Parental Mental Health and the Longitudinal Neglect of Children & Young People

Sarah Reade & Lisa Morton
Independent CP Chairs

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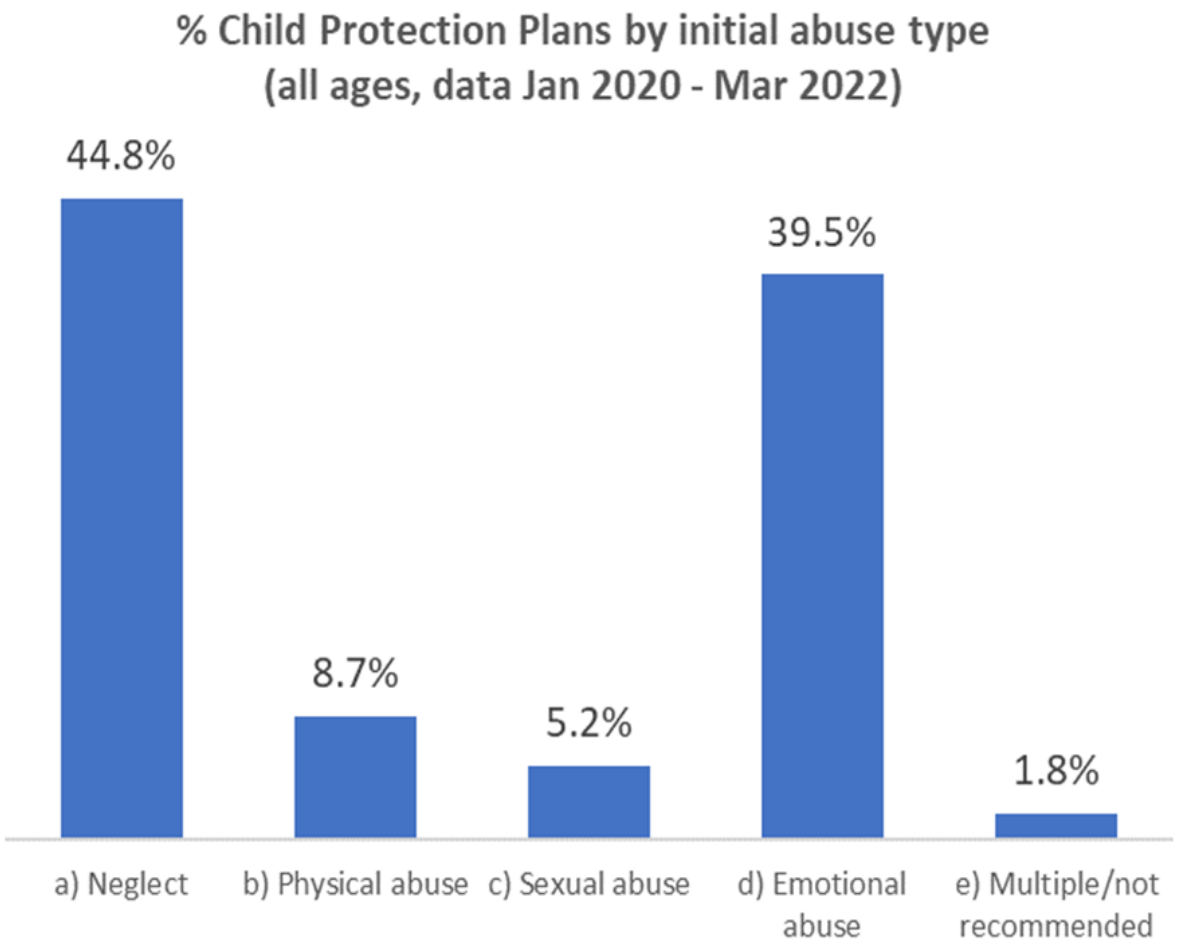
Neglect in Norfolk



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What is Longitudinal Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance 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**

(HM Government 2010, p. 38)

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Types of Neglect

Disorganised neglect

Description:

Families have multi-problems and are crisis-ridden.

Care is unpredictable and inconsistent, there is a lack of planning, needs have to be immediately met.

Mother/parent appears to need/want help and professionals are welcomed, but efforts by professionals are often sabotaged.

Consequence or impact:

Children become overly demanding to gain attention.

Families constantly recreate crisis, because feelings dominate behaviour.

Parents feel threatened by attempts to put structures and boundaries into family life.

Interpersonal relationships are based on the use of coercive strategies to meet need.

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Emotional neglect

Description:

Opposite of disorganised families, where focus is on predictable outcomes.
Family may be materially advantaged and physical needs may be met but no emotional connection made.
Children have more rules to respond to and know their role within the family.
Parental responses lack empathy and are not psychologically available to the child.
Parental approval/attention achieved through performance.

Consequence or impact:

Children learn to block expression or awareness of feelings.
They often do well at school and can appear overly resilient, competent/mature.
They take on the role of care giver to the parent which permits some closeness that is safer for the parent.
Children may appear falsely bright, self-reliant, but have poor social relationships due to isolation.
The parent may have inappropriate expectations in relation to the child's age/development.

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Depressed neglect

Description:

Parents love their children but do not perceive their needs or believe anything will change.
Parent is passive and helpless.
Uninterested in professional support and is unmotivated to make change.
Parental presentation is generally dull/withdrawn.

Consequences or impact:

Parents have closed down to awareness and understanding of children's needs.
Parents may go through the basic functions of caring such as feeding, changing, but there is a lack of response to a child's signals.
Child is likely to either give up when persistently given no response and become withdrawn/sullen or behaviour may become extreme.

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“Neglect occurs when the basic needs of children are not met, regardless of cause”

Family violence, modelling of inappropriate behaviour.

Multiple co-habitation and change of partner.

Alcohol and substance abuse.

Maternal low self-esteem and self-confidence.

Poor parental level of education and cognitive ability.

Parental personality characteristics inhibiting good parenting.

Social and emotional immaturity.

Poor experience of caring behaviour in parents’ own childhood.

Depriving physical and emotional environment in parents’ own childhood.

Experience of physical, sexual, emotional abuse in parents’ own childhood.

Health problems during pregnancy.

Pre-term or low birth weight baby.

Low family income.

Low employment status.

Single parenting.

Teenage pregnancy.

(Neglect Toolkit, Action for Children)

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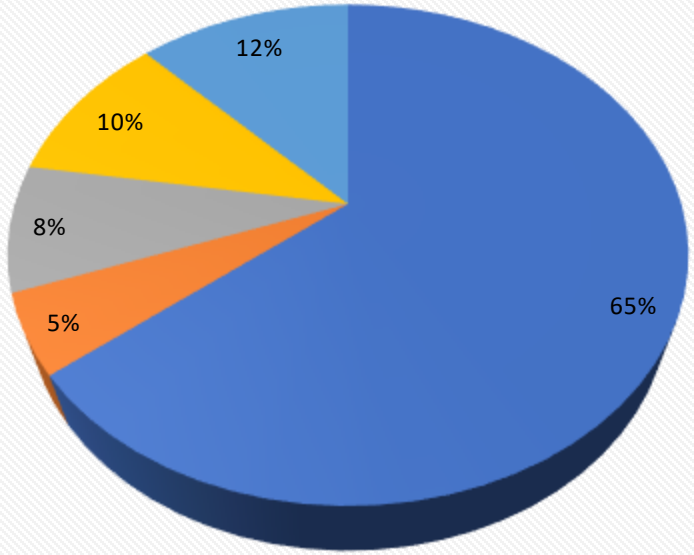
Primary Carer clinically confirmed Mental Health Diagnosis



- MH needs clinically confirmed by specialist service and/or GP = 63
- Parent / Carer self reporting MH difficulties. Not clinically confirmed = 5
- Low mood / lack of joy - due to personal environmental factors, e.g. difficulties with housing, finances/debt, bereavement, loss of relationship or other significant life event = 8
- Worker/s concerned there are unconfirmed MH needs for parent/carers = 10
- C/YP with significant EWB and/or MH needs which impact on daily life; parents not engaging with and/or supporting access to services = 12

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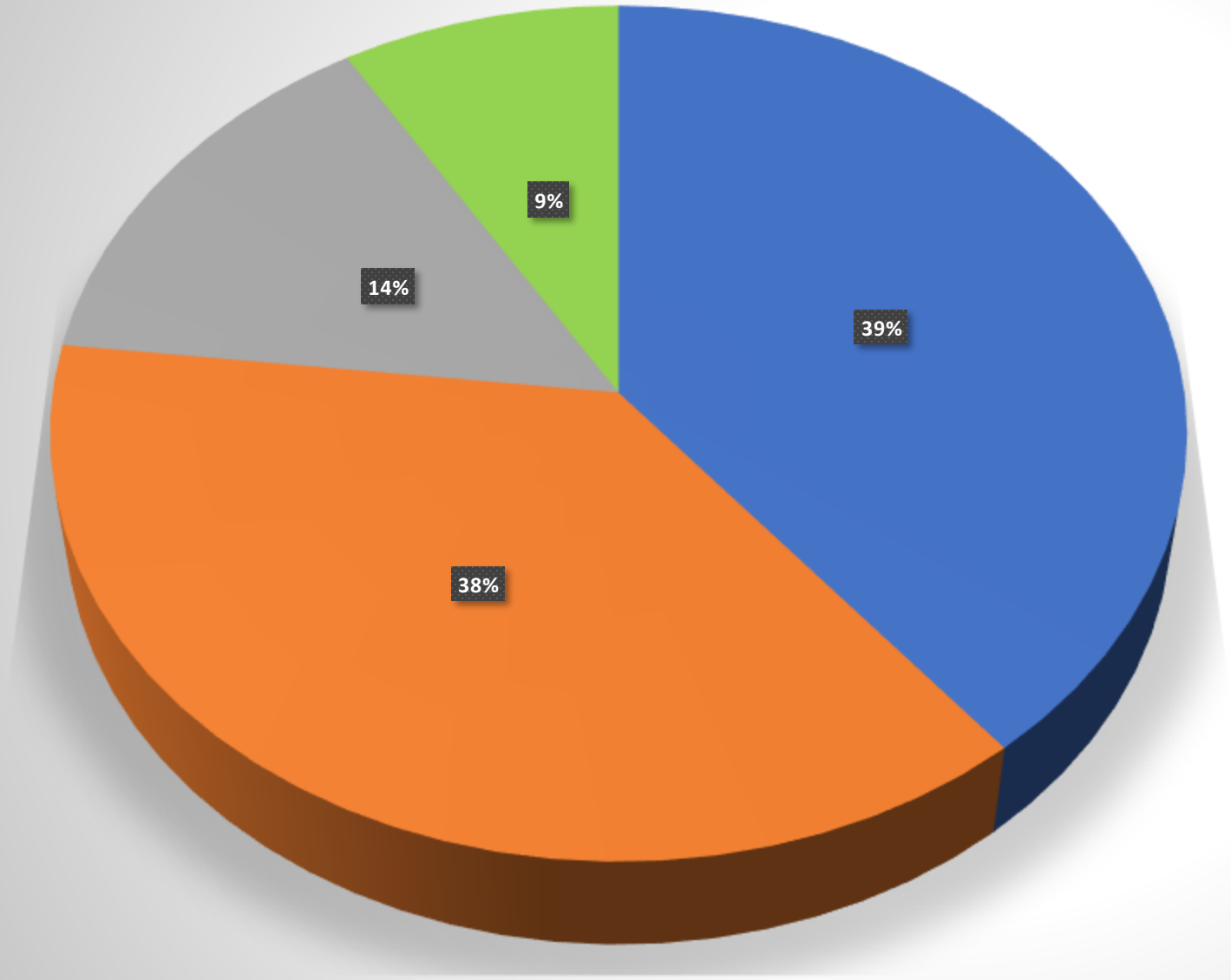
Mental Health Support provided for the Primary Carer



- Specialist MH services - inc. Community Teams, Crisis teams, Hospital Outreach, Psychologist / Psychiatrist, EH Pathway, MBU = 27
- Confirmed GP support = 26
- Perinatal MH support = 10
- CAMHS Community & Acute = 6

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How do we, in co-production with families, identify and deliver effective plans that address not only immediate safety for children but which also ensure focus on resolving longer term neglect issues rooted in parental mental health?

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Participant feedback

Encourage parents to seek help and support.
Barriers and how parents can access support
offer support and suggestions opposed to telling what to do
Focusing on naming impact on children
Working joined up with the parent and services
Open channels of working with parents and carers
Role of wider family and friends
Use o of Norfolk Graded Care Profile
Working alongside Mental Health profs when they are involved
Family plans – what can they do?
Looking at where the neglect comes from, reasons why and barriers to stopping parents changing – breaking that cycle
Be curious and asking appropriate questions
Strength based approach – looking at worries and what worries are needed

How do we addressed root cause?

- *Family history and functioning*
- *Patterns of behaviour*
- *Network of support for family.*
- *Clear voice of children and an understanding of their lived experiences.*
- *Clear understanding of the involvement of other agencies.*

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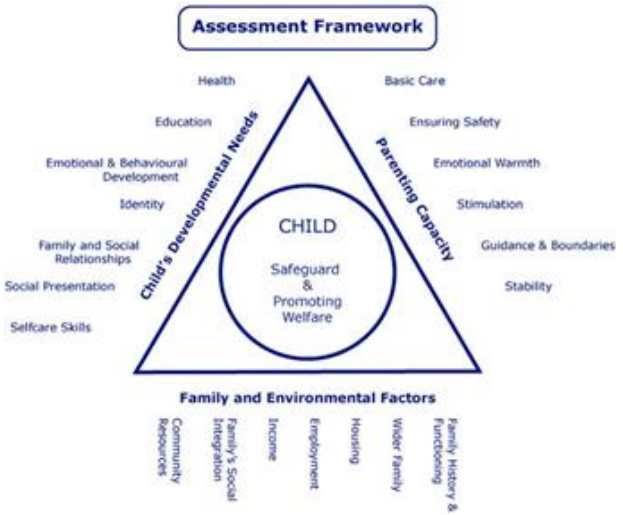
What's the evidence that shows that this has happened:



- *Social work / parenting assessment*
- **Comprehensive multi agency chronology.**
- **Graded care profile**
- **Family network meeting or Family group conference.**
- **Direct work with children evidence of relationship building. 'All About me'**
- **Joint agency supervision including with mental health agencies supporting parents.**
- **Preparation for Child Protection conferences**

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The Graded Care Profile (GCP)

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1) Child focused care giving.	2) Adult focused care giving.	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer does not talk about feelings of depression /low mood in front of the children and is aware of potential impact.	Carer does discuss feelings of depression and low mood, but does not discuss suicide and is aware of the impact of parental mood on children, but their own mood or circumstances means there is inconsistency in awareness of this.	Carer talks about depression and suicide in front of child and is unaware of potential impact on child. Carer indifferent to advice about the importance of not talking about this issue.	Caregiver has attempted suicide in front of child. Carer can hold the child responsible for feelings of depression and is open with the child and/or others about this. Carer is hostile to advice focussed on stopping this behaviour and carer does not recognise the impact on the child.

The Agency Child Protection Conference Report with Chronology

Date / time of event:	Source of Information: Where information originated from e.g. a worker, the child, parent, friend, or relative	Significant event Brief description of event. Language must be clear and concise	Impact for child: **RED** = safeguarding event and/or cumulative negative, harmful events/outcome. **AMBER** = significant life events. **GREEN** = positive events / outcomes	Action taken/Actual outcome: Very short statement of action. E.G. Increased home visits / S47 Strategy Meeting & ICPC held / Parent responded immediately, took child to A&E Narrative must be in the child's agency record or clinical notes	Name, title, agency of practitioner who provided the information [Mandatory completion]	Overall impact for child: **RED** = confirmed negative, harmful outcomes. **AMBER** = some continuing risk OR improving/positive outcome, further change needed **GREEN** = confirmed positive outcomes – parenting strengths utilised, child experiences safe care

People see me running around, climbing on the furniture and hitting my sister a lot; I don't want to talk about how I feel – BF, 6 yrs

Childs Views

I like it when people listen to me. I won't talk to people that make me feel uncomfortable. I need to feel I can be myself and that people aren't making me do something I don't want to do. – YP with clinical MH needs: RS 17 yrs

Clear lived experiences

Spoken observed and felt

Not just what they like

Trusted relationships

Advocacy for children 8 and above.

I hate it when mum won't get out of bed – I get really worried about her, I can't sleep properly – ST 11 yrs

I want to go to after school revision club, but I can't because I have collect my brother from school, mum doesn't hear the alarm on her phone – TT, 15 yrs

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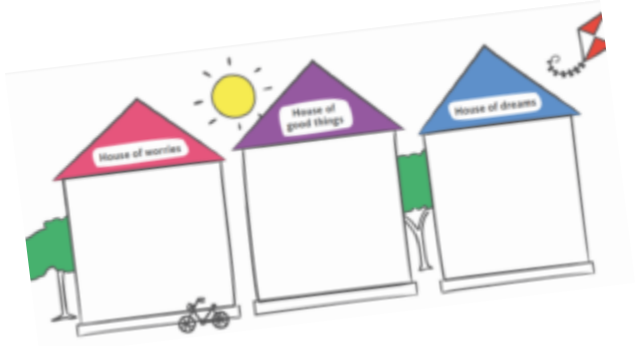
Tools used with children to evidence change



All About Me

Three houses

The Fairy/ wizard Tool

Safety House.

Advocacy.

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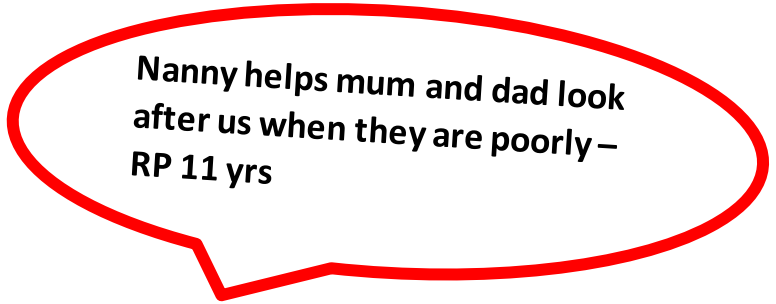
Family networks.



This approach is 'business as usual'

The expectation of the use of the FGC Team – before ICPC

What's the benefit?

- ***Identify and engage whole family.***
- ***Find their own solutions to their problems.***
- ***Empower families support their resilience.***
- ***Promotes sustainable change.***

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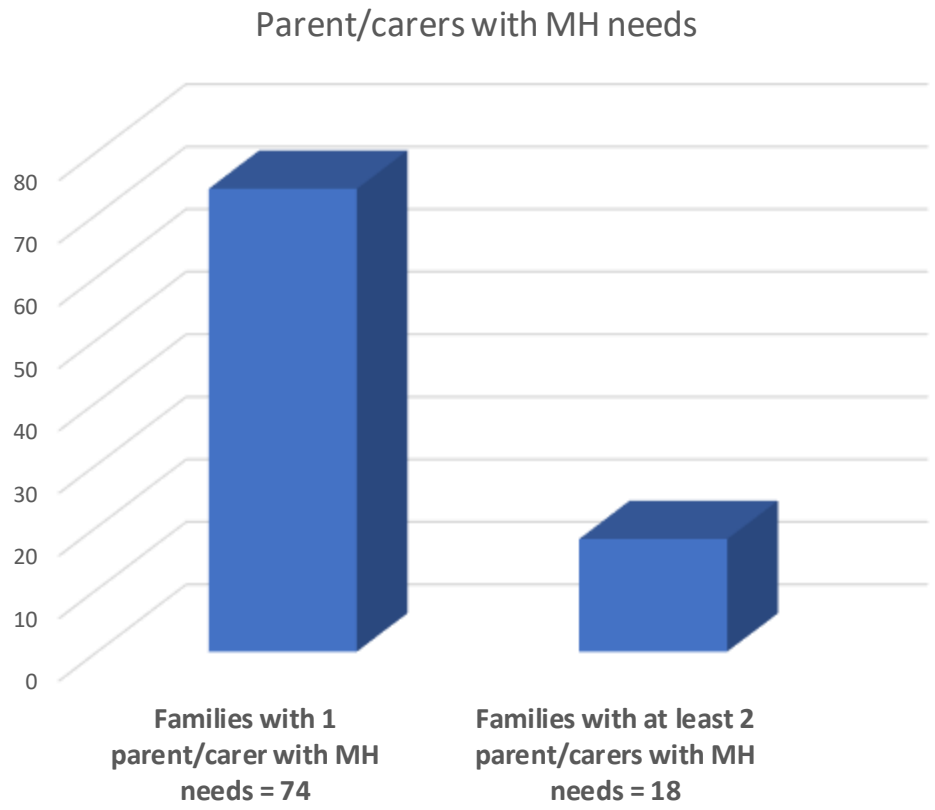
Out of the 98 subjects from the 18 families, a second parent or career also had mental health needs.



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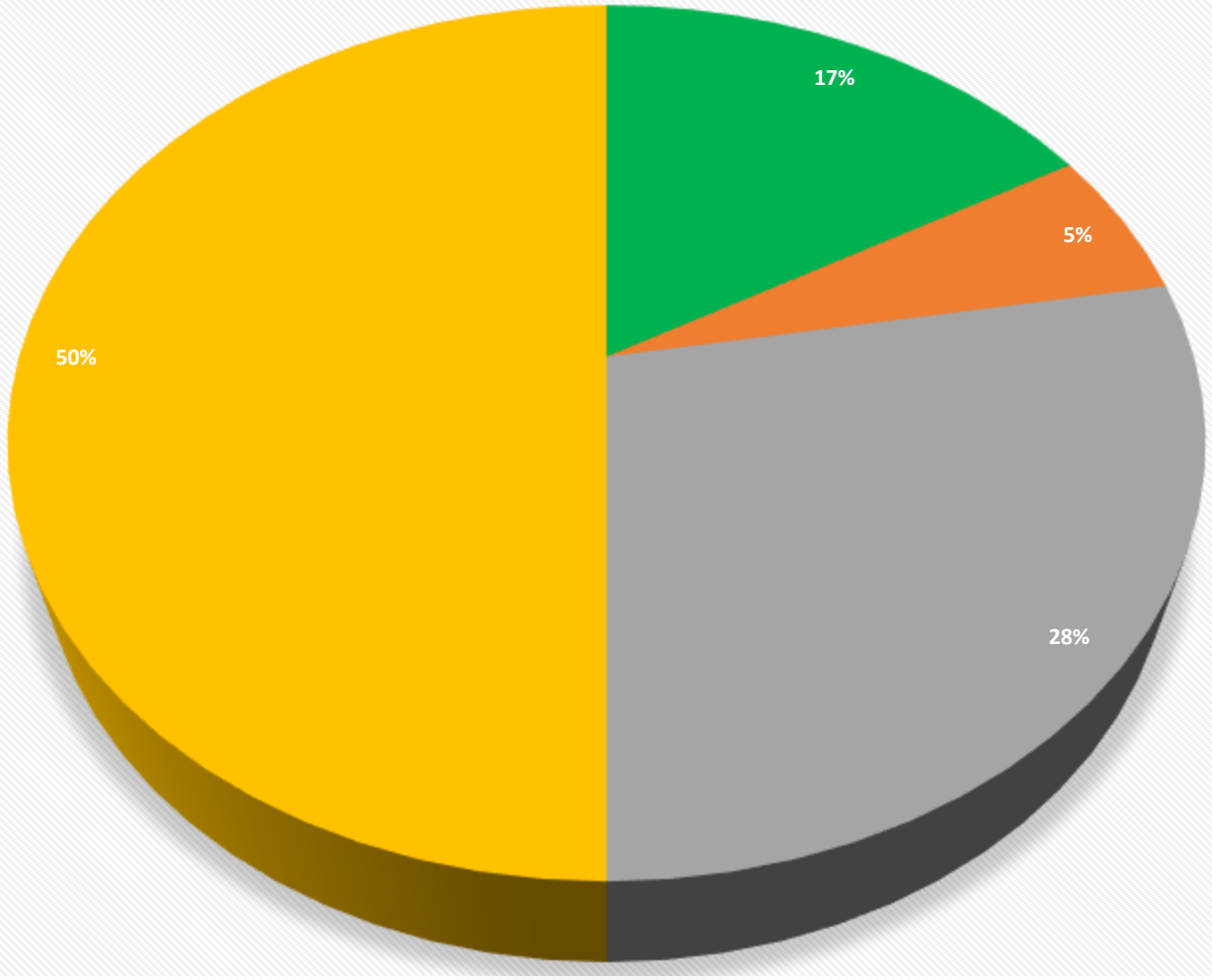
Mental health Support for 2nd parent.



- GP support = 3
- Psychologist support = 1
- Parent / Carer self reporting MH difficulties. Not clinically confirmed = 5
- Worker/s concerned there are unconfirmed MH needs for parent/carers = 9

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Why do we know so little about the 2nd parent/carers MH needs?

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Participant feedback.

- Professionals only consider those they directly see
- Professionals have a primary contact that they usually see so little is known about the 2nd parent
- Focus on the main career
- Limited time that practitioner have to explore as deeply as they would like or limited access and questioning about partners
- 2nd adult maybe unavailable for meetings, working or not directly involved
- 2nd parent may be male and then subconsciously not engage in their mental health needs.
- 2nd care giver may work full time
- Can be difficult to find a time to involve them
- Stigma around men's mental health – dads may not be open
- Maybe the parents are separated and do not live together

Working with Fathers/Father figures

Over 96% of father figures are having regular contact at this time with children.

- **We cannot solely rely on the mother or other family members to tell us about fathers**
- **Fathers, alike mother can bring both risk and resource**
- **We have to hear the father's voice**
- **Listening carefully to fathers' narratives**
- **Empathic listening**

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Why are Child Protection conferences key to agreeing a strong child focussed plan.

- ONE Plan made in Conference
- Collaborative process with parents, child, young person, family network and multi-agency group
- Shared plan involves all participants from the family and multi-agency group
- Ownership and accountability
- Forward change process
- Focuses agencies on the risks of the child
- Outcomes driven for the child

How do we know it's good enough?

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Participant Feedback (contd)

Child's voice

Outcomes for children start to improve

Positive changes for the children through their voice

Children are safer and happier their voice is heard and parents feel supported

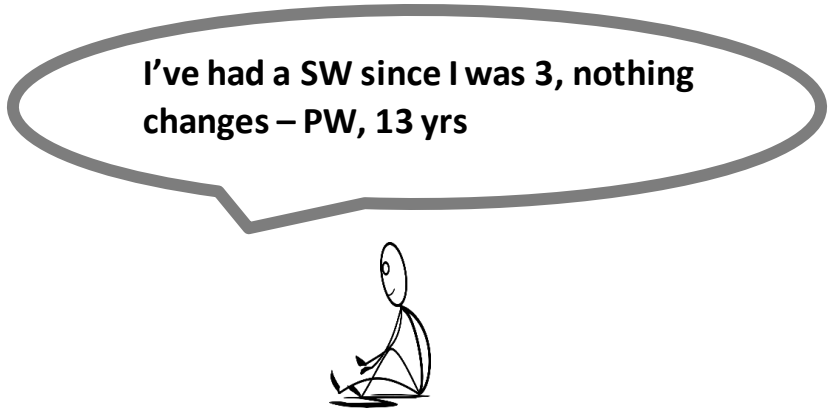
Risks identified and all agencies are able to express their concerns

Family have a support network in place

Sustained changes not just a change physically at home but also observing a change in mindset, motivation and commitment to working with support services

Incidents of DA are lessened, risk level is reduced

Ending Child Protection Planning



Children will continue to experience Longitudinal Neglect if step down too early

Immediate Successes
Superficial changes being made
Support/intervention only just been put in place or engaged with
Change only just begun to take place
Changes not sustained
Have we triangulated of information to evidence change?

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Practice recommendations….

Family focused Conferences

Better communication between the Independent Chair, Parents and Young People

Gaining the voice of the child;

- All About Me
- Child's Views Tools
- Advocacy

Agency Child Protection Conference Report with Chronology

Graded Care Profile

Intensive Specialist Support Team - Adult Mental Health Support

CP Plans developed with Conferences – fully inclusive of parents and Young People

Children having their own Child Focused Plan

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Dad says he's 'full up' he hasn't got time for me – AH, 8 yrs

People see me running around, climbing on the furniture and hitting my sister a lot; I don't want to talk about how I feel – BF, 6 yrs

I hate it when mum won't get out of bed – I get really worried about her, I can't sleep properly – ST 11 yrs

I want daddy to brush my hair every day so I look like my friend B – TA, 7 yrs

I want to go to after school revision club, but I can't because I have collect my brother from school, mum doesn't hear the alarm on her phone – TT, 15 yrs

Daddy says his head hurts, he shouts a lot when it hurts – DM 5 yrs

When mummy feels poorly we don't go to school – BB 6 yrs

When I feel angry and upset I kick and bite people and slam doors really hard – EH, 4 yrs

Mum and dad forgot to take me to see the dentist, my tooth still hurts – AF, 9 yrs

Nanny helps mum and dad look after us when they are poorly – RP 11 yrs

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Thank you for listening.
Any questions?