Noticing and Helping the Neglected Child: Summary of a Systematic Literature Review

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Abstract

This paper summarizes key findings from a systematic literature review that sought to identify existing evidence about the ways in which the needs of neglected children and their parents are signaled and the response to those needs. Using systematic review guidelines 14 databases were searched for primary research studies published in English from 1995-2005. An initial 20,480 items were systematically filtered down to 63 papers for inclusion. The evidence suggests that there is considerable evidence about how needs are indirectly signalled, less on how they are directly signalled. There is evidence that health professionals can identify those signals, but very little evidence relating to educational professionals. We conclude that, as well as improving response to indirect signals it is also important to improve the evidence base about what makes services 'hard to access' for many parents and children.

Key Words: neglect, recognition, response, maltreatment

Background

One of the broadest definitions of neglect is: 'neglect occurs when a basic need of a child is not met, regardless of the cause' (Dubowitz, Black, Starr, & Zuravin, 1993). This is a helpful definition because it keeps the focus squarely on the child and the range of ways in which unmet need can affect cognitive, behavioural and emotional development. However, the protective legislation in many jurisdictions tends to define neglect much more narrowly in terms of parental omission of care. For example, the operational definition of neglect for professional practice in England is:

> ... the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance 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)
> - ensure access to appropriate medical care or treatment.
> It may also include neglect of, or unresponsiveness to, a child's basic emotional needs (Department of Health, Home Office, & Department for Education and Employment, 1999) (p.12).

Researchers' definitions can be at any point along the spectrum depending on the focus of the research. Studies of the workings of the protective systems tend to use the local operational definitions, whereas others may take a broader definition that allows for analysis of the impact of structural factors.

In practice, recognition that a child's needs are not being met is inconsistent and referrals to services are often triggered by other events or concerns about vulnerable children. This is partly due to a lack of 'fit' between the needs for assistance of parents, the signs of unmet need in children, the way all these needs may be signalled and expressed, and the ways in which practice options are constrained by operational definitions of neglect. Nonetheless, the accumulating evidence suggests that because of the significant effect of unmet need upon children's development in health, cognition and behaviour, signs of potential harm should be evident to health and education professions. Similarly, services supporting adults with problems in mental health or substance misuse should be aware of the potential effects upon parenting capacity. Early recognition that a child's needs are not being met and swift provision of appropriate help is key to ensuring that development is not seriously compromised.

In the UK and other jurisdictions with similar systems there has been widespread 'awareness-raising' training across all universal services. This training, and associated guidance on 'referral' processes has been driven by the evidence of a disparity between prevalence rates of child maltreatment and official statistics. In other words, there are many children whose distress is not being identified. This paper describes a systematic literature review that aimed to draw together empirical evidence to assist with the process of helping practitioners with recognition and response. The study was structured around three research questions:
1. What is known about the ways in which children and families directly and indirectly signal their need for help?
2. To what extent are practitioners equipped to recognise and respond to the indications that a child's needs are likely to be, or are being neglected, whatever the cause?
3. Does the evidence suggest that professional response could be swifter?

Methods

The methods are described in detail elsewhere and were subject to review by a reference group (author, 2009 and forthcoming). In brief the method was based on systematic review guidelines (Centre for Reviews and Dissemination, 2007). The search strategy was devised to locate national and international primary research studies published in English from 1995-2005. Because the study was not primarily concerned with establishing the effectiveness of intervention, but rather was considering the 'greyer' area of early recognition it was appropriate to include studies using the range of methodologies: systematic review, randomised controlled trial, quasi-experimental, cohort study, cross-sectional study, before-and-after study, case series or survey. Keywords were used to locate empirical studies that explored recognition and response of neglect directly and that also considered recognition of proxy signs of neglect including parental characteristics known to be associated with neglect and signs in children's development. Studies exploring views about service accessibility and help-seeking were also searched for. 14 bibliographic databases covering all key professions and disciplines were searched and yielded 20,480 possible items for inclusion. A systematic process of removing duplicates, initial screening and more detailed abstract filtering reduced the numbers to 112. Each study was read in full and a standard data extraction form used to collate information and to evaluate the quality of each study according to the established quality criteria and to assess its relevance to the research questions. Studies of poorer quality and/or of less relevance to the topic were removed. Twenty-five per cent of the papers were blind double-read with 100% inter-rater reliability. The final dataset for inclusion was 63 studies (see appendix for list of included studies).

Results

Ways in which Children and Families Signal their Need for Help

Overall our analysis showed that there is more evidence about how parents and children indirectly, rather than directly, signal their needs for help. The biggest gap was in relation to children. A notable exception described a child self-report scale for neglect which was able to distinguish between a sample of neglected children and a control group (Kantor et al., 2004). Carpenter showed that the drawings of maltreated children are significantly different from non-maltreated children (Carpenter, Kennedy, Armstrong, & Moore, 1997). The differences were not sufficiently distinctive to provide a 'diagnosis' of neglect but the findings suggest that drawings could be included as part of an assessment. School nurses interviewed in Finland described the subtle ways children can signal the need for help (Paavilainen, Astedt-Kurki, & Paunonen, 2000):

> The first sign pointing to problems was often the fact that the child consulted the school nurse more frequently than before. Young children often spoke more openly than older ones, but there were great individual differences. It was easier to make young children talk by questioning them (p. 5).

There is an existing significant body of evidence about the impact of neglect upon the development of children and this review confirmed that children may show behavioural signs related to neglect by the age of three (Dubowitz, 2002).

Studies of interaction with health services show the potential for recognition. For example, studies conducted in specialist burns units in the US and the UK showed that where children suffered neglect they were less likely to receive first aid at the time, wounds were deeper, families often delayed seeking help and the children fared worse than physically abused children in keeping appointments and receiving adequate wound care (Chester, Jose, Aldlyami, King, & Moiemen, 2006; Hultman et al., 1998). Friedlaender's study in the US showed that seriously maltreated children were 2.62 times more likely than non-maltreated children to have had one change in primary care health provider in the previous year, and 6.87 times more likely to have had 2 or more changes (Friedlaender et al., 2005).

Factors such as parental substance misuse and poverty are well-established to be associated with referrals and registrations for neglect. However, no factor can be seen as an absolute predictor because of the number of children experiencing such circumstances who are not neglected. The studies had different starting points and controlled for different factors so it was difficult to draw overall conclusions but in summary:
- when poverty is controlled for, risk of neglect was found to be associated with an impoverished home environment, fewer parental resources and a previous history of maltreatment (Scannapieco & Connell) and parental substance misuse (Ondersma, 2002)
- when tracking families considered to be 'at risk' the likelihood of neglect was elevated by domestic abuse (McGuigan & Pratt, 2001)
- when examining cases of substantiated neglect substantiation was shown to be predicted by parental mental health or substance misuse problems (Carter & Myers, 2007)
- in the context of confirmed maternal substance misuse, risk of neglect was elevated by factors including childhood sexual abuse, severity of drug use, a drug-using social network, receipt of welfare assistance and problems accessing childcare (Cash & Wilke, 2003) and youth of parent, 2 or more children, previous child removal and depressive symptoms (Nair et al., 1997).

Overall, the evidence confirms the overwhelming effect of poverty and the corrosive power of an accumulation of adverse factors (Nair, Schuler, Blacka, Kettinger, & Harrington, 2003; Scannapieco & Connell-Carrick, 2003).

There were hints that, if asked the right questions, parents might be able to articulate their concerns – when asked to complete a measure of parenting concerns a small proportion (1.4%) of mothers of new-borns noted concerns that they might neglect their children (Combs-Orme, Cain, & Wilson, 2004). In the UK recovering heroin addicts could describe the impact of their drug taking on their children, including material deprivation and neglect, exposure to drugs and drug dealing, exposure to criminal behaviour and family break up (McKeganey, Barnard, & McIntosh, 2002).

There appears to be a huge emphasis in research on exploring the factors that are associated with neglect. Indeed the majority of retrospective studies were concerned with the measurement and examination of associated risk factors (such as maternal sensitivity, maternal mental health, alcohol and substance misuse, poverty). However, there was a gap in precise exploration of the ways in which a population risk translates into a specific risk for a specific child and the best way for practitioners to recognise potential harm. Overall, the studies point to the importance of considering compromised development and behavioural problems as potentially indicative of neglect. At the same time, the findings are rarely clear-cut and could not be used predictively without large numbers of false positives and negatives. Harrington *et al.*, for example, found no significant relationship between maternal substance misuse and neglectful parenting and no significant relationships with child cognitive, motor or expressive language development at 30 months (Harrington, Dubowitz, Black, & Binder, 1995).

Recognition and Response

The first step to answering this question is to look at the evidence as to what people identify as neglectful. Dubowitz *et al* noted that neglect is difficult to define conceptually and operationally because it is a heterogeneous phenomenon, usually referring to complex situations and experienced differently by individual children (Dubowitz et al., 2005). Neglect is often described on a continuum of care which ranges from excellent to grossly inadequate. It is easier to discern whether the care is meeting a child's needs at either end of the spectrum than in the middle.

Neglect can be defined in terms of the impact upon the child or in terms of parental characteristics and behaviour, or both. Dubowitz *et al.* suggest that whilst specific developmental milestones that children need to reach are well established in child developmental theory, there is much less discussion or agreement about the minimum caregiving required in order to meet those milestones (Dubowitz, Klockner, Starr, & Black, 1998). Nor are there clear empirical standards for the parenting and conditions necessary for optimal child growth and development.

Perhaps, not surprisingly, the evidence from the studies in the review pointed to a narrowing in definitions of neglect the closer the child comes to professionals and especially those who deliver a protective service. In a series of studies Rose and colleagues compared the views of the general public with those of professionals (Rose & Meezan, 1995, 1996). They asked respondents to rate a series of one-line statements relating to the adequacy of care of a 6 year old child. In the States the responses of White, Hispanic and African American mothers were compared with each other and with child protection investigators and case workers. The statements tended to cluster into four main factors and there was general agreement that behaviour such as not offering a 6 year old child food at a fixed time each day; leaving the child alone outside after dark; not taking the child to a doctor when ill, were likely to cause the child harm. However, there were differences between the groups in their absolute judgements of seriousness: African American and Hispanic mothers judged all categories as more serious than white mothers. And overall, the mothers gave higher ratings of seriousness than the workers.

A smaller study in England also found that social workers consistently rated statements as less serious than a group of mothers (Rose & Selwyn, 2000). In a similar study Dubowitz *et al.*

found that middle class white and African American respondents expressed greater concern about psychological care than their working class peers; that both groups of African Americans were more concerned than white respondents about physical care and that overall the members of the community expressed higher levels of concern than child maltreatment professionals (Dubowitz et al., 1998).

The difference between professionals' judgements and the general public is highly relevant to the research question. The studies were not designed to explore the reasons for such differences, and nor do they provide evidence about developmental outcomes, but they do suggest that the general population is at least as well equipped as professionals to *recognise* aspects of neglectful care, if not more so.

Dubowitz *et al* also suggest that different professionals from different disciplines may employ different definitions reflecting their background, training and purpose of the definition (Dubowitz et al., 1998). In a Scottish study in which social workers rated statements about children's care, Daniel showed that social workers tended to place greater value on emotional than physical care (Daniel, 1999). Rose and Selwyn argue that the definitional components of neglect within the UK are influenced by:
1. the role of the definer;
2. the current political and economic climate with narrower definitions of neglect during times of scarce resources;
3. the time period when a definition occurs i.e. parenting behaviour may remain constant, but what is considered the norm may change;
4. the legal framework supporting a definition; and
5. the societal context within which the definition is framed (Rose & Selwyn, 2000).
The evidence suggests that operational definitions of 'neglect' can affect the number of children receiving a service. Such variations in definition potentially contribute to concerns about different thresholds for access to services. This limitation also restricted the review: most included studies used a legal or administrative definition for the term *neglect*, and the research often focused on reported or substantiated cases where neglect was already defined.

The most direct evidence about the capacity of professionals to recognise neglect relates to health staff. Paavileinen found that of 513 staff in a children's hospital in Finland, two thirds believed that they could recognise maltreatment despite the associated difficulties (Paavilainen et al., 2002). Four studies provide the most direct evidence about the extent to which health visitors in the UK are equipped to recognise that children may be in need of help. Ninety two health visitors completed a questionnaire in which they were asked to rate the importance of 45 signs and symptoms of neglect (Lewin & Herron, 2007). There was considerable agreement about the 5 that were rated as most serious: violence to the child, the child being excluded by the family, the child being left unattended or left to care for other children, violence within the home and a domestic atmosphere of high criticism and low warmth. There was less agreement and lower ratings for factors described as those that 'might traditionally be expected to be central for health vistors' including poor weight gain/nutrition, under-stimulation, developmental delay and untreated infestations. The findings suggest that health visitors are equipped to recognise the importance of the parenting and emotional aspects of neglect. This is supported by the findings from a survey (n=58) and interviews (n=12) with health visitors about their work with 'vulnerable' families (Appleton, 1996). The emergent concerns were not so much about recognition as about problems of identifying resources for the families. Indeed the health visitors indicated that they were able to identify a wider range of vulnerable children than would be picked up using the Trust's formal criteria. In a similar vein Appleton and Cowley describe the inconsistent and patchy application of formal guidelines and assessment checklists for the identification of families in need, and question the value of such guidelines for improving outcomes for families (Appleton & Cowley, 2004):

> We recommend that health visitors seriously question whether it is ever appropriate to attempt to replace professional judgement by the apparent shift towards greater adoption of general and invalid formal guidelines in health visiting practice (p. 796).

The complexity of the health visiting task is also underlined in Ling and Luker's small-scale ethnographic study which provides interesting insights into ways in which health visitors use 'intuitive awareness' in the prevention and detection of abuse and neglect (Ling & Luker, 2000). Overall, these studies suggest that health visitors in the UK are well-equipped to recognise signs of neglect.

The role of education professionals is picked up in some of the studies that use multi-profession-al subject groups or some that describe characteristics of children – however, it is striking that we only found one study where the exclusive focus was staff in educational settings – and these were, in fact, school counsellors not classroom teachers (Bryant & Milsom, 2005). The focus of the study was not so much recognition as reporting. Another overlooked group is the police, whose potential role in identifying neglected children appears not to have been researched.

An interesting, but sparsely covered line of research is systematic exploration into whether members of the community would be prepared to take action, and what form of action, if con-cerned about neglect. Some hints come from a study of South Asian Canadians' views about levels of acceptable care (Maiter, Alaggia, & Trocme, 2004). The study was limited to the views of mothers and fathers who had immigrated to Canada during the last 12 years from South Asia – no direct comparisons were made with the indigenous population, but the authors suggest that their views about acceptable care were not markedly different from the general popula-tion. In focus groups respondents were asked to comment on help-seeking and in one example 85.7% thought it inappropriate to leave a 6 and 4 year old out late alone – 85.7% said the par-ents should get help, mainly from relatives/friends, although 27.8% said from social services. These respondents demonstrated the capacity to identify neglect in the community, but – as the authors concluded – 'participants voiced their reluctance to contact child protective services should they encounter families struggling with abuse' (p. 309).

Andrews described a survey carried out as part of a public awareness intiative in the US that focused on encouraging community support for children of parents who misuse substances with a view to 'the development of strong neighbourhoods where people care about, watch, and sup-port each others' families.' (Andrews, 1996, p20). The underpinning theory to this approach is that people are more likely to seek and use help from those with whom they already have a relationship. In the survey of over 800 members of the public in a southern state 89.1% said they would help if they became aware of a child being abused or neglected as a result of parental substance misuse. However, the vast majority (86%) stated that 'help' would take the form of reporting the problem to formal agencies. Far fewer would offer more direct forms of help.

Evidence relating to the UK is minimal. Appleton's study (Appleton, 1996) showed that 80% of respondents saw themselves as referral agents, but many perceived the lack of social services resources as a barrier to referral and were '...angry and frustrated over the lack of social services input with families, particularly in those areas of 'high concern' often described as 'grey areas" (p.8). Similarly, in the US English *et al* found that a failure to provide basic needs, and caregiv-er's verbally aggressive behaviour were predictive of significant delays as described previously (English, Thompson, Graham, & Briggs, 2005). However, despite the potential for harm they observed that referrals of this nature did not always meet the organisations' defined thresholds of risk for substantiation.

In Finland Paavileinen *et al* took a broader perspective on the concept of response (Paavilainen et al., 2000). They interviewed 20 school nurses about perceptions of their role in 'supporting

and caring' for families and children where there is abuse or neglect. The authors identified two operational modes:
- a passive and uninvolved mode
- an active and firm mode.

For nurses who adopted a passive and uninvolved mode 'responding' to family or child problems equated to referral to other professionals as found in the US studies. Collaboration with others was minimal and home visits were viewed as unnecessary '"...you can't help them if they don't want help" ' (p. 7). By contrast, for nurses who adopted an active and firm mode, the concept of referral was less prominent. Instead, these nurses were confident about their role in supporting families, made home visits, were clear about their concerns and saw themselves as an active member of a collaborative network:

> Active and firm school nurses were not afraid of interfering and did not wait needlessly, expecting things to turn out right by themselves. They searched for these families and supported them also by making home visits. Many of the nurses sent a letter to the child's home or telephoned the family as problems arose. The school nurse might also ask the whole family to visit him or her; they showed interest in their clients and cared for their well-being (p. 6).

For children suspected as maltreated Thyen found that medical practitioners were more likely to report concerns about infants than school-age children, and to refer in relation to the severity of the condition, for example, toxic ingestion or meningitis (Thyen & And, 1997).

The evidence about the social work/social services response is rather minimal and tends to focus on investigation and assessment. In a well known UK study of practice with 712 referrals to social services because of child protection concerns or the need for a service, Wilding showed that concerns about neglect were given less priority and acted on 39% of the time compared with an average of 70% for physical or sexual abuse (Wilding & Thoburn, 1997). The pattern continued as cases of neglect were less likely to be taken to case conference or the children registered, and families tended to be steered away from services. Generally, there was agreement in the studies on the characteristics identified as significant in the substantiation of neglect: children were more vulnerable, fragile and had more challenging or difficult behaviour and were less likely to be protected.

In conclusion, therefore, the bulk of evidence on response is on reporting – there is far less evidence about what universal services can offer directly to support neglected children. Crudely, 'response' for the general public and professions other than social work/services/CPS tended to mean 'referral' or 'reporting' whilst 'response' for social work/services/CPS tended to mean 'investigation'.

Improvement of Professional Response

The majority of studies identified training as the solution to improving recognition and response. However, there has been very little systematic research into the impact of training on recognition and reporting (Ogilvie-Whyte, 2006). Only two studies that met the criteria for this study focused on training. Narayan et al's study (Narayan, Socolar, & St Claire, 2006) suggested that physician preparedness to address child abuse and neglect at qualification from paediatric training in the States was related to the extent and quality of direct teaching and involvement in mandatory clinical rotations in child abuse and neglect. This study was limited to self-report and there was no measurement of actual recognition or reporting behaviour. A two-phase intervention study in Spain did show a dramatic increase in recognition and appropriate referral as a result of a comprehensive programme of training of all key professional groups, coupled with flexible consultation and support (Angeles Cerezo & Pons-Salvador, 2004).

Conclusions

Our study revealed little evidence to help understand whether parents whose children are neglected try and fail to seek help, or whether they tend not to seek help from professionals. However, whilst children and adults in such challenging circumstances may not directly seek help in respect of neglect, there is ample evidence that the signs of the potential for neglect should be evident to professionals.

Children may show behavioural signs of neglect by the age of three and psychological neglect was shown to be particularly damaging. The accumulated evidence also confirms that a range of factors can impact upon parenting capacity. Parental substance misuse, in particular, has been the subject of much research. However, it is not possible to pinpoint very specific links between neglectful parenting and particular effects on children. The fact that parents were able to identify the impact upon their children confirms the need for professionals working with adults to recognise that paying attention to the parenting role will enhance their practice with the adults themselves (Burke & Gruenert, 2005). Coupled with existing evidence about the impact of neglect (Egeland, Sroufe, & Erickson, 1983) the evidence confirms the importance of early intervention. The overwhelming impact of poverty, regardless of levels of neglect, suggested that public health approaches to children living in deprivation should be combined with any specific targeting of neglected children.

The review also suggested that many professionals have the knowledge and skills required to respond to children who may be neglected but the evidence also suggests that protocols and guidelines are not a sufficient spur to response. Human issues such as trust, relationships, communication, anxiety, fear and confidence affect willingness to act on concerns. The concept of a 'space for negotiation' as described by Cooper allows for the fact that issues such as child neglect are rarely concrete – they are complex, multi-faceted and merit discussion (Cooper, Hetherington, & Katz, 2003). The area about which there is less evidence is how public and voluntary services can best ensure that children's developmental needs are met whatever the level of parental capacity, especially within structures that revolve around substantiation of maltreatment. The evidence about the perceived barriers to referral supports the importance of developing more effective integrated approaches to children where all professions regard themselves as part of the child well-being system.

The UK and many jurisdictions with similar child protection and safeguarding systems are in the process of unprecedented reform and development. At the heart of the policy developments is an explicit articulation of the role of the universal services of education and health in the promotion of children's welfare and protection from harm.

Primary health care providers and teachers have always been concerned for the welfare of their child patients, and many children's lives have been significantly improved as a result of the actions of alert professionals. However, there has been considerable variation in interpretation of roles and responsibilities. Quite understandably, many health professionals have been concerned about the often uncomfortable collision of patient confidentiality and child welfare and protection. Over recent years extensive attention has been paid to this issue and health professionals have now been provided with much clearer support and guidance about the limits and extents of confidentiality. Of course, health professionals and teachers are in a prime position to recognise signs and symptoms of child maltreatment; many professionals are also in a key position to identify aspects of parental health, behaviour and disposition that are likely to impact upon their children. There is no doubt that the level of awareness of child abuse and neglect has rocketed and that professionals see the safeguarding of children as squarely part of their core activity. This awareness has gone hand in hand with, and been reinforced by, the increasing consensus that child abuse and neglect is best conceptualised as a public health issue (Scott, 2008).

There is a need now to move from a focus on shared *communication* to a focus on shared *expertise* to ensure that all children can access the universal services of health, education and leisure. Asking all professions to work together *does not* mean everyone trying to do everyone else's job or everyone becoming a 'child protection' worker. But it *does* mean:

- creating the conditions that will allow children to benefit from the core service that each profession offers
- ensuring that *all* children get access to health care, education, social and emotional support – whatever the level of parental capacity.

Attempts to develop a swifter response to neglect must be informed by the views of parents and children about what would help. The biggest gap in evidence we identified related to the views of parents and, even more, of children about what kind of services they would access and the supports required to bridge the gap between the capacity to articulate anxieties and to act on them. The evidence suggests that it should not be assumed that parents or children will seek help in response to experiencing the factors associated with neglect. The term 'hard to reach' is often used to denote parents who exhibit the kind of characteristics associated with neglect, however, we suggest that services should actively seek more evidence about what it is that makes them 'hard to access' for some people.

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