremely high prevalence of adverse parental and family circumstances. Often there was not one single issue, but a combination of different parental and environmental risk factors which accumulated over time.
- Adolescents living with neglect were particularly vulnerable to having their needs and the risks that they faced overlooked.
- Parents often had previous negative experiences of statutory agencies, which could make them defensive when asked questions about their children.
- Fathers and partners sometimes felt alienated and forgotten. Services need to find ways to become more 'male friendly' to encourage involvement of men in their children's lives. Opportunities for working with the family and wider community in preventative or protective interventions were often missed.
- The wider community often holds resources which can be used to help combat the impact of adverse circumstances.
- Professionals were sometimes reluctant to name or discuss neglect and poverty. Clear use of language is needed to encourage multiagency working and learning from case reviews.
- Services are increasingly fragmented, outsourced or cut and there are high caseloads and staff turnover. Managers and commissioners need to put in place structures to provide support, time and guidance for frontline practitioners.
- The complexity of families' situations and the high volume of information held by different agencies made it harder to identify and respond to the risks faced by children. A multi-agency approach to identification, assessment and support is needed.

(NSPCC March 2020; A triennial analysis of SCRs 2014-2017, NSPCC.org.uk/learning)

Brain development, Adverse Childhood Experiences, prevention, resilience, and reduction

In the first years of a child's life, brain development is rapid. Neural pathways are formed which provide the foundations to support future development. The development of neural pathways allows the child to manage stress in their lives.

Learning how to cope with adversity is an important part of healthy child development. A response to stress is normal and essential in everyday life. Experiencing ACEs can cause what is known as toxic stress. This excessive activation of the stress response system can lead to long- lasting wear-and-tear on the body and brain. When we are threatened, our bodies prepare us to respond by increasing our heart rate, blood pressure, and stress hormones, such as cortisol. When a young child's stress response systems are activated within an environment of supportive relationships with adults, these physiological effects are buffered and brought back down to baseline. The result is the development of healthy stress response systems.

However, if the stress response is extreme and long-lasting, and buffering relationships are unavailable to the child, the result can be damaged, weakened systems and brain development, with lifelong repercussions.

- **Positive stress** response is a normal and essential part of healthy development. Some situations that might trigger a positive stress response are the first day with a new caregiver or receiving an injected immunisation.
- **Tolerable stress** response activates the body's alert systems to a greater degree as a result of more severe, longer-lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time-limited and buffered by relationships with adults who help the child adapt, the brain and other organs recover from what might otherwise be damaging effects.
- **Toxic stress** response can occur when a child experiences strong, frequent, and/or prolonged adversity – such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship – without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of the brain and other organ systems and increase the risk for stress-related disease and cognitive impairment, well into the adult years.

Impact of ACES

When toxic stress response occurs continually, or is triggered by multiple sources, it can have a cumulative toll on an individual's physical and mental health which may last for a lifetime. The more adverse experiences in childhood, the greater the likelihood of developmental delays and later health problems, including heart disease, diabetes, substance abuse, and depression.

Experience of adversity or trauma in childhood can significantly increase the risk of mental and physical ill health in adolescence and adulthood which results in these young people potentially dying sooner than their peers in later life. Evidence suggests 4 or more ACEs during childhood leads to an increased risk of the person participating in risk taking behaviours and experiencing difficulty in making changes, which can result in poor health outcomes such as:

- Alcohol abuse
- Chronic Obstructive Pulmonary Disease
- Depression
- Fetal death
- Illicit drug use
- Heart and Liver Disease
- Risk of partner violence
- Multiple sexual partners
- Sexually Transmitted Disease
- Unintended pregnancies
- Poor academic achievement
- Type 2 diabetes

'Perpetrator of violence' research suggests that people who have had 4 ACEs are twice as likely to have accessed medical services (such as visiting a GP, A&E or sexual health services) and have spent a night in hospital. 64% of service users working with substance misuse services have 4+ ACEs, as well as 50% of homeless people.

Compared with people with no ACEs, those with 4+ ACEs are more likely to binge drink or have a poor diet, to be a current smoker, to have had sex while under 16 years old, to have smoked cannabis, to have had / caused unintended teenage pregnancy, and to have been a victim and/or perpetrator of violence.

Prevention

- Prevention in this area is key. There are significant long-term costs of ACEs. However, there is growing evidence that if work to prevent ACEs intervenes early enough, some of the lifelong health and social negative impacts can be ameliorated. There are three broad approaches to reducing the impact of ACEs:
- **Primary Preventative Approach** – this aims to support children to grow up in nurturing homes, with stable and supportive family relationships in order to achieve the best start in life. This involves supporting parents, building resilience in children and universal health services.
- **Secondary Preventative Approach** – this works on identifying adverse events when they occur, at the earliest opportunity, in order to reduce the impact these experiences have on children and young people, which could also reduce the likelihood of multiple experiences occurring. This can involve services such as perinatal mental health services, early years services, early help services and early intervention for mental health issues.
- **Tertiary Preventative Approach** - this approach works to identify ACEs in those with established physical and emotional disease/ problems and ensuring their needs are met, including opportunity for therapeutic and practical support. This may involve CAMHS, trauma informed services and early intervention.

Developing resilience

Research shows that having access to a trusted adult in childhood, supportive friends, and being engaged in community activities (such as sports) can reduce the risks of developing mental illness - even in those who have experienced high levels of ACEs. Overall, having supportive friends, opportunities for community participation, people to look up to and other sources of resilience in childhood can more than halve current mental illness in adults with four or more ACEs (from 29 per cent to 14 per cent) and again halve ever having felt suicidal or self-harmed (from 39 per cent to 17 per cent). Participation in sports both as a child and adult was a further source of resilience to mental illness, with being in current treatment for mental illness reducing from 23 per cent in adults that did not regularly participate in sports, to 12 per cent in those that did.

Reducing the impact of Adverse Childhood Experiences (ACEs)

Reducing the impact of Adverse Childhood Experiences (ACEs) is a pressing issue currently facing our society. Barnsley Council are committed to driving forward improvement in service provision, ensuring that children and young people's health and well-being remains a priority.

The experiences children go though in early life have a huge impact on how they grow and develop both physical and mental health, and these experiences can have a long-lasting impact on adult life.

Frontline practice, poverty, and cumulative harm

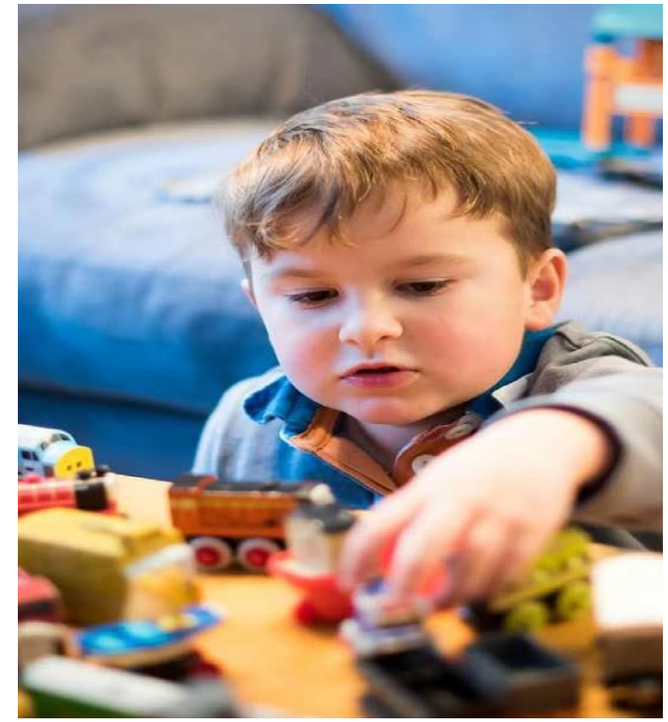
ACEs are highly stressful events or situations that happen during childhood and/or adolescence. It can be a single event, or prolonged threats to, and/or breaches of a young person's safety, security, trust or bodily integrity. Evidence consistently demonstrates a strong association between ACEs and a wide range of health and social problems across the lifespan – impacting the children and young people who experience them in lifelong ways.

There are **10** recognised ACEs:

- Living in a home with domestic abuse
- Living with someone who abused drugs or alcohol
- Parent in prison
- Losing a parent through divorce or bereavement
- Living with someone who has a serious mental health condition
- Physical abuse
- Sexual abuse
- Emotional neglect
- Physical neglect
- Verbal abuse

Children and young people with disabilities

Children and young people who have disabilities are at an increased risk of being abused compared with their non-disabled peers (Jones et al, 2012) and are also less likely to receive the protection and support they need when they have been abused (Taylor et al, 2014).



For the purposes of this strategy, we are using the term disability to encompass the following conditions and identities. This includes children and young people who:

- are deaf
- are on the autistic spectrum
- have a condition such as attention deficit hyperactivity disorder (ADHD)
- have a learning disability
- have a physical disability such as cerebral palsy
- have visual impairment
- have a long-term illness.

According to Miller and Brown (2014), disabled children and young people who are at greatest risk of abuse are those with behaviour or conduct disorders.

One large scale study (Sullivan P.M. and Knutson J.F., 2000, Maltreatment and Disabilities: A Population based Epidemiological Study, Child Abuse and Neglect) found that disabled children and young people were 3.4 times more likely to be abused or neglected than non-disabled children. Disabled children were 3.8 times more likely to be neglected, 3.8 times more likely to be physically abused and 3.9 times more likely to be emotionally abused. The study concluded that 31% of disabled children and young people had been abused, compared to a prevalence rate of 9% among the non-disabled child and young person population.

Disabled children and young people may be especially vulnerable due to a number of reasons.

For example, they may:

- have fewer outside contacts than other children and young people.
- receive intimate care, possibly from a number of carers, which may both increase the risk of abusive behaviour and make it more difficult to set and maintain physical boundaries.
- have an impaired capacity to resist or avoid abuse.
- have communication difficulties which may make it difficult to tell others what is happening.
- be inhibited about complaining through fear of losing services.
- be especially vulnerable to bullying and intimidation.
- be more vulnerable to abuse by peers.

Neglect of disabled children and young people is not always easy to identify. They may experience the same types of neglect as non-disabled children (physical, emotional and sexual abuse), but there are also certain types of harm that may be experienced solely by disabled children. These include:

- failure to meet the communication needs of the child.
- equipment that is issued to a child but seems to be unavailable for them child or young person's use, or alternative equipment that is ill-fitting or inappropriate for the child or young person's use causing pain or injury.
- a parent or carer refusing to follow professional advice, which is considered to be in the child or young person's best interests, for example: refusing to take up services or treatment, pursuing evasive procedures which are unnecessary or carried out against the child or young person's will or carried out by people without the right skills, or refusing to support school attendance.
- physical interventions that are not carried out in accordance with good practice guidelines and protocols.
- inappropriate behaviour modification.
- misuse of medication.
- being denied access to education, play and leisure opportunities.

What is adolescent neglect?

Adolescents are more likely to experience neglect at home than any other form of child abuse. Neglect is not something which only happens to young children: adolescents can also be subject to neglect. There is evidence that professionals struggle to identify adolescent neglect and are unsure what to do when they come across it. Therefore, work with parents to address the neglect of older children is critical.

Adolescent Neglect refers to young people aged 11-17yrs old. There are misconceptions that adolescents become resilient to neglect, however like all forms of abuse, young people regardless of their age remain vulnerable to the impacts of neglect through the standard of parenting that they receive. Their lived experiences may include a lack of emotional care, warmth and encouragement, young people not being adequately supervised or not being given sufficient physical care to preserve their health and having little or no interest shown in their education.

There are several parental risk factors that can lead to or cause adolescent neglect. These include:

- Poor mental health
- Problematic drug and/or alcohol misuse
- Deep seated attitude/behavioral/psychological problems
- Domestic abuse
- Parents own exposure to abuse and lack of positive parenting during childhood
- Illness of parent/carer
- Young parents
- Lack of support/socially isolated
- Wider determinants include:
- Poverty
- Unemployment or family pressures and difficult working hours
- Poor social support

The above underline the importance of a preventative, contextual approach that focuses on the risk factors that may cause child and adolescent neglect.

The impact of adolescent neglect

The impact of neglect during childhood can have significant and long-lasting consequences, affecting all aspect of children's and young people's development. The behaviour of young people must be understood in the context of trauma.
For adolescents, this includes:

- Poor Physical health
- Poor educational engagement, achievements, and prospects
- Running away/missing from home/risk of vulnerability to CSE and CCE
- Increase risk taking, offending or anti-social behaviour and violence
- Substance misuse
- Social isolation, difficulty in making and sustaining relationships with peers and adults
- Dissociation/insecure attachments
- Poor emotional regulation and impulsivity
- Conflict and hostility in relationships
- Depression, anxiety, and long-term mental health problems
- In the future, their lived experiences as a young person can affect how they parent their own children and can perpetuate intergenerational cycles of neglect.

Primary prevention of adolescent neglect

Primary prevention is about preventing neglect before it occurs. This includes provision of a range of universal services such as education, health care, youth and recreation facilities who can all have an important role to play in engaging and promoting the health and well-being of adolescents. It is vital that all professionals who work with adolescents, or the parents of adolescents, are alert to the possibility that neglect at home may be happening and should exercise 'professional curiosity' by asking questions which could reveal signs of neglect and involve others, including colleagues from other agencies, to assess the gravity of the situation.

Secondary prevention of adolescent neglect

There is insufficient understanding of adolescent neglect across the multi-agency network and its link with complex adolescent behaviour. This can result in a fragmented and reactive response to different aspects of behaviour and leave young people at risk of harm. Tackling identified neglect of young people requires a coordinated strategic approach across all agencies.

In any intervention, professionals need to view the family situation and parenting received through the eyes of the young person and ask, 'what is life like for this young person?'.

Persistent engagement is needed to support adolescents. This will involve a balance of preventative work and crisis management and needs to be trauma-informed and built on an understanding of relationship-based practice.

Decision making and cumulative harm

It is vital that threshold decision making takes account of the length of time and impact that ongoing neglect has had on children. When making decisions on whether the harm being described meets a statutory threshold it is important to look at the cumulative, historical landscape and use this to influence decisions. Evidence from case reviews (DFE, 2020) suggests that there can be a propensity when making threshold decisions to look for 'an incident' or ' new occurrence' that 'tips the balance'; however, what we know is that when neglect is entrenched it is important to see past the need for a one-off incident and look beyond, to the impact of cumulative harm caused by prolonged periods of neglect and understand how this directly impacts on daily life for the child.

Barnsley has an exploitation team that is linked to the Youth Justice Service and works alongside some of our most at risk young people, a strong early help offer and an Integrated Front Door for all professional and public concerns regarding children, young people and families. Incorporated within this is a strengthened multi-agency response.

The core Multi-agency Safeguarding Hub model and vision was intended to cover the whole spectrum of harm, from early intervention and prevention through to statutory intervention. Hubs was not designed to just deal with cases of child abuse.

The word **SAFEGUARDING** was deliberately used within the name of the model in line with its widest English Language meaning:

'Protect from harm or damage with an appropriate measure. A measure taken to protect someone or something or to prevent something undesirable' Oxford Dictionary online (2014)

Multi-agency Safeguarding Hubs, or Integrated Front Doors as this is called in Barnsley, were designed to remove once and for all the inhibitors to effective sharing of information and communication between partners. The model is built on the premise that partner organisations need to be co-located and not virtual entities, and they were designed to deliver three clear outcomes in relation to children and vulnerable adults.

- Early identification and understanding of risk and harm - all available information is seen to ensure that need, harm and risk are identified as early as possible.
- Victim identification and intervention - victims are identified, heard and actions considered. Multiple concerns from different organisations are seen in a single location and collated together to gain a full picture of a child/ren and adults' life.

- Harm identification and reduction - the full partnership information picture is seen and can inform activity to reduce and prevent harm and risk.

Enhancing our response in Barnsley

We need to be reassured that the partnership approach to neglect and cumulative harm embeds the following in practice:

- Quality assessments are completed, early in the development of a problem, to address neglect and prevent cumulative harm. This includes enhanced uptake of the Early Help Assessment by partners from a range of agencies, below statutory thresholds.
- Graded Care Profile becomes embedded in both the Early Help and/or statutory assessment of children and families.
- Practitioners are able to articulate neglect and cumulative harm with evidence related to the lived experience of daily life for the child.
- Practitioners understand how to assess the impact of poverty on neglect and cumulative harm.
- Practitioners capture the child's voice and meaningfully apply this to the planning process, using a range of evidence-based tools.
- Practitioners feel equipped and confident to name neglect when they see it and have restorative conversations with parents and carers to find solutions and ways to improve circumstances for the child and family.
- Practitioners receive restorative and reflective supervision that offers high challenge, support, and guidance.

How will we know that we have made a difference to children's lives?

We will consider meaningful outcome-based measures to understand the impact our strategy is having on the lives of children. We will use both quantitative and qualitative information to provide evidence.

We would expect to see:

- An increase in Early Help Assessments that identify when neglect is the key concern and that these assessments are supported by Graded Care Profile assessments.
- An initial increase and longer-term decrease in referrals about neglect and related indicators such as parenting capacity and stress in the home and relationships within the family.
- A decrease in the number of children subject to child protection plans for neglect.
- A decrease in the number of children who become looked after because of neglect.
- Increase in the number of cases where cumulative harm is discussed in supervision.
- Evidence of improving practice from multi-agency audits.
- Enhanced self-esteem and confidence in the parents of children where neglect has been an issue.
- Enhanced understanding and confidence in the professionals working with the parents and children where neglect is an identified issue.

Key indicators for measurement of the effectiveness of the strategy

It is important that measures of success are established and agreed. The following outcome indicators will demonstrate the effectiveness of our strategy and its implementation:

- Safely and appropriately reduce the number of children needing to become looked after as a result of neglect.
- Improve secondary attendance for children with an open social care case for neglect.
- Increase the % of 5-year-olds experiencing neglect who achieve a good level of development in the Early Years Foundation Stage.
- Increase the number of children, young people and families supported with neglect through Early Help Assessments and plans.
- Reduction in the number of repeat referrals due to neglect.
- Reduction in the number of children subject to a Child Protection Plan under the category of neglect for a second time or more.
- Children, young people, and families supported with neglect make good progress against their support plans.

The partnership recognises that with an improved recognition and understanding of neglect, there may be an increase in some of the above indicators where a reduction would demonstrate effectiveness.

Action plan:

A detailed action plan sits alongside this strategy to support and monitor the aims and objectives of this strategy.

Appendix A

Classifications	Experiences of neglect by Horwath's classifications					
Age Group	**Medical**	**Nutritional**	**Emotional**	**Educational**	**Physical**	**Lack of Supervision**
infancy: 0-2 years	Includes failure to notice that a baby is unwell, and failure to seek medical treatment. Not attending routine health screening appointments may be indicative.	Under-nourishment leads to restricted growth and brain development. There can be a link between neglect and obesity, e.g. if parents use sweets as 'pacifiers'.	Lack of stimulation can prevent babies from 'fixing' neural connections. Infant attachments are damaged by neglect, which makes learning skills more difficult	Some parts of the brain, e.g. cortex, are dependent on experience and stimulation to develop. Language relies on reinforcement and feedback from carers.	Dirty home conditions may affect infant immune system; lack of changing and nappy rash; lack of encouragement may delay skill development.	Babies should be supervised at all times, particularly when lying on surfaces they could fall from or in the bath. If babies feel abandoned, this can affect the development of attachments.
Pre-School: 2-4 years	May include missed health and dental appointments, and failure to seek medical treatment following accidents or for routine conditions such as head lice or squints.	Not eating 1200 – 1500 calories per day, and/ or unregulated amounts of fat and sugar in the diet, which can lead to heart problems, obesity and tooth decay.	Neglected children without a secure attachment may experience difficulties playing with their peers, sharing feelings and thoughts, coping with frustration and developing empathy.	Neglect can be a significant factor in delaying a child's language development e.g. through the amount and quality of interactions with carers. This delay affects their education.	Child may present as dirty or malnourished, and living conditions may be poor. Child may not have been toilet trained, sleeping sufficiently or have adequate boundaries.	Home may lack safety devices e.g. stair gates, dangerous items such as drugs or knives may be within reach, child may not have appropriate car seat, child may be left home alone.
Primary: 5-11 years	Children may have more infections and illnesses than their peers due to poor treatment, or lack of prevention e.g. through hand washing, good diet or adequate sleep.	Food isn't provided consistently, leading to unregulated diets of biscuits and sweets. Concerns should not just focus on weight; children of normal weight could still have unhealthy diets.	Insecure attachment styles can lead to children having difficulties forming relationships and may express their frustration at not having friends through disruptive behaviour.	Neglected children can experience a number of disadvantages at school, including low educational aspirations, lack of encouragement for learning and language stimulation.	Ill-fitting, inadequate or dirty clothing, poor personal hygiene, lack of sleep, lack of routines or boundaries which can lead to frustration with school rules and boundaries.	Primary school children may be left home alone after school or expected to supervise younger children. They may be left to play outside alone or to cook meals without supervision.

Adolescent: 12+ years	Poor self-esteem and recklessness can lead to ignoring or enduring health problems rather than accessing services. There may also be risk-taking behaviour e.g. in sexual activity.	Adolescents may be able to find food, but lack of nutritious food and limited cooking experience can lead them to unhealthy snacks, which affects both health and educational outcomes.	Peer groups and independence are important at this age; young people who are isolated by neglect (e.g. through poor hygiene) will struggle. Conflict with carers may also increase.	Likely to experience cognitive impairment e.g. in managing emotion, challenging behaviour in school. Low confidence and academic failure can reinforce negative self-image.	Adolescents' social development is likely to be affected by their living conditions, inadequate clothing, poor hygiene and body odour. This can affect their self-esteem.	Neglected adolescents may stay out all night with carers not aware of their whereabouts, which can lead to opportunities for risk-taking behaviours that can result in serious injury.

Where to go for help

For further information and support services contact:

If you think the child is in immediate danger, call the police on **999** or **01142 202020**.

If the child's not in immediate danger, but you're still concerned about them, call our Integrated Front Door service on **(01226) 772423** (weekdays before 5pm).
Saturday, Sunday or a Bank Holiday, or after 5pm (4.30pm on a Friday), call our Emergency Duty Team on **0844 9841800**.
Or contact the NSPCC on **0808 800 5000** or **Help@nspcc.org.uk**.

BARNSLEY SAFEGUARDING CHILDREN PARTNERSHIP

BARNSLEY Metropolitan Borough Council

NSPCC EVERY CHILDHOOD IS WORTH FIGHTING FOR