DOCTOR OF PHILOSOPHY

Prevention of neglect: The development of a childcare skills programme for vulnerable parents of young children

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Award date:
2003

Awarding institution:
Queen's University Belfast

Link to publication

Chapter 1

Child Neglect

Introduction

In this chapter the historical context of neglect is set, followed by a discussion of the influences on definitions. Associated factors and outcomes of neglect will then be explored, followed by consideration of neglect within the framework of the child protection system. Finally assessment and intervention with families is addressed.

Child neglect continues to be the most prevalent form of child maltreatment, yet it has received less specific research attention than other forms of maltreatment (Zuravin, 1999). It is only in recent years that neglect has been seen as a phenomenon that needs to be conceptualised separately to other forms of abuse (Gershater-Molko, Lutzker & Sherman, 2002). No single agreed definition of neglect has been created; one possible reason for this is the lack of consensus about minimally adequate standards of childcare either within professional groups or in existing research (Rose & Meezan, 1996; Stone, 1998). No ultimate definition is likely to be reached until agreement is obtained about the responsibilities of parents and the accountability of society in cases of neglect (Gaudin, 1999; Stratton, 1988).

Historical Context

Although the history of child abuse and neglect is often seen to begin with the battered child syndrome of the 1960s, when the term 'abuse' was first used (Crittenden, 1988; Thorpe, 1994), child maltreatment is not a modern phenomenon. 'The further back in history one goes, the lower the level of child care, and the more likely children are to be killed, abandoned, beaten, terrorized, and sexually abused.' (deMause, 1991, p.1). DeMause (1991) paints a bleak picture of the history of childhood, stating that infanticide in Western society was only reduced in the Middle Ages and until the Nineteenth Century illegitimate children continued to be killed. Many childcare practices, such as the employment of wet nurses to feed children, tight swaddling of infants, or sending children from home at a young age, which would now be viewed as physically, emotionally or psychologically harmful for children were normal practice and seen as beneficial for children.

From Victorian times child protection activity in Britain increased, resulting in the formation of child protection societies and child care legislation (Corby, 1993). Thorpe (1994) reports

three distinct successive phases in the development of child protection practice; initially concern was focused on child labour and homeless children, then baby farming and more recently the care of children within families.

Neglect was first identified in relation to children who were living in poor environments or abandoned due to the effects of industrialisation, urbanisation and population growth. This resulted in poor housing, overcrowding, and poverty, and the abandonment of children when their parents could not afford to look after them (Corby, 1993; Swift, 1995).

Different types of abuse have been seen as concerning by the public and professionals at different times; 'in 1871 the concern was abuse by adoptive parents; in 1885 it was teenage prostitution; in 1908 incest; then later, neglect, physical abuse, sexual and emotional abuse' (Department of Health, 1995, p. 15).

Definitions of Neglect

What is defined as neglect will depend on the cultural and economic values of a given time, as well as beliefs about the rights of children, individuals and families (Department of Health, 1995). These beliefs and values subsequently shape legal and practice responses to cases of neglect (Bridge, 1995). Definitions of child abuse or neglect are 'legal constructs, not biological conditions, so definitions tend to change over time taking into account increasing knowledge about adequate parenting and developmental needs of children' (Mattaini, McGowan & Williams, 1996, p. 225).

Stevenson (1998) describes neglect as 'an administrative category covering a range of behaviours which are characterised by the omission of care' (p. 14) rather than being any unitary concept. Varying theoretical frameworks offering a range of definitions have limited progress in prevention, intervention and research in the area of neglect because it is difficult to compare findings due to a lack of consensus about what is defined as neglect (Dubowitz, Black, Starr, & Zuravin, 1993). This is further complicated by a lack of clarity about what constitutes acceptable standards of childcare and what the role of the state should be in enabling parents to maintain these standards.

Definitions are largely influenced by the purpose of the definition; for example legal definitions are deliberately vague to allow interpretation (Corby, 1993). A limited range of factors are included in legal definitions as this makes implementation more straightforward (Dubowitz et al., 1993). Definitions used by the legal system often point towards parental behaviour focusing on the parent's ability or inability to parent (Wolfe, 1999; Dubowitz et al., 1993).

The definition of neglect as outlined by the Children (NI) Order regulations and guidance (1996) is:

> 'The actual or likely persistent or significant neglect of a child or the failure to protect a child from exposure to any kind of danger, including cold or starvation, or persistent failure to carry out important aspects of care, resulting in the significant impairment of the child's health or development including non-organic failure to thrive.' (p. 6).

This definition is open to interpretation. No attempt is made to offer direction in defining neglect other than severe neglect which results in extreme harm to the child. The purpose of the definition is to enable professionals and the courts to make decisions about legal action, as opposed to a social work definition that enables professionals to decide what supports to offer. Professionals need to decide what constitutes significant impairment, and define the important aspects of care. These decisions are likely to be based on personal and community standards and take into account the resources available (Gaudin, 1993; Parton, 1995). The focus of this definition is on the failure to provide care, implying parental responsibility. Addressing neglect only in terms of parental failure, ignores the fact that neglect can also occur as a result of wider factors that may be harmful for children, for example poor housing, or inadequate or unsafe play facilities (Dubowitz et al., 1993). Stone (1998) suggests that working within broad parameters may prevent social workers from using appropriate legal action in neglect cases.

Gil (1970) offers a wider definition of child maltreatment:

> 'Any act of commission or omission by individuals, institutions, or society as a whole, and any conditions resulting from such acts or inaction, which deprive children of equal rights and liberties, and/or interfere with their optimal development, constitutes by definition, abusive or neglectful acts or conditions' (p.16).

This definition includes a wider range of factors, and suggests a more collective responsibility for child welfare, however no direction is given on which acts constitute neglect, nor does it attempt to tackle issues such as intentionality, remorse or family resources (Wolfe, 1999).

Child protection descriptions offer more specific definitions; for example, Wolfe (1999) describes neglect as: 'failure to provide for children's basic physical, educational, or emotional needs' (p.8). Each area can be further divided into subcategories of neglect. These may include:

- Failure, delay or refusal to provide: adequate physical and/or mental health care; adequate supervision; custody; a stable, safe and clean home; personal hygiene; adequate nutrition and education (Dubowitz et al., 1993).
- Failure to provide adequate clothing or incapacitation of the parent or caregiver (Nelson, Saunders & Landsman, 1993).

- Adults refusing to meet family needs, or allowing unsafe child behaviour to occur, for example not controlling a child's access to drugs or alcohol. Parents lacking knowledge of childcare (Wolfe, 1988)

- Adults displaying a disregard of a child's safety, for example driving while intoxicated, inattention to the child's emotional needs, exposure to domestic violence (Gaudin, 1993).

Within these subcategories dimensions such as severity, chronicity, and frequency also need to be considered (Crouch & Milner, 1993). One omission may be classed as neglect if it is likely to cause serious harm to a child, for example failure to seek emergency medical treatment. Another omission may not be neglectful if it does not happen very frequently, for example a child missing a single meal (Dubowitz et al., 1993).

The vast range of behaviours that can be included within subcategories coupled with consideration of frequency, severity and chronicity explains in part the difficulty in reaching a clear definition (Crouch & Milner, 1993). Zuravin (1999) states 'Because the … etiology and sequelae of different subtypes of neglect may differ, their classification should include conceptual and operational definitions of each subtype' (p. 28). No typical neglect case exists because of the potential range and combinations of behaviours involved, 'no simple litmus test will reveal the presence or absence of neglect' (Stone, 1998, p. 49).

Dubowitz et al. (1993) suggest that definitions of neglect should focus on the child's unmet needs, rather than blaming parents. They argue that as neglect is rarely intentional, and occurs mainly because of parental omission, intentionality does not need to be included in the definition of neglect. Macdonald (2001) however, argues that intentionality is important as parents should not be held responsible for aspects of childcare that are beyond their control.

The importance of including a developmental perspective on definitions of neglect is highlighted by Dubowitz (et al., 1993). Children's needs will depend on their developmental level, and for example, be greater in pre-school aged children who are more dependant on adults. Children's basic needs are defined as 'adequate shelter, food, healthcare, clothing, education, protection and nurturance' (Dubowitz et al., 1993 p. 12).

Glaser and Prior (2002) state that neglect should not be defined only in terms of the harm experienced by the child, as children may be experiencing difficulties which are not caused directly by maltreatment. Defining neglect only through evidence of harm to children could prevent early intervention, as professionals would not take action until harm had been demonstrated.

Variation in definition will impact on services available to children, and children remaining with their parents. The incidence of any type of abuse is directly linked to how broad a definition is used (Merrick, 1996), in other words, the higher the expected standards for childcare, the greater the number of parents who are likely to be below that standard. If too many children are classed as neglected then statutory agencies are unlikely to have the resources to respond.

Long Term and Recent Neglect

Some authors differentiate between recent and long term neglect, viewing the latter as much more severe, others in contrast, include only long term neglect in their definition. Nelson et al. (1993), for example, found that neglecting parents could be separated into recently and chronically neglecting groups; the former were seen as having had a recent crisis while the chronically neglecting group had multiple, long established problems. In contrast, Fitzgerald (1997) views neglect as 'something that is persistent and cumulative and occurs over time with little change, despite intervention' (p. 66), rather than merely being related to environmental factors, or lack of parental skills which can be alleviated by practical assistance. Stone (1998) also found that most neglect cases tended to have had long term involvement with Social Services. Although some agreement exists about the long term nature of neglect, the difference between chronic and recent neglect may be that recent neglect cases are in the initial stages of chronic neglect (Gaudin, 1993). The differentiation in British studies between families who are seen as in need as opposed to more serious child protection cases also reflects the difference between recent and chronic neglect (Fitzgerald, 1997).

Standards for Parenting

Problems in defining neglect exist because of difficulty in agreeing standards and norms; these are influenced by the differences in culture and class between professionals and parents in most cases (Corby, 1996). Professionals may be wary of imposing their own values on families, and have no set minimum standards from which to work (Walton, 1993). Neither the Children Order nor the UN Convention address standards, leaving them open to interpretation (Smith, 1991). Definitions need to reflect a combination of professional and community standards, and also be culturally sensitive. Garbarino and Collins, (1999) state that 'child maltreatment is a social judgement about the minimum standards of care' (p.11). These standards change according to current scientific, professional and public awareness about what is harmful for children (Garbarino & Collins, 1999).

Neglect and emotional abuse are seen as being particularly difficult to define in comparison with other forms of maltreatment, because of uncertainty about parenting standards.

Examples include lack of agreement about the age that a child can be left at home alone, or what level of intoxication leaves a parent unable to care for a child (Macleod, 1997). However a study by Dubowitz, Klockner, Starr and Black (1998) found that parents across three income groups had substantial agreement about neglectful situations which could harm young children.

Further research from the United States found a consistency in parents' beliefs about what should be reported as neglect in both rural and urban areas, parents in general had higher expectations than professionals (Craft & Staudt, 1991). Rose and Meezan (1996) found that agreement existed within three groups of mothers from differing cultural backgrounds about the severity of components of neglect. The mothers in all groups viewed the components of neglect as more serious than professionals did.

Middle class parents have been found to be more preoccupied with psychological aspects of their children's care, while working class mothers were more concerned with physical aspects (Dubowitz et al. 1998; Polansky, Chalmers, Williams, & Buttenwieser, 1981). This is likely to be related to the difficulties that mothers from lower socio-economic groups experience in providing basic care for their children because of their living environments. Professionals need to ensure that parents' values and priorities are understood when assessing parenting standards.

Birchall and Hallett (1995) found that different professional groups are likely to have differing thresholds in defining abuse. Agreement was reached within and between groups on the most severe cases, the cases in which there was the greatest dissension were those of neglect and emotional abuse. Social workers generally perceived cases as less severe than other professional groups.

Stone (1998) undertook a study with a group of professionals from a range of agencies of 20 cases on the Child Protection Register under the category of neglect. Professionals reached a consensus on physical and emotional neglect, mainly focusing on primary needs such as food, shelter and medical needs as well as emotional care. Although protection from harm and safety were identified as neglect issues, supervision of children did not receive the same attention. When looking at case scenarios, interagency agreement was reached more easily on cases that were classed as dangerous, than those that were considered safe. Professionals linked neglect with poverty, deprivation and other social factors.

Recognising neglect at its most extreme may be relatively straightforward, for example unhygienic living conditions, repeated infections, malnutrition, or failure to thrive. In particular failure to thrive is likely to have clear medical evidence through ongoing measurement of weight and growth. It is more difficult to reach agreement about less serious cases.

Differences in definitions do not necessarily reflect differing value judgements by professionals, other factors such as the caseload of workers and available resources influence professional judgement.

Stevenson (1998) states that no research on neglect has been carried out in the UK in relation to different cultural or ethnic groups. She suggests that social workers tend to focus on 'racism which causes suffering to children and families … rather than dwell on variations and subtleties of child rearing practices' (p. 37). The importance of knowledge about variations in childcare practice within cultural and ethnic groups is highlighted. Professionals must be able to differentiate between parenting practice that occurs because of cultural differences and childcare practice is unacceptable to any culture. Cultural practices need to be viewed within a continuum of those practices that could be deemed harmful, and those practices that benefit children. This can only happen when professionals work in close partnership with parents and community leaders to ensure a full understanding of the cultural background of the child (Karamoa, Lynch & Kinnair, 2002).

Korbin and Spilsbury (1999) also highlight the importance of taking cultural factors into account. They suggest that basic needs for survival, such as food and water are agreed across cultures, but beyond this there are likely to be cultural variations in child care practice. Examples given include the importance given to education across cultures, or cultural practices in relation to health care, or sibling caretaking practices.

Neglect and Other Forms of Abuse

Neglect differs from other forms of abuse because it is not always intentional or deliberate and may occur because of the parent's lack of knowledge about children's needs (Iwaniec, 1995). As neglect is not generally a crisis situation, professionals may not respond with the same urgency as they would with other forms of abuse. Neglect does not always fit in with the usual child protection procedures because it is not a specific incident to be investigated (Stone, 1998). The Bridge Childcare Consultancy (1995) contrast neglect with other forms of abuse as neglect depends on 'establishing the importance and collation of sometimes small, apparently undramatic single pieces of factual information which, when seen together, are of considerable significance' p.4.

Neglect is more difficult to define than physical abuse because it is not usually a single action, therefore intervention for neglect is likely to be a long term process rather than a single act of protection (Garbarino & Collins, 1999). When neglect occurs with other forms of abuse it may be overlooked or be viewed as less harmful (Kelly & Milner, 1996). Neglect may make children more vulnerable to other forms of abuse, and is often overlooked when it occurs alongside other types of abuse (Bridge, 1995).

Figures from the United States suggest that neglect occurs twice as often as other categories of abuse which are likely to receive more attention from professionals (Nelson, Sanders & Landsman, 1993). In spite of the frequency of occurrence, there is a shortage of research that addresses neglect specifically in comparison to other kinds of abuse (Stone, 1998; Crouch & Milner, 1993; Zuravin, 1999). Most current literature includes neglect as a form of abuse, rather than viewing it as a separate category of abuse.

In a review of 489 articles on child maltreatment, Zuravin (1999) reports that only 25 reported any findings on child neglect, and only two focused exclusively on neglect. Most researchers relied on official agency definitions; none reported on subtypes of neglect; seven used the researcher's own definition. Margolin (1990) calls for neglect to be researched separately from other abuse categories to establish what the differences are, so that policy and practice can be developed accordingly.

Explanations for Neglect

Differing theoretical perspectives focus on a range of explanations about the causes of abuse and neglect. Problems may arise in multidisciplinary work if professional groups are working with different theories (Bridge, 1995). Stone (1998) categorises approaches to neglect into two groups: 1) medical and psychological research, and 2) and socio-psychological studies. Medical and psychological research are said to have a common background theory of disease and pathology, as in the individual model discussed below. Socio-psychological theories are more likely to view neglect in the context of the parent-child relationship, and the impact of wider environmental factors.

Gough (1988) combines these approaches through differing levels of explanation for child abuse. These range from individual level, which includes factors in the parent such as personality, psychological state, and motivation to parent, and child factors such as temperament, and developmental issues. As the levels of explanation widen, more social factors are included, broadening to include family, community, and society. Each of these levels offers a range of explanations about the causes of abuse. Most child protection policy is suggested to operate from the individual or disease model, looking inward at aspects of family functioning and largely ignoring the wider social aspects of the problem (Stevenson, 1992). Individual ecological and social interactional models are explored in the following sections.

Individual Models

During the 1960s, explanations about the causes of abuse and neglect focused mainly on the individual medical model, viewing abusive and neglectful parents as deviant. This resulted in a division between abusive and non abusive parents, with abusive parents being

judged more harshly. The roots of child maltreatment were seen in the parents' psychiatric or pathological symptoms (Wolfe, 1991). The influence of psychoanalytical theories in social work led to more emphasis on the emotional qualities of parenting rather than any external stresses (Corby, 1993).

In cases of neglect, individual explanatory models have focused on the personality deficits of mothers. Two later examples of individual models of neglect are those proposed by Polansky and Crittenden. Polansky's (et al. 1981) research found that women who were likely to neglect their children had character disorders, classifications used included 'impulse-ridden' and 'apathetic-futile'. Neglectful mothers were viewed as having immature personalities because of their early deprivation.

Crittenden (1993) proposes an information processing perspective that focuses on individual cognitive processes of parents and the influence of these on parent-child interaction. There are said to be four stages at which parents can fail to respond to children's needs. These are a) that the parent does not perceive the child's signal; b) the parent interprets the infant's signal as not requiring a response; c) the parent recognises the signal, but cannot respond; and d) the parent knows how to respond but does not. Failure at any of these stages is said to result in different types of neglect, and require different forms of intervention. Crittenden does acknowledge the impact of environmental factors in cases of neglect, but suggests that these in themselves are not enough to explain neglect, 'knowledge of internal processes leading to the failure to respond may provide essential information regarding neglectful behavior' (Crittenden, 1993, p. 29).

Crittenden (1999) suggests that three forms of neglect exist a) disorganised neglect b) emotional neglect and c) depressed neglect. Disorganised neglect is present in crisis-ridden families who offer inconsistent parenting. Emotional neglect is identified where families can provide materially for their children but fail to connect emotionally. Depressed neglect occurs when parents are withdrawn and do not seem motivated to care for their children. Because of the suggested inability on the part of neglectful parents to process the information necessary for adequate childcare, parent education is suggested to be ineffective on this group of parents. Crittenden (1999) recommends that interventions should instead be long-term and nurturing for the parent.

Both Crittenden (1993) and Polansky (et al. 1981) view neglecting parents as different to other parents because of individual characteristics that influence how they parent. Although both acknowledge that wider factors impact on parenting, the emphasis is on internal processes. Limitations in accepting internal processes as causes of any behaviour will be explored further in section three.

Ecological Models

The limitations of single causal and theoretical models used to explain both child abuse and neglect led to the adoption of a broader and more complex ecological framework (Daro & Donelly, 2002). Ecological models focus on the interaction between a wide range of variables, 'forcing us to consider the concept of risk beyond the narrow confines of individual, personality and family dynamics' (Garbarino, 1993, p.7). Abuse is seen to occur as the result of forces within a system of four interactive systems, which are the individual, the family, the community, and culture. The essence of this model is the interaction of protective and risk factors, affecting which parents are likely to abuse. Exploring protective factors in non-abusive families can give an idea of how to improve child rearing practices within families. The focus is on children's unmet needs, rather than deficiencies in parents' behaviour and includes exploration of the wider factors that contribute to neglect (Langeland, & Dijkstra, 1995; Parton, 1995; Dubowitz et al. 1993).

Using explanations of neglect that include a wider range of factors may seem to remove parental responsibility (Dubowitz, et al., 1993), however, the use of an ecological model does acknowledge the role of parents, but also includes other factors which impact on parenting coming from the family and wider community. All levels of society share responsibility for neglect rather than trying to place the blame solely on individual parents. While recognising that in some extreme cases neglect may be deliberate and malicious, Dubowitz et al. (1993) suggest that in the majority of cases it is not. An ecological perspective leads to intervention targeted at the wide range of interactive factors associated with neglect.

Although an ecological viewpoint is useful in expanding the possible causes of abuse and neglect, it may be difficult to translate into intervention when working with individual families. When all possible factors at all levels are taken into consideration the results may be of unmanageable proportions (Sidebotham, 2001). One possible danger is that the answer to neglect is seen to be increasing the numbers of services available to families, rather than looking trying to engage the families who are most difficult to reach, who are in most need of services (Daro & Donelly, 2002). Wolfe (1991) suggests that ecological explanations for maltreatment should direct us towards long term policy changes 'rather than trying to patch together the casualties of such societal ills' (p. 25).

Social Interactional Model

Wolfe (1991) proposes a social-interactional perspective which combines individual and ecological models. In this model abuse and neglect are seen as disturbances of child rearing, where the balance between positive and negative aspects of parenting has not been achieved. Maltreatment is seen as 'a visible sign of serious problems in the parent-child relationship' (Wolfe, 1991, p 31). This relationship is seen as central to any explanation rather than solely focusing on either parental psychopathology, or individual external

stresses. Interaction between the parent and child is viewed in the context of the family, community and wider environment (Wolfe, 1991).

Factors Associated with Neglect

Factors found to be associated with neglect, include young children, lone parent families, teenage mothers, financial pressures, social isolation, deficiencies in child management skills, substance abuse, and child factors such as low birth weight and prematurity (Olds, 1997; Roberts, 1988; Corby, 1993). These characteristics are also associated with other families who do not neglect their children, and so cannot be seen as directly causing neglect. Belsky and Stratton (2002) suggest that factors be seen as contributory 'rather than determining agents' (p. 96). They also highlight the difficulties in trying to assess the impact of single contributory factors, and state that the presence of more than one factor may greatly increase the risk of maltreatment to the child.

Information generally comes retrospectively in cases where abuse or neglect features, and so does not give information about families who have succeeded in spite of these 'predisposing' factors (Roberts, 1988). Many studies focus on factors which make families vulnerable to child abuse and neglect, few studies look at which factors are protective (Macdonald & Roberts, 1995).

In this section a number of factors associated with neglect are described, these include the role of mothers, learning difficulties, child characteristics, social isolation and poverty.

The Role of Mothers

Research in Wales and Australia indicates that referrals to Social Services are most likely to involve single parent families, with a female as the main carer. These families are also the least likely to receive services (Thorpe, 1994). Child protection investigations often follow gender stereotyping, seeing mothers as carers and fathers as providers. Mothers are held responsible for any difficulties that the family may be facing in relation to parenting (Milner, 1995) while the role of the father is often overlooked (Turney, 2000).

Definitions of neglect are mainly based on the behaviour of the mother while 'themes of poverty and deprivation have taken second place' (Swift, 1995, p. 85). Placing children of vulnerable parents on the Child Protection Register because of concern about parenting standards rather than actual harm to the child, is likely to increase pressure on parents who are already facing many difficulties. These cases are often more suitable for family support rather than child protection services (Farmer, 1997).

Mothers who are classed as neglecting are unlikely to have a supportive relationship with a partner, and may also be subject to domestic violence (Stevenson, 1998). Savage, (1994)

found that relationship difficulties with partners were the most significant problem in a comparison between neglecting and non-neglecting families. Domestic violence occurs in between 40% and 50% of all cases involved in the child protection system (Cleaver, Unell & Aldgate, 1999).

Difficulties such as depression and marital problems that impact on parents' ability need to be taken into consideration in assessing families. The parents' ability to care for a child may be affected, and the child may learn negative social skills through observational learning, this learning can in turn be generalised by the child to other relationships and so cause further difficulties for the family (Cummings, 1997).

In a study of 20 neglecting families Stone (1998) found that substance abuse, mental illness and learning difficulties were present in approximately half of the cases. Savage (1994) also reports a high rate of alcohol abuse in a sample of neglecting parents. Stevenson (1998) suggests that substance abuse may also be a contributory factor in other forms of abuse, but that in neglect cases it is likely to be linked particularly with supervision issues. Parents who are under the influence of drugs or alcohol are less likely to be able to attend to the safety needs of their children. Parents may be emotionally or physically unavailable to their children because of heavy drug use. Children may be exposed to additional risks because of the unsafe storage of drugs, combined with poor levels of supervision (Tunnard, 2002).

Women who are mothers have been found to have a higher rate of mental illness than men. This is also linked to social class, possibly because of adverse living conditions such as unemployment and poverty. Parental mental illness and drug addiction may affect children in similar ways. For example depressed parents may be unavailable to their children, or have difficulty planning or organising their lives (Cleaver et al., 2001).

The presence of difficulties such as domestic violence, the use of alcohol or drugs or parental mental illness in isolation may not be predictive of negative outcomes for children. It is when these difficulties occur in combination and added to other factors, such as 'family disharmony' that children are at greatest risk (Cleaver et al., 2001).

Parents with Learning Difficulties

Since 1980 there has been an increase in literature on parents who have learning difficulties. This directly relates to increasing numbers of parents with learning difficulties who would previously not have been give the opportunity to care for their children, who are now living independently in the community (Feldman, 1994). Most of this literature is American or Canadian in origin. Booth and Booth (1993) report fewer than twenty British studies. Many of these families experience the same life stresses as other families where neglect occurs. Research findings about risk, outcomes and intervention methods with this group of parents

are therefore applicable to the wider population of families who are vulnerable to abuse and neglect (Greene, Norman, Searle, Daniels & Lubeck, 1995).

Although it is now accepted that many parents with learning difficulties can live independently when given the necessary supports, there are concerns that their children are at risk of neglect and developmental delay (Tymchuk, 1992; Tymchuk & Feldman, 1991; Glaun & Brown, 1999). This may be partly because these parents come under closer scrutiny than other parents by child protection agencies 'even common accidents and illness may be interpreted by child protection workers as indicative of parental incompetency' (Tymchuk & Feldman, 1991, p. 487). Professionals may have low expectations of these parents, and therefore focus entirely on difficulties, rather than building on existing strengths.

Parents with learning difficulties are likely to experience low rates of formal education, unemployment, poverty, low self esteem, few supports, few resources and transient living conditions (Tymchuk, 1992; Tymchuk & Feldman, 1991). Those parents with learning difficulties who come to the attention of child protection agencies are likely to have few family supports; lack stability in family circumstances; lack normal childhood experiences and have difficulties in their relationships with professionals (Glaun & Brown, 1999).

A study by Feldman, Léger and Walton-Allen (1997) found that mothers with learning difficulties suffered clinically significant levels of stress, and that this increased for parents with older children. Maternal stress is thought to be associated with a range of parenting difficulties, which may include lack of warmth towards children and more general problems in parent-child interaction (Feldman, Varghese, Ramsay & Rajska, 2002).

Existing research is not seen to be representative of all parents with learning difficulties as it is generally based on populations who have been referred to child protection services because of concerns about childcare issues. Research therefore, is only representative of parents who have experienced difficult life circumstances in addition to having learning difficulties (Booth & Booth, 1993; Llewellyn, 1994). It is difficult to ascertain which difficulties arise as a result of learning difficulties, and which result from other stresses.

Factors that can impact on parental competency include the number of children living in the home, the availability of social support, and levels of parental stress (Tymchuk & Andron 1990; Llewellyn, 1994). Other suggested reasons for difficulties in parenting are lack of social and relationship skills; and lack of childcare skills because of limited access to good models of parenting. This is particularly relevant if a parent has been raised outside the home in a school or institution (McGaw & Sturmey, 1994). Although all of these factors affect parenting ability, they are often over-looked, with the mother's learning difficulties being seen as solely responsible for parenting difficulties (Llewellyn, 1994).

Tymchuk (1992) reports that an IQ of below 60 can be predictive of inability to parent, however 'the best predictor appears to be the absence of suitable social or familial supports who can help prevent neglect conditions' (Tymchuk, 1992, p. 168). In a study of 30 adult children of parents with learning difficulties, Booth and Booth (1997) found that support networks were more important than parental skills; this was similar to the experiences of children of parents without learning difficulties.   Other potential predictors of parenting problems are the length of time difficulties have existed; having more than one child; maternal depression; and a partner with medical or emotional problems (Tymchuk, 1992).

IQ scores should not be seen in isolation as accurate predictors of parenting capacity. IQ needs to be considered alongside parental behaviour. This should be done on an individual basis, because of the many variations in circumstances, which 'show more similarities than differences with other ordinary families from the same social background, and the problems they encounter or present tend to mirror those of other 'at risk' groups' (Booth & Booth, 1993 p. 476).

Children

Children may be more vulnerable to abuse or neglect because of a combination of factors including prematurity, illness, disability, or being unwanted. The presence of one risk factor increases the likelihood of others (Newman, 2002). Reder and Duncan (2002) suggest that children who are unwanted are at increased risk of fatal abuse or neglect. Abuse or neglect may be more likely if characteristics as described above are present in a family that is already under pressure (Roberts, 1988; Iwaniec, 1995; Dubowitz, 1999). Age and gender are also linked to vulnerability; children are at more risk of neglect during their first year of life. Official statistics of children on the Child Protection Register in England suggest that boys are marginally more at risk of both physical abuse and neglect than females (Corby, 1993). This is also reflected in Northern Irish child protection statistics (Switzer, 1997).

A recent English study compared 115 children on the Child Protection Register with 14,105 non registered children to establish characteristics of children that might be linked to maltreatment (Sidebotham & Heron, 2003). Children were aged less than three years. Results suggested that children who are maltreated differed from other children in some areas. Maltreated children were more likely to have low birth weight, health problems, and developmental difficulties. Although behavioural problems including feeding problems and temper tantrums were present in the maltreating group, these factors were not strongly related to maltreatment. Mothers in the maltreating sample were less likely to recognise positive attributes in their children.

Child Resilience

When exploring factors that make children vulnerable to neglect it is also necessary to look what makes some children more able to survive adversity. This does not mean that the presence of such factors make children invulnerable, 'past a certain threshold of increasing adversity, any child is likely to buckle and succumb to the pressure' (Gilligan, 2001, p.7). Although it may not be possible to change or remove all negative aspects of a child's life, adding what are known to be positive factors may balance out some of the negative effects (Gilligan, 2001).

In young children individual characteristics that can promote resilience include having an easy temperament, being female and being attractive to others. Protective factors for young children in the family and wider environment include having warm supportive parents, good quality housing, adequate financial resources and support from extended family or a close relationship with a trusted adult (Newman, 2002). Children who are neglected are unlikely to have many of these supportive factors in their lives.

Children of Parents with Learning Difficulties

Children of parents with learning difficulties have been found to be at increased risk of developmental delay (Tymchuk, 1992). Research by Feldman and Walton-Allen (1997) separated the effects on children of having a parent with learning difficulties from the effects of living in poverty. The study included children of 54 parents, all of whom were living in poverty, half of whom had learning difficulties. All of the children of parents with learning difficulties had lower IQ scores, lower levels of academic achievement and higher rates of behaviour problems than the children in group whose parents did not have learning difficulties. The group with learning difficulties were found to be more socially isolated and had less stimulating home environments than the comparison group. This study concludes that being raised by a parent with learning difficulties has an effect on child development, beyond the effects of living in poverty.

A more recent study (Keltner, Wise & Taylor, 1999) also found an increased risk of developmental delay for children of parents with learning difficulties. A comparison of 38 mothers with learning difficulties with 32 mothers without learning difficulties, who were matched for income, age, race and number of pregnancies, showed that 42% of children of the mothers with learning difficulties were cognitively delayed, compared with 12% of children in the comparison group.

A study of 12 families where the mother had learning difficulties from a court sample in Australia, found that 47% of children were classed as developmentally delayed, a further 12% had been diagnosed as having a psychiatric disorder (Glaun & Brown, 1999).

Dowdney and Skuse (1993) draw attention to the lack of investigation on the impact of child characteristics on the parent's ability, if the parent has learning difficulties. The age, health and temperament of the child and having more than one child are all areas of potential stress for any parent and may increase the need for support (Gath, 1995). A common stress factor experienced by neglectful families and parents with learning difficulties is social isolation. This can result in children being stigmatised within their communities (Polansky, Gaudin, Ammons & Davis, 1985).

Social Isolation

Social isolation is seen to be a contributory factor in child maltreatment. It is unclear whether this is as a result of parents perceiving social contacts as aversive, or if parents become socially isolated because of other difficulties, for example being rejected by others because they unable to provide adequate parenting.

It appears that neglecting parents may view social interaction differently to other parents. For example, Beeman (1997) undertook in a study of 9 neglecting mothers and a comparison group of 10 non-neglecting mothers. Both groups were African American, low-income and single. Findings indicate that although the neglecting group of mothers placed higher demands on others for support, they were generally dissatisfied about the amount of help they received. The non neglecting group in contrast believed it was important to be independent, and that help should be mutual. Beeman concludes that it is the perceived quality of social support that is important, rather than availability.

Coohey's (1996) study of social isolation reports similar findings. 'Maltreating' mothers perceived their support networks to be less responsive. Neglecting mothers in particular were found to have fewer emotional supports. Although mothers of neglected children did have the same opportunity to have contact with their own mothers as a control group, this relationship was viewed negatively by mothers in the sample group. Relationships with partners were less stable than those in the comparison sample.

A study undertaken by Feldman (Feldman et al., 2002) with thirty mothers with learning difficulties found that mothers suffered from high levels of stress, which were linked to social isolation. This study reports a correlation between mother's positive perceptions of their support networks and positive parenting behaviours. As stress is also a potential antecedent to child maltreatment in parents who do not have learning difficulties, it is clearly necessary

to look beyond any cognitive limitations of parents to ascertain reasons for parenting difficulties (Booth & Booth, 1993; Dowdney & Skuse, 1993; Tymchuk, 1992).

Briere (1997) suggests that neglected children may not develop social skills because of the lack of opportunity to develop interactive skills in the home, or that children may learn to avoid social contact if violence is present in the home. A parent who has not had the opportunity to develop positive relationship skills while growing up may transfer this learning to relationships with their own children and other adults.

Polansky (et al., 1985) interviewed 152 neglectful mothers and a group of 154 non-neglectful mothers who were matched on race, economic status and other life circumstances. Polansky reports that parents' perceptions of help available differed between a group of neglecting mothers and a matched control group, even though supports were available for parents. The parents in the neglect group viewed available supports more negatively than the parents in the control group. Polansky found that 'average' families were likely to distance themselves from neglectful families (et al., 1985). The study concludes that neglecting parents were likely to be isolated and rejected within their community, and had negative views of the support networks that were available.

Social isolation may not therefore be directly linked to the availability of supports. Other factors need to be considered including the mother's social skills and the appropriateness of available supports. This will be explored further in a behavioural context in Chapter Three.

Neglect and Poverty

In the UK child poverty has continued to increase. The number of children living in households with less than half the average income has grown from 10% to 32 % between 1972 and 1992 (Utting, 1995). Since the mid 1990s there has been a reduction of the percentage of children dependent on Income Support, however in 2001, 24% of all children in the UK continue to rely on this source of income. In some areas in Northern Ireland, for example North and West Belfast this figure rises as high as 47% of children (DHSSPS, 2003).

Poverty results in immediate and long term difficulties. In the short term, poverty is likely to result in inadequate diets, poor health, and debt; longer term effects include lower educational achievements, an increased risk of serious illness, and a greater chance of delinquency (Holman, 1994; Roberts, 1997). Changes in Social Security entitlements have exacerbated this problem. In particular, the move towards loans rather than grants has resulted in families going into debt to obtain essential items. Gaudin (1999) suggests that

families lacking the resources to provide for the basic needs of children are suffering from societal neglect.

Children living in poverty have more health risks than other children. They are at a greater danger of being born prematurely and having low birth weight, which increases the chances of mortality during the neonatal period. The increased risk to health continues through childhood into adulthood (Roberts, 2000).

Although a correlation between poverty and neglect exists, this does not establish poverty as a cause of neglect. Poverty is not a single variable, but a set of inter-linked circumstances. Poverty does not only effect material resources, it is also likely to effect other areas of family life including housing, living and working environment, status and power, education, health services and access to leisure (Baldwin & Spencer, 1993). Poverty may impact on child health, for example through greater exposure to environmental dangers, and poor diet (Dubowitz, 1999).

Parents who are seen to be neglecting are likely to be from the poorest sections of society, including women, single parents, and families from minority ethnic groups. All of these groups face discrimination which impacts on income and life chances (Thompson, 1997). Poverty attracts the attention of authorities. For example, parents who regularly ask for financial assistance from Social Services are likely to have their parenting practices more closely scrutinised (Hay & Jones, 1991). Financial hardship impacts on parents' ability to provide for their children, and may also cause chronic stress, which is associated with the likelihood of depression which is in turn said to be associated with child neglect (Minty & Pattinson, 1994).

Professionals may be prevented from recognising physical and emotional neglect because of the belief that poverty is the cause of neglect, and see increasing services and resources as the solution. Fitzgerald (1997) suggests that this belief may cause families which he describes as 'emotionally impoverished' to be overlooked. These parents are seen by Fitzgerald to be unable to parent their children even with material support. Although neglectful families often have multiple problems and live in severely deprived areas, not all parents living in these circumstances neglect their children. Seeing material deprivation as a direct cause of neglect is clearly discriminatory towards those parents who live in poverty and do not neglect their children. It is important to consider the personal as well as wider social factors in attempting to establish causes of neglect (Stevenson, 1992, Gough, 1994).

The Effects of Neglect

Research is not always clear about the effects of neglect because of inconsistency in defining neglect. Some studies fail to differentiate between neglect and other forms of abuse

and many studies are based on small samples (Gaudin, 1999). It is difficult to compare outcomes because of the use of a range of definitions, which differ in the severity of the neglect included, and vary in the attention which is given to other factors (Parton, 1995). It is also difficult to separate the effects of neglect from the effects of poverty and social deprivation (Parton, 1995). In the following section a number of effects are discussed, including physical and developmental effects, emotional and psychological effects, and long term effects.

Physical and Developmental Effects

Neglect, depending on the level of severity, is likely to have some immediate effects on the child's physical health, for example: repeated accidents from lack of supervision; repeated infections due to unhygienic living conditions; preventable illness such as severe nappy rash that has not received medical attention. Children may receive poor dental care, have dirty appearances and be infested with lice (Hobbs & Wynne, 2002). A neglected child may be viewed as unattractive because they are unkempt or dirty, which can lead to rejection by peers, and so contribute to social isolation and difficulties in relationships. Neglected children are likely to experience global developmental delay, particularly in the areas of language and social skills (Hobbs & Wynne, 2002). Language delay may be due to a lack of stimulation (Savage, 1994). In exploring the effects of neglect on young children Stevenson (1998) stresses the importance of detailed observation of the child in the family context to ensure that a child is not mistakenly seen to be contented or placid rather than withdrawn.

While any family may fail to meet the needs of a child at some time, it is the cumulative effects of failure to care for a child which make it significant and harmful to the child (Bridge, 1995). The potential harm to the child also needs to be considered, children may die as a result of a single incidence of neglect, for example a young child left unsupervised in the bath, or a young baby who is dehydrated.

Crouch & Milner (1993) suggest that the effects of neglect can begin before birth, for example a child being exposed prenatally to drugs, tobacco or alcohol. This may result in low birth weight, a risk factor for developmental problems. It is difficult to establish which developmental problems are associated with substance exposure prenatally, and which can be attributed to the life styles and child rearing problems of parents who use substances (Chasnoff & Lowder, 1999).

'The age and developmental stage at which the neglect occurs are critical determinants of its effects on the child' (Gaudin, 1999, p. 93). Children at different stages have different needs, for example an infant is more dependent on adults for feeding and supervision than an older child.

Fatal Child Neglect

Hobbs et al. (1993) suggest that many child deaths recorded as due to other causes could be due to neglect, for example children dying from preventable diseases because they have not had routine immunisations. The main causes of child deaths include natural causes, non-inflicted injuries, homicide and suicide. These categories can include death from neglect, for example death due to injury or poisoning may be as a result of inadequate supervision (Bonner, Crowe & Logue, 1999).

In a study of 34 deaths in the US, which were attributed to neglect, Margolin (1990) reports that the majority happened in the child's own home, mainly because this is where young children spend most time. Drowning, scalding, house fires, ingestion, choking and failure to follow medical instructions caused child fatalities. One of the main risk factors for fatal child neglect was the child's age; younger children were more likely to be fatally injured than older children. Gender was also found to be a risk factor, the number of boys exceeded girls by two to one. Difficulties in predicting such fatalities exist because these deaths occurred as a result of single incidents, rather than long term neglect. Only 39% of the families in the study were previously known to Social Services.

US studies suggest that neglect is reported twice as often as other forms of child maltreatment, and that neglect is responsible for 44.3% of child maltreatment deaths (Nelson et al. 1993).

In a review of fatal house fires in Scotland over a ten year period, Squires and Busuttil (1995) found that children under one year old were at the greatest risk. As almost one third of all fires were started by children playing with matches or other flammable objects, poor supervision was a contributory factor.

Accidental Injury

Children in families who are most vulnerable to neglect are also most likely to experience accidental injury in the home. Parents who are experiencing a high number of stresses are less likely to be attentive to their children's safety needs. Accidental childhood injury has been found to be more likely in areas of high social deprivation (NISRA, 2000).

A review of the causes of home accidents over a ten year period, of 481 children attending the Accident and Emergency department of the Central Middlesex Hospital found that accidents were most common in children aged one to two years, and were more likely to happen to boys (56.5%) than girls (43.5%). The most frequent cause of injuries were falls (41%), poisoning (15.7%), cuts or lacerations (13.4%), burns and scalds (12.2%), forceful contact between the body and a hard object (10.2%) and the introduction of foreign bodies into noses or ears (7.5%) (Alwash & McCarthy, 1987).

In Northern Ireland 41.4% of all accidents happen in the home, 19.5% involve children below five years old. The most common form of accident for this age group are scalding or poisoning (NISRA, 2000). These data are based on hospital statistics only and exclude data from GPs, dentists, or accidents treated at home and are likely to underestimate the rates of child injury through accidents in the home.

Death due to childhood injury is up to five times more likely in areas with high rates of social deprivation, in comparison to other areas (Roberts & Power, 1996). This is not necessarily because parents living in poverty lack awareness of potential risks to their children, they may not be able to afford safety equipment (Woods, Kendrick & Rushton, 1994). As one mother in Glasgow stated 'Because I do not have safety equipment for my child does not mean that I need to be educated in the fact that such equipment exists… I simply do not have the money to purchase it' (Rice, Roberts, Smith & Bryce, 1994, p. 7).

Lone parenthood has been strongly associated with risk of childhood injury. Roberts and Pless (1995) suggest that this is explained by the high rates of poverty, poor housing and social isolation experienced by lone parents. The link between poverty and childhood injury has been found to be strongest for traffic accidents. This is explained by the increased number of roads to be crossed by families living on the lowest levels of income. Children in these families have to cross 50% more roads than families in the highest income bracket (Roberts & Pless, 1995).

Lone parents are over represented in families living in substandard or temporary housing. These types of housing pose increased risks to children because of unfenced play areas, lack of smoke alarms and risk of fire (Roberts & Pless, 1995). For example in one housing estate in Glasgow parents had to raise children in homes with 'open verandas, live sockets, easily opened windows and fungi on the walls' (Rice et al. 1994 p.6).

The provision of social support has been shown to reduce the frequency of injury to children, however, the reasons for this are unclear. One reason may be that the presence of social support improves psychological health. The reverse is known to be true; lack of support is a risk factor for depression (Roberts & Pless, 1995).

While some accidental injuries to children can be directly attributed to parental neglect, it is clear that others happen as a result of poor living environments, and it is unfair to hold parents responsible for environmental risks over which they have limited control. Many environmental risk factors need to be addressed at an institutional level (Roberts, 2000).

Emotional and Psychological Effects

Neglect has a negative impact on children's psychological and emotional development. Difficulties may include low self-esteem, difficulty in trusting others, poor school performance, and problems in interacting with peers due to difficulties in emotional and physical development (Parton, 1995). Crittenden (1988) found that neglected children were likely to be very passive, disorganised, easily distracted, and to have learned to ignore adults. In addition they were found to be cognitively delayed, this increased with age. Dubowitz (et al. 1993) report negativity and unhappiness in neglected children, even when compared to children who have experienced other forms of abuse. This affects children's ability to relate to other children and adults. In general it appears that the longer a child is neglected, the worse the outcome in relation to emotional and social development (Hobbs, Hanks & Wynne, 1993).

The Minnesota Mother-Child Project, a longitudinal study following the development of 267 children of first-time mothers, deemed to be at risk of parenting problems found that emotional neglect, or psychologically unavailable parenting, was the most serious form of maltreatment in terms of long term consequences for children. Children who experienced emotional neglect were found to have attachment problems, displaying 'anger, non-compliance, lack of persistence, and little positive affect' (Erickson & Egeland, 1996 p. 12).

Long Term Effects
In the long term, children who have suffered neglect may have difficulty parenting, and sustaining relationships (Bridge, 1995). A tenuous link exists between child neglect and mental illness, substance abuse, and delinquency (Parton, 1995). Gaudin (1999) suggests that intergenerational transmission of neglect occurs only in a minority of chronically neglecting families. Egeland, Bosquet and Levy Chung (2002) disagree and report that although 40% of parents who had been maltreated also maltreated their children, 70% of parents who had experience abuse or neglect could be classed as having significant parenting problems.

Influences on Definition and Practice

A number of events have impacted on Social Work in the UK over the last ten years. These will be explored in this section. Included are the findings of inquiries into the deaths of children caused by maltreatment, changes in childcare legislation, and the operation of the Child Protection Register. Other events addressed are the expectation that social work is evidence based, and the publication of Messages from Research (Department of Health, 1995).

Inquiries
During the years 1972-1989 there were thirty-nine inquiries into the deaths of children caused by abuse and neglect. Less support for preventative social work followed inquiries,

beginning in 1973 with the inquiry into the death of Maria Colwell (Parton, 1995). Inadequate information sharing was identified as a factor that contributed to Maria's death. Poor interagency communication has also been highlighted as a difficulty in later inquiry reports (Hill, 1999). These cases have had a high media profile, raising public awareness, and causing anger that abuse occurs (Reder, Duncan & Grey 1993).

Recommendations drawn up following inquiries have caused changes to legislation and practice and form the basis for the current child protection system (Corby, 1993; Farmer, 1997). Changes have included strengthening the role of social workers in child protection and increases in multi agency and multi disciplinary intervention to focus on children's needs and assess potential risk in families (Bridge, 1995). Other recommendations have included the need for accurate recording and ensuring that workers are suitably experienced and supervised (Corby, 1993; Department of Health, 1991).

Recommendations from inquiries have been criticised for ignoring the impact of issues such as deprivation and poverty on children's lives (Department of Health, 1991; Frost & Stein, 1989). Merrick (1996) states that the purpose of inquiries is to look at the law and policies, not wider resource implications. There is said to be an assumption that further deaths can be prevented by measures such as changes in the law, and improved training, rather than tackling the problem of insufficient resources (Fox Harding 1991).

Kelly and Milner (1996) suggest that in spite of the implementation of procedural systems child deaths have remained at the same rate. This is disputed by Corby (1993) who states that there has been a reduction in the number of child deaths, but urges caution in interpreting the figures as a definite trend because the numbers are small. Inquiries have focused on the most extreme cases of child abuse and neglect, rather than the more typical cases that form the caseload of family and childcare social workers. The emphasis on cases that have gone wrong is said to have lead to practice that is more concerned with defensive action than what is right for the child (Parton, 1997).

Social workers have been criticised for failing to recognise serious neglect in many inquires including Maria Colwell, Jasmine Beckford, Kimberly Carlisle, Darryn Clarke and Heidi Koseda. All of these reports indicated that the children were suffering from significant neglect alongside other forms of abuse; however, this was not given the same attention by social workers (Minty & Pattinson, 1994).

The inquiry into the death of Paul by The Bridge Child Care Consultancy (1995) is the first report where neglect was the cause of death, rather than a combination of forms of abuse. Paul was an eighteen-month-old child who died as a result of severe neglect. The family was known to Social Services for many years, and although difficulties in the family were

recognised, the family was offered ongoing material support, rather than being treated as a child protection case. The outcome of this inquiry criticises interagency communication, and workers failing to recognise the signs of neglect. One of the key recommendations was that further guidance is needed on ways of quantifying neglect.

The outcome of many inquiries was to create a climate where professionals are expected to take a more punitive approach to child protection, directing social work attention to investigating allegations of physical and sexual abuse while paying less attention to concerns about neglect (Langan, 1996). There is a need to balance attention more evenly between less serious cases and the extreme end of child maltreatment (Gibbons & Bell, 1994). The focus on extreme cases may prevent resources being allocated to the much greater numbers of children who are in need preventative services.

Messages from Research

Messages from Research (Department of Health, 1995) summarises a series of research reports commissioned by the British Government as a response to the gaps in social work knowledge highlighted by the Cleveland and other inquiries. Social workers lacked knowledge about defining and diagnosing child maltreatment; the responses of child protection agencies to abuse; and effective forms of intervention.

This document has attempted to influence social worker's conceptualisation of child maltreatment. Although neglect does not receive specific attention, a broad definition of child abuse that includes neglect is offered. Abuse is defined in the context of normal childhood experiences and normal parenting behaviour. It stresses that there is no absolute definition; incidents need to be looked at in context of the child's needs, against what happens in ordinary families. It is the chronicity and severity of the behaviour that defines maltreatment, rather than seeing parental behaviour as divided into any distinct categories of adequate parenting or maltreatment. Abuse is best viewed as part of a continuum of parenting behaviour normally encountered by children, which in certain situations could be harmful for children. For example, many parents shout at their children, this could be seen as normal behaviour within families, or might be evidence that the child is being emotionally abused if it is excessive, or the child is too young to understand. Parenting styles are said to have a negative impact if they are low warmth and high criticism, rather than specific single incidents of abuse.

Abuse is defined in terms of thresholds, which helps workers to decide at which point behaviour can be viewed as abusive, and when professionals need to intervene. These thresholds are thought to be the most important part of a definition of child abuse and neglect. The amount of abuse in society dictates where the threshold is drawn, what is judged to be abusive may change over time, even if parenting behaviour does not.

There are currently three distinct thresholds that require action by social workers. The first is where concerns lead to a child being identified as in need, the second is when a protection plan is needed through the Child Protection Register, and the third threshold is when legal proceedings possibly leading to the removal of a child are required (Stevenson, 1998).

The influences on deciding the threshold that defines maltreatment are; moral influences about what is socially tolerable; legal influences that give a framework for professional practice; professional concerns, outcome evidence about what is harmful for children, as well as the concerns of parents and children. Definitions of maltreatment often reflect one of these influences more strongly than others. It is important to ensure that definitions are not made against the latest moral panic, rather than clear thinking and consideration of all standpoints (Little, 1997). Moral panic, for example, can result in the threshold being moved so that large numbers of children are drawn into the child protection process. An example given was the outcome of the Cleveland Inquiry in 1987, which resulted in pressure in opposing directions. On the one hand, there were suggestions that the threshold should be reduced so that professionals could intervene with more children, and at the same time there were criticisms that professionals were being heavy handed, and suggestions that the threshold should be increased (Department of Health, 1995).

Legal Issues

Childcare legislation is said to balance the tensions between two discourses; treatment and punishment (Merrick, 1996). This is also reflected in the concepts of prevention of child abuse and protection of children. Prevention emphasises that children are best looked after within their own family while other alternatives are seen as a last resort. Fox Harding, (1991) describes this as the 'pro-birth' family stance. The role of the state is to provide services to support parents and prevent admissions to care. Poor parenting is seen as the result of social deprivation rather than individual factors. The focus is on the family unit rather than the child as an individual. Where there are tragic consequences as a result of the above stance, legal changes are likely to place more emphasis on protection at the expense of treatment (Merrick, 1996).

Protection, described by Fox Harding (1991) as 'state paternalism' is said to favour intervention to protect the child from inadequate care, using legal powers where necessary. The state is seen as classless and able to impose its own standards of childcare. The justification for state paternalism or protection is the avoidance of children being killed by their parents. As this happens rarely social workers only need to take this stance in exceptional circumstances.

The Children Act 1989, and in Northern Ireland, the Children Order 1995, attempts to balance prevention and protection (Fox Harding, 1991). Responsibility for protecting children is placed with parents, when this is not possible the state has a duty intervene. It aims to balance unnecessary intrusion with the protection of children. The emphasis is on keeping children within their families where possible (Barker, 1996). The term 'in need' has been introduced by the Children Order to define children who need support services to ensure adequate health and development (DHSS, 1999). The local authority has a duty to identify and provide services to children who are classed as in need.

Neglect and Child Protection

Child protection practice in the UK has evolved from recommendations of the many public inquiries into the deaths of children from maltreatment. This has resulted in a system which has a 'plethora of government guidelines and training packages' (Kelly & Milner, 1996, p. 91). Parton (1995) suggests as the many procedures that underpin child protection practice have become 'complex, detailed and wide-ranging, the chances of making a procedural mistake are ironically increased' p13.

Child Protection Registers are intended to reflect a central record of those children in need of an inter-agency protection plan (Gibbons & Bell, 1994). The names of children who have been harmed or are considered to be at risk of harm are entered on the register. Professionals must review care plans at a minimum of six monthly intervals. Registers are used to 'document, gatekeep and regulate intervention into children's lives' (Walton, 1993, p. 145).

While the child protection system is reported to ensure the physical safety of most of the children on the Child Protection Register, it overlooks the wider needs of children and their families (Farmer, 1997). 'Child protection in Britain is said to focus on punishing abusive behaviour, rather than addressing the wider issues associated with abuse and neglect (Boushel, 1994). For example, observations of 120 case conferences by Farmer and Owen (1995) found the preoccupation with risk assessment meant that little attention was given to the broader needs of the family.

Child Protection Registers reflect only the most extreme cases, and are therefore not reliable sources of statistics in relation to prevalence, nor are any changes on the registers necessarily indicative of changes in parents' behaviour. The total number of children in England whose names are placed on the Child Protection Register each year each is estimated to be 24,500 (Department of Health, 1995), while in contrast, the numbers of children who contact the telephone counselling service Childline are estimated to be over 3.5 million per year (Jack, 1997). This indicates that a much higher number of children are experiencing difficulties than Child Protection Registers would indicate. Cases known to

Social Services make up only a small portion of children who are living in difficult circumstances and may be experiencing neglect (Jack, 1997).

Neglect continues to be the single largest category of children on the Child Protection Register in Northern Ireland (Switzer, 1997; DHSS, 1999). Recent figures indicate that in Northern Ireland 47% of all registrations are under the category of neglect. The other categories were physical abuse 36%, sexual abuse 15%, and 13% emotional abuse (DHSSPS, 2003). In England over 50% of all children registered are under the category of neglect (Creighton, 2002). Throughout the UK, neglect is the fastest growing single category, and also present in other categories of abuse, yet receives less professional attention and fewer resources (Parton, 1995).

In the United States the percentage of children reported for sexual abuse declined from 17% in 1990 to 10% in 2000. Similarly, the percentage reported for physically abused declined from 27% to 19% over the same period. In contrast, the percentage of children reported for neglect increased from 49% in 1990 to 60% in 2000 (U.S. Department of Health and Human Services, 2002).

Gibbons, Conroy and Bell's (1995) study of referrals in eight local authorities found wide variations in the numbers of children's names entered on the Child Protection Registers in different areas. Factors that influenced which children in each area were placed on the register included available resources, the severity of social deprivation, the working relationship between professionals, and cultural differences that impact on how and when cases are reported.

Findings show that only 15% of all cases referred to social services were eventually placed on the Child Protection Register. Large numbers of children were therefore unnecessarily caught up in the system causing less thorough investigations, and attention to be diverted from the most serious cases. Sixty five percent of cases referred to social services because of neglect received no extra supports or protective action. Only 7% of referrals for neglect were placed on the register. Gibbons (1997) suggests raising the threshold for entry into the child protection system would 'result in fewer families being caught up in the early stages of child protection procedures; less strain on provisions intended for those in serious danger; and less pain for parents struggling to rear children in difficult circumstances' p. 90.

Many neglect cases would be better conceptualised in terms of family support as 'the legalistic, policing, investigatory response is inappropriate for the vast majority of cases referred for neglect' (Parton, 1995, p. 86). Addressing the wider problems known to be associated with neglect would be more appropriate than bringing families unnecessarily into the child protection system (Beresford & Croft, 1997). The split between child protection

services and other services to children is said to occur because child protection only considers individual aspects of the problem rather than looking at the wider social aspects (Stevenson 1992).

Fitzgerald (1997) raises concerns, however, that if neglectful families were seen as in need rather than at risk, the procedures and structures for interagency communication and investigation do not exist to the same extent and children who are in need of protection because of severe neglect could be overlooked.

Katz (1997) suggests that family support and child protection are not incompatible, but should both be part of services to children. Families may be more willing to accept support if it is offered in a non-stigmatising way. The move to family support rather than protection is argued to be based on moral grounds rather than based on empirical evidence of better outcomes. It is ethically better to focus on families in need, rather than labelling families as abusive or neglectful.

Minimisation of Neglect by Social Workers

Social workers may underestimate the potential impact of serious neglect on a child, because they do not fully understand the nature of it. No social work theory of neglect exists to guide social work practice; theories tend to come from other disciplines, for example psychology, psychiatry or medicine (Stone, 1998). Tanner and Turney (2003) state that it is only recently that an expectation of practice based on research has been placed on practitioners, and that previously social workers worked with neglect without any clear framework.

The necessity of showing evidence in court that neglect is likely to cause long term harm to a child may dissuade social workers from pursuing legal action (Minty & Pattinson, 1994; Stevenson, 1998). Neglect needs to be demonstrated over a period of time, as 'a long term developmental issue rather than a short term crisis' (Stone, 1998, p. 5). Because of the long term nature of neglect cases, rather than specific incidents, neglecting families may be allowed to drift without a full assessment being undertaken (Department of Health, 1988; Tanner & Turney, 2003).

Fitzgerald (1997) suggests a factor that prevents professionals from recognising neglect is 'a belief that children do not die from neglect in the 1990s' (p.67), he argues that the inquiry report into the death of Paul shows that this is clearly not the case. Fitzgerald also highlights the long-term negative effects on children of living in neglectful families.

Fitzgerald (1997) suggests that social workers involved with neglecting families often empathise with parents because of the parents' own vulnerability, seeing even minimal

amounts of progress as evidence of improvement. Tanner and Turney (2003) further suggest that as neglect occurs on a long term basis, social workers may become desensitised to low levels of childcare and the impact these are having on children.

A study of 33 British professionals reported that almost all experienced very negative feelings when working with child neglect, these included sadness, despair, anger and frustration (Stone, 1998). As a result of these feelings social workers may have few expectations of achieving any change in neglecting parents.

Assessment

One of the challenges facing social workers working with neglect is assessing which children are at risk from neglect, and the subsequent allocation of resources for families at risk. Assessment can be defined as 'a range of situations in which practitioners are attempting in a structured way to arrive at judgements about the nature and severity of the problems confronting children and families…in order to propose solutions' (Department of Health, 2001, p.146). In this section general risk assessment in child protection is considered, followed by descriptions of assessment methods directly relevant to neglect.

Risk assessments may help predict which children are at most risk of abuse or neglect, and could potentially be used to screen families to ensure that only children who are at serious risk are caught up in the child protection system (Wattam, 1997). Risk assessment instruments may be of use in maintaining consistency in decision making, based on the best available knowledge, and could in turn help professionals from different disciplines reach an agreement (English, 1999).

The best risk assessment tools take into account a range of variables, including demographic, social, biological, cognitive, and behavioural characteristics, to gain information about individuals, their families and their communities (Corby 1996). Corby urges caution in using such checklists because of the difficulty in weighting individual risk factors. He stresses the importance that any risk assessment is used to enhance, not as a substitute for clinical judgement.

Risk assessments based on single variables do not take account of the complexities of the causes of child abuse and neglect. Single variables need to be looked at as chains and linked sequences, some combinations of risk factors may be more dangerous than others (Baldwin & Spencer, 1993; Hamilton & Browne, 2002). The presence of any risk factors in a family does not automatically mean that children in a family are neglected but 'their presence and the interaction between them increase the likelihood of maltreatment' (English, 1999, p. 204).

Corby (1993) reports that it is possible to predict between two-thirds and four-fifths of future abuse. This also means that 20% of any sample is likely to be wrongly identified. It is important therefore that professionals consider that instruments are based on factors that correlate, but are not necessarily causes of child maltreatment (Campbell, 1991, Gough & Murray, 1996).

Checklist may leave out important factors such as the severity of the current incident, the age and ability of the child, the co-operation of the main caregiver, the intent of the perpetrator, and previous contact with Social Services (Campbell, 1991). They may focus only on individual attributes, rather than interactional processes (Reder, Duncan & Grey, 1993).

One of the best known assessment tools for neglect is the Childhood Level of Living Scale (CLL) (Polansky et al, 1981). This instrument aims to assess elements of care, including physical, emotional and cognitive care, and explores parenting strengths and weaknesses. The list is detailed and includes 99 items. Although Polansky reports that trials using the checklist have shown that it can differentiate between neglecting and non neglecting families, many authors question its sensitivity and cultural relevance for current UK social work practice (Minty & Pattinson, 1994; Stevenson, 1998; Stone, 1998; Sullivan, 2000). For example, one item on the list is 'planned overnight vacation trip has been taken by family', (Polansky et al., 1981, p. 247). British social workers are unlikely to see this as a realistic expectation for families who are living on state benefits.

Minty and Pattinson (1994) devised a British instrument to measure neglect in children under 7 years old. The Scale for Assessing Neglectful Parenting is in the form of a questionnaire, exploring the quality of physical and emotional care that children receive. The scale contains 110 questions under the categories food and eating habits, health and hygiene, warmth/clothing, safety and emotional neglect. Trials of the scale with 38 families referred to an NSPCC child protection team found definite links between physical and emotional neglect. The authors conclude that all physical neglect has an emotional component, which differs from the effects of poverty. Emotional neglect however, may exist without physical neglect.

Stevenson (1998) suggests that neglect can be assessed using the dimensions of child well-being based on the 'Looking After Children' material. This looks at identity, family and social relationships, emotional and behavioural development, self presentation, and self care skills. Although these categories are useful in raising professional awareness of the needs of children, they have their limitations, in that they do not address the capabilities of parents.

The 'Framework for Assessment for Children in Need and their Familes' (Department of Health, Department of Education and Employment and Home Office, 2000), and accompanying practice guidelines are suggested to be useful in assessing neglect (Howarth, 2002). The assessment framework looks at the child in the context of parenting capacity, the child's developmental needs and environmental factors. Each domain is further broken down into subcategories. The framework aims to enable the practitioner to identify the effects of maltreatment, including neglect on the child, and assess how the child's needs can be met.

Howarth (2002) states that if all aspects of the framework are attended to then neglect will be assessed in terms of the parental behaviour and the impact on the child, rather than focusing only on parenting capacity which could lead to over empathising with the parents, and overlooking the child's needs. Macdonald (2001) asks if the focus of the framework on all children in need may cause children who are in need of protection to be overlooked.

The range of potential factors, combined with other dimensions such as frequency and chronicity means that no one instrument is likely to be effective in assessing neglect if used in isolation. Assessment needs to be multidisciplinary, to ensure that none of the child's needs are overlooked.

Intervention

This section describes the range of interventions that can address neglect. Interventions in the form of home visiting and accident prevention are explored, although these interventions are not aimed specifically at neglect. Home visiting deals with many difficulties associated with neglect such as basic childcare and social isolation; and accidental injury to children may be the direct result of neglect, for example through poor parental supervision.

Interventions for neglect can be categorised into three levels: primary, aimed at the entire population; secondary, aimed at families at risk; and tertiary, to prevent abuse reoccurring (Gough, 1993). Primary intervention for neglect would involve large scale programmes to target wider social issues such as poverty and poor housing. Most intervention addressing neglect is at a secondary and tertiary level. Secondary interventions may include daycare programmes for preschool children, home visiting services, practical support or parent skills training. Tertiary programmes may include direct work with children, and individual therapy or group work with parents to deal with difficulties such as drug or alcohol addiction (DePanfilis, 1999;Gaudin, 1993; Holden & Nabors, 1999).

Only a small number of evaluative research studies on the effectiveness of intervention with neglect exist, the results of these demonstrate limited success, with high rates of post intervention recidivism (Gaudin, 1993; Gershater-Molko et al. 2002). For example, in a review of 19 demonstration programmes in the US, over the period 1978-1982 directly

addressing neglect, Daro (1988, in Gaudin 1993) reports that 66% of families had additional reports of neglect during treatment, and only 53% had improvements of overall family functioning. Daro suggests that the strongest predictor of outcome was the severity of family problems, particularly alcohol and drug abuse.

Gaudin (1993) states that intervention needs to be tailored towards the specific type of neglect 'because most neglectful families are multiproblem families with many deficits, no one intervention technique or method can be successful' (p.41). Gaudin identifies many forms of intervention to address different aspects of neglect. These range from individual and group work with parents, to interventions such as the provision of day care that are directly aimed at children, and legal intervention if voluntary intervention is not effective. Gaudin's guidelines for intervention can be summarised as follows:

1. Professionals must assume that parents want to improve the quality of their childcare.
2. All parents have strengths that need to be identified and built on.
3. Interventions must be culturally sensitive.
4. Each family is unique, interventions should be individually tailored.
5. Treatment goals need to address parent's levels of self esteem and confidence, and workers may need to 'parent the parent'.
6. Families should be encouraged to use naturally occurring formal and informal supports to avoid over dependency on professional services.
7. Intervention should work towards achievable goals that are agreed with the family. Any progress towards these goals should be rewarded by praise.

Daro and Donnelly (2002) add to this a reminder that not all families will be reached by services, even high quality services. They point to the erroneous belief that the answer to prevention of child maltreatment lies in the provision of more services.

Tanner and Turney (2003) highlight the need for long term supports in cases of chronic neglect. Although intervention may need to be long term, they argue that this should not mean that it is not focused and purposeful. If progress is not made, then plans should be made for the removal of the child. They raise the issue of creating dependency when work is long term, however they suggest that dependency can also be seen in terms of the development of a positive working relationship. Short term interventions are said to be effective for more recent cases of neglect (Tanner & Turney, 2003). Intervention at the earliest stages is therefore more likely to be cost efficient.

Home visiting services have been provided to families in the US since the 1970s, and can offer long term supports to families. Daro and Donnelly (2002) suggest that the benefits of home visiting are: a) they can provide services to hard to reach families, b) child

development is assessed and remedial services are likely to be put in place sooner, c) overall improvement in parenting and life skills, for example, parents are more likely to be employed.

There are some limitations of home visiting services, namely a) home visiting does not reach all families, particularly families who misuse substances, experience domestic violence or have mental health problems, b) there is limited evidence that these services improve the communities where families live and c) a high number of families drop out of treatment (Daro & Donnelly, 2002).

David Olds and colleagues (Olds, Eckenrode, Henderson, Kitzman, Powers, Cole, Sidora, Morris, Pettitt, and Luckey, 1997) undertook a fifteen year follow-up of a randomised control trial to explore the long term effects of home visiting services. The families had received monthly visits from the prenatal period through to the child's second birthday. Results indicated that compared to the control group, women who received visits had fewer subsequent pregnancies and longer spaces between children; they were less likely to abuse or neglect children or be dependent on welfare; they had fewer arrests and fewer problems with drugs or alcohol. Holden and Nabors (1999) state that this study offers the following useful information for intervention or prevention of neglect.

1. Professional support is effective for high risk families during periods that may stressful, for example the prenatal period and during the child's infancy.
2. Follow-up data should be collected on a long term basis to determine if effects continue when children are at different developmental stages.
3. As intervention was shown to be effective with high risk families, services should be targeted at these families, rather than offering universal services to a wider range of families.
4. Services for neglect need to be long term and labour intensive.

The successful outcomes of this study are not reflected in all studies of home visiting. For example Chaffin, Bonner and Hill, (2001) evaluated outcomes for 1601 families of the US government funded Family Preservation and Family Support Programs. The evaluation included centre based and home visiting services. Findings indicate little difference between families who completed the programme and families who dropped out in terms of future maltreatment rates. There was little improvement found in self-reports of lifestyle or economic circumstances. Although centre based services served families who were considered to be higher risk, results of centre based services showed lower rates of failure than home based services. One suggested reason for the low rates of successful outcomes is that none of the programs directly addressed known risk factors for abuse and neglect, including substance abuse, poverty, domestic violence and depression.

Interventions to prevent accidental injury in the home show mixed results. For example, in a meta analysis of 33 studies using home visiting programmes aimed at reducing childhood injury, Roberts, Kramer and Suissa (1996) report that the rates of injury were reduced overall. Clamp and Kendrick (1998) also found that GP advice on safety in the home combined with the provision of low cost safety equipment increased the use of safety equipment, and safe practices such as the storage of sharp objects. A later randomised controlled trial, however, indicates that the provision of advice and equipment by health visitors was not effective in reducing the rates of unintentional minor injuries (Kendrick, Marsh, Fielding & Miller, 1999). The authors acknowledge that exposure to the intervention may have made parents more willing to seek medical attention.

Studies using behavioural methods to address specific aspects of parenting report high success rates with neglecting parents and will be explored in detail chapter three.

Chapter 2

Behavioural Social Work

Introduction

Social work theory and its application to practice are discussed in this chapter. This is followed by an outline of basic principle of classical and operant conditioning. Finally the application of behavioural theories to social work practice is considered.

Social Work Theory

A range of factors influence social work practice including theory or knowledge, morality, legislation, procedural guidelines, political pressure and the availability of resources (Little, 1997). While these are important factors to be considered when devising the detail of social work interventions, on the whole social work theory and research should remain the linchpin to professional practice, policy, procedure, and legislation.

In the past theory for social work has come mainly from either sociology or psychology (Howe, 1987). Sociological explanations have traditionally taken societal factors into account, viewing the root cause of social problems in the environment, for example in poverty, inequality, and politics. Psychology based theories have in general paid more attention to the individual, looking internally for explanations of behaviour.

More recently it has been acknowledged that difficulties can occur if concepts are applied directly from other subjects rather than being adapted for social work, especially if theories from other subject areas do not link directly to social work practice (Shepperd, 1998). For example, information from other subjects, such as sociology may offer an explanation about the development of social problems, but not necessarily offer ways of addressing these through social work. In current social work practice the main emphasis is on developing theories that are specifically designed for social workers and that help practitioners 1) to understand service user behaviour within the social context and 2) to devise effective practice.

There is agreement that sound social work theory is preferable to common sense approaches and general texts on social work theory (Payne, 1991; Howe, 1987) demonstrate the wide range of theories and working methods, largely leaving the reader to select their own theory. In fact, practitioners are often encouraged to select more than one theory. Howe (1987), for example, argues that a full range of theories should be utilised especially because social work can be 'several contradictory things at once' (p.166). He gives the example that a social worker who uses only a functional approach, starting from the premise that human behaviour can be observed and predicted, would need to recognise

that this approach could be viewed as controlling and used to maintain the interests of dominant established groups.

Theory in social work can be applied at many levels, from wide bodies of knowledge to specific working methods. Sheppard (1998), for example, notes disagreement about the establishment of a knowledge base for social work, and also how existing knowledge is applied to practice. He points out that the approach taken by an individual practitioner can either be determined by a chosen theory, often based on ideological preferences, or by the presenting service user's problem and the work environment. In the former situation, the theory that is selected will dictate the approach to intervention and will determine which aspects of the service user's problem are seen as most relevant (Howe, 1987). In the latter case, the selection of theory will depend on which theory is deemed to offer the most useful approach to solving the service user's problem.

Although social work training promotes theory to practice links, many practitioners still treat the two as separate and rely mainly on practice wisdom. Munro (1998) highlights the difficulties that social workers have in applying theory to practice. Social workers are said to begin with 'a pre-existing body of common sense wisdom' (Munro, 1998, p. 97). Munro contends that common sense psychology needs to be integrated with theory, rather than dismissing the former, particularly as this is the context in which service users view themselves. She suggests that this is done by initially interpreting service users' words and actions within a common sense framework before reinterpreting them within a theoretical framework. If theory is not applied in any coherent way, evaluative research on practice is difficult to undertake; although outcomes may be studied, the social work process is difficult to evaluate.

A study of the application of theory to practice by students and more experienced social workers in South Australia shows the wide range of theories used in decision making in child protection social work. The most commonly identified theories included systems theory, crisis intervention, child development and family therapy. Difficulties in integrating theory with practice were highlighted for inexperienced social workers, although they had knowledge of the same range of theories as experienced workers. Inexperienced workers tended to apply theory in retrospect to justify their decision making, rather than using theories to help inform child protection decisions (Drury-Hudson, 1999).

Evidence-Based Practice

Current emphasis on evidence-based practice highlights the need for social work decisions to take account of the best available practice research based on critically reviewed research findings (Newman & Roberts, 1999; Macdonald & Roberts, 1995). The use of theory and practice based on the personal preference of the individual social worker is no longer

acceptable. Research shows that social work interventions have not always been anymore effective than no intervention, demonstrating that social workers' untested beliefs that they are effective are untenable (Munro, 1998; Sheldon, 1998b).

Empirical practice is based on scientific principles that can be tested using a wide range of methods, including both quantitative and qualitative research. For practice to be classed as empirical it needs to be both systematic and replicable (Thyer & Wodarski, 1998). This view is based on an objective realist approach, which contends that social facts exist independently of the individual. In this approach individuals are viewed as products of a combination of environmental influences and genetic inheritance (Howe, 1987). This realist approach appears to be the opposite of a subjective approach, which sees social facts as created by the meaning imposed on them through the experience of the individual (Thyer & Wodarski, 1998). Thyer and Wodarski (1998) suggest that the two approaches can coexist; that there can be both a subjective and objective reality. They argue, however, that the latter approach is of more use in social work practice. They point to the limitations of a subjective approach with a focus on changing the service user's perception of their situation rather than changing circumstances. They agree with Shepperd (1998) that if social work related issues are entirely subjectively defined, many open questions about standards are left unanswered, offering little direction for practice.

Gough (1993) highlights the efficacy of behavioural interventions in relation to the increasing demand for evidence-based practice. He points out that behavioural social work practice is anchored in rigorous research methods that are based on a detailed and well researched theory-base. Gough notes that, while in many studies, more rigorous research designs result in less favourable outcomes, this was not the case with studies using behavioural methods. Furthermore, behavioural theories combine both the sociological as well as the psychological perspectives mentioned previously, taking account of the individual within the environment. Most importantly, behavioural theories can be directly applied within a framework of anti-discriminatory social work practice because they are based on principles that remain constant across service users and settings.

Behaviourism

The original behaviourists adhered to a realist philosophy, current behavioural thinking moves beyond this to a pragmatist philosophy, in that interest is in not just what science can explain, but in what it allows us to do with this knowledge (Baum, 1994). Realism has limitations, in that it differentiates between the external and internal world of the individual. Pragmatists view the internal and external world of the individual as being subject to the same natural laws, making the differentiation between the two unnecessary (Baum, 1994).

Schlinger (1995) states that behavioural approaches use theory in a scientific sense, as a set of broad principles that can and have been tested. This includes both a body of factual knowledge as well as the abstract principles that are derived from it. Human behaviour is attributed to 'a constellation of variables including the individual's genes, physiological makeup that stresses the role of the environment, both past and present' (Schlinger, 1995, p. 38). This view differs from other social work approaches that see behaviour as coming directly from within the person, for example psychoanalytical theories, which suggest that internal factors are the cause as well as the result of behaviour. Skinner (1974) suggests that psychoanalytical approaches in particular focus on the hypothesised internal workings of the mind and view behaviour as merely a by-product.

The view that behaviour occurs as a result of interaction of the individual with the environment, rather than emanating from within, and therefore rejecting the idea of internal causes of behaviour is a fundamental difference between behavioural theories and cognitive theories. In behavioural theories ideas of consciousness, mental states, or other hypothetical events as the cause of behaviour are rejected. The focus is on scientific explanations of behaviour that can be observed, and tested (Baum, 1994; Schlinger, 1995). This includes thoughts and feelings that are viewed as behaviours that can be observed by the person experiencing them.

Behaviour analysis focuses on the function of behaviour rather than its structure. Structural approaches categorise the form of behaviour under predetermined classifications, while functional approaches explore the purpose that behaviour serves for the individual. Although behaviours may be entirely different in form, they may serve a similar function and require similar interventions (Sturmley, 1996). Behaviour analysis does not deny the existence of structures of behaviour, but views the function as more important (Schlinger, 1995).

Examples of structural approaches include traditional developmental theories, for example, the theories of both Freud and Piaget. Structural approaches are said to confuse description of behaviour with explanation, in other words, descriptive labels are used tautologically as explanatory terms. In addition, the reliance of many traditional developmental theories on internal causes of behaviour such as sense, perception or judgement draws attention away from environmental or genetic causes of behaviour.

Behavioural Social Work

Behavioural social work is based on the theory and methods of applied behaviour analysis, cognitive-behavioural theory and social learning theory. Research from non-social work settings is applied to work with social work service users because the basic laws of behaviour are generalised across settings and service user groups. Behavioural social work has been shown to be effective across a wide range of service user groups. It is also one of

the few social work theories that offers clear methods of evaluation. Its empirical base allows practitioners to combine research with practice in a non-intrusive way because the research question is aimed directly at practice evaluation.

Hudson and Macdonald (1991) state that although behavioural social work and other social work theories may share common goals, such as service user empowerment and self-determination, solution focus, and partnership, they differ because of the methods of specifying and pursuing these goals. What differentiates behavioural approaches from other social work theories includes the empirical base for behavioural social work, the emphasis on what is observable and measurable, and the focus on the present rather than the past. Social workers can use the theory directly to devise methods of work, or may subscribe to the wider philosophy of behaviourism, which recognises that behavioural laws apply to all aspects of their interaction with service users (Mattaini, 1996).

Basic Principles of Behavioural Social Work

Since the early twentieth century behavioural scientists have been investigating learning and conditioning, exploring the interactive relationship between individual's learning histories, and the environment. Behavioural social work is largely based on knowledge gained from these studies, including classical and operant conditioning, as well as observational learning and rule governance.

Classical Conditioning

The basic principles of classical or Pavlovian conditioning are that all humans have genetically programmed reflexes that if paired with a neutral stimulus can cause the neutral stimulus to become a conditioned stimulus. Behaviours are classed as conditioned if a response becomes paired with a stimulus that would not usually produce that response. Classical conditioning generally involves involuntary behaviour, and may be a key factor in the development of a range of difficulties including anxiety, depression and child abuse (Gambrill, 1997). Grant and Evans (1994) state that applications of classical conditioning are more likely to be concerned with emotional behaviours in contrast to operant conditioning, which is concerned with teaching skills.

Classical conditioning can often provide an explanation for behaviours such as phobias. Treatment for phobias may use counterconditioning. This process changes the effect of the conditioned stimulus, so that it causes an incompatible conditioned response, for example replacing a fear reaction with humour (Grant & Evans, 1994). Treatments using classical conditioning can include systematic desensitisation, where the fear or anxiety stimuli are gradually introduced either in imagined or real form, while the person being treated practices relaxation techniques. Relaxation techniques include identifying tension throughout the body, and relaxing each of the muscles. Initially tapes or verbal instruction are used to guide

relaxation, until the technique has been learned (Iwaniec, 1995). Relaxation techniques become the conditioned response, and replace the initial fear or anxiety response (Grant & Evans, 1994). Not all phobias or anxiety can be attributed to classical conditioning however some may occur as a result of a combination of both operant learning and classical conditioning (Hudson & Macdonald, 1991).

Operant Conditioning

Operant behaviour is the study of how behaviour effects and is affected by the environment (Hudson & Macdonald, 1991). This behaviour is voluntary, rather than the more automatic behaviour in classical conditioning. Knowledge about operant learning that forms the basis of most behavioural social work comes mainly from the work initiated by B.F. Skinner. Skinner discovered the basic principles of operant conditioning through his work in the laboratory with animals and later found that the principles of operant learning are also applicable to human subjects. His ideas have formed the basis for a range of behavioural treatment techniques.

The basic units in operant learning are antecedents, behaviour and consequence (Schlinger, 1995). This is known as the three-term contingency, often termed the 'ABC' of behaviour analysis. The three-term contingency shows the temporal and functional relationship between antecedent, behaviour and consequence (Cooper, Heron & Howard, 1987). In other words, it shows that in the presence of certain antecedents, some behaviour is followed by specific consequences. Skinner and others have shown clearly that the future probability of the behaviour in questions depends on these consequences.

Consequences

Consequences are anything that happens after behaviour has occurred and are functionally linked to the behaviour. Some consequences increase the probability of the behaviour occurring again (reinforcers) while others decrease the probability of the behaviour occurring again (punishers) (Mattaini, 1997; Neitzel & Bernstein, 1987). Reinforcement and punishment are now described in more detail.

Reinforcement

Reinforcement is a term used to describe a specific functional relation between behaviour and consequences. The functional relation in question is between anything that is added after behaviour has occurred that increases the likelihood that this behaviour will happen again (Gambrill, 1997). Reinforcers are defined by the effect that they have on behaviour, not by intent (Sheldon, 1998b). In other words, something can not be described as a reinforcer until it has been shown to function as such.

Given this functional definition of reinforcement, the range of stimuli that can function as reinforcers is vast. Reinforcers can be unconditioned and biologically determined or conditioned. Unconditioned reinforcers have some kind of survival value, for example food or shelter. Conditioned reinforcers gain their functional value either through association with unconditioned reinforcers or through direct conditioning and usually include tangible items such as a preferred food or money, or social reinforcers such as praise or touch (Grant & Evans, 1994; Mattaini, 1997). Obviously then something that acts as a reinforcer for one person will not necessarily function in the same way for another individual. Gambrill (1997) points out that this functional disparity is based on differences in the individual's learning history. If a consequence does not increase the strength of behaviour, this does not mean that reinforcement does not work; it suggests instead that the correct reinforcer has not been identified (Grant & Evans, 1994).

Positive Reinforcement

Reinforcement is classed as positive if it causes behaviour to be strengthened or maintained; this forms the basis for most behavioural interventions (Sulzer-Azaroff & Mayer, 1991). In behavioural social work many procedures initially use artificial or conditioned positive reinforcers, for example star charts or token economies. However, successful intervention is likely to be maintained if the reinforcement is gradually replaced by those occurring naturally in the environment. One of the benefits of using conditioned reinforcers is that they can be awarded immediately. Naturally occurring reinforcers may be delayed, and working towards these 'depends on the ability to comprehend instructions, to learn that a delayed response-reinforcer dependency exists, and to bridge delays with mediators' (Grant & Evans, 1994, p. 51). In other words, working towards delayed, naturally occurring reinforcers involves a range of skills that may need to be learned and should be included in any treatment plan.

Schedules of reinforcement dictate when reinforcement will be delivered, behaviours that are reinforced, and those that are not, and influence the rate of behaviour. The schedule of reinforcement selected will affect the timing of the response and also how subject the behaviour will be to extinction (Sheldon, 1998b). Exploration of existing schedules can offer explanations about performance rates of any behaviour, and may avoid labelling people as lazy or unmotivated (Gambrill, 1997). Planning schedules of reinforcement allows behaviour to be changed by the least amount of reinforcement (Grant & Evans, 1994).

Continuous schedules of reinforcement occur when every performance of the behaviour is reinforced, and can be used initially to strengthen behaviour. However in the long term reinforcers may become less effective because of satiation (Cooper, Heron & Heward, 1987). An intermittent reinforcement schedule, where behaviour is reinforced only on some occasions, is usually introduced to strengthen behaviour once it has become established. Intermittent reinforcement schedules are the most likely to persist in the long term, with low

rates of reinforcement, particularly if the intermittent schedule is gradually introduced (Grant & Evans, 1994). Gambling is an example behaviour that is subject to intermittent reinforcement, gambling behaviour is reinforced on an unpredictable schedule, which strengthens the behaviour regardless of the amount of reinforcement received. This schedule of reinforcement has a more powerful effect than the actual amount of reinforcement received (Skinner, 1971).

Negative Reinforcement

Like positive reinforcement, negative reinforcement increases the likelihood that behaviour will be repeated however, the term "negative" indicates that in this instance the consequence entails the removal of a stimulus. The removed stimulus is usually an aversive stimulus, something that 'an organism turns away from' (Skinner, 1971, p.32). Like positive reinforcers, negative reinforcers are identified by their function in relation to behaviour. The term is appropriately used if a sequence of behaviour which results in the removal of an aversive stimulus is likely to be repeated in the future (Sheldon, 1995). Negative reinforcement is involved in avoidance or escape behaviour. Avoidance behaviour is where the failure to perform behaviour results in the presentation of an aversive stimulus. An example given by Grant and Evans (1994) is non payment of electricity bills resulting in the supply being disconnected. Future bill paying behaviour is strengthened to avoid the aversive stimulus. Escape procedures strengthen behaviour through the removal of an aversive stimulus that is already present. The penal system is an example of an escape procedure, through good behaviour the prisoner is no longer confined, thereby negatively reinforcing or increasing good behaviour by the removal of the aversive stimulus (Grant & Evans, 1994). Negative reinforcement in the form of intentional or unintentional aversive control is said to be in 'the pattern of most social coordination - in ethics, religion, government, economics, education, psychotherapy and family life' (Skinner, 1971, p. 33).

Punishment

The function of punishment differs from that of reinforcement in that the term is used when behaviour is decreased either through the removal of a pleasant stimulus (negative punishment), or the application of an aversive stimuli (positive punishment) (Gambrill, 1997). Sheldon (1995) states that many social work service users live in environments that provide high rates of punishment. Although punishment may be effective in the short term most behavioural interventions use positive reinforcement rather than punishment because of the possible side effects of punishment. Side effects may include habituation to the punishment stimulus thus requiring increased punishment to maintain effectiveness, aggression, escape behaviours, and imitation of the use of punishment (Grant & Evans, 1994; Hudson & Macdonald, 1991).

If punishment procedures are used to decrease behaviour, the practitioner has to remember that these procedures do not teach more appropriate behaviours. Punishment, therefore, should be used only in conjunction with procedures using positive reinforcement to increase desirable behaviours (Mattaini, 1996). If used in combination with positive reinforcement, behaviour reduction procedures are likely to be more acceptable to the service user, and this can lead to an acceleration of behaviour change (Sulzer-Azaroff & Mayer, 1991).

Antecedents

Although behavioural interventions often focus on manipulating the consequences and their effect on target behaviour, it is important that antecedent events are included in any assessment, especially if they serve as a cue for problematic behaviour (Gambrill, 1997).

Antecedent or discriminative stimuli are the setting or context in which behaviour is likely to occur. The individual's history of reinforcement dictates which stimuli are effectively discriminative for specific behaviours, in other words, different people behave in different ways in different settings (Baum, 1994). Mattaini (1997) states that antecedents can be 'occasions' signalling that certain behaviour will be followed by a specific consequence; 'structural', such as physiological ability or environmental structures, or 'motivating' as in changing the sensitivity towards a particular consequence.

Establishing operations (Michael, 1982, 1983, 1992) are conditions that affect sensitivity to a consequence. These include deprivation and satiation, (Mattaini, 1997). An example is a child on one occasion performing a task, which is reinforced by being given a sweet, if they have not recently had sweets (deprivation), but on another occasion the sweet not functioning as a reinforcer because the child has just eaten sweets (satiation).

Rule Governed Behaviour

Human behaviour is often governed by rules, which may be learned from other people or be self-generated based on prior experience. Once a rule has been learned it may not be easily changed by contingent consequences (Mattaini, McGowan, & Williams, 1996). Rule-governed behaviour differs from contingency shaped behaviour in that it is influenced by the given or implied description of the likely contingency, rather than from direct contact with contingencies. The discriminative stimulus in rule governed behaviour is verbal, whereas contingency shaped behaviour may occur without instruction (Baum, 1994).

If the person stating the rule controls the consequences for the behaviour this is classed as a command, if the person stating a rule draws attention to the contingencies this is classed as advice (Grant & Evans, 1995). Rule governed behaviour is important in learning complex behaviour, possibly with delayed consequences, but can be problematic if excessive or inaccurate (Mattaini, 1996). The concept of rule governed behaviour can offer explanations

for many behaviours without the need for reliance on internal hypothesised causes of behaviour (Cromie & Baker, 1997).

Generalisation

Stimulus generalisation occurs when the same behaviour is evoked by a variety of stimuli. Stimulus generalisation can be socially appropriate or inappropriate; racism is an example of the latter. Response generalisation is where the form or topography of behaviour changes, for example a child learning to write gradually perfects the shape of letters, so that the final response differs from early attempts (Sulzer-Azaroff & Mayer, 1991). Desirable behaviour can be transferred across settings, time or subjects outside training conditions, for example the transfer of skills learned from a clinic setting to the home. This is of central importance in any intervention, and should be given the same attention as other components of intervention. It is not enough to hope that this will take place naturally once intervention has finished (Stokes & Baer, 1977).

Any generalised changes will reduce the number of behaviours to be targeted, and may prevent the need for further intervention (Struass & Atkeson, 1984). The most effective generalisation programmes fade out artificial contingencies, replacing these by naturally occurring ones that already exist in the service user's environment. If naturally occurring contingencies do not exist, they may be engineered by modifying the environment, or teaching the service user to solicit reinforcement (Stokes & Baer, 1977). Other people involved in the service user's life can promote generalisation by using treatment procedures, so that improvement in behaviour occurs in different settings (Reese, 1978).

Generalisation can be encouraged through the use of intermittent schedules of reinforcement because of their resistance to extinction. This means that behaviour occurs in settings where it may or may not be reinforced. Methods likely to encourage generalisation include reinforcing accurate self-report by service users of the target behaviour in the natural environment and occasional reinforcement of generalised behaviour (Stokes & Baer, 1977).

Common Themes in Behavioural Work

All behavioural working methods share the view that normal and abnormal behaviour are shaped by the same basic principles. This moves away from the medical or disease model that views problems as emanating from within the individual. The use of negative labels is avoided; these are unhelpful as they offer no directions for intervention and are likely to stigmatise service users (Gambrill, 1995). Labels are viewed as a potential source of misinformation, in that a label cannot give information on how a person behaves in every setting. The label may cause others to behave in a particular way towards and individual, and in turn result in the individual behaving in a way that fits the label (Grant & Evans, 1994; Gambrill, 1997).

Behavioural approaches test assumptions about what is maintaining behaviour by observation, usually in the natural environment, rather than looking for causes of behaviour within the individual. Past events are considered important in so far as they influence current behaviour; however, the main emphasis is on current behaviour that can be changed (Hudson & Macdonald, 1991). It is important to explore the history of longstanding behaviour to fully understand the contingencies that have shaped and maintained the behaviour (Baum, 1994). Baum (1994) suggests that when long gaps occur between antecedents and behaviour, mentalistic explanations for behaviour are often offered. These are likely to be inaccurate, for example, viewing low self esteem or anxiety as causes of behaviour, rather than exploring historical events that have shaped and maintained behaviour.

Differences exist in behavioural approaches mainly in relation to the role of 'private events' such as thoughts and feelings. Behaviourism views thoughts and feelings as subject to the same laws as any other behaviour. The only recognised difference is that thoughts or feelings, classed as 'private' behaviour can only be observed by the person who is experiencing them. Thoughts and feelings are not seen as causes of behaviour, and are shaped by the same contingencies as other behaviours. This contrasts with cognitive behavioural models, such as Social Learning Theory, which view thoughts and feelings as mediating variables that intervene between stimulus and response (Gambrill, 1995).

Social learning theory in particular highlights the importance of observational learning, or modelling, although this method is also used in applied behaviour analysis (Cooper et al., 1987). Modelling is a stimulus control procedure, where the behaviour of the model acts as a discriminative stimulus for the observer's response. If the model's behaviour results in positive reinforcement, the behaviour is more likely to be imitated than behaviour that is followed by punishment (Gambrill, 1997). Modelling occurs frequently in the natural environment, and can offer explanations about the origins of some behaviour. For example, maternal fear responses have been shown to evoke fear responses in young children (Gerull & Rapee, 2002). Infant's imitative behaviour is often heavily reinforced by parents, for example in playing games such as 'peek a boo'. Games that older children play often require modelling, for example, 'Simon Says' (Sulzer-Azaroff & Mayer, 1991). These games allow children to develop imitation skills in their behavioural repertoire.

Grant and Evans (1994) state that models are most likely to be imitated under the following conditions: 1) the model is successful at the task, 2) the model is perceived to be high status, for example a child who is popular in class, 3) the model is similar to the observer, 4) the model shows positive attitudes and emotions and 4) models are consistent in their performances.

Modelling can be used to teach new behaviour, and often shows more rapid results than shaping procedures. It is an effective technique with a number of problems, including improving communication, teaching self care skills, and promoting better performance from employees (Grant & Evans, 1994).

One of the disadvantages of modelling is that unwanted behaviour may also be learned. For example, parents who use physical punishment to chastise children for fighting are modelling the behaviour they want to prevent (Carlson, 1990).

Criticisms of Behavioural Social Work

Behavioural work is often criticised for ignoring feelings and relationships; however by using the principles of positive reinforcement, service users are encouraged to engage in positive working relationships with workers. The interpersonal skills needed to engage service users do not differ from those used by social workers using other methods, however using interpersonal skills, backed by knowledge of positive reinforcement is suggested to be more effective than other methods (Thyer, 1992).

A further misconception identified by Thyer (1992) is that behavioural work treats only the symptoms and not the real causes of problems, as behaviour is suggested to be the outward symptom of internal problems. However by assessing current and past contingencies, the real causes of behaviour can be identified. Behavioural social work does not look for causes through hypothesised mental events or stages, as these are immeasurable.

The misunderstanding of the basic concepts of behavioural work is outlined in Strean's response to Thyer (Thyer & Strean, 1992). The relevance of behavioural research is questioned because numerical measures are used. Strean suggests that the use of numbers causes the complexities of the human condition to be overlooked. Numbers are important in monitoring progress; however, behavioural social workers in undertaking assessment and intervention also need to explore contextual and background factors, and ensure that they have the necessary skills to engage the service user.

Lack of Application in Social Work

In spite of the demonstrated effectiveness of behavioural methods, they are not widely used in social work practice. Thyer (Thyer & Strean, 1992) argues that this could be addressed by the inclusion of behavioural training as part of basic social work education. He recommends that behavioural methods should be the preferred option for social workers because of the empirical base, supported by 'scientifically credible literature'. Scientific approaches face criticism because they are viewed as ignoring important concepts such as intuition, and feelings. Although behavioural work is based on an established framework, with clearly identified working methods it is not mechanical in application. It requires each intervention to

be tailored to meet the unique situation of the individual service user. This requires in depth knowledge about the individual and their environment, which is unlikely to be achieved without well-developed communication skills. The objectivity of empirical social work is questioned because it is done by humans with their own values and beliefs, however if results are replicated then objectivity can be demonstrated (Thyer & Wodarski, 1998).

Social workers also have concerns, that by using scientific methods, behaviours that are easily measured will be given more weight than ones that are difficult to measure, and as a result the theory may dictate which aspects of the service user's situation are treated (Munro, 1998). This is less likely to happen if service users are fully involved in selecting target behaviours.

In spite of the demonstrated effectiveness of behavioural work many social workers continue to show a preference for more cognitively based interventions. Tierney and Smith (1997) suggest that change in service users is more valued when it happens through inconspicuous measures rather than the more obvious ones involved in behaviour therapy. Less transparent ways of working can rely on internal mental causes of behaviour rather than exploring wider environmental causes meaning that treatment can be focused on the individual's deficits, rather than having to change the environment. This in turn removes responsibility from social workers, if interventions are not effective.

Chapter 3

Behavioural Social Work and Child Neglect

In this chapter, neglect is explored within a behavioural context. Some of the antecedents and consequences of neglect are presented. Finally behavioural interventions that address neglect related issues are discussed.

Introduction

As with more general literature on child abuse, behavioural studies focus mainly on preventing physical abuse or improving child management skills, rather than specifically addressing neglect (Gershater-Molko et al., 2002). Abuse and neglect share common themes; both include difficulties in parent-child interaction, and are susceptible to wider environmental stresses. An overlap exists between the two categories of maltreatment; some neglectful parents may become abusive if childcare demands increase (Crittenden & Ainsworth, 1989). Neglect is generally viewed as a deficit of parenting behaviours, while physical abuse is viewed as an excessive response to the child (Mattaini, McGowan & Williams, 1996). In other words, neglect differs from abuse as it is likely to be the absence of caring behaviour by the parent which characterises neglect, rather than the parent over-reacting to the child's behaviour (Wolfe, 1988).

Existing Research

Behavioural interventions with parents cover a wide range of methods, settings and disciplines. An early review by Isaacs (1982) recognises the benefits of behavioural work in addressing physical abuse; however she recommends that greater attention needs to be paid to research methods. In recent years this has begun to been addressed. For example, Feldman (1994) undertook a review of 20 published studies of parenting education for parents with learning difficulties, using mainly behavioural methods. He comments that although most studies had clear methodologies, further attention needs to be given to a number of issues including the longer term benefits to both parent and child, and interobserver reliability. In many studies the professional who trained the parent was present when parental performance was recorded, and in some cases the trainer completed the recording. Although this can impact on the reliability of results as the trainer's presence may cue the target behaviour, many families wanted to have familiar worker involved in the procedure rather than 'strangers'. This highlights the difficulty of balancing research and practice needs when working in applied settings.

Even with these criticisms, behavioural studies are likely to be more methodologically sound than intervention studies using other theoretical approaches. For example, Gough's (1993) review of 225 formal evaluations of interventions on child abuse and neglect highlights behavioural approaches to physical abuse because of the clear methods used when compared to other approaches. Ammerman, (1998) acknowledges that published behavioural interventions for child maltreatment appear to be successful, but argues that as successful interventions are more likely to be published than unsuccessful ones, an overly optimistic picture may be presented.

There are a limited number of behavioural studies that address issues relating to neglect, however Gaudin (1993) suggests that behavioural techniques are likely to be effective with neglectful families because 'they break problems down into manageable components, emphasize immediate positive reinforcement for limited improvements, include real-life application and practice to acquire skills, and provide for follow-up to maintain gains' (p. 74).

It is difficult to evaluate existing research specifically relating to neglect because of the multiple problems and maintaining factors involved. Most research evaluates specific interventions which do not always assess the wider involvement of other agencies that also provide services to families (Hansen, Warner-Rogers & Hecht, 1998). Behavioural studies relevant to neglect addresses specific aspects of parenting behaviour, for example, basic child care skills or parent-child interaction (Greene, et al. 1995; Feldman, Sparks & Case, 1993; Feldman, 1994; Lutzker, & Rice, 1984; Tymchuk & Feldman, 1991). Although studies demonstrate positive outcomes in relation to the target behaviour, they do not give a picture of the overall quality of parenting (Greene & Kilili, 1998).

Behavioural Definitions of Neglect

Reaching a single behavioural definition of neglect is hampered by the difficulties outlined in Chapter One of this literature review. Neglect is a description of a range of behaviours that fail to meet a child's needs. Neglect is not usually the outcome of one incident; the effects are cumulative and build up over time. This makes neglectful behaviour more difficult to define than observable and measurable behaviours directly related to childcare (Azar, Povilaitis, Lauretti, & Pouquette, 1998). As with all definitions of neglect, problems exist because of the lack of basic acceptable standards for parenting (Greene & Kilili, 1998). Further difficulties occur in creating definitions because the range behaviours that result in child neglect may not be directly related to childcare (Mattaini et al., 1996). An example is parental substance abuse, which may lead to a child being injured or harmed because of lack of supervision. Neglect is therefore an outcome of any behaviour that fails to meet the child's needs.

Explanations of Neglect

Behavioural explanations of neglect explore genetic and environmental influences on current behaviour using behavioural principles, rather than relying on internal processes such as personality traits. Skinner (1974) stated 'Many supposed inner causes of behavior, such as attitudes, opinions, traits of character, and philosophies, remain almost entirely inferential' (p. 175). The use of descriptive labels to explain behaviour blocks the fuller exploration of environmental and genetic influences that act as antecedents and consequences of behaviour.

Behavioural approaches acknowledge the role of thoughts or feelings as private events, or the 'small part of the universe … enclosed within a human skin' (Skinner, 1971, p. 186). Thoughts and feeling are therefore viewed as subject to the same laws of behaviour as the external world, although less easily observed. This contrasts with approaches that view the causes of behaviour as emanating from within the individual. An example is research on neglect undertaken with low-income white mothers, by Polansky previously disribed in Section Two of this literature review (Polansky, et al., 1981). Mothers were grouped in terms of character disorders, the mother's personality was viewed as the cause of neglect. Personalities were thought to have been shaped by childhood experiences. Although current environmental stresses were acknowledged, these were not seen as having the same impact as childhood experiences.

Attributing the causes of mothers' behaviour to individual personality traits, gives an incomplete explanation of behaviour. Even if the mother's behaviour is shaped by past experiences, ignoring current contingencies fails to fully explore the potential influences on the mother's behaviour. The mother's behaviour may have been classed 'apathetic' or 'futile'; however, this is a description of behaviour, not an explanation.

Polansky questioned whether the basic characters of neglecting mothers can be changed: 'The agency personnel did not know what to make of them or how to treat them and neither did we' (Polansky, et al., 1981, p. 39). Viewing characteristics or personality traits as the cause of behaviour offers no direction for change, whereas if the mother's behaviour is viewed in the context of the wider environment, factors directly related to the problem behaviour can be manipulated to bring about change. The influence of the wider environment will be considered in the following section.

Ecobehavioural Perspectives

During the 1960s parental psychopathology and underlying psychiatric disorders were viewed as the causes of maltreatment; the impact of environmental factors was largely ignored (Pianta, Egeland, & Erickson, 1989). Treatment, based mainly on psychotherapy tried to change the parent's personality (Mattaini et al., 1996).

In the 1970s recognition was given to the impact of environmental factors such as poverty, stress and social isolation. Maltreatment began to be viewed as a 'multidimensional and multidetermined phenomena' (Pianta et al., 1989, p. 214). This has since developed into an ecological model which emphasises the interactions of four levels: Ontogenetic (individual), Microsystem (family), Exosystem (social network) and Macrosystem (cultural). At each level compensatory and risk factors interact, and the relative strength of risk or compensatory factors denotes the outcome for the child (Kaufman & Zigler, 1989). This approach attempts to offer a combined approach to social work practice in which work is undertaken with the individual, but recognition is given to the impact of the wider environment.

Ecobehavioural work views the family within its social ecology (Lutzker & Campbell, 1994). Prior to the 1980s behavioural work was mainly undertaken in a clinic setting, and largely ignored the need for assessment and treatment within the service user's wider social ecology. An ecobehavioural approach includes assessment and treatment in the home environment, with all relevant family members. A range of variables outside the immediate interaction between parent and child are explored, 'Parental behavior toward children is clearly a function of more than the pattern of antecedent and consequent events children provide contingent of parental conduct, although these contingencies are important' (Sanders & Dadds, 1993, p. 41).

Behavioural Principles Applied to Neglect

Care giving behaviours are subject to the same principles as other behaviours and are therefore learned through the same processes. These processes will be discussed here and include a range of antecedents that impact on parenting behaviour.

In order to learn how to look after a child it is important that models for imitation are available within the family, socially, in the media, and through professionals. Sources of information about appropriate childcare practices include models of childcare, written information, professional advice, and a degree of contingency shaped or trial and error behaviour. Information on how parenting skills are usually learned can direct intervention when these skills are absent.

Mattaini et al. (1996) suggest that parents need to have: parenting skills, be able to follow complex rules, environmental supports and access to basics like food or housing in order to parent successfully. If parents do not have these skills or resources they are likely to

encounter difficulties. Parents who have experienced poor care themselves may have had little opportunity to learn from appropriate role models, and may live in environments where neglectful child care is accepted as the norm, and as a result have difficulty in recognising concerns raised by professionals (Lutzker, 1990).

Behavioural work begins with an assessment based on 'reliable and direct observation of precisely defined behaviours' (Greene & Kilili, 1998, p. 59). Assessment data collected using a range of methods for example, observations or service user self-reports, are used to generate a functional assessment about what is maintaining, restricting or reducing behaviour (Sulzer-Azaroff & Mayer, 1991). This is then tested by altering antecedents or consequences, and measuring the effects of this on behaviour (Thyer, 1993). Treatment is designed based on the known functions of behaviour, 'without an understanding of the environmental variables which maintain the behaviour and the functions which the behavior serves for the individual it will not be possible to design and effective and comprehensive treatment' (Sturmey, 1996, p. 59).

Antecedents

Antecedents or events that happen prior to behaviour influence the occurrence of behaviour because of their relationship to the consequences that follow (Mattaini, 1998). The antecedents to behaviour that results in neglect may be part of a complex chain of behaviour. It can be difficult to trace these accurately because of the range of variables that can be included and also other events will have impacted on behaviour over time (Baer, 1997).

There are many different aspects to antecedents, for example, they can be classed as proximal or distal depending how closely they are linked to behaviour. Proximal antecedents or events that immediately precipitate neglect may in fact be antecedents to other behaviour that takes precedence over caring behaviour. Examples include a parent drinking heavily, which subsequently impacts on their ability to care for their child. Distal antecedents are events that may be less directly associated with maltreatment, for example unemployment could cause stress that directly impacts on parental coping.

Antecedents can also be current or historical, for example, the parent's experience of abuse in childhood may have an influence on current parenting ability (Tymchuk, 1992), although a direct link between historical antecedents and current behaviour is more difficult to trace. Behaviour is subject to a wide range of influences in the natural environment; what serves as a consequence for one behaviour will be an antecedent for another. Behaviour occurs within streams that are constantly changing; these interact with the behavioural streams of others (Glenn, 1997).

Mattaini (1998) describes five subcategories of antecedents; these include structural antecedents, occasions, establishing operations, rules, and models for imitation.

Structural Antecedents

Structural antecedents are aspects of the person's environment that are relatively permanent (Mattaini et al., 1996). These include environmental stresses such as poverty, unemployment, crowded living conditions, marital conflict, lack resources, low educational achievement (Pianta et al. 1989, Ammerman, 1990). Any physical or psychological limitations of parents also come into this category. Public policy interventions are likely to address structural antecedents, for example anti poverty strategies and the provision of good quality housing or safe play areas.

Occasions

An occasion or discriminative stimulus is a form of antecedent that signals the likely consequence of behaviour, when that stimulus is present (Baer, 1997). For childcare tasks the stimulus can be the time of day indicating when meal times should be, or the time of year dictating what clothing the child needs to wear. Cues from the child can also act as prompts for caring behaviour, for example, a baby crying when he is hungry. When naturally occurring cues do not act as an antecedent for caretaking more artificial prompts may need to be added to the environment to facilitate caretaking behaviour (Mattaini et al., 1996). Examples of artificial prompts might include written or pictorial prompts, verbal cues or having set times to carry out tasks.

Establishing Operations

Establishing operations affect sensitivity to the consequence that follows behaviour and can include social isolation, depression, low self esteem, and opportunities for activities that are incompatible with caring (Mattaini et al. 1996). This form of antecedent affects motivation and can include deprivation and satiation (Mattaini, 1998). For example, when an isolated parent is deprived of social reinforcement any behaviour that increases social contact is likely to take precedence over other behaviours. Motivation is also effected by some schedules of reinforcement. For example, if social reinforcement is available intermittently, the parent's social behaviour is likely to be strengthened.

Rules

Rules differ from other antecedents because the verbal description of the contingency is the main influence on behaviour rather than the actual contingency (Bijou, 1993). Rule governed behaviour is important for childcare because it allows behaviour to be learned without immediate contingencies. Behaviour can be learned more quickly than is the case with contingency shaped behaviour (Skinner, 1971). Examples of rule governed-behaviour include childcare practices without immediate or obvious consequences. An example would

be a mother following medical advice, and feeding her child a healthy diet. The immediate effects of this behaviour will not necessarily be reinforcing for the parent, in fact the child may protest when presented with healthy food. The reinforcement provided by the child's good health is likely to be a delayed consequence, and has been pointed to by the advice given.

Rules related to childcare include be social conventions about child rearing; these are generally reinforced by other members of the social group. By adhering to the rules of a culture or community, a parent is likely to be accepted by other members of that social group (Baum, 1994). Failure to comply with community rules relating to childcare practice may result in neglectful parents being ostracised. This may explain why some neglecting mothers have been found to be socially isolated (Polansky, et al. 1985).

Adherence to rules will depend on the individual's learning history with regard to following rules and whether or not this behaviour has been shaped by prior experiences (Bijou, 1993). Parents who have been maltreated may see maltreatment as normal behaviour and develop rule-governed behaviour in relation to childcare in accordance with their own experiences (Kaufman & Zigler, 1989).

Rule following behaviour is necessary for some elements of childcare particularly those elements that do not have obvious or immediate consequences, for example immunisations. Rule governed behaviour is also necessary for many contingencies that would be dangerous to test out, for example, leaving a young child alone in the bath, or allowing a young child to cross the road without supervision. Many parenting behaviours also require contingency shaped learning as this is responsive to cues from the child.

Skinner (1975) suggests that the social environment may have rules that people care for the vulnerable even though they receive low rates reinforcement. Parents who have difficulties with childcare may be not receiving adequate reinforcement for parenting behaviours; difficulties may be further increased if they do not have a history of following rules within the social environment.

Drawbacks to rule governed behaviour are that contingencies contained in the rule are not immediately tested, and so behaviour may not change through experience in the same way as contingency shaped behaviour would. Over compliance to rules, or over generalisation, may lead to parenting practices that are abusive or neglectful. Parenting based entirely on rule following rather than responding to the child's individual needs, may be insensitive, for example if a parent has a fixed routine for childcare tasks such as feeding, and is unable to modify this even if a child is unwell.

Models for Imitation

Behavioural work highlights the influence of modelling or observational learning in the acquisition of new behaviours, and to explaining current ones. Observational learning is a form of operant behaviour, and although the reinforcer may not be obvious, those who imitate have received reinforcement for imitation in the past, and have generalised this behaviour (Thyer, 1992). The opportunity for observational learning does not guarantee that behaviour will be performed by the observer; the observer also needs to have learned the skills for imitation. Many of these skills are shaped in the natural environment from early childhood onward.

Observational learning is an important source of parenting behaviour and like rule governed behaviour allows behaviours to be learned without the observer experiencing immediate consequences. As neglecting parents are often socially isolated (Coohey, 1996; Wahler, 1980; Polansky et al., 1985), they may lack appropriate role models in their natural environment. If parents have been maltreated in childhood, their own parenting behaviour may be influenced by neglectful or abusive childcare practices modelled within their family of origin.

Child Characteristics

Children are active participants in early interaction, not passive recipients (Brazelton & Cramer, 1990). It is therefore important to consider any child characteristics that may leave the child more vulnerable to abuse or neglect. This does not suggest that children are in any way responsible for their own maltreatment, but does acknowledge that some children are more difficult to care for than others, particularly if parents are lacking in skills, or have extreme levels of stress in their lives. Characteristics of children that have been associated with physical abuse include being under five, prolonged crying or having a physical handicap (Ammerman, 1990). Some qualities may make a child more difficult to care for, and may have an impact on the sequence of a particular behaviour. Child characteristics are not in themselves likely to affect the overall standard of care that a child receives, and need also to be linked to the parents' knowledge and skills. It is difficult to differentiate between characteristics that occur as a result of abuse or neglect and those that contribute towards its occurrence, particularly as research is generally based on children who are known to have been maltreated (Pianta et al., 1989).

Before birth a child can be exposed to a range of factors that can impact on subsequent development, these include: nutrition, toxins, medication, drugs, alcohol, and maternal activity. These factors may cause problems in the development of the foetal nervous system, and impact on later behaviour (Brazelton & Cramer, 1990). A child's individual temperament is thought to be linked to vulnerability to abuse or neglect because of the impact of the child's style of behaviour on parental interaction (Rutter, 1981; Iwaniec, 1995). Thomas Chess and Birch (1968) categorised children into behavioural styles, measuring: activity level, emotional

responsiveness, mood quality and social adaptability and were divided into three classes, a) easy, b) difficult and c) slow to warm up.

Easy children are seen to be the most rewarding children to care for because of their regular reactions, positive mood and adaptability to new situations. Difficult children are viewed as the most difficult to rear because of irregular biological functions, and hypersensitivity to new situations. Slow to warm up children are slow to adapt or withdraw from new situations. Temperament is a combination of genetic and environmental influences; genetic influences may lessen as a result of exposure to environmental factors (Rutter, 1981). If a child has a severe disorder such as autism, genetic factors may have a greater influence on future behaviour (Sanders & Dadds, 1993).

As these labels summarise descriptions of behaviour over a long period of time they may prevent the exploration of changing environmental influences on specific behaviours (Gewirtz & Peláez-Nogueras, 1992). Although temperamental classifications are of use in identifying children who may be more vulnerable to environmental stresses and more difficult to care for, temperament is shaped by experience and may change over time (Herbert, 1998). A child who is quiet and passive may be more easily ignored by a parent than an active child (Iwaniec, 1995), which may result in neglect if parents are distracted by other stresses in their lives. It is also true that a child may become passive because of lack of contingent attention from the parent (Crittenden, 1988). This clearly needs to be assessed in conjunction with the parents' behaviour as many children who are classed as passive receive good standards of care.

Brazelton's Neonatal Behavioral Assessment Scale (NBAS) (Brazelton & Cramer, 1990) looks at new-born infants' temperamental characteristics through measurements of the new-born infants' responses to their environment. It tests the behavioural capacity of an infant to attend, differentiate and habituate to a range of stimuli. These stimuli include touch, rocking, and facial expressions, which are used to soothe or alert the infant. Measures are taken of vigour, motor activity, muscle tone and colour changes as the infant's state of arousal changes. The child's reactions are seen to be a predictor of individual temperament. This test allows parents to respond appropriately to their child's individual behaviour, and can also predict which infants may be more difficult to care for; it does not however attempt to make long term predictions about behavioural styles. The NBAS has also been used to explore the effects of malnutrition, medication during labour, alcohol and narcotics on newborn babies' behaviour.

The temperamental style of the child influences interaction with the environment, and may result in difficulties if a mismatch exists between the style of parenting and the child's temperament (Brazelton & Cramer, 1990; Iwaniec, 1995). A child who is categorised as

difficult may have increased behavioural or emotional problems. These difficulties may have emerged as a result of temperamental characteristics, or because of insensitive or inappropriate parental behaviour (Iwaniec, 1995).

Parent-Child Interaction

Child abuse or neglect does not occur as the result of single factors, or characteristic of the parent or child. It evolves because of the interplay of individual, family and social factors. Direct observation of parent-child interaction can give a picture of how the parent and child influence each others' behaviour. As with other areas of parenting, a mother's past experience and current stressors or supports impact on her ability to interact with her child (Iwaniec, 1995). Neglectful parents may avoid interaction with their children, and become increasingly withdrawn from them, developing a pattern of not responding to the child (Crittenden, 1993; Mattaini et al. 1996; Wolfe, 1988). Difficulties in interaction may link to a range of factors including: lack of support, a child who is not responsive or difficult to feed or maternal depression, (Iwaniec, 1995).

Children are thought to be most susceptible to the effects of maternal depression between six and eighteen months (Glaser & Prior, 2002). Although it appears that depression will 'prevent the mother from interacting in an optimally sensitive and psychologically available manner with her baby' (Martins & Gaffin, 2000, p. 737), the direct impact of depression is difficult to differentiate from other stresses in the parent's life.

Postnatal depression is thought to affect 10-12% of all mothers, and is likely to have a negative impact on children's cognitive development (Martins & Gaffan, 2000). Adolescent mothers may be at increased risk of postnatal depression. This has been linked to low levels of social support and self esteem (Hudson, Elek & Campbell-Grossman, 2000). Depression decreases the strength of any social reinforcement (Hopko, Armnento, Cantu, Chanders & Lejeuz, 2003). Depressed mothers are therefore likely to engage in lower rates of positive exchanges, and be less sensitive to their infants. Infants are likely to match their mother's negative emotions and may become withdrawn and discontented when interacting with their mothers, and may also present in the same way during interaction with other adults (Zeanah, 1997). Infants of depressed mothers are likely to exhibit a 'depressed mood style' as early as three months (Gewirtz & Peláez-Nogueras, 1997a). Delay in children's cognitive development may continue even when postnatal depression is no longer present (Murray, Cooper & Stein, 1991).

Although problems in interaction between parent and child are often seen as central to exploring the aetiology of abuse and neglect (Iwaniec, 1995), directly neglectful or abusive behaviours are unlikely to be observed by professionals. Parents are unlikely to maltreat their children in the presence of an observer because of the professional obligation to report such action. However, observing other day to day interactions makes it possible to obtain a picture of how the family interacts, and establish the common antecedents and consequences of negative interactions. This is based on the assumption that neglectful or abusive acts are part of a continuum of everyday behaviours within a family, and are learned and maintained in the same way as other behaviours that would not be classed as abuse or neglect (Wolfe, 1988).

Infants directly shape their parent's behaviour. For example, babies behave in ways that elicit care giving, often through crying, which is both a conditioned and operant response. Crying in newborn babies is likely to be reflexive behaviour that becomes a learned behaviour through the increasing influence of the environment. As with all areas of development, the infant's interaction with the world becomes ever more complex as wider environmental influences influence behaviour (Schlinger, 1995).

One of the main influences on an infant's crying behaviour is the parent's response, which will influence future crying behaviour. For example, Papoušek & von Hofacker (1998) undertook a study that compared 63 persistently crying babies with a control group of 49 low crying babies. They found that parents of persistently crying babies tried to soothe children by over stimulation even when the children were ready to sleep; this was only successful for a short time before infants began to cry again. Infants were given less attention when they were settled and quiet, which meant that they learned crying as the main cue for maternal attention, and did not learn to self-soothe. Infant's crying was being positively reinforced by maternal attention, and therefore was likely to increase. The absence of reinforcement meant that settled behaviour was extinguished. The authors suggest that this results in infants being unable to self-regulate their behaviour and in the long term is likely to result in a range of difficulties including sleep disorders, feeding problems, temper tantrums and hyperactivity.

Wahler and Dumas (1986) suggest that children prefer predictable environments. When parents' responses are not contingent with their children's behaviour, children are likely to behave in ways that provide a predictable response, as 'unpredictable contexts serve an aversive function' (p.15). In other words, children show a preference for parental behaviour that they can anticipate and control, even if this is negative attention. In cases of physical abuse this may be through the child displaying aggressive behaviour, which results in a predictable, if abusive, response from parents.

When parents occasionally or intermittently respond to they child's signals, they are likely to strengthen signalling behaviour. This can lead to problems in parent-child interaction if the behaviour that is reinforced makes increasing demands on a parent who is already withdrawn from the child. In contrast, when parents consistently fail to respond to a child's cues, the child is likely to initially become upset, and then stop signalling to parents. Parents who ignore initial signals from their child are suggested to be more likely to withdraw if the child becomes upset (Crittenden, 1997).

The child's relationship with the parent is often assessed using attachment theory; the following section will explore behavioural interpretations of attachment.

Attachment

Attachment theory is commonly used in social work to assess the quality of child's relationship with the parent (Daniels, Wassell & Gilligan, 1999). Attachment can be defined as 'the disposition of the child to seek proximity to and contact with a specific figure and to do so in certain situations, notably when he is frightened tired or ill' (Bowlby, 1982, p. 371). Derived mainly from the work of Bowlby, attachment is based on biological, ethological and evolutionary principles necessary for survival. It is said to be a theory of normal development that offers explanations for atypical development (Crittenden & Ainsworth, 1989). Attachment systems are thought to be important throughout the life span, and are suggested to be 'most intensely activated under stressful conditions that evoke alarm or anxiety' (Crittenden & Ainsworth, 1989, p. 437).

Sensitive care giving is thought to be directly linked to the quality of attachment, specifically being able to read and respond appropriately to cues given by a child (Crittenden & Ainsworth, 1989). If a mother has not already developed the basic steps necessary for social communication, for example, eye contact, turn taking, or smiling, it is possible that she will have difficulty in entering reciprocal interaction with her child. This interaction is complex and varied: 'the identity and topography of response elements of the set of turn-taking responses (e.g., smiles, touches, vocalizations, turning away) of each member of the dyad can change at every turn of the series' (Gewirtz & Peláez-Nogueras, 1992, p. 1413).

When a mother has difficulty in reading her baby and for example, initiates activity when the child is sleepy, the child is unlikely to respond in a manner that is reinforcing for the parent (Brazelton & Cramer, 1990). As the child's state of arousal can change during an interaction the mother needs to adjust her behaviour towards the child accordingly (Gewirtz & Peláez-Nogueras, 1997a). Parents also need to adapt some aspects of their interactional behaviour to match their child's rate of development (de Weerth & van Geert, 2002).

Infant attachment is commonly described using measures obtained by using the Strange Situation (Ainsworth & Wittig, 1969). This test involves observation of a child's behaviour following exposure to an unfamiliar person and setting, plus the child's reaction to being left alone. The behaviour of the child when reunited with its parent is classified and forms the basis for assessment of the quality of attachment (Rutter, 1995).

The classifications of attachment identified from the Strange Situation are a) secure attachment, b) anxious/avoidant attachment and c) anxious/ambivalent attachment. Infant patterns of behaviour are related to the behaviour of the attachment figure. The infant who has a sensitive parent is thought to protest less at separation from the parent, and is classed as showing secure attachment. This is in contrast to the other categories that are thought to arise because of insensitive or unavailable parents (Crittenden & Ainsworth, 1989).

Although widely used, the strange situation has been criticised because it is not culturally sensitive, for example, it would not reflect some cultures where children are rarely separated from their parents, and depends on separation and reunion having the same meaning for all children (Rutter, 1995).

Children are said to form internal working models based on their experiences of relationships with their main carers, which subsequently influences their ability to form and maintain adult relationships (Rutter, 1995). It is thought that early negative experiences need to be integrated to form a coherent working model of relationships, if this does not happen problems with later relationships may occur (Kaufman & Zigler, 1989).

From a behavioural viewpoint attachment is a metaphor for specific behaviours. These are seen as subject to the same laws as any other behaviour. The idea of an internal working model of attachment is untestable, and is likely to hinder the exploration of wider environmental causes of behaviour (Schlinger, 1995). Mental causes of behaviour are seen to be fictional and unnecessary as 'the origins of behavior lie in heredity and in the environment, present and past' (Baum, 1994, p. 47). If a child is seen to be behaving in a particular way because of attachment, professionals may not look beyond this inferred internal entity at the genetic and environmental causes of behaviour. This leads to circular reasoning: attachment is thought to be present because of behaviour, and is also seen to be the cause of attachment behaviour.

The importance of early interaction with the environment is recognised in behavioural work:

> 'From birth onwards, infants and those around them, primarily the parents, engage in increasingly complex social interactions in which the behavior of the parents effects the behavior of infants and vice versa, and the behaviors of both are changed as a result' (Schlinger, 1995, p. 185).

Behavioral views of development recognise the importance of early experience and the influence that this may have on later adult life, however they also recognise that experience can influence behaviour at any stage in the life cycle. Gewirtz and Peláez-Nogueras(1992) state that early skills may need to be mastered so that more complex ones can develop, for example the social skills learned in infancy may be important for later relationships, these include appropriate eye contact, smiling and turn taking.

The most important behaviours seen to be indicative of attachment are cuddling, smiling and crying (Poling, Schlinger, Starin & Blakely, 1990). These behaviours become increasingly more responsive to specific social stimuli associated with attachment figures (Poling et al. 1990). Attachment behaviours such as signalling, smiling, approach behaviours are subject to the same laws as other behaviours and are mainly cued and reinforced by maternal responses (Gewirtz & Peláez-Nogueras, 1992).

When an infant protests at separation from the parent the function of behaviour towards the parent is to delay or shorten separation. This behaviour is likely to be repeated if it has been positively reinforced on previous occasions (Gewirtz & Peláez-Nogueras, 1997a). Gewirtz and Peláez-Nogueras (1992) state that the strange situation overlooks the mother's behaviour in past or present situations, it does not account for behaviour being sensitive to its context; a child is likely to behave in different ways in different settings.

In a study of 23 infants, Gewirtz and Peláez-Nogueras (1997b) found that mothers were able to deliberately shape non-protest responses in their children on separation from parents. This study demonstrates that a child's reaction to separation from their parent is linked to immediate contingencies and individual learning histories. Variations in infant behaviour can be explained by the relationship with antecedent and consequent stimuli which are provided by the parent (Gewirtz & Peláez-Nogueras, 1997a).

Consequences

Consequences are events or conditions that follow behaviour, and increase or decrease the likelihood that the behaviour will reoccur (Mattaini, 1998). Long term exposure to stress is an antecedent or setting event that may reduce the value of all reinforcers including those provided by the child's behaviour. Similarly 'a parent who is deprived of important reinforcers and pressed by multiple aversives is less likely to act in care taking and nurturing ways and is more likely to act aggressively toward or ignore the child' (Mattaini et al., 1996 p. 244).

Consequences for positive childcare practices may be immediate or longer term. An example of immediate reinforcement is a child who smiles when approached by his mother. The child's smile positively reinforces the mother's approach behaviour and increases the

chance that this behaviour will be repeated. Examples of delayed reinforcers include the child's long term health following immunisations.

Behaviour is strengthened by immediate delivery of reinforcement, if reinforcement is delayed behaviour is likely to be repeated less often (Bijou, 1993). Aspects of parenting that have delayed consequences may be affected by this, for example, the regular feeding of an infant may be reinforced by the infant's weight gain. The delay between the two events may make it necessary to construct or identify reinforcers earlier in the chain of behaviour in order to establish the behaviour (Mattaini et al. 1996). If the child's well being does not function as a reinforcer for parental care taking behaviour, reinforcement may come from external sources, for example praise from family, friends and professionals. When a family is isolated within the community they may not have these sources of reinforcement, or alternatively may be reinforced for behaviours that would be regarded as abusive or neglecting. The absence of negative consequences for neglecting or maltreating children, from either the community or professionals may also maintain the behaviour (Hansen et al., 1998).

Social Isolation

Social isolation may be a consequence of neglect as well as an antecedent, and is just one of many interlinked stresses that can impact on parenting. For example depression is likely to result in lower rates of social contact, and as result depressed mothers are at increased risk of social isolation (Hopko et al. 2003). Social support is a complex issue, it is clearly not just the quantity of contact that a parent has with the wider community; the value of social and professional relationships for the family also needs to be considered (Seagull, 1987). Even when a range of social contact and potential supports are available, some parents may lack the skills to avail of these networks, and subsequently view contacts as aversive.

Coohey (1995) undertook a comparison study between 69 neglectful mothers, identified by Child Protection Services, and a demographically matched sample of 138 mothers. Findings showed that neglecting mothers had fewer social supports and more difficulties in their relationships with partners and their own mothers. Although neglecting mothers were more likely to live near to their own mothers and have frequent contact, they were less likely to state that their own mothers had positive attributes. They also received significantly fewer resources and less support.

Wahler (1980) reported that families who had a high number of external stresses were at increased risk of social isolation and reported interpersonal problems outside their families. A correlation was found between mother-child problems and the amount of positive social contact that the mothers had on a particular day. The mothers viewed contacts that occurred either with professionals or family members as aversive. The interchanges were suggested to be similar to coercive exchanges present in mother-child problems. Professionals or

family members gave mothers commands in relation to childcare; commands were positively reinforced when the mother complied. Although mothers' compliance was negatively reinforced, to escape the command, the behaviour was unlikely to be repeated when the person issuing the command was not present. Aversive contact was not initiated by mothers. Wahler suggests that it is necessary to look beyond the parent child relationship and to improve social contacts when planning interventions. Although the mothers in this study had contact that was potentially supportive, their perception of the supports and their social skills in making and maintaining friendships were problematic.

These studies show that social contact in itself does not relieve social isolation, parents also need to have the social skills to elicit appropriate supports, and support networks in turn must offer adequate levels of positive reinforcement for good childcare. Social or professional contact that is viewed as aversive by parents is likely to result in withdrawal, or avoidance behaviour by the parent, and may serve to increase social isolation.

Intervention

Behavioural interventions follow a thorough and individualised assessment, based on objective measures of specific behaviours. In cases of maltreatment assessment is likely to include observations of interaction and parenting skills (Ammerman, 1990). Intervention generally includes procedures such as modelling, instruction, feedback, rehearsal and positive reinforcement to produce changes in behaviour (Gershater-Molko et al., 2002). A range of behaviours may be targeted, linked directly or indirectly to parenting. The results of behavioural interventions are likely to be maintained because the emphasis is on skills acquisition and behaviour change, whereas other forms of intensive supports, that do not include plans for generalisation may stop once the supports have been withdrawn (Gaudin, 1993).

A number of difficulties may impact on the effectiveness of intervention with maltreating families. These include; the range of stressors and limited resources available; the potentially coercive nature of the referral; neglect or abuse is not usually observed; and the need for interventions to target many areas of the family's life (Hansen et al., 1998).

Gershater-Molko (et al.2001) recommends that behavioural interventions for neglect should take account of the following:

1. Services should be culturally sensitive, and validated by members of the same social/cultural group as parents.
2. A comprehensive assessment of the family's social ecology and parenting skills related to a wide range of childcare tasks should inform treatment.

3. Direct observation should be the main measure used; this may be supplemented by other measures of indirect assessment. Any indirect measures of assessment should be valid and reliable and aimed specifically at neglect.

4. Staff should be trained to criterion levels; the effectiveness of both staff and intervention should be monitored.

5. Interventions should be done in families' homes and be long term, 8-18 months.

Parent Training

Parent training aims to enable parents to learn different ways of interacting with their children, to reinforce and maintain pro-social behaviour (Bourn, 1993). Triadic methods of work are undertaken between the professional, parent and child. Techniques used in parenting training may include immediate coaching and feedback; teaching parents to reinforce appropriate behaviour and ignore unwanted behaviour and modelling and role play (Bourret, 2002).

Parents are involved in all stages of treatment, for example recording their children's behaviour, identifying the contingencies that maintain or increase problematic behaviour, and implementing treatment in the home (Bourn, 1998). Involving parents in assessment and treatment helps the parent to recognise the impact they have on their child's behaviour and development, and allows the withdrawal of professional services once parents have developed the necessary skills (Iwaniec, Herbert & McNeish, 1985). Parental involvement may also be an advantage when working with diverse cultural groups as it ensures that plans for treatment reflect the parents' personal values and goals (Webster-Stratton, 1999).

Parent training has been applied to a wide range of common child behaviour problems, including non-compliance, feeding difficulties, aggression, school refusal and temper tantrums (McAuley & McAuley, 1980; Strauss & Aitkenson, 1984). The role of the family in maintaining or changing problems is central to most interventions. Intervention usually aims to change the child's behaviour by identifying and altering environmental factors and also includes any behaviour of other family members that maintain the problem (Sanders & Dadds, 1993). Many child behaviour problems occur as a result of parents inadvertently reinforcing problem behaviours, for example by giving more attention when a child is misbehaving. Treatment addresses this by teaching parents to ignore antisocial behaviour and reinforce prosocial behaviours (Bourn, 1998).

Some discipline methods that are taught in parent training may be used in abusive ways if families have long-standing difficulties, for example, the use of 'time out'. Time out is a procedure where the positive reinforcer that is maintaining the problem behaviour is removed. This is usually done by temporarily removing the child from the setting where the problem behaviour occurs to a setting where the behaviour is not reinforced. Time out should only be used as a last resort, and should last for no more than five minutes. Unfortunately it

can be misinterpreted and if wrongly used to exclude a child for long periods of time, can be abusive (Neville, King & Beak, 1995). It is unsuitable to teach this method to parents who have previously used isolation as punishment (Hudson & Macdonald, 1991). Intervention with families where abuse or neglect occurs must address improving the relationship between child and parent before addressing positive discipline techniques (Hembree-Kigin & McNeil, 1995).

Behavioural methods as used in parent training may enable parents to manage their children's behaviour in less aversive ways, but do not necessarily ensure that the overall day to day care that a child receives is more sensitive (Azar, 1997). The target behaviour may increase or decrease in line with treatment goals, but may not reflect an improvement in the child's overall environment (Isaacs, 1986).

Failure in parent training is reported where there are high rates of stresses such as poverty, depression, and lack of social support (Wahler, 1980; Sutton, 1992; Kazdin, 1990) or where problems are severe and long established (McAuley & McAuley, 1980). Parents who are at greatest risk of maltreating children are most likely to drop out of parent training (Sanders & Cann, 2002). Interventions to improve overall standards of parenting clearly need to have a wider focus than parent child interaction (Macdonald & Roberts, 1995; Sanders & Cann 2002). Parent training methods are generally used when family problems are manifested through child behaviour difficulties, which have become well established. It would be better when possible to focus on developing parenting skills at an earlier stage to prevent problem behaviour from developing.

Individual work with parents may be necessary to address wider issues that impact on their ability to care for their children before parent training is likely to be effective. This may include stress management techniques such as relaxation, anger control, and problem solving techniques that help parents to deal with the other stresses in their lives (Gough, 1993; Mattaini et al. 1996; Macdonald & Roberts, 1995). Developing these skills may offer increased protection for children, particularly if combined with improved child management skills.

Interventions with Parents with Learning Difficulties
Interventions for parents with learning difficulties are generally targeted towards parents who would be classed as having borderline learning difficulties, as parents who have more severe difficulties would be unlikely to be given the opportunity to care for their children (Feldman, 1994). Neglectful parents in general have been found to have lower IQ scores than a comparison group of parents, matched on income who were not neglecting their children (Pianta et al. 1989).

The results of interventions to teach parenting skills to parents with learning difficulties are generally positive, and suggest that many parents can learn to look after their children with appropriate supports and training programmes (Llewellyn, 1990; Tymchuk & Feldman, 1991; Feldman, 1994; Greene et al., 1995). Less successful results are likely if parents are dealing with a high number of stresses such as domestic violence, poverty, isolation, or poor housing (Llewellyn, 1990; Tymchuk & Andron, 1992). These finding also apply to parent training with parents who do not have a learning difficulties (Wahler, 1980; Sutton, 1992; Kazdin, 1990). Questions have been raised about the wider application of existing studies because of the relatively small numbers involved in each study (Tymchuk & Feldman, 1991; Dowdney & Skuse, 1993). However the collective results of 16 studies that gave data on individual mothers showed an improvement in 96% of parents in one or more of skills trained. Most interventions were based on behavioural methods, specifically using task analysis, modelling, feedback and positive reinforcement (Feldman, 1994).

Parents may be seen by professionals as incapable of learning to care for their children, however, it is important that consideration is given to the appropriateness of the teaching method. Parental reading ability should be taken into consideration and teaching materials adapted as necessary. One example is the use of pictorial manuals to teach basic child care skills (Feldman & Case, 1997; Feldman, Ducharme, & Case, 1999). It is important that training strategies are based on concrete rather than abstract concepts, for example using modelling rather than instructional techniques (Feldman, 1994). Unfortunately when parenting programmes do not work, it is often seen as a failure on the part of the parents rather than consideration being given to the possibility that the service needs to be adapted (Feldman, 1994).

The Surrey Place Centre has developed a programme of parent education for parents with learning difficulties. Criterion-based tests are used as an aid to direct observation in the natural environment. The programme covers a wide range of task analysed child care tasks such as feeding, bottle making, nappy changing, and home safety (Feldman, Case & Sparks, 1992; Feldman & Case, 1993a; Feldman &Case, 1997; Feldman, Garrick & Case, 1997; Feldman, Ducharme & Case, 1999). Training techniques include discussion, modelling, social reinforcement and self-recording. Results from these studies showed that following training, the vast majority of parents' skills in all tasks increased and were maintained at follow- up observations.

Interaction Training
A study by Feldman, Towns, Betel, Case, Rincover, and Rubino, (1986) found that parents with learning difficulties interacted less with their children, compared to middle class parents without learning difficulties. In particular lower rates of praise, and imitation were exhibited.

These skills were trained to, and in some cases above, the level of parents without learning difficulties. Changes were maintained at five to ten months in the home environment, although not consistently with all participants. Child vocalisation also increased beyond the levels expected due to maturation. Mothers were reported to have become more sensitive and responsive to their child's vocalisations.

A later study (Feldman, Sparks & Case, 1993) reports that interaction training increased responsive and reinforcing interactions between mothers and children and also resulted in significant increases in language performance and social development in the children. Mothers in the study are reported to have become more aware of their role in their child's language development. Follow up data for this study showed more consistent maintenance than in previous studies; the authors suggest that this may because the tangible reinforcers used, were gradually faded after treatment and therefore promoted generalisation. Other benefits of this treatment were that fewer children were removed from parents; before the study 78% of the participating families had a child removed from their care, following the study this number was reduced to 20%.

Tymchuk and Andron (1992) undertook a similar study with nine parents with learning difficulties contrasted with a group of mothers from similar backgrounds. Findings from this study also indicated that parents with learning difficulties praised less than the comparison group. Results were not as successful either during treatment or maintenance as those described in the previous two studies. Mothers, who were experiencing other difficulties such as domestic violence or depression, benefited least from treatment. It is suggested that parents' problems need to be addressed prior to, or at the same time as interaction skills.

Social skills deficits are suggested to be common in parents with learning difficulties, particularly the tendency to be unable to read social cues and overtaxing of social support systems (Whitman, Graves & Accardo, 1989). Parents who are at risk of neglecting their children may also have difficulties with social skills. Difficulties in interaction with children may be linked to mothers having problems reading social cues. For example a review of ten studies looking at risk factors for neglect by Schumacher, Slep and Heyman (2001) found that neglectful parents in general interacted at lower rates, or less sensitively than non-neglecting parents. Interventions aimed at improving parental sensitivity will be explored in the following section.

Improving Maternal Sensitivity
Van IJzendoorn, Juffer and Duyvesteyn (1995) undertook a meta-analyis and review of 16 interventions aimed at improving parental sensitivity and attachment security. Interventions included were divided into two categories , first at a behavioural level, to change the parent's

behaviour toward the infant, and second, at a representational level, to change parents' mental representations of attachment.

Interventions at a behavioural level were classed as short term preventive, and included mothers being given a soft baby carriers for their new born babies. The carriers were used for lengthy periods on a daily basis to enhance physical contact and promote infant feelings of security. Interventional at representational level was classed as long term, and included mothers being encouraged to explore her past and how it affected her relationship with her baby. Results showed that short-term preventive interventions were more effective in changing maternal sensitivity than long term therapeutic interventions.

Gewirtz and Peláez-Nogueras (1997a) explored the impact of specific components of interaction with infants of a group of ten depressed mothers. This study compared the effects of contingent touch with those of contingent smiling and cooing on infants. Infants were positively reinforced for making eye contact with the observer, with touch or smiling/cooing. Infants responded positively with increased eye contact, smiling and vocalisation and showed a preference for touch. Results suggest that contingent touch may be an important component of intervention to prevent infants from mirroring parental depression.

Specific Child Care Skills
Since 1979, Project 12-Ways has provided in-home parent training using behavioural techniques with families with a history of abuse and neglect. Some of the families have had learning difficulties and nearly half of the cases have been referred because of child neglect. Training has been aimed at teaching a wide range of skills including personal cleanliness, nutrition, home safety and cleanliness, and identifying children's illness (Delgrado & Lutzker, 1988; Lutzker, 1990). In addition other supplementary skills have been addressed including stress reduction, self control, social support and assertiveness training (Lutzker & Rice, 1994). Each aspect of the service has been evaluated and shown to be effective (Gershater-Molko et al. 2002).

The Checklist of Living Environments to Assess Neglect (CLEAN) was developed by Project 12-Ways to evaluate the impact of treatment aimed at improving hygiene conditions in the home (Watson-Perczel, Lutzker, Greene & McGimpsey, 1988). The process aims to quantify and improve conditions in the homes of parents referred to the project because of neglect concerns. In a study reported by Watson-Perczel (et al. 1988) the procedure was undertaken with three families, with comparative data from four other families attending the project. Families were given information on cleaning, and specific instructions linked to contingencies. Results showed improvements in standards in the home with all families; however, information alone was ineffective in improving conditions, and needed to be

combined with instructions and contingencies. The authors note that intervention lasted for 'several months' before changes were obtained.

This procedure was tested across a group of parents in a study of 62 families ranging from parents with low income and education, to approved foster parents. Families with a history concerns about environmental neglect obtained lower score in comparison to all other families, regardless of levels of income or education. The authors suggest that this instrument can enable parents and professionals to establish basic standards that can differentiate environmental neglect from the effects of poverty (Greene & Kilili, 1998).

Greene et al. (1995) reports on two individual cases referred to Project 12-Ways because of concerns about abuse and neglect; the children in each family had been placed in foster care. The parents in both families had learning difficulties. In the first case the mother was taught basic childcare skills using simple texts, rehearsal, and role-play. Following the successful completion of the programme the mother was able to resume full time care of her child. Following a similar training programme the second family were able to demonstrate their ability to perform parenting skills but were inconsistent in their application. In the second family, extended contact with the children was contingent on the performance of specific tasks related to parenting. The parents' failure to complete these tasks was used as court evidence in decisions about the children's futures. Several reasons are suggested to explain the difference in outcomes in the two studies; the second family's children were older and more settled in foster care, the parents had a history of difficulties with child rearing. The first mother was a first time mother and had a network of supports which was absent in the second family. The results of the second family in this study demonstrate the failure of intervention with families with high levels of environmental stress.

Tertinger, Greene and Lutzker (1984) highlight the need for interventions that address home safety for families at risk of neglect. Interventions that consist solely of advice, written information or the provision of safety equipment have been found to be ineffective. Parents need to be able to identify and correct any hazards in their homes. The Home Accident Prevention Inventory (HAPI) was devised for parents referred to Project 12-Ways. A study reported by Tertinger, Greene and Lutzker (1984) used the HAPI programme with 6 families with children aged from birth to four years. Observers used a check list to identify dangers in the home that were accessible to young children. Hazards were grouped into five categories including a) fire and electricity, b) suffocation by ingested objects, c) suffocation by mechanical means, d) firearms and e) poisoning. Each category was targeted in turn, once hazards had been reduced by 50% from the preceding category. Intervention included advice on making hazards inaccessible, demonstrations on safe storage, verbal feedback on performance, and praise for reaching and maintaining target scores. Results for all families showed a decrease across all categories as a result of intervention. Generalisation to new

categories did not occur before intervention took place. Feedback from participating parents indicated that they viewed the procedure in a positive light, and believed that the levels of safety in their homes had improved because of the intervention.

Summary

No one definition of neglect exists, this appears to be because of the wide range of behaviours that can be included, and the need for these to be further broken down in terms other dimensions such as frequency and severity. The purpose of the definition influences the range of factors included, and whether responsibility for childcare is placed entirely with parents or the impact of the wider environment is acknowledged. Even without a clear definition, the range of potential influences on parenting clearly shows which families are most likely to be vulnerable to abuse or neglect. A wide range of environmental and personal stresses such as poverty, isolation, poor communication skills, relationship problems, poor living conditions, and poor employment prospects may impact on any parent's ability to care for a child. The greater the numbers of stresses present the more impact they are likely to have. It appears that the form of maltreatment is largely due to the behavioural style of the parent, for example a parent who withdraws when under extreme stress may withdraw from their child.

These stresses are likely to be present to a greater degree among subgroups of parents, for example young lone parents or parents with learning difficulties, and leave these parents more vulnerable to difficulties in parenting. This needs to be explored within the context of the environment that parents live in, rather than seeing neglect as an inevitable consequence of having learning difficulties or being a young lone parent. As no typical neglecting parent exists, individual cases therefore must be assessed, taking into account the contextual and personal variables that impact on that particular parent.

Behavioural social work offers several benefits to working with parents who are vulnerable to neglect. First it does not discriminate between neglectful and non-neglectful parents because it avoids placing blame on the parents; instead the focus is on methods of change (Neville, King & Beak, 1995). Any parent may fail to meet the basic needs of their children at some stage, or may avoid interaction occasionally with their child. It is when this behaviour becomes extreme that difficulties arise. Rather than looking for the causes of neglect in the person through personality traits, or genetic components, environmental causes of behaviour need to be explored as these may be changed.

Second, clearly defining target behaviours addresses the issue of standards for parenting. No standards for parent exist for practitioners to draw on, and any that exist are open to interpretation. It is clearly important that social workers have a good working knowledge of possible indicators of neglect, normal child development, as well as the impact of wider social factors. Although any definition is socially constructed, it would be helpful if practitioners had basic acceptable minimum standards for childcare that could be agreed with parents. A close working relationship with other professionals could also possibly lead to a consensus on thresholds for intervention.

Although research clearly points towards more emphasis on family support for the majority of cases there is still the need for child protection for the most extreme cases. Clearer definitions about thresholds for intervention may allow resources to be more evenly spread. The use of the term 'neglect' in relation to less extreme cases may cause families to become unnecessarily caught up in the child protection process. As the risk to the child is not perceived to be serious, these families may be filtered out of the system without any services, even though some factors associated with neglect are present. Such experiences are likely impact on the willingness of parents to accept any professional help with parenting.

Child neglect has not been given the same attention as other forms of abuse. This is because it is difficult to define, due to the long-term cumulative nature of the problem, and also because it is difficult to assess as neglect is based on what parents are not doing, rather than what they are doing. Within existing research on child neglect, behavioural studies stand out because of their methodological rigour, and successful outcomes. Many of these studies have focused particularly on parents with learning difficulties, and have been undertaken in parents' homes. The aim of this research is to develop these methods of assessment and intervention and to apply them to a wider service user group, within a residential setting.

Chapter 4

Methodology

This chapter will provide a detailed outline of the methodology, including data collection instruments, procedures, research designs, data analysis and ethical issues.

Permission to undertake this research was obtained from line management within Barnardos. Project residents and staff were consulted in the design of instruments used. The contents of data collection instruments were agreed with a health visitor independent of the agency. All work undertaken with mothers was part of the usual service provided by the project.

Research Aims
- To develop and evaluate behavioural interventions to prevent child neglect for children under four years.
- To enable parents to develop childcare skills in a way that is sensitive to their individual child.
- To adapt models that have been developed in Canada and the USA, and to adjust these so that they can be used with young parents in Northern Ireland.

Objectives
- Development of a detailed behavioural programme that is individually tailored to meet the needs of both parent and child
- Enhanced parental ability to undertake childcare tasks at appropriate times
- Enhanced communication between parent and child
- Improved parental ability to provide a safe and hygienic living environment for their children
- Increased parental sensitivity to their child's physical and emotional needs

Background
Behavioural interventions with families at risk of neglect have been outlined in the third section of the literature review. In particular the working methods of Project 12-Ways and the Surrey Place Center will form the basis for this study. The literature review has given more detailed accounts of the work carried out in each setting.

Project 12-Ways operates under the Behavior Analysis and Therapy Programme at Southern Illinois University through the provision of in-home services for parents. Parents are referred by child protection services because of concerns about abuse and neglect. Forty percent of referrals are due to neglect. This programme offers twelve core services to address

parenting problems, these include parent-child training, stress reduction training, self-control training, basic skills training for children, leisure time counselling, alcoholism treatment, social support groups, job finding, budgeting, heath and nutrition, home safety, behaviour management and prevention services (Lutzker & Rice, 1984).

Maurice Feldman and colleagues in the Surrey Place Center, in Toronto have worked extensively with parents with learning difficulties. Behavioural interventions have been used to enable parents to develop basic childcare skills, and prevent developmental delay in children through improved parent-child interaction (Feldman, et al., 1986; Feldman et al., 1992; Feldman, Sparks & Case 1993). Although most of this material has been specifically devised for use with parents with learning difficulties, it is also suitable for use with any client group who may lack basic childcare skills, in particular those who have literacy difficulties.

This study aimed to build upon research from both sources through the following:

1. Similar methods were applied in a residential setting. Both the Surrey Place Center and Project 12-Ways have undertaken work in parent's homes. Work in the home allows observation in a naturalistic environment; however, this is likely to be restricted by the times that workers are available. Undertaking this work in a residential project allowed observations to be completed at times when childcare tasks were normally carried out, rather than at times arranged by workers.

2. Mothers were encouraged to dictate the standards and frequency of childcare tasks, and were involved in planning intervention. Some participants recorded their own progress in specific areas of child care. The setting can promote parental self-recording as staff are available at all times and can therefore remind parents to record, and offer assistance with recording if parents have difficulty with forms.

3. In addition to developing necessary childcare skills, measures were also taken of the frequency of childcare tasks. This is an important component of neglect prevention, because it ensures that childcare tasks are carried out at regular intervals. The setting allows opportunities for observations at a wide range of times, and allows contingencies that impact on all aspects of childcare to be observed.

Each study undertook assessment and intervention on a range of behaviours relevant to child neglect. Materials were modified and developed as necessary. Procedures were tested across a selection of behaviours, with a range of families who had children of varying ages and with a variety of members of the staff team.

Participants

Participants were selected from residents in a unit for young mothers and their children. Fifteen sets of families took part in the studies. Further background information on individual families is given in each study. Children ranged in age from birth to three years. Thirteen (86%) families had children on the Child Protection Register under the category of neglect. Five children were subject to Interim Care Orders. All of the families were perceived to be at high risk of neglect because of their current and previous life experiences. All mothers in the project, including those who participated in this research had experienced most of the following:

Difficult Childhoods

All participants experienced maltreatment as children. This included neglect and physical, emotional or sexual abuse either singly or in combination. As a result of these childhood experiences many mothers had limited exposure to consistent or positive parenting. Although the majority of mothers continued to have contact with their families, in many cases this was not supportive. Just over half of mothers had lived in local authority care for more than two years.

Interrupted Schooling and/or Learning Difficulties

Moves through care or difficult home circumstances meant that many mothers did not attend school regularly. As a result mothers often had poor literacy skills, few qualifications and subsequently very limited job prospects. Some mothers with learning difficulties were not statemented while at school because of poor attendance, which meant that they had not been able to access specialist services. Four mothers (26%) had been statemented and were classed as having mild or borderline learning difficulties. Learning difficulties were often diagnosed in mothers as the result of psychological assessment requested by social workers or the courts when there were serious concerns about childcare. It is possible that other participating mothers had undiagnosed learning difficulties.

Frequent Moves

Mothers who had been in care often experienced many moves through a variety of settings including children's homes, foster homes and training schools. Mothers who remained in the care of their families also experienced frequent moves during early adolescence. They often went to stay with other family members or friends to escape difficult home circumstances. Nine mothers (60%) had experienced three or more moves in the eighteen months prior to moving to the project. As a consequence of these moves, and disruption of family relationships, mothers often did not have a family or community to which they felt they belonged, and were socially isolated. Following discharge from local authority care, some mothers had periods of homelessness and frequent house moves. In some cases this disruption caused mothers to have unpredictable lifestyles that had little regularity, without

any routines for activities such as sleeping or eating. This could be problematic when routines needed to be established for their children.

Young people leaving care are likely to be over represented among the homeless, or to suffer from instability and changes of address to a greater degree than this age group in the population as a whole. In addition stresses from poverty, and unemployment further disadvantage this group (Action On Aftercare, 1996).

Involvement with Social Services

Most mothers had been involved with social services since childhood. As a result professionals may have monitored the mother's ability to parent more closely than they would necessarily have with other young parents. Four mothers had learning difficulties, which also resulted in high levels of professional concern and close monitoring. Mothers did not always see social work involvement as supportive, many were resentful of any professional involvement.

Lack of Experience of Independent Living

The majority of mothers had no positive experience of living alone, and lacked basic life skills such as budgeting, shopping or maintaining a home. Skuse (1996) suggests that many young people leaving care have difficulty with living skills, for example money management, or cooking. This is no different to any adolescent leaving home, but most adolescents have both emotional and practical family support at this stage in their lives. Care leavers with the extra responsibility of a baby to care for are further disadvantaged.

Early Parenthood

Mother's ages ranged from 16 to 25 years, the average age was 18, and almost half the mothers were under 18 years old. Young women in or leaving the care system are more likely to have had a child, or become pregnant soon after leaving care. Figures vary between 14% for the UK, (Action On Aftercare, 1996), to 40%, in Northern Ireland (Pinkerton & McCrea, 1996). Negative stereotypes prevail towards teenage parents; pregnancy and childbearing are seen as automatically problematic, in a way which is not true for other women of average childbearing age (Schofield, 1994).

Negative outcomes associated with teenage pregnancy include mothers being three times more likely to develop post-natal depression, and children having lower birth weights, and higher incidences of infant mortality (Coles, 2000).

Limited Support from Partners

Only four mothers had partners, and out of these, one had restricted contact with his child because of concerns about sexual abuse; two were not allowed any contact because of

domestic violence. The remaining partner visited infrequently as he lived some distance from the project. Eight mothers (53%) in total had previously experienced domestic violence at some stage, in some cases this had taken the form of assaults resulting in serious injury. Although fathers cannot be resident in the project they can be involved in the assessment process.

Selection

All families coming into the project over a four year period were screened using instruments as described in Study One, Childcare Skills and Study Four, Home Hygiene. Any families who scored below criterion levels during baseline observations in either of these procedures were asked to participate. Families who were having difficulty with routines were asked to undertake work as outlined in Study Two, Routines; six mothers in total agreed to undertake this work. Three mothers failed to complete agreed records and were excluded from this study, intervention with the remaining three mothers is reported in Study Two.

The mothers who participated in Study Five had all reached criterion levels in basic childcare, and were selected because of concerns raised by project staff about either the quality of interaction that had been observed informally, or because of concerns about the baby's presentation. Although many of the mothers presented in both Studies One and Two would have benefited from this intervention this was not possible because placements ended before work was completed on the physical care of their children.

All families who had children over eight months old were screened using the instruments to measure levels of home safety as outlined in Study Three. Any mothers who scored below criterion levels were asked to participate in the study. Two families who were eligible only participated in one observation, and were therefore excluded from this study. The age limit restricted the number of families who could participate as most of the children in the project are aged from birth to six months. However this intervention was only relevant to families when children became mobile.

Setting

The setting is a residential assessment unit for young mothers and their children. It is housed in a purpose built facility that offers accommodation in six individual two bedroomed flats.

Referrals come from Social Services, and are made due to concerns about parenting knowledge or skills, or child protection concerns. Mothers in the project range in age from sixteen to twenty five years, their children range from birth to three years. The majority of children in the project are on either Care Orders or on the Child Protection Register. Neglect

is the most common category of registration for children. If mothers are under eighteen years old, they may also be subject to Care Orders or on the Child Protection Register.

Areas of assessment are agreed for each family, and generally focus on two broad areas; the mother's ability to care for and protect her child, and the mother's ability to care for herself. Placements usually range in length from three months to one year, although on occasion placements may be ended earlier if there are concerns about risk to the child. Decisions about moving into the community following assessment are generally taken at Case Conferences or Looked After Children reviews.

Living in a residential setting offers a degree of protection against wider environmental stresses. Poverty, one of the main factors associated with neglect (Minty & Pattinson, 1994), does not affect the mothers in the project to the same degree as it would in the community, because staff ensure that they do not run out of the essentials for their children. Other benefits to living in a residential setting include the availability of a good standard of living accommodation, and social and practical support from both staff and other residents.

Drawbacks to living in residential accommodation include the stress caused by being constantly monitored and the sense of isolation when mothers move into the community with their children and no longer have the high level of social and professional contact available in the project. Many mothers do not have a choice about coming to the project, and may be there under direction from court.

Families who participated in this study continued to receive the range of other services provided by the project. These are agreed on an individual basis prior to admission, and include individual counselling, work on homemaking skills, and ongoing advice and support with childcare from residential staff.

Data Collection Instruments and Measures
The development of individual data collection instruments is outlined in each study. These took the form of assessment checklists. Instruments used in Studies One and Five were based on those used in the Surrey Place Centre. Those used in Studies Three and Four were based on the work of Project 12-Ways. Instruments used in Study Two were based on practice experience in the project. Each instrument was checked for cultural relevance through discussion with residents and staff. Checklists were also tested through observations of residents who were considered competent at each task, and adapted as necessary. This ensured that the standards in the checklists were realistic for parents in the project. Instruments were designed to fit within the normal working process of the project, and aid assessment. Staff and parents completed assessment instruments.

Prior to implementation residents were consulted to ensure that parents' forms were free from jargon and easily understood. Although a wide range of instruments were devised, all parents did not require intervention in all areas of childcare. The instruments were designed to be developmentally sensitive; instruments selected for each family depended on the developmental level and needs of the individual child. Supervision and safety, for example, become more important once the child is mobile; giving solid feeds needs to be addressed once a child is over four months.

Measures were taken in each study of the percent of steps performed correctly as defined on each instrument; this was calculated by dividing the total score by the maximum possible score multiplied by 100. This measure allowed assessments to be adapted for individuals while still providing comparable scores, as steps could be added and or removed as appropriate.

Experimental Designs

Each study was undertaken using a single-system design appropriate to that study. Using these designs demonstrated the effectiveness of intervention through repeated measurements taken before, during, and after intervention. Single-system designs can be evaluative, showing that change took place during intervention or experimental, demonstrating that improvement was due to intervention (Thyer, 1993).

Single-system designs can offer three different types of knowledge. First, they offer a description of behaviour at all stages. Second, they offer correlational information, obtained by comparison of each stage. Third, they can offer causal information regarding treatment and behaviour (Tripodi, 1994). Information obtained was used as feedback to service users about progress made, or if intervention was not effective, demonstrated where changes needed to be made.

Although used extensively in behavioural work single-system designs are not linked to any one theory (Gabor, 1989). Regardless of the theory or working method used, single-system design encourages the use of a systematic approach to assessment, goal setting and monitoring, and allows for continuous assessment (Kazi & Wilson, 1996). Using such designs allows workers to fully evaluate the impact of their work, and base decisions about theories or methods of work on empirical evidence about effectiveness rather than the personal preference of the worker (Mutschler, 1984).

In order to undertake any form of single-system design it is necessary to operationally define the target problem in a way that allows measurement through the use of valid and reliable tools such as observation, self report or physiological measures (Thyer, 1993).

Potential designs range from measures of intervention only, without any before or after measure, to more complex designs offering comparisons of target behaviours prior to and after intervention. The simplest form is the B design where a measure is taken only of the 'B' or intervention phase. This offers descriptive information on the target behaviour during intervention, but cannot offer information on how intervention has increased or decreased this behaviour, nor does it show if any changes have been maintained following intervention. It is preferable therefore to take initial baseline, and follow up measures to fully allow the effectiveness of intervention to be evaluated.

Establishing a baseline is important to monitor progress, and show the initial severity of the problem (Gambrill & Barth, 1980). The baseline gives a measure of the target behaviour, as it would continue without intervention (Dillenburger, 1998). It is possible to take a retrospective baseline if intervention cannot be delayed to allow the collection of baseline measures, however this can be unreliable unless based on existing concrete measures, for example school attendance records (Kazi & Wilson, 1996). In some cases it is only necessary to take brief baseline measures, for example if behaviour is rarely emitted (Sulzer-Azaroff & Mayer, 1991).

An evaluative design, for example a simple 'AB' design, takes a measure at baseline or the 'A' phase, and intervention or the 'B' phase, and can illustrate that change has happened but cannot give definite information about the cause of change, or demonstrate that change has been maintained. More complex experimental designs are required to prove that treatment is responsible for change. These include multiple-baseline, ABAB withdrawal and changing criterion designs. If an experimenter can demonstrate the effects of treatment more than once then the chances of explanations other than intervention being responsible for treatment are greatly reduced (Thyer, 1993).

A multiple baseline design records a number of target behaviours using baselines of different lengths, with intervention implemented successively. Measures are also taken after intervention has finished and can show that changes have been maintained. The results of a multiple baseline design demonstrate that change occurred only when intervention was introduced, and so show that intervention was responsible for changes in behaviour. This design can be used to measure changes in behaviour across different behaviours, people or settings. All dependent measures must be independent of each other; changing one should not affect other behaviours (Poling, Methot & LeSage, 1995).

Drawbacks to multiple-baseline designs are that withholding treatment for an extended baseline may be unethical and impractical. It may be difficult to establish effectiveness if some behaviours in a study improve and others do not (Poling et al. 1995).

Withdrawal designs or 'ABAB' designs take repeated measures of behaviour at baseline and intervention to measure the effect when intervention is withdrawn then reinstated. Removing intervention allows behaviour to return to the baseline level. Information is given about the effectiveness of intervention, and also whether change is likely to be maintained without intervention (Sulzer-Azaroff & Mayer, 1991). Although the use of this design raises some ethical questions about removing treatment, it can be implemented where unplanned breaks in intervention have occurred (Thyer, 1993).

In a changing-criterion design the criterion is gradually increased in steps toward the target rates of behaviour, each step serves as a baseline for the following one. Each time behaviour reaches its target the criterion is increased, until the final target behaviour is reached (Sulzer-Azaroff & Mayer, 1991). Benefits to the use of this design are that early success can be rewarded as each criterion level is reached, which means that the target response can be reached in gradual steps (Sulzer-Azaroff, 1998). This design does not require an extended baseline, which is useful when intervention cannot be delayed, for example if dealing with childcare tasks. Drawbacks to using this design are the difficulties in evaluating behaviour that does not match criterion levels; it does not therefore allow the evaluation of treatments that do not require changes in performance to be stepwise (Poling et al., 1995).

Regardless of the design chosen it is vital that data is gathered at a follow-up period to ensure that any changes in behaviour are maintained and not only happening during the intervention phase (Gambrill & Barth, 1980).

Criticisms of the use of single-system design in practice include concerns that the research agenda may take priority over practice priorities. However, the use of this method can improve practice because it ensures that goals are clearly defined, can be made explicit to the service user, and that recording is done in a systematic way (Tripodi, 1994). Another suggested limitation of this method is that not all aspects of the service user's situation are addressed. However any measures are considered in the context of other background information that supplements the quantitative data (Mutschler, 1984).

Kazi and Wilson (1996) undertook a British study of twenty one social workers applying single-system designs over eighty three cases. They found that the type of design selected was influenced by practice, for example, using an 'ABAB' design when there has been an unexpected break in intervention. This study showed that qualitative data was able to be quantified, for example graphing data recorded on a simple ABC chart. Social workers were

found to be unlikely to use statistics, and were more likely to rely on visual analysis of graphed data. Research outcomes demonstrated that social workers were effective in their intervention for 92% of cases.

Assessment and Intervention Process

The assessment and intervention process began with an initial meeting with the mother, field social worker, and keyworker from the project to identify areas of assessment. Baseline measures of basic childcare skills were then taken by staff, and formed a basis for the identification of specific areas of childcare to be addressed. Areas of work were prioritised between staff and individual residents based on baseline measures, and agreed criterion levels were set for each task. Intervention on each task consisted of a combination of verbal and written prompts, modelling and positive reinforcement in the form of vouchers and praise. When criterion levels were met intervention moved onto another area of childcare. If criterion levels were not reached, the external impacting factors were explored, criterion levels were renegotiated, and the working method was reviewed and adjusted as necessary.

Assessment and intervention tools were divided into five areas; 1. Basic Childcare Skills, 2. Frequency or Routines for Childcare Tasks, 3. Parent -Child Interaction, 4. Home Safety Programme and 5. Home Hygiene Programme. (See Appendices). These areas were selected based on experience in the project that many mothers had difficulties in these areas and evidence from the literature review that these areas are closely related to neglect and negative outcomes for children.

A voucher scheme was implemented in the project and was used throughout assessment and intervention to reinforce target behaviours, the principles of token economy are explained in the following section.

Vouchers

A voucher scheme is a form of token economy that offers vouchers as reinforcement for desired behaviour. Vouchers can be exchanged at a later stage for a range of items or activities. One of the main advantages of using tokens is that reinforcement is initially offered with minimal delay; and can be gradually reduced once the behaviour is established (Suzler-Azaroff & Mayer, 1991). Vouchers also have the advantage that they provide variety, and 'the principle of reinforcer variety states that the more varied and diverse the reinforcers, the more effective they will be' (Grant & Evans, 1994, p. 44). Satiation is avoided through the use of a wide range of reinforcers. Behaviours reinforced by vouchers were based on identified areas of work as outlined in each study. Immediate reinforcers have been found to be more effective than delayed reinforcers; vouchers can act as a bridge between the two and are likely to become conditioned reinforcers in their own right (Grant & Evans, 1994).

A voucher menu was drawn up based on a questionnaire completed by a range of residents to identify possible reinforcers (See Appendices 0a & 0b). The reinforcement menu also allowed additional items to be negotiated by individual residents.

The voucher system aimed to:
• Reward any progress, and keep a focus on what mothers were doing well
• Keep work focused and planned through setting, monitoring and reviewing goals
• Cue staff through the use of vouchers to give praise and encouragement to residents
 Residents continued to receive vouchers for participation in the assessment process,
 regardless of whether or not they were included in this research.

Vouchers should be gradually phased out once target behaviours have been established, and gradually be replaced by more naturally occurring reinforcers, for example praise from staff, and self-praise. It is important that mothers' behaviour comes under the control of natural contingencies so that behaviour changes are maintained when mothers move into the community with their children (Suzler-Azaroff & Mayer, 1991).

Reducing the vouchers changes the reinforcement schedule from continuous to intermittent. A continuous schedule occurs when every performance of a behaviour is reinforced, and is useful for increasing behaviours. Intermittent schedules reinforce only occasional responses and are used to maintain established behaviour, particularly when paired with naturally occurring reinforcers (Suzler-Azaroff & Mayer, 1991).

Data Analysis

Data are presented and analysed in graphic form for each study undertaken. Measures of changes to the target behaviour were plotted to show the impact of intervention. Line graphs were used; the format of each was dictated by the experimental design used. Visual analysis determines if change took place during intervention periods, and if the intervention was possibly responsible for the change. Graphing data after each observation demonstrated effectively the impact of intervention and identified when procedures need to be adapted (Poling et al., 1995). Graphs promote objective analysis of data because they are based on concrete measures rather than the interpretation of workers (Cooper et al., 1987). As graphs are easily understood they could be shared with parents and workers to evaluate progress.

Critics of behavioural work question the relevance of behavioural research because of the numerical measures used. Using numbers is suggested to result in the complexities of the human condition being overlooked (Thyer & Strean, 1992). Numerical measures are an important component of behavioural work, both as evidence of outcomes and to demonstrate progress, however, when undertaking assessment and intervention contextual factors also need to be explored, and workers need to have interpersonal skills to engage the client.

Ethical Considerations

This research was designed within the obligations and duties outlined in the British Association of Social Workers (BASW) Code of Ethics (2002). Particular attention was paid to the specific research responsibilities outlined in 4.4 of the code, including maintaining ethical awareness throughout; working within the values of respect for human dignity; ensuring openness and fairness in dealing with service users, colleagues and employers; working within the principles of informed consent and maintaining confidentiality.

The behavioural methods used in each study were designed within the recommendations of the code of practice of Behavioural Social Work Group (UK) (Hudson & Macdonald, 1995). These recommendations include working in the best interests of the services user, balanced against potentially harmful effects on others; intervention based on the best available evidence; goals and methods that are agreed with service users and intervention designed so that it can be evaluated for effectiveness. This will be discussed in more detail below.

Consent

Under the principles of the Data Protection Act (1998) consent to keep any records was obtained from all families prior to and following admission to the project. To ensure that this is informed consent this was renewed regularly with all residents in the project. Participation in research through allowing the use of information recorded during placements was voluntary. Verbal and written consent were obtained from all mothers on admission to the project, no families refused consent. On admission to the project parents also consented to participate in observations with staff. Observations of parents are undertaken as part of the

normal work practices in the project, so participants were not being asked to do anything beyond the normal assessment process. Many parents are initially apprehensive about being observed, however this in linked to the work carried out by the project rather than the research process.

Parents were assured that they had the choice of becoming involved in the research, and that they would receive the same range of services regardless of whether or not they participated, and that their decision would not influence their assessment outcome. This was particularly important as many parents were anxious about their placements and potential outcomes, and could have believed that they did not have a real choice. As some parents had problems with literacy it was important that this was fully discussed before getting written consent. This was addressed individually in the mother's flat by a social worker in the project. Consent could have been coercive if it had been obtained by the author, as the author was in a management position in the project.

Confidentiality

Mothers who agreed to participate were given assurances of confidentiality, by ensuring that names were changed and that participants could not be identified. All mothers were aware that a full guarantee of confidentiality could not be given because of the agency responsibility to pass on any child protection concerns. Each mother was encouraged to read and contribute to any record kept on them or their child, however because of the obligation to keep information confidential, outcomes for other families could not be shared.

No information that could identify the mothers or children who participated in this research was used. This is particularly important given the small size of the project. A guarantee of total confidentiality could not be given because the results of this research formed part of the overall assessment of parenting and information gained contributed toward the future outcome for the child. In some cases this resulted in the removal of the child from the parent's care if the parent could not provide adequate standards of care. As this was already a potential outcome of the assessment it can not be attributed to the research process.

Mothers who participated in video work were assured that their videos would be stored safely, viewed only by those observers who had the mother's consent, and would be the property of the mother following the end of the placement.

Protection from Harm

The needs of service users took priority over research needs at all times, for example, results would have been more robust had two observers completed all observations and provided interobserver reliability ratings, however this would have been difficult for mothers, who already felt under pressure because of ongoing monitoring. A second observer was

only used during training sessions for live observations, and with the mother's consent for video recordings.

The mother's right to privacy was respected at all times, observation sessions were arranged at times agreed with parent, and not undertaken if other residents or visitors were present.

Children were protected from harm through the agency policies and procedures and statutory child protection procedures. Although decisions about children's futures were not taken based entirely on the assessment outcomes detailed in this research, they did contribute significantly to the overall assessment.

It is important that results of this research are not used out of context, for example, as evidence that young parents who are vulnerable because of their previous life experience are unable to parent. Some of the mothers who participated in the studies and had extreme difficulties in parenting are not representative of the many other parents who have been able to successfully parent their children in spite of experiencing many disadvantages. Those mothers who had difficulties provide evidence only that this method of working was not effective with them at this stage in their lives.

Anti-discriminatory Practice

Child protection practice has been criticised in recent years for failing to include fathers or male partners in assessment and intervention (Milner, 1993; O'Hagan & Dillenburger, 1995). In cases of neglect professionals may hold the mother responsible for meeting all the child's needs for care and nurture, and ignore the responsibilities of fathers. Mothers may be blamed if children's needs are unmet, even if a father is present in the home (Turney, 2000). Failing to involve fathers or partners discriminates against mothers, and may also increase the risk to children if fathers are excluded from assessment. In contrast the positive or protective role that fathers may have in their children's lives may also be overlooked (Daniel & Taylor, 2000).

Fathers have not been intentionally excluded from this research, initially it was hoped that some fathers would be available to participate in studies. However, as outlined earlier, only four of the participant mothers had partners. Attempts had been made by Social Services to involve all fathers in the assessment process by inviting them to attend meetings to discuss their involvement. Two fathers attended these meetings and were actively involved in their children's lives, but restricted from becoming involved in the studies for the reasons described at the start of this chapter. As the partners who had been violent towards the remaining two mothers repeatedly refused to have any contact with professionals they were prevented from having any contact with their children, and could not therefore be involved in the assessment process.

Behavioural social work fits within an anti-discriminatory framework because it does not seek to blame or label mothers as bad parents, instead it offers methods of change and can remove the stigma of being seen as a failure as a parent (Neville et al., 1995). Behaviour is seen in the context in which it occurs, which means that the causes of difficulties in parenting are not seen to be within the parent, instead wider environmental, genetic and historical factors are considered. Many theories used in childcare work offer explanations of behaviour, while behavioural social work also provides such explanations; it also offers ways to change behaviour.

Empowerment is central to the BASW code of ethics and to social work practice in general. Empowerment can be defined as 'the means by which individuals, groups and or/communities become able to take control of their circumstances and achieve their own goals, thereby being able to work towards helping themselves and others to maximise the quality of their lives' (Adams, 1990, p.5). Working in a way that empowers service users involved in child protection poses challenges for workers because of the power imbalance inherent in the role of social workers in this area. For example, parents and workers may not share the same views about the levels of risk a child is exposed to, and subsequently what is best for the child (Daniel & Taylor, 1999).

Professionals are legally obliged to work in partnership with parents, although, in some cases partnership may be restricted to ensure that children are protected. Partnership may take many forms, and can be viewed as a continuum of parental involvement, ranging from parents being informed about decisions to full participation in decision making (Daines, Lyon & Parsloe, 1990).

Although residents did not always have a choice about moving to a residential unit with their children, and undergoing assessment of their parenting, they were encouraged to actively participate in the assessment process. Mothers were offered choices about whether or not to undertake work as outlined in this research, and were consulted about the content and process of assessment.

Ethical Considerations of Behavioural Social Work
The ethics of behavioural social work are similar to those of social work generally, and do not change because of the method used (Dillenburger, 1998). As behavioural work has been shown to be effective with a range of service users across a range of settings, it is suggested to be more acceptable than working methods that have not been empirically tested (Hudson & Macdonald, 1991). Empirical practice promotes social work values as it demonstrates the effectiveness of any intervention (Thyer & Wodarski,1998).

Behavioural social work addresses the issue of consent with any intervention undertaken. The service user should give informed consent, based on knowledge about the goals and process of treatment. When consent to participate in intervention cannot be obtained because of the age or ability of the service user, the consent of the carer or guardian should be sought (Reese, 1978).

The issue of control is an area that has been subject to criticism and misunderstanding in behaviour analysis. Control already exists within the environment as described by Sheldon (1995)

> We are each bombarded daily by countless controlling influences and that to see control as a game of billiards where only one influence at a time operates is indeed to take a naïve and mechanistic view of human behaviour p. 234

Concerns exist that behavioural social workers will use control to coerce service users into behaving in ways that society dictates. Sheldon (1995) points out two weaknesses in this argument, first it assumes that behavioural social work practice is so powerful that it can cause change even if service users are resistant, second it ignores the many other controlling factors that are already present in service user's lives.

Behaviourism does not suggest that individuals cannot make choices, and are therefore easily subjected to the more powerful control of others. The choices made by individuals however, are not entirely free because of the influence of the individual's learning history (Baum, 1994). Individuals are not merely passive recipients; they influence as well as being influenced by their environment (Nye, 1992). Control exists in all aspects of human behaviour, and can be used positively or aversively, but is generally seen to be more obvious when it blocks growth or development (Skinner, 1971). However this belief is contentious because without self-determination or the ability to make free choices individuals cannot be blamed or praised for their actions (Skinner, 1971).

Payne (1997) suggests that a central objection to behavioural methods is that behaviour is manipulated by the worker rather than being under the control of the service user, and this could lead to workers' goals rather than the service user's taking priority. The principle of service user consent addresses this; intervention is less likely to be effective with an unwilling participant.

The issue of workers manipulating the behaviour of service users has more to do with the power inherent in the social worker's role and how this is addressed with service users. Although the power difference in child protection work is unlikely to be rebalanced, agreeing shared goals and methods of work can begin to address this and allows the service user

clarity about what is expected from them. By allowing service users to set priorities, and define their own difficulties, workers can ensure that it is the service user's goals that are being met.

Ethics governing behavioural work include the right of the individual to the most effective treatment available (Van Houten et al., 1987). Workers therefore have a responsibility to use techniques that research has shown to be effective. Basing the current research on empirically tested methods that have been shown to be effective with similar groups of parents addresses this issue. The methods used were subject to ongoing evaluation with participants so that intervention was adapted if necessary when it was not effective.

Behavioural methods may be viewed as dangerous because of their effectiveness and the potential misuse of such methods by those with power to control others (Reese, 1978). Methods may be abused, for example using behavioural interventions to make a client behave in a way that is beneficial to the setting or worker rather than the individual, but it is then the goals that are unethical not the method (Hudson & Macdonald, 1991). The voucher system for example could potentially have been used to meet the needs of the project rather than mothers' goals. This was avoided by ensuring that vouchers were awarded for individually agreed goals related to specific parenting tasks.

Scientific approaches in social work often face criticism because they are viewed as ignoring concepts such as intuition, and feelings. Social workers may prefer to rely on personal skills and values such as empathy, and building relationships rather than the direct application and evaluation of a specific theory (Munro, 1998). Although behavioural work is based on an established framework, with clearly identified working methods, it is not mechanical in application. Each intervention needs to be tailored to meet the unique situation of the individual client. This requires in depth knowledge about the individual and their environment that is unlikely to be achieved without well-developed communication skills.

Abstract

This research was undertaken with fifteen young mothers and their children aged 0 to 3 years in a residential assessment unit. All families were vulnerable to neglect because of a range of background factors. Many of the parents had grown up in care; all had experienced maltreatment in childhood. Thirteen families had children on the Child Protection Register under the category of neglect; five of the children were also subject to Interim Care Orders.

The literature review explores the range of factors associated with neglect, and the impact of neglect on children. This is presented in a behavioural context, where antecedents and consequences of neglect are discussed.

A range of interventions were designed to increase parental skills in areas of childcare that can be linked directly to neglect. These included basic childcare skills, childcare routines, home hygiene, home safety and parent child interaction. Each intervention was adjusted to suit the developmental stage of the child involved. Parents were involved at all stages of assessment and intervention, and in some cases recorded their own progress. Undertaking work in a residential setting allowed direct observation in the natural environment at the normal time for completing childcare tasks. Intervention consisted of verbal prompts, modelling, feedback from checklists and video recordings, and positive reinforcement.

Results show that some mothers were able to develop the necessary skills, and maintain progress during follow-up, while other parents could perform tasks but did these inconsistently. Some parents had difficulty responding to cues from their children. Inconsistent parenting emerges as a key theme throughout the studies. Reasons why intervention was effective with some parents and not with others are explored.

Chapter 5

Neglect Prevention

Each study presented in this chapter addresses significant areas of childcare relevant to neglect prevention. These include basic childcare skills, routines, home hygiene, home safety and parent child interaction. The results of individual studies are discussed in each section. The overall findings will be explored in the following chapter.

Study One- Child Care Skills

Introduction

Literature on parents with learning difficulties suggests that parents can be taught the skills to care for their children (Feldman et al., 1992; Greene et al., 1995). Most of this work has been done on a sessional basis, either at a centre or at times when workers call to the home. In contrast, the current study took place in a residential assessment unit for families, where staff can observe at the normal time for specific childcare task to be undertaken.

Feldman and colleagues have developed skills based parent education methods for working with parents with learning difficulties (Feldman, Case & Sparks, 1992; Feldman & Case, 1993; Feldman & Case, 1997; Feldman, Garrick & Case, 1997; Feldman, Ducharme & Case, 1999). These include task analysed child care tasks observed in the natural environment. A task analysis is the breaking down of complex behaviour into a chain of simple steps. Targets can be set for the gradual acquisition of the behaviours in the chain. This ensures ongoing reinforcement for steps completed, rather than reinforcement being provided only when the whole task is completed (Sulzer-Azaroff & Mayer, 1991). Techniques used by Feldman and colleagues to train parents in childcare included discussion, modelling, and social reinforcement. The study reported here applies similar methods to a range of parents where there are concerns about neglect, aiming to ascertain if neglect of basic physical care of infants can be attributed to a skills deficit and therefore addressed through skills training.

Feeding problems are explored in this study. While none of the children's weight had led to a diagnosis of failure to thrive, this could have been a possible outcome for some of the children in the study had intervention not taken place. Literature on failure to thrive infants shows that not only is feeding a basic requirement for the physical growth of an infant; difficulties in this area can lead to problems in all areas of development, including physical, mental and emotional development. Early intervention during the first year of life has the most positive outcomes for children, in both the short and long term (Iwaniec & Sneddon, 2001). Research into failure to thrive has found that negative styles of interaction by parents during feeding have been linked to poor intake of food, and in some cases food refusal

(Iwaniec, 1995; Wolke, Skuse & Mathisen, 1990). Mothers of failure to thrive infants have also been found to be less likely to persevere with feeding (Drotoar, Eckerle, Satola, Pallotta& Wyatt,1990).

Participants

Name	Age	Learning difficulties	Care History	Care Order (Mother)	Care Proceedings (Child)	Child's Age	Skills Trained
Laura	16	N	Y	Y	N	1 week	Bathing
Evelyn	24	Y	N	N	Y	2 weeks	Bathing
Jane	16	N	Y	Y	N	2 weeks	Feeding
Charlotte	18	N	N	N	Y	1 week	Feeding
Lee	21	Y	N	N	N	5 months	Feeding
Caroline	16	N	Y	Y	Y	1 week	Bathing & Feeding
Ruby	25	N	N	N	N	6 months	Bathing & Feeding

Table 1

Seven mothers took part in this study, as highlighted in Table 1. All had been referred for assessment and support by Social Services because of concerns about their parenting ability. Seven children participated in the study; three boys and four girls. All of the children were on the Child Protection Register because of neglect concerns; two were also registered under additional categories. The additional categories were based on concerns about other family members. In one case this related to concerns about to potential physical abuse from the mother's former partner. In another case registration was because of potential sexual abuse from the mother's partner, and other family members.

Laura
Laura was admitted to care at the age of three because of sexual abuse by a family member. She grew up in a foster home until the age of fourteen, when the placement broke down. Prior to admission to the project she had several moves including an admission to a children's home and a short period in supported accommodation. Laura had just given birth to her first baby when she was admitted to the residential project. Laura had a supportive

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partner, but as he lived forty miles from the project his contact was limited. Laura also had regular contact with some family members. Laura was to be subject to a Care Order.

Evelyn

Evelyn became known to Social Services at the birth of her first baby. Evelyn had learning difficulties and prior to admission to the project had never looked after herself independently. Although Evelyn had been statemented in childhood she was not deemed eligible for adult disability services. Evelyn had had very limited contact with children as she had been at a residential school. Evelyn had regular contact and ongoing support from her family.

Jane

Jane's family had been known to Social Services for many years because of neglect concerns. Jane was referred to the project because of her young age, and concerns about a violent much older partner. Jane had regular contact with family and friends. Jane was subject to a Care Order.

Charlotte

Charlotte's family were also known to Social Services for many years because of concerns about neglect and sexual abuse. Charlotte's previous child had been freed for adoption because of neglect. Charlotte was referred to the project because of concerns about the impact of her lifestyle on her child. Charlotte's baby was exposed to heavy alcohol and tobacco use pre-natally. Charlotte's baby had a serious medical condition which required particular care to be taken with childcare tasks. Charlotte's family contact was supervised because of concerns about perpetrators of sexual abuse in the wider family. Charlotte's baby received respite two nights per week to allow Charlotte to have contact with her family.

Lee

Lee's family had a long history of Social Services involvement because of neglect concerns. Lee had been living with her family prior to admission, but had expressed a desire to live independently in the community with her child. Lee had learning difficulties, and no experience of independent living. Lee was not eligible for adult disability services. It was unclear how much childcare Lee had been undertaking while living with her family, professionals involved with the family were concerned that Lee's mother had been completing most childcare tasks. Lee continued to have regular contact with her family following admission.

Caroline

Caroline was taken into care at the age of two because of neglect concerns. Caroline remained with foster parents until she was thirteen when the placement broke down because the foster parents were unable to manage behaviour. Caroline then had a series of moves before being admitted to the project prior to the birth of her first baby. Caroline's baby did not

gain weight at the expect rate and was referred to a paediatrician, no physical reason for this could be found. Caroline had occasional contact with her family, and frequently felt rejected by them. Caroline's baby was placed with foster parents for weekend respite on a fortnightly basis.

Ruby

Since the death of her mother when Ruby was fifteen, Ruby had moved frequently between homeless hostels, and had several unsuccessful attempts at independent living. Ruby's previous child was freed for adoption as the result of serious neglect concerns. Ruby's current child was born prematurely but had no serious health concerns. Ruby's baby's weight gain was at times slower than expected, and closely monitored by the family's health visitor. Ruby was admitted to the project when her baby was six months old. Ruby had infrequent family contact, which often resulted in arguments. Ruby also had occasional contact with a violent partner. Ruby's only other social contacts were with professionals.

Materials

Task analysed childcare checklists were devised to record all areas of basic physical care of children based on the Step-by-Step Childcare Manual (Feldman & Case, 1993) (See appendices 1a & 1b). Bathing and feeding are reported in this study.

Observations were undertaken with two residents who were not aware of the steps in the task analysis to ensure that no important steps had been overlooked and that standards were those normally expected of all residents in the project. These residents were selected based on previous positive assessment reports and were not included in this study as they were nearing the end of their assessments. The steps included on the task analysis were discussed with the same residents following observation, to ensure that each step was acceptable, easily understood and free from jargon.

For each task a member of staff initially performed each of the steps on the task analysis, to ensure that the steps followed a logical sequence. This was recorded on video to be used for staff training. The checklists were adapted with reference to commonly used childcare literature to ensure that no safety steps had been omitted (Leach, 1997; Health Promotion Agency Northern Ireland, 1994). A health visitor also reviewed the checklists.

Checklists were sensitive to the child's age, for example two bathing checklists were drawn up, one for young babies bathed in baby baths and the other for older children bathed in the 'big' bath. Checklists could be modified for use with individual mothers if the mother had an equally safe method of carrying out the childcare task. Additional steps were also added as necessary, in agreement with mothers, for example one child was receiving medication with feeds and needed to be fed in a specific way because of health problems.

Steps that did not apply to individual mothers were scored as N/A and omitted from the final scoring, for example if a mother chose not to use talcum powder. Criterion levels were set at 80% of relevant steps completed correctly, based on Feldman's findings (Feldman et al. 1999) that this is the normal range for parents. This needed to include essential safety steps. Safety steps for feeding included checking the temperature of the milk or food, and ensuring that the baby was strapped in his or her seat securely for solid feeds. Bathing safety steps included checking the temperature of the bath water and setting the baby somewhere safe while preparing and clearing up after the bath.

Observations on checklists included the step 'mother looks at the baby and maintains eye contact' while undertaking the task. Staff also recorded general comments on the sheets, which offered further information on the observation, often in relation to other events that were preventing the mother from fully completing the task. These comments were shared with mothers as part of the discussion that followed observations after the baseline phase.

Baseline measures had previously been taken with the same mothers for a range of childcare skills. Scores that were consistently above criterion levels either at or following the first observation required no further intervention.

Mothers who scored below a criterion level of 80% of steps performed correctly during baseline observations of feeding and bathing were included in the study. Feeding was selected because of the importance of this skill in ensuring the overall health and development of infants. Concerns about weight gain had been raised by health visitors for two out of the seven children who participated in the study. Bathing was selected as the second skill because mothers in the project were often anxious about bathing their babies and welcomed staff support while carrying out this task. Both these skills offered mothers the opportunity to interact and develop a relationship with their babies.

Consent

The study was explained to all mothers on admission to the residential project, written consent was obtained from all mothers. No mothers refused to take part in the study.

Training for Observers

Staff in the project were trained as observers in the use of all assessment instruments, and basic behavioural principles over eight hours, with follow-up discussions. Written guidelines on completing assessments were also provided. A Video of a member of staff completing childcare tasks as outlined in the task analysis was observed and scored by staff using the childcare checklists, all observers were training to a criterion of 80% correct during training.

Observers were also tested on their knowledge of behavioural principles following the training in a written test (See appendix 1c). All participants scored above 85% correct in the test.

Procedure

The procedure was explained to mothers as part of the overall assessment process. Observations were undertaken in mother's flats at the time the mother usually carried out the task, and were undertaken by the member of social work staff on duty. Observations lasted for the duration of the task. During the baseline phase residents were asked to carry out tasks as they normally would. Staff prompted mothers if an essential safety step was omitted during baseline observations, no other feedback was offered other than thanking the mother for allowing the observation to take place. Although prompts were likely to have an influence on the mother's behaviour in future observations, they were essential to ensure the safety and wellbeing of the children. The number of baseline sessions for both skills ranged from one to three depending on the urgency for intervention and work schedules. Vouchers, as discussed in the methodology chapter were awarded for participating in observation sessions during the baseline phase, then only if criterion levels were reached during intervention.

Interobserver Reliability

As observations were taken in mothers' flats as part of the normal work process interobserver reliability checks were not possible during observations. A range of staff trained to the same standard in the use of checklists were used. Staff discussed and agreed the scoring with mothers immediately after observations during the intervention phase.

Research Design

An ABA design was used with three mothers for bathing; follow-up data was not available for the fourth mother so an AB design was used. An ABA design was used with three mothers for feeding, with an ABAB with the remaining two mothers as they required further intervention.

Measures

The primary measure for childcare tasks was percent correct, gained by calculating the following:

$$\frac{\text{Total number of steps completed without prompts}}{\text{Total number of steps} - \text{Any steps scored as N/A}} \times 100$$

A step was scored correct if it was completed as described on the checklist. If a step was completed following a prompt this was scored as incorrect.

Intervention

Intervention consisted of the following:

1. Verbal prompts were given during intervention for any missing steps, with praise given for steps completed correctly.

2. Checklists and scores were reviewed and the importance of missing steps was discussed with the mother, referring as necessary to childcare literature.

3. Vouchers and praise were awarded for reaching target levels for steps completed correctly. Vouchers could be used to 'buy' items from the voucher menu as outlined previously.

4. Staff modelled specific components of the task if the mother did not complete steps following a verbal prompt.

Training continued until mothers could complete 80% of the task without prompts on two successive occasions for bathing, and three successive occasions for feeding, including safety steps. Intervention for feeding was extended because of the difficulty some mothers had in reaching criterion levels while feeding their babies.

During intervention observation sessions lasted for the length of time it took to complete the task, and were followed by praise for steps completed correctly, and a discussion on any steps that had been missed.

Follow-up

Follow-up observations were planned to be undertaken weekly after mothers had completed 80% of all steps over two observations for bathing. Feeding follow-up was planned to be undertaken daily after reaching criterion for three observations. Vouchers were no longer given during follow-up observations.
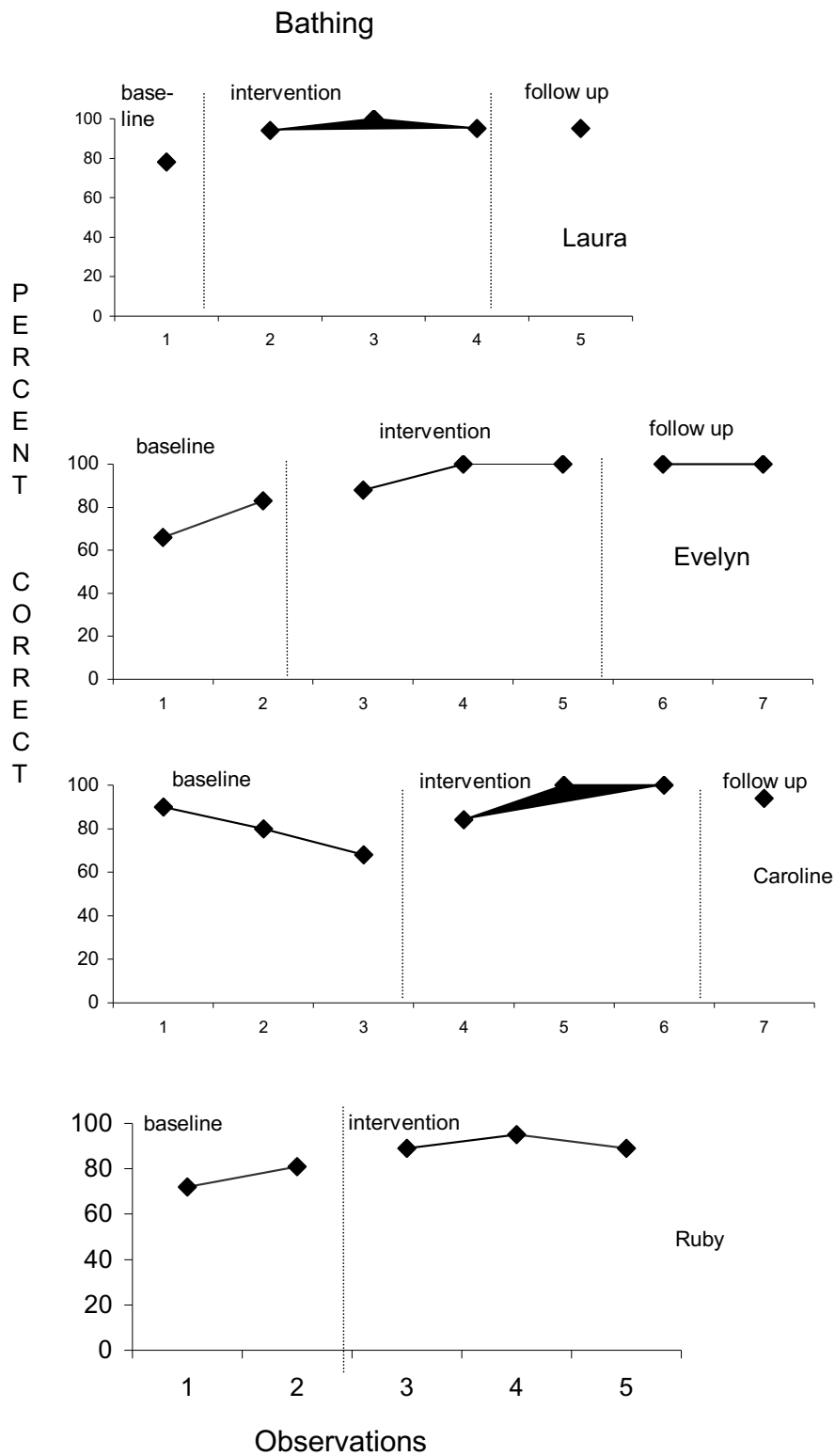
Figure 1.1 results for bathing at baseline, intervention and follow-up for Laura, Evelyn and Caroline. Baseline and intervention results for bathing for Ruby
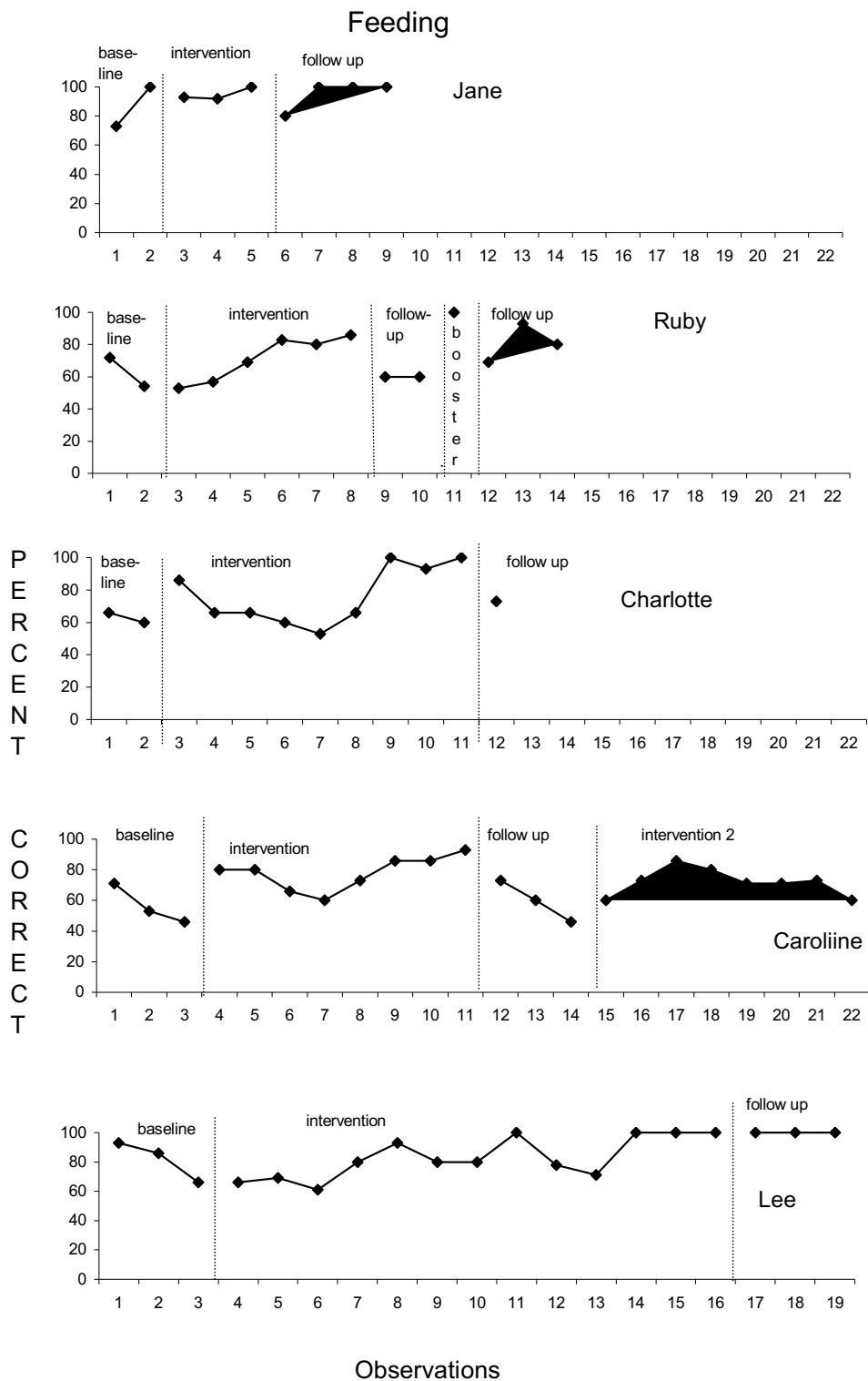
Figure 1.2 Feeding results at baseline, intervention and
follow-up phases for Jane, Ruby, Charlotte, Caroline and Lee.

Bathing

All four mothers who took part in the study improved their skills to above criterion levels during training. Three reached criterion levels after one baseline observation which suggests that any prompts given during the baseline were effective in changing behaviour without the addition of praise or vouchers. Follow-up observations were completed on three mothers and showed that skills had been maintained above the criterion level. Follow-up data were not available on bathing for Ruby as she began to avoid staff contact by changing the arranged times for bathing. Ruby was experiencing difficulties in all areas of childcare at this time.

Feeding

Results for feeding do not show the same overall improvement. Although all mothers reached the target of three successive scores above the 80% criterion level, progress in this area was only maintained during follow-up observations for Jane and Lee.

Jane reached and maintained criterion levels after one baseline observation. Steps that were missed were discarding the milk left in the bottle and rinsing out the bottle and did not directly effect the baby.

Ruby initially responded slowly to intervention, and did not maintain criterion levels at the follow-up phase. Some improvement occurred following a further booster session; however as the placement ended further data were not available. General comments on Ruby's observations sheets highlighted that Ruby was frequently distracted during feeds, often watching television, talking to staff about herself, or walking around during feeds. This meant that Ruby's interaction with the baby was limited while feeding, during 29% of observations Ruby did not talk to or look at the baby at all during feeds. On other occasions staff noted that when she did talk to the baby this was in the form of commands. Other staff comments included concerns about the baby's clothes being too small, and bottles not being washed properly. A further problem was the erratic pattern of feeding for Ruby's baby. Long periods often passed between feeds, and Ruby at times informed staff that the baby 'wasn't hungry'. Ruby responded well to praise, but became angry if staff tried to address any childcare issues with her and subsequently tried to avoid staff observing feeding by changing the baby's feeding times.

Charlotte's baby had a reflux problem, which meant that additional steps were added to her task analysis in line with medical advice. The baby required medication and a nappy change before giving a bottle; she was to be given the full bottle before winding. It was important that steps were followed in exact sequence which meant that Charlotte's task analysis of feeding was more complex than the ones used by other mothers. Charlotte improved initially following baseline observations but did not maintain progress. Charlotte had to be prompted during 36% of observations to administer medication before feeding. Although at one stage

Charlotte scored above criterion levels over three successive observations, she was unable to maintain this at follow up. Staff comments indicated that Charlotte was at times distracted during feeds, often watching television. On other occasions Charlotte was quiet and withdrawn. During 59% of all observations Charlotte did not talk to or look at her baby. It was difficult to assess the impact of Charlotte's feeding behaviour on the baby's weight, as the baby had overnight respite on a weekly basis, which helped to maintain her weight. Further data were not available as Charlotte's baby was admitted to foster-care because of a range of concerns about Charlotte's lifestyle.

Caroline made some progress during the first two sessions following baseline observations; this was not consistent during the intervention phase or maintained during follow-up. It was necessary therefore to introduce a second intervention phase using the same methods. Although Caroline's baby was referred to a paediatrician because of concerns about slow weight gain, Caroline did not accept that this was problem. Caroline also had an erratic feeding pattern for her baby, often feeding the baby outside the project. Staff comments indicated that Caroline frequently hurried feeds because she wished to go out with friends. As a result Caroline often refused to wind the baby, or give any remaining formula.

Caroline also had limited interaction with her baby and during 31% of all observations did not talk to or look at the baby. On some occasions Caroline was noted to interact very positively with the baby, while during other observations she was talking on her mobile phone while feeding. Caroline's baby became increasingly difficult to feed; often taking more than thirty minutes to take a bottle, and became increasingly withdrawn and unresponsive to adult attention. Caroline's baby was admitted to foster care where her weight increased dramatically.

Lee's progress was initially slow, and as she frequently missed out basic safety steps including strapping the baby into his seat, and checking the temperature of the milk, the intervention period was extended. Lee was the only mother in the feeding group who had learning difficulties. Like the other mothers who had difficulty with feeds, Lee's interaction with the baby was initially limited. During early observations Lee did not talk to or look at the baby, as she was watching television. Lee accepted advice to switch the television off during feeds, resulting in an immediate improvement in her interaction with the baby. Lee also acted on advice regarding other aspects of feeding, and was able to maintain a maximum score.

Discussion

A skills based training programme was implemented to increase parenting skills with seven young women and their babies. Following baseline observations across a range of skills, bathing and feeding were identified as requiring intervention because scores for these tasks

fell below the 80% criterion. The programme was based on task analysed childcare checklists devised by Feldman (et al. 1992) for parents with learning difficulties. Feldman found that parenting skills for basic physical care could be improved through behavioural intervention (Feldman et al. 1992). The results of this study found this to be true in relation to bathing, but results were less defined for feeding. It is difficult to compare results because of the difference in the backgrounds between the mothers who participated in this study, and those who participated in Feldman's study.

Parents who participated in this study had been referred to a residential unit because of high levels of child protection concerns about their ability to care for their children. Before being permitted to move into the community with their children they were required to undergo an assessment. Of the five mothers who participated in the feeding study, two had their children placed in local authority care before assessment was completed because of overall concerns about the quality of care offered to their children. In contrast the parents who participated in Feldman's study were older; over half were married, and already living in their own homes. Although the parents in Feldman's study were referred because of concerns about childcare, they were already living independently with their children, which would suggest that the levels of difficulty in childcare were likely to be less acute than with parents who need to undertake a residential assessment because of child protection concerns.

Results showed that intervention was effective for teaching all mothers how to bath their babies, but only effective in two of the mothers who participated in the feeding study. Difficulties arose for three mothers during feeding, although all of these mothers had successfully reached criterion levels during for bathing.

The main difference in the feeding group between the one mother who had learning difficulties, and the remaining mothers was that although Lee took several sessions before she reached her target levels; once this was reached it was maintained consistently. This shows that Lee's earlier difficulties were linked to a skills deficit, and once the skills had been learned they were maintained by naturally occurring contingencies. However had intervention not taken place it is likely that Lee's skills deficits would have possibly been viewed by childcare professionals and the courts as evidence of inability to parent, possibly resulting in her baby being admitted to care.

Although bathing and feeding may appear to require similar levels of skills, there are some key differences. One of the main differences is that mothers can select the time they want to bath their babies, and do not necessarily have to do this on a daily basis. Bathing usually

takes around five minutes and can easily be arranged around other activities, and does not depend on the baby's response.

In contrast feeding places more demands on parents, times are largely dictated by the baby at intervals throughout the day, and may take half an hour or more with young babies, or babies that are difficult to feed. Babies generally cry before feeds, giving signals that require a response. This can place additional pressure on mothers particularly if feeds are not prepared in advance and feeding is delayed. Crying is an aversive stimulus, and negatively reinforces any behaviour that stops the crying (Schlinger, 1995). Parent's responses to their child's cries shape the crying behaviour of their babies. If parents only respond when crying is loud and prolonged, as would be the case if bottles are not prepared in advance, they are likely to shape future loud and prolonged crying, which in turn increases pressure on the parent. The reverse is also true, if a parent responds to every cry by feeding the baby; it becomes difficult to ascertain when the child is hungry, and therefore establish a routine for feeding.

Although mothers had individual difficulties, there were some common threads, although these need to be treated with caution given the small number of families involved in the study. The mothers who had difficulties tended to be cued to feed their babies by staff prompts rather than predicting when their babies were likely to be hungry. Feeds often took place when staff reminded the mothers that a feed was due. Staff frequently had to prompt the mothers to persevere with feeds if babies did not feed easily, suggesting that babies may not have received sufficient amounts of food if staff had not been present. This is similar to the findings of Drotar (et al., 1990) that parents of failure to thrive infants were more likely to end feeds prematurely.

The mothers included in this study all met or surpassed criterion levels at some stage for feeds during observations demonstrating that they had the necessary skills to undertake the tasks, however some mothers were unable to maintain the skills. Although improvements for these mothers may have been due to intervention, at times other external contingencies had a more powerful effect on feeding behaviour. For example Caroline often missed essential steps when feeding her baby so that she could go out and meet friends. In this case friends were offering more reinforcement than her child or staff were able to provide. Caroline had a very limited network of supports, and therefore any attention from friends acted as a reinforcer for behaviours that at times took precedence over childcare. The mothers who had the most difficulty in general, were the ones with the lowest levels of social support from friends or family. Two mothers from the feeding group had previous children removed because of neglect concerns, and were therefore very aware of the potential outcomes of their assessments. Stress can impact on the value of reinforcers (Mattaini, 1996), and it is possible that at times this impacted on their overall performance, because of fears that their

babies would be removed. This very real concern easily outweighed the value of praise or vouchers.

Inconsistent levels of performance over feeds were often linked to external events or distractions rather than the babies' behaviour or staff intervention. The decrease in performance scores at follow-up shows that staff presence was the cue to following all the necessary steps in feeding and that these steps were not maintained unless observers were present. Staff repeatedly highlighting the steps that were missed acted as a negative reinforcer for the mothers who had difficulty. This increased avoidance behaviour by mothers, who became increasingly reluctant to engage in observations.

All mothers who had difficulty in maintaining criterion levels with feeding, fed their babies without any talking or making eye contact with them at any point during feeding during some observations. This contrasts with bathing observations; all mothers interacted appropriately with their children when bathing them. This may indicate that feeding had become stressful experience for mothers due to concerns raised about weight gain, and staff reminding mothers about missing steps acting as a negative reinforcer, resulting in avoidance of feeds, or feeding babies while out of the project so that feeds could not be observed.

During observations when mothers did not talk to their babies they were engaged in watching television, talking to staff or other residents or talking to friends on mobile phones. Mothers were therefore missing the opportunity to receive social reinforcement or smiles from their babies, and were unlikely to be sensitive to cues provided by their children during feeds. The lack of contingent responses to the baby's cues meant that children would eventually cease to offer cues to their mothers. This was particularly evident with Caroline's baby who became increasingly withdrawn and unresponsive to any adult attention. There was also a risk that mothers would blame or reject their babies because they associated any difficulties with feeding with criticism or stress.

Mothers who had to be reminded to feed their babies received frequent prompts from staff, these prompts were viewed by staff as evidence of their inability to care for their babies. Carrying out childcare activities at times set by mothers themselves based on their children's needs, reduces the need for staff prompts, and encourages parents to take responsibility for childcare; this will be addressed in Study Two.

Many of the naturally occurring potential reinforcers for feeding a baby, for example development or weight gain, are delayed. A mother's behaviour is more likely to be strengthened if reinforcement is more immediate. Study Five will address ways of helping

mothers to be more receptive to cues given by their babies, so that the children's behaviour becomes a reinforcer for the mother.

Instruments used in this study were able to measure if mothers had the basic skills to carry out tasks; included in this was 'mother talks to child' or 'makes eye contact'. These instruments are not sensitive to the quality or frequency of the interaction between mother and child, but were able to show that mothers on some occasions failed to interact with their children. Closer attention needs to be paid to the quality and frequency of the interaction that did take place to build on existing skills. Intervention needs to be undertaken to improve interaction, and to help mothers to develop an understanding of how they affect their babies' behaviour and development. This will be addressed in Study Five

The results of this study indicate that a failure to meet the basic physical needs of a young child, particularly with regard to feeding is not always the result of a deficit of skills directly related to the task. All mothers were able to score highly on each checklist, but those who had difficulties were unable to do this consistently and repetitively due to competing external contingencies. Although intervention was successful in improving bathing skills, and partially successful in increasing skills for feeding, the assessment was useful in highlighting the difficulties arising during feeding, and indicating where further work needs to undertaken. Studies Two and Five will address this by looking at overall childcare routines, and parent-child interaction.

Study Two – Childcare Routines

Introduction

The lack of an acceptable universal standard for any aspect of parenting and the subsequent difficulties that this causes in defining or assessing neglect has been highlighted in the literature review (Corby, 1996; Greene & Kilili, 1998). Variations in cultural childcare practices make it unlikely that universal standards will be agreed as 'What constitutes minimally adequate parenting is ultimately a social judgement subject to varied interpretations over time and with the particular circumstances of individual cases' (Greene & Kilili, 1998, p. 59).

This study attempts to identify some minimal standards of physical care of infants for individual parents by encouraging parents to set out their own standards for frequency and timing of childcare tasks. This means that standards are those of parents rather than professionals. Parents in general have been found to set higher standards than professionals, and if adhered to, should improve outcomes for children (Craft & Staudt, 1991; Rose & Meezan, 1996).

Research demonstrating the effectiveness of teaching parenting skills is generally undertaken through a series of observations taken over a number of weeks or months in a home or clinic setting. This cannot demonstrate how skills are maintained on a continuous daily basis. A residential setting offers an opportunity to monitor the overall daily patterns of childcare.

Parents not only require the skills to perform childcare tasks, they also need to be able to perform these tasks in a consistent way. Some participants in the first study had the necessary skills to complete childcare tasks, but were unable to perform them during all observations mainly due to external competing contingencies. These mothers had difficulties in both timing and frequency of tasks, particularly feeding. As a result many feeds were being undertaken as a result of staff prompts. Although mothers were often disorganised in their childcare routines they resented being prompted by staff to carry out childcare tasks. Wahler (1980) found that parents were likely to follow advice on childcare from professionals, only as long as the professional was present and offering advice. It is essential therefore, that parents can undertake tasks with ongoing prompts from professionals. The first part of this study aims to encourage parents to continue with childcare tasks with prompts provided through a routine plan rather than prompts provided by staff. The second part of this study offers a gradually reducing level of staff prompts.

The consequences of disorganised routines can have a serious impact on children, and therefore cause additional stress for parents. For example, mothers from the first study often

did not have bottles made up in advance of feeds, meaning that they had to sterilise bottles, make up formula, and wait for bottles to cool, while their child was crying because she or he was hungry. This could delay feeding for up to an hour. When nappies are not changed regularly, the baby is likely to develop nappy rash, which in severe cases may result in broken, bleeding skin. This is clearly painful for the child, and likely to result in increased crying, which increases pressure on parents. Professionals are likely to highlight such deficiencies in child care, which may act as a negative reinforcer, leading to parents avoiding professional contact.

Neglect often occurs through the cumulative effects of inadequate childcare practices. A baby may be fed later than normal on one occasion, which would not be classed as neglect. It is the overall pattern of regularly failing to meet the child's needs, for example repeatedly missing feeds, or failing to bath or wash the child that gradually builds up into a picture of neglect.

A parent who has a consistently disorganised childcare routine and frequently does not respond to their infant's cues, for example when they are hungry or tired, is likely to create an unpredictable environment for the child. Unpredictable environments have been suggested to be aversive to children, who learn to behave in ways that elicit a predictable response from parents, even if the response is negative. Unpredictable environments are thought to be the forerunner to later behaviour problems (Wahler & Dumas, 1968). This is likely to have long term effects as 'the child whose mother fails to respond to his or her signals will eventually shut down, no longer seeking or accepting contact with her' (Erickson & Egeland, 1996, p. 15).

The mothers who participated in this study all had limited social contacts. Having a structured routine meant that they would have more free time to establish and maintain social contacts.

This study aims to:
a) Ascertain if parents can identify what constitutes a reasonable routine for their child.
b) Assess the impact of planning and contracting a routine on parental caretaking behaviour.
c) Enable parents to track their daily patterns of childcare and so monitor their own progress.
d) Offer positive reinforcement to parents for following routine plans.
e) Enable mothers to identify and address other factors that impact on their routines.

Participants in this study set their own timetable for childcare tasks, and were then reinforced for following their own childcare plan. This study is presented in two sections to reflect variation in the methods used.

Participants

Three mothers and children took part in this study. Caroline and Ruby both participated in Study One. Their babies were three and seven months old respectively at the start of the study. Both had the necessary skills for bathing, feeding and other childcare tasks, and although they had reached criterion levels, had difficulties maintaining them consistently. Susan also participated in the study. Susan reached criterion levels on all childcare skills during baseline observations and therefore did not require further intervention for these skills. The three mothers who participated in this study all had irregular daily patterns of eating and sleeping for themselves, these had been established over a number of years. All of the parents involved in this study were at risk of having their children removed from their care because of the levels of concern about inadequate childcare, the parents were aware of this possibility.

Susan

Susan had been taken into care following the death of her father when she was twelve years old. Susan had moved through a series of children's homes and foster homes; placements had broken down because staff and foster parents found Susan's behaviour unmanageable. Susan frequently absconded, was aggressive towards professionals, and misused solvents. Susan was the only child out of her sibling group who did not live the family home. Susan had physically assaulted her mother, and was due to appear in court. Susan was seventeen when she was admitted to the project, her baby was five days old; the baby was three weeks old at the start of this study. Susan was on a Care Order; her baby was on the Child Protection Register under the category of Potential Neglect.

Following the birth of the baby Susan received a lot of practical and emotional support from her mother. Susan's mother lived fifty miles away from the project and did not drive, however during the initial three weeks, visited Susan three times per week, and maintained daily telephone contact. After the first three weeks Susan's mother rarely visited, although Susan visited her at her home once per week. Susan's care of her baby became disorganised and erratic following the reduction in contact with her mother. Susan began to change the baby's nappy less frequently than she had previously. In the first three weeks of her life the baby had developed nappy rash, thrush, and an infected umbilicus, and although these could not be definitely attributed to infrequent nappy changes, long delays in changing the baby were likely to slow down healing. The baby was not bathed regularly, which may also have slowed down the healing process. Susan often did not have bottles sterilised or made up in advance of feeds, which resulted in either a delay before the baby was fed, or not having bottles

sterilised or made up correctly. The changes in Susan's parenting behaviour may have been because of the increasing demands of caring for the baby coupled with a reduction in support from her mother. Susan began to spend long periods away from the project, making it increasingly difficult for her to undertake necessary childcare tasks in a planned way. Susan's baby was a settled placid baby, who only cried when she was hungry.

Ruby

Background information on Ruby was outlined in the previous study. The main child care concerns for Ruby's baby were that the baby was not gaining weight at the expected rate, and had experienced nappy rash. There were also concerns that Ruby's baby was often put down for more sleeps than he needed. Staff had frequently found the baby in his cot awake, particularly on days when Ruby appeared to be under pressure. On other occasions the baby slept for very long periods during the day. It is possible that Ruby may have been using paracetamol-based medication to make the baby sleep.

Ruby had difficulty remaining in her flat alone with the baby and often spent time with staff or other residents away from her flat, which prevented her from carrying out childcare tasks. Ruby spent lengthy periods away from the project. Ruby's baby also presented as a quiet settled baby.

The mothers were selected because of staff concerns about the frequency and timing of childcare tasks on a daily basis.

Consent

Written consent was obtained as in Study One.

Part One- Susan and Ruby

Materials & Procedure

Key childcare tasks that were required to be addressed at regular intervals throughout the day were identified by project staff and each mother. This was based on records of informal daily observations of all areas of childcare, which highlighted areas that both mothers had difficulty attending to at regular intervals. These areas included feeding, bathing, play, nappy changing, making bottles and regular sleep routines. Although Susan had been observed playing frequently and positively with her baby this was also included on Susan's initial target behaviours to ensure positive reinforcement. Time spent outside the project was recorded to enable mothers to track if this had an impact on mother's ability to follow routines (see appendix 2a).

During the baseline phase both mothers completed a dairy of the normal times that tasks were completed, and when the babies slept, so that a routine could be developed around the baby's normal sleeping and waking patterns.

Intervention

Mothers drew up a routine contract with a member of staff prior to intervention (see appendix 2b). This outlined the latest time and minimum frequency for completing each task. Tasks were planned around the babies' natural routines, for example, as Susan's baby generally had a nap in the late morning, bottle making and sterilising were planned for this time. Each task was added to the contract immediately before inclusion of that task as a target behaviour. Mothers continued to record all tasks throughout all phases. Tasks were planned to be targeted in sequence, a further task was added to the contract when previous targets had been reached.

A member of staff met with each mother to review progress. Each new behaviour was discussed and agreed with mothers prior to inclusion; this included the importance of timing and frequency of that specific behaviour for the baby. Mothers were awarded vouchers and praise for tasks completed as planned. An additional voucher was added for completing recording. When targets were not achieved antecedents and consequences to alternative behaviours were explored with the mother. Targets were set at 80% correct to allow some flexibility in routine, and to ensure that mothers did not have an overly rigid routine that was not sensitive to their babies' needs. It was planned that charts would be reviewed on a weekly basis, however due to the urgency of childcare tasks this happened more frequently.

Both mothers continued to keep a record of time spent away from the unit, so that they could see if this impacted on childcare.

Susan

Target behaviours selected for Susan were a) Making bottles, b) Feeding, c) Nappy changing and d) Bathing. Susan's ongoing progress in playing with her baby was acknowledged from her baseline recordings, and it was agreed that this required no further intervention. It was originally planned that baselines for each behaviour would last for one week. However due to concerns about the frequency and timing of feeding and nappy changing and the potential impact of this on the baby's health these behaviours were targeted at three day intervals.

The sequence was dictated by the level of urgency regarding each behaviour, based on Susan's self recording during the baseline phase and on staff recordings of informal observations. Bottle making and sterilising were the first target behaviour. When bottles were not prepared in advance feeds were disrupted. Sterilising and bottle making were to be completed by 12 noon every day, this time was selected by Susan.

Feeding the first bottle by 10am and subsequent bottles at three to four hourly intervals throughout the day was the second target behaviour. Feeding was targeted after three days of intervention because of concerns about the baby missing feeds.

Nappy changing was the third target behaviour, and was set by Susan at every three hours or five nappies per day. This was selected as the next priority as the baby had suffered from severe nappy rash and thrush, and Susan's baseline recording reflected that she was not meeting her agreed targets for nappy changing.

Bathing was the fourth target. During baseline Susan recorded that she had washed but not bathed the baby for three days. Susan contracted to bath the baby each morning by 11am and 'top and tail' the baby each evening before 10pm.

Ruby

Target behaviours selected for Ruby were a) Feeding, b) Bathing, c) Nappy Changing d) Sleep Routine and e) Play

Ruby contracted to feed her baby bottles and spoon feeds with no more than four hours between feeds, with a minimum of four feeds per day. Feeding was selected as the first behaviour because of concerns about the baby's weight
Bathing was planned daily by 7pm; Ruby also contracted to top and tail the baby by 10am each day.

Ruby agreed to change the baby's nappy at least every four hours when the baby was awake with a minimum of four nappy changes per day.

Ruby's planned sleep routine for her baby was initially two half hour naps during the day, and to try and have the baby settled for the night between 7.30pm and 8 pm, however as the baby often slept for forty five minutes during day time naps this was adjusted after the first two weeks. It was agreed that this pattern could change if the baby was unwell. Ruby recorded each time the baby was placed in his cot, regardless of whether he slept or not.

Play was defined as any positive face to face interaction other than when completing childcare tasks. Ruby planned to play with her baby four times per day for ten minutes.

Follow-up

Follow-up data were to be collected after intervention on all behaviours had been completed. This was not possible as Susan stopped recording before all behaviours had been targeted, and Ruby's recording stopped before all behaviours stabilised.

Research Design

A multiple baseline across behaviours was used; however the urgency of childcare tasks did not allow the target behaviour to stabilise before introducing a new behaviour.

Measures

Measures were taken of the percent of tasks that were completed within the time planned by each mother. This was calculated as percentage correct on a daily basis for each target behaviour through the formula:

$$\frac{\text{number of times task was completed within the agreed time}}{\text{maximum possible score for that task}} \times 100$$

Reliability was calculated on feeding only, by comparing staff daily records with mothers'. Staff observed between three and four feeds per day for each mother. Reliability was calculated by:

$$\frac{\text{Number of staff recordings that matched with mothers' recordings}}{\text{Total number of feeds observed by staff per day}} \times 100$$

Overall during feeding accuracy was 97% for Susan. On the few occasions that staff recording did not match with Susan's, it seems likely that this was because of the time that the feed was started. For example if Susan began a feed at 4.50 pm she would tick the 4-5 box, where staff may have gone into the flat and observed the end of the feed at 5.10 pm.

Accuracy during feeding was 87% for Ruby. This was because on occasions Ruby forgot to record feeds.
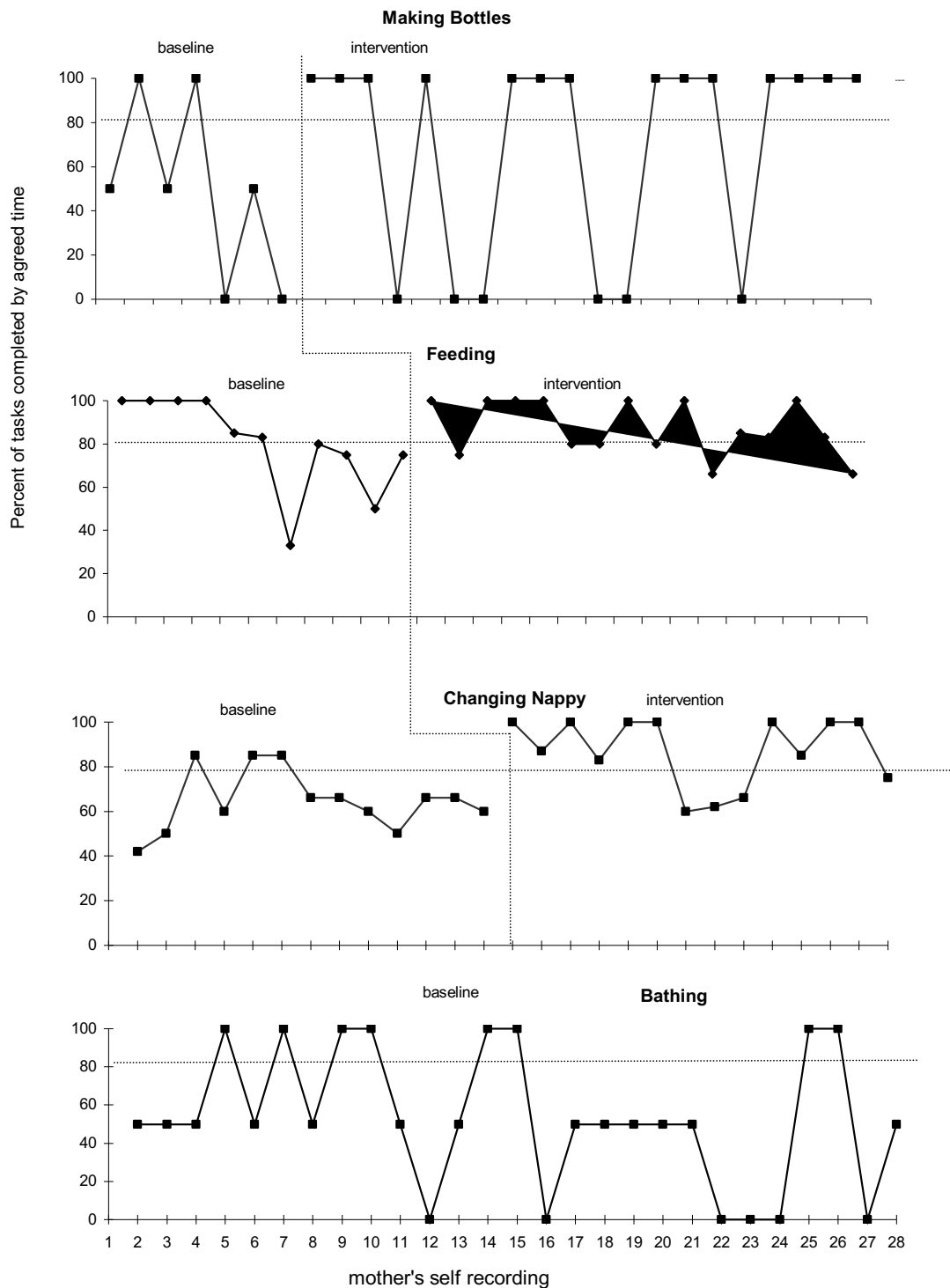
Results

Figure 2.1 Susan's results for baseline and intervention for making bottles, feeding, changing nappies and baseline measures for bathing. The broken horizontal line represents the target score of 80% of all tasks completed within agreed times.

Susan

Bottle Making & Sterilising

Susan began to make up bottles by the planned time and maintained this during 70% of the intervention phase.

Feeding

Although there had been previous concerns about feeding this is not reflected initially during baseline recordings, Susan scored at or above the 80% criterion levels for the first six days, however scores during baseline dropped as low as 33%, reflecting a day when the baby experienced long delays between feeds. During the intervention phase Susan's average score for feeing was 84%; on four occasions Susan did not meet criterion levels, the lowest score was 66%.

Nappy changing

Some initial improvement in the rate and frequency of nappy changing occurred during the baseline phase for this task; however this was not maintained and led to severe nappy rash. There was a marked improvement initially during the first six days of the intervention phase; however during the following three days nappy changing became less frequent.

Bathing

Bathing remained at baseline as recording stopped before intervention could be implemented. Although Susan had contracted to bath and top and tail the baby on a daily basis, Susan's recordings reflect an eight day period when the baby was washed only for five days, and not washed or bathed for three days.

Incompatible behaviours to those outlined on the routine chart included being on the phone to friends, spending time in other resident's flats, and having visitors. Nappy changing and feeding in particular were disrupted through these activities. Susan had difficulty in getting up in the mornings, and often remained in bed until 10am or later. The baby began to sleep through the night, meaning that she missed her feed during the night as well as her first feed in the morning and was not changed for lengthy periods. Susan was able to recognise the behaviours that prevented her from following her planned routine, and agreed that she needed to change her behaviour, but was unable to do so.

By the 28th day of recording Susan was finding it difficult to manage many childcare tasks and stopped recording. Susan was unable to maintain her routine and the baby had recurring diarrhoea, possibly linked to poor hygiene standards. In addition, a number of safety issues arose, including not responding to the baby when she choked. Susan informed staff that she would like to be placed with her baby in foster placement. This was not

possible due to Susan's age and the unavailability of foster placements. Susan began to have difficulty in her relationship with her family and became verbally abusive and threatening towards any staff who offered support or advice. Susan's placement ended two weeks later after the baby was taken into care under an Emergency Protection Order.
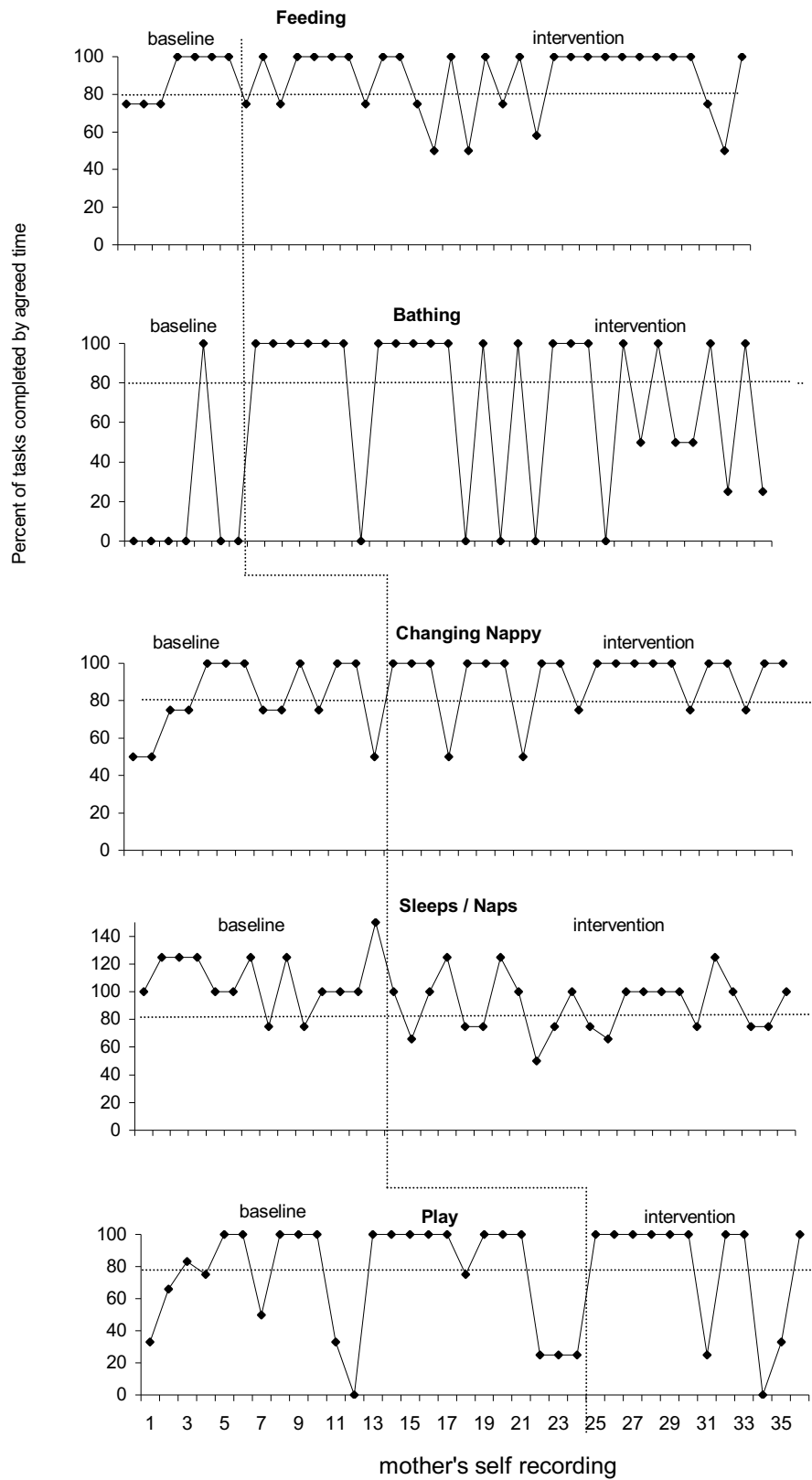
Ruby

Figure 2.2 Results for Ruby baseline and intervention for feeding, bathing, nappy changing, sleeps and play. The broken horizontal line shows the target score of 80% of all tasks completed within agreed times.

Initial plans to target behaviours individually in sequence were adjusted because of the urgency of childcare tasks. Target behaviours were introduced two at a time. Ruby recorded her routine for thirty seven days, and then refused to do any further recording stating that she was 'too busy'. Ruby had collected a number of vouchers during the period of recording and used these to obtain a large toy for her son. Recording stopped following the acquisition of the toy. Although Ruby made some improvements in the frequency of childcare tasks during intervention, this was not consistent. Progress was generally affected most by the need for social contact, mainly with other residents in the project. Ruby had ongoing contact with a former partner, who assaulted her during the second week of the feeding intervention phase. This had an impact on all areas of Ruby's childcare. Ruby avoided attempts to discuss her progress in maintaining routines, frequently changing the subject or becoming tearful when issues were raised.

Feeding and Bathing

Feeding improved immediately during the baseline phase, which would suggest that this was the result of self monitoring. At the end of the second week of intervention feeding decreased in regularity; results reflect long period between feeds. After one week of recording Ruby received childminding two days per week for four hours, this continued throughout the intervention period. Ruby continued to have difficulty with the frequency of feeds although Ruby was only due to feed the baby twice per day on days when the baby attended the childminder. Ruby often claimed that her baby refused feeds, although he took feeds if offered them by staff. It seems likely that feeding had become aversive for both Ruby and the baby. He was often fed quickly, and given food that was dry and difficult to eat, without anything to drink.

Bathing was included with the first target behaviour as during the baseline phase Ruby recorded that she had only bathed the baby once in seven days. Scores of 50% indicate that Ruby washed the baby twice during the day. Scores of 25% reflect the baby being washed only once per day. Bathing responded immediately to intervention. Ruby bathed and washed her baby daily for the following thirteen days, only missing bathing on one occasion. On the 21st day of recording Ruby stated that she had changed her routine plan to bathing on alternate days. There is a marked decrease in the frequency of bathing during the last week, which reflects the overall difficulty Ruby was having with childcare tasks.

Nappy Changing and Sleep

Nappy changing and sleeping patterns were addressed together again due to the urgency of these tasks for the baby.

The frequency of nappy changing was a concern because the baby had eczema and nappy rash. Ruby aimed to change the baby four times per day when he was awake. Results of 100% reflect four or more nappy changes, 75% represents three nappy changes, and 50% represents two nappy changes. Although there was some improvement in the rate of nappy changing, on two occasions during intervention the baby's nappy was changed only twice during the course of the day.

Ruby frequently put the baby in his cot for extra naps limiting the amount of interaction and stimulation that he was receiving. During baseline recordings Ruby often far exceeded her set targets for the baby's sleeping routine; this is reflected in scores above 100%. Often this was immediately after breakfast, when the baby had been awake for less than an hour, or shortly after the baby had wakened for a feed. Staff recordings indicate that they found the baby lying awake in the cot, at times when Ruby reported that he was sleeping. The baby was healthy and there was no physical reason for him to require additional sleep. This pattern improved slightly during intervention, however on three days Ruby put the baby is his cot for additional sleeps. This coincided with Ruby having difficulties in her relationships with staff and other residents in the project. The baby had less sleep than planned on several occasions; this was often because Ruby had other residents in her flat making it difficult for her to settle the baby.

Play

Play improved for one week following baseline recording, however this became more inconsistent during the last week of recording. During two days of the last week Ruby recorded that she had only spent one ten minute session playing with her son, and on one day did not play with him at all. These results reflect project staff's concerns about the limited interaction between Ruby and her son. Ruby was unwilling to accept suggestions that her baby would benefit from an increase in interaction, stating that he preferred to lie alone on the floor.

Discussion

Results for both mothers show some improvement for all childcare tasks. Both mothers were able to plan a routine for childcare, but were unable to follow their plans consistently. The use of contracts and self recording had little impact on parental behaviour. The introduction of vouchers had a limited short term effect. Had routines been recorded only through observations by staff it is likely that the level of reactivity would have prevented a clear picture from emerging.

Mothers completing their own recordings attempted to avoid the pattern of negative reinforcement described by Wahler (1980) where mothers undertook tasks only as long as the person issuing the command was present. However staff continued to need to remind

mothers of childcare tasks that were not completed, which acted as a negative reinforcer for completing tasks and resulted in avoidance behaviour by the mothers in the study. It seems likely that routine charts also became aversive as both mothers stopped recording their routines when their routines became disrupted.

Crittenden (1993) identifies some neglectful parents as having the skills to respond to their children, but being unable to because of competing priorities. The main factor that impacted on routines for both parents was their need for social contact, which took priority over childcare tasks. Both mothers had few positive social supports, which resulted in any social contact becoming a more powerful reinforcer than undertaking childcare tasks. There was no obvious connection between time spent away from the project and disrupted childcare, however as both Ruby and Susan spent long periods of time with other residents in the unit, this does not fully reflect the levels of social contact that each had.

Allen & Warzak (2000) suggest that positive reinforcement should follow performance of behaviours and that naturally occurring negative consequences need to follow when behaviours are not completed. In this study reinforcement was delayed until the recording was reviewed. 'Parents, like everyone else, will most often engage in behaviour that results in (a) more frequent reinforcement, (b) a greater magnitude of reinforcement, (c) more immediate reinforcement and (d) less response effort'. (Allen & Warzak, 2000, p. 383). More immediate reinforcement for alternative behaviours was offered through friends, company or time spent away from the project. Both parents were socially isolated, which strengthened the value of reinforcement from friends and other residents.

Allen and Warzak (2000) suggest that the strength of external competing contingencies may be reduced by increasing the opportunities for reinforcement, for example setting easily met targets, which also reinforces the workers' behaviour. Daily collection of data would have provided opportunity for reinforcement. In the second part of this study the effect of more immediate reinforcement is explored.

Most of the behaviours included in the routine plans were subject to naturally occurring delayed consequences. For example feeding may lead to the gain or loss of weight, but this is not evident until the baby is weighed at the baby clinic, usually on a weekly basis. Infrequent nappy changing may cause nappy rash, but this is likely to build up over a number of days. Mattaini (et al. 1996) suggests that parents without a history of rule following are likely to need immediate reinforcers when working towards 'distant, uncertain, and cumulative consequences' p. 245. The child's immediate comfort and wellbeing was not acting as a reinforcer for the parents in this study, and clearly requires further attention.

Intervention may have been more effective if each target behaviour had been stable before the introduction of the subsequent behaviour; however new behaviours needed to be introduced to ensure that the baby was being adequately cared for.

It is difficult to assess the accuracy of recording for all tasks, as data is based on recordings by mothers. Accuracy could be checked in relation to feeding as project staff were frequently present for feeds. The high levels of accuracy of recording of feeding for both mothers suggest that they were accurate in other areas, particularly as both mothers' recording indicates where progress was not maintained.

Work on routines contributed to the assessment of childcare giving a clear overall picture of the quality of care that children were receiving on a daily basis. However both mothers were unwilling to continue with recording when they were having extreme difficulty with all areas of childcare. The use of charts enabled the staff team to review each mother's progress objectively, and highlighted areas of childcare that needed further work. Although charts were shared with mothers, the process of transferring data to the charts was overly complex because of the combination of timing and frequency used, meaning that mothers did not fully understand the data. If this process had been simplified, the charts could have been an additional source of positive reinforcement for mothers.

Part 2

Caroline

Caroline also took part in Study One. Caroline's overall childcare had no regular routines, partly due to spending lengthy periods away from the project. As Caroline's baby was not gaining weight at the expected rate Caroline had been advised to keep a record of feeds to explore the reasons for this. Caroline rarely filled in her feeding record, and often failed to administer prescribed medication. Caroline had frequent visitors to her flat, which disrupted any planned routines. As Caroline had no regularity in her daily routine it was more appropriate to concentrate initially on a specific time of day, to ensure that she received intensive support from staff to enable her to complete tasks. Previous informal observations had shown that Caroline did complete tasks if staff were present.

Materials and Procedure

During the baseline phase staff remained in the flat with Caroline each evening from 7pm to 9pm, prompting her to complete childcare tasks. Tasks carried out by Caroline were recorded by staff. Following baseline Caroline and a member of staff identified the key tasks that needed to be completed during the period 7pm – 9pm. Tasks identified by Caroline and a member of staff included preparing bottles, giving medication, feeding the baby, completing a feeding chart, bathing the baby, settling the baby for the night and tidying the flat. Caroline contracted the latest times for the completion of each task. This was outlined

on a chart to be completed by staff and Caroline (see appendix 2c). A retrospective baseline was then taken based on previous staff recordings. Caroline agreed that she would discourage visitors from calling during this time. Intervention was planned Sunday to Friday as Caroline's baby was looked after by respite carers each weekend.

During baseline, and the first week of intervention staff were present from 7pm to 9pm, and gradually decreased the time spent with Caroline over the following weeks. When staff were present they worked alongside Caroline and helped her to complete tasks, for example nursing the baby to allow Caroline to complete other tasks, or helping her to tidy her flat. During the second week staff arranged to be present for thirty minutes, leave for thirty minutes, return for a further thirty minutes. During the third week staff planned to go in for fifteen minutes at the beginning and end of the two hour slot. During subsequent weeks staff were to call randomly during the two hour period to ensure that Caroline was completing tasks. Following each two hour period staff and Caroline completed the Evening Routine Chart and was praised for any steps she had completed. Targets were set on a weekly basis, 60% for week one, 70% for week two and 80% for subsequent weeks. Target behaviour in this case was following the routine plan, rather than focusing on specific behaviours. Caroline was given vouchers on a daily basis for completing tasks on time.

Measures

Measures were percent correct of the steps on the routine plan completed by the planned time without prompts from staff; calculated by

$$\frac{\text{Number of steps completed by agreed time}}{\text{Total number of steps}} \times 100$$

Research Design

A changing criterion design was used; the weekly target was set based on the targets achieved the previous week, up to a maximum of 80% correct. The maximum was set at 80% to allow some flexibility, for example if the baby refused a feed, or was unsettled. The use of a changing criterion design ensured that Caroline received positive reinforcement for any progress and that intervention was planned at Caroline's pace. This could have raised ethical questions if essential childcare tasks had been left undone; however staff completed any tasks that Caroline failed to do.
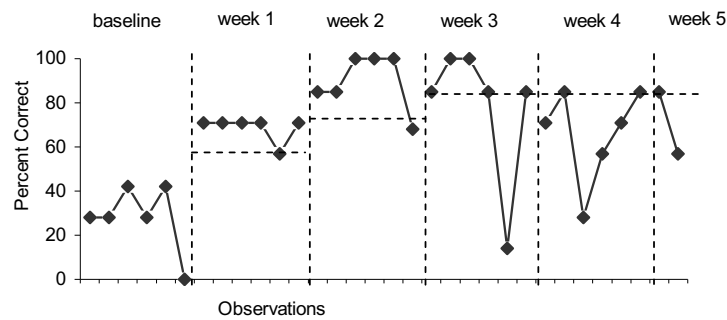
Figure 2.3 Results for Caroline across all tasks during baseline and intervention. Horizontal lines represent target scores for each week.

During baseline Caroline completed few of the routine tasks, and was prompted frequently. Caroline had visitors in her flat during this time, which distracted her from childcare. There was a marked improvement in the number of tasks completed after the routine agreement was drawn up at the end of week one. Caroline was able to complete tasks as long as staff were present in the flat, however she did require prompting to undertake all tasks, for example in remembering to give medication. Caroline also needed ongoing encouragement to stay on task. Caroline easily surpassed the first criterion level during the first week of intervention. The step that was missed throughout the week was the completion of the feeding chart. The importance of this recording was addressed with Caroline and she began to complete this over the following two weeks.

During the second and third week of intervention Caroline met or surpassed the criterion level with the exception of one day when Caroline missed all tasks, except for putting the baby to bed on time. This was due to visitors calling at the flat.

During the final weeks of intervention staff had planned to call randomly during the routine period; however because of concerns about Caroline's childcare, staff remained present during most of the routine. Caroline's scores decreased dramatically over the final eight recordings. Factors that impacted on this were Caroline returning late, so that she began tasks later than planned; Caroline had to be prompted to undertake all tasks; and was frequently in other resident's flats or had visitors in her flat. Recording stopped after the baby was taken into hospital because of feeding difficulties. On discharge from hospital the

baby remained in Caroline's care for one week. During this week childcare became increasingly problematic; Caroline refused to undertake any further work on routines. The baby admitted to foster care because of overall concerns about childcare.

Discussion

Although Caroline's progress was not maintained, this section of the study shows a steadier rate of progress than the previous section, suggesting that this is a more effective method of addressing routines. The task was smaller and less daunting because it was concentrated on a specific time of day. The programme would have gradually moved towards self-monitoring, had intervention continued and progress been maintained. Reinforcement from staff was immediate initially, and moved to intermittent reinforcement in an effort to strengthen behaviour. Vouchers were given on a daily basis with a bonus voucher at the end of the week. If tasks were not completed by Caroline, staff could undertake them, and ensure the child's wellbeing. Staff were also able to discuss not being on-task with Caroline when it happened, making it easier to identify antecedents and consequences to alternative behaviour.

Caroline's charts were kept in her file in the office, so other members of staff were aware of her progress, and offered additional praise. As project staff completed recordings with Caroline recordings were more likely to be accurate. The process of charting Caroline's progress was simpler than the first section of this study, meaning that Caroline was able to clearly understand any charts. The use of a variety of staff during all phases improved the chances of generalisation of behaviours.

Drawbacks to using this intervention as opposed to the first one in the study are that it fails to address routines at other times of the day, and may result in the child not receiving adequate care outside the structured routine times.

General Discussion

The methods applied in this study were useful in giving an ongoing picture of childcare; however results offer no picture of the quality of individual tasks undertaken. It is necessary therefore to ensure that these methods are carried out in conjunction with skills based assessment and training on each task as outlined in Study One.

Each of the mothers was able to outline the tasks they needed to do, identify the timing and frequency of each task, and carry them out as planned on some occasions. However they were unable to sustain this when the possibility of social contact with peers was present. Each of the mothers was socially isolated, which resulted in social contact being a powerful reinforcer. Many of their social contacts resented mothers being unavailable because of childcare demands, and so offered reinforcement for behaviour incompatible with childcare.

Susan's childcare during her initial weeks in the project was of a good standard, when she was receiving positive reinforcement on a regular basis from her mother. As her mother undertook some of the childcare tasks she also had the opportunity for observational learning in relation to childcare. This would suggest that social contacts who offered reinforcement for appropriate childcare may improve standards.

The child's wellbeing was not acting as a source of positive reinforcement for the mothers who participated in the study, nor was the potential discomfort of the child acting as an aversive condition. Mattaini (et al, 1996) suggests that interventions that enable the child to become a more effective reinforcer may be central to improving outcomes in cases of neglect. Increasing parent's positive interactions with their child, and making parents more aware of the positive effect they can have on their child's behaviour may begin to address this. This will be explored further in Study Five.

Study Three - The Home Safety Programme

Introduction

Although unintentional injury to children shares many of the same risk factors as child abuse and neglect it is often viewed as having different causes. These risk factors include the number of siblings in a family, parents who are young and without supportive partners, the child's gender and living in an area with high rates of social deprivation (Reading, Langford, Haynes, & Lovett 1999). Alwash and McCarthy report that Accidents resulting in injury are most common in children aged one to two years, and boys are at a slightly higher risk than girls. Living rooms are the commonest place for accidents, followed by bedrooms, kitchens and stairs.

Unintentional injury may be an outcome of neglect, for example a child who is left unsupervised, or allowed access to hazards within the home. Unsafe living environments can result in child fatalities. Most fatal injuries are likely happen to children less than three years old, in the home, when a carer is not present at the critical moment (Margolin, 1990). The most common causes of death in young children have been found to be drowning, scalding, and house fires. Deaths of children due to injury or poisoning may occur as a result of inadequate supervision, but will not necessarily be attributed in public records to neglect (Bonner, et al, 1999).

This study aims to reduce known sources of danger for young children in the home by improving parental understanding of potential risks, and encouraging parents to remove these hazards by rearranging the environment. It is clearly not enough to make environmental changes without also changing parents' behaviour (Brehaut, Miller, Raina, & McGrail, 2003). This is addressed through parental involvement in identifying dangers and potential outcomes for children, and sharing responsibility for removing or fixing any hazards.

Other issues addressed with parents in conjunction with this study included developmental expectations of children, and the importance of supervision. Developmental issues were important because of the difficulties some parents had in recognising the abilities of their children. The level of supervision required in individual families is difficult to quantify as at times parents need to fully supervise their children, for example when bathing, while at other times awareness of what the child is doing is enough. The age of the child also dictates how much supervision is needed, for example, the supervision needs of a very young baby differ from those of an older preschool child.

Young lone parents who are solely responsible for the supervision of very young children are under increased pressure if the environment is unsafe. Difficulties increase if parents have low levels of social contact as this means that parents are unlikely to have another adult

present who can care for their child to allow them to complete everyday tasks. This makes it more difficult, for example, to supervise an active preschool aged child while cooking or doing housework. If high rates of dangers exist in the home, parent-child interaction may be affected by the high rate of aversive commands necessary to ensure child safety (Peterson & Gable, 1998). Modifying the environment to reduce hazards can allow children more freedom to explore and learn. Risk taking is a normal part of child development, and one way that children learn about their environments (Roberts, 1991). Children are less likely to be able to explore in homes that are unsafe. A safer home does not decrease the need for parental supervision, and knowledge about a child's capabilities, but should decrease aversive commands, and avoid some preventable accidents. Parental involvement in identifying and removing risks is important to enable parents to ensure that parents can maintain safety standards when they move into the community.

This study is presented in two parts to reflect the development of the instruments used.

Part One

Participants

Judy

Judy aged nineteen and her eighteen-month-old daughter were referred to the project because of neglect concerns, mainly related to the levels of hygiene and safety when Judy was living in her own home. This concern continued after admission, Judy's flat was often untidy and potentially dangerous for her daughter.

Judy had been living in her parent's home prior to admission, although she had previously lived independently with her daughter. Judy had never been in care, and had a supportive relationship with her parents. Professionals involved with the family were concerned about standards of safety and hygiene in Judy's parent's home. Informal observations previously undertaken with Judy in the project highlighted that she had a very positive relationship with her daughter, and could undertake childcare tasks, but needed to learn basic home management skills.

Judy's daughter was a very lively child who was steady on her feet, but not yet climbing onto furniture. Judy's daughter's name was on the Child Protection Register under the category of potential neglect.

Lynne

Lynne was referred to the project to give her the opportunity to care for her daughter, who she had initially wanted to place for adoption. Lynne was seventeen years old. Her daughter was eight months old at admission and Lynne had previously had very little contact with her. Lynne had been admitted to foster care at a young age because of neglect concerns, and had lost touch with her natural family. The foster placement had broken down immediately prior to admission and Lynne had no contact with her foster family. Lynne's overall childcare was of a good standard, however as her daughter became increasingly mobile it was evident that Lynne often underestimated potential risks to her daughter. Lynne's daughter was one year old at the time of the study, and had just begun to walk.

Consent

Before commencing the programme the aims were explained and written consent was obtained from both mothers. Mothers could identify any areas where they did not want observers to check for dangers, for example specific cupboards or drawers, neither mother identified any areas.

Materials

The Home Safety Checklist was devised to identify hazards within the home (see Appendix 3a). The checklist was derived from the Home Accident Prevention Inventory (HAPI) (Tertinger, Greene & Lutzker, 1984). The original HAPI checklist was modified as many hazards identified in the original study did not apply to families living in temporary accommodation. For example, parents in the project would not have been storing items such as paint and did not have any open fires. The project was responsible for the safety of any equipment provided including cots or electrical equipment and undertook regular inspections to ensure that these items met safety standards.

Dangers were divided into seven general categories including a) supervision and falls, b) hygiene, c) choking, d) ingestion, e) fire & burns f) electric shocks and g) suffocation. Each category was divided into further subcategories. Categories reflect the most common causes of serious and fatal accidents to children in the home (Alwash & McCarthy, 1987; Tertinger, Greene & Lutzker, 1984). Specific items included under each category were identified through observation of residents' flats, workers' experience with previous residents, and information from the Child Accident Prevention Trust (1989). Dangers were classed as present only if a child had access to them, and were classed as not present if they were out of the child's reach or in a locked cupboard.

Mothers were asked to complete a 'Dangers in My Home sheet' (Appendix 3b). Mothers listed dangers that had been identified on this sheet, outlined the possible consequences of each hazard for the child and necessary steps to remove or fix the danger. This ensured that the programme was based on the developmental level of the individual child, and

encouraged mothers to identify dangers as they could affect her child, rather than removing dangers because they had been instructed to do so.

Other materials required for completing the home safety check included a tape measure and a choke tube.

Training for Observers

Observations were undertaken by a range of staff that had been trained to use the procedure. Training involved discussions of the dangers included on the sheet, and a trial observation and scoring a resident's flat that had been arranged to ensure that hazards in all categories were present. Agreement during training was calculated using the formula:

$$\frac{\text{Number of Agreements}}{\text{Number of Agreements + Number of Disagreements}} \quad X\ 100$$

 (Sulzer-Azaroff & Mayer, 1991).

Agreement scores from observers across all categories of hazard averaged 88% and ranged from 71% to 100%. Observers also completed a written test following training (Appendix 3c). Scores in the test ranged from 85% to 100%.

Procedure

Prior to beginning the observation measures, were taken of the child from eye level to the floor while the child was standing. As a child may climb on anything at or below eye level any dangers below this measure were classed as accessible (Tertinger, Greene & Lutzker, 1984). Measures were also taken of the child from the tip of the hand to the floor to assess how high and how far the child could reach. These measures were used to assess any dangers that were classed as being within reach.

Before commencing observations, the procedure was explained to each mother as a way of making their homes safe for their child. Observations were undertaken in the mother's flat. Each room was assessed by walking through once in a clockwise direction, recording each danger present on the checklist. Small objects that could potentially choke a child were checked in the choke tube, any object that fitted entirely within the tube was classed as a choking hazard. The tape measure was used to measure if potentially harmful objects were within the child's reach.

Measures

Measures were taken of the total number of dangers present, and the number of dangers in each category.

Research Design

A changing criterion design was used with both mothers. Gradually reducing criterion scores were contracted on a weekly basis with each mother, based on the score obtained on the previous observation. Judy's criterion scores for example, were 13 following the baseline observation, then 5 for subsequent observations. Lynne's weekly targets were set at 50, 30 and 5.

Intervention

Intervention consisted of the following:

1. Mothers accompanied the observer when completing the checklist and were encouraged to identify any dangers described on the sheet and tell the observer how this could be remedied. If mothers were unable to identify any hazards, each danger was pointed out by the observer and ways of removing or fixing the danger were discussed.

2. Mothers were given a list of dangers to fix or remove before the next observation and were asked to complete the 'dangers in my home sheet', outlining potential consequences for their child, and how risks could be removed.

3. A contract was drawn up agreeing tasks to be undertaken by the mother and the observer; setting target scores for the following week, and the agreed reinforcer if targets were met.

4. Actions that observers needed to undertake were recorded, for example providing socket safety equipment including socket guards, safety gates and high shelves.
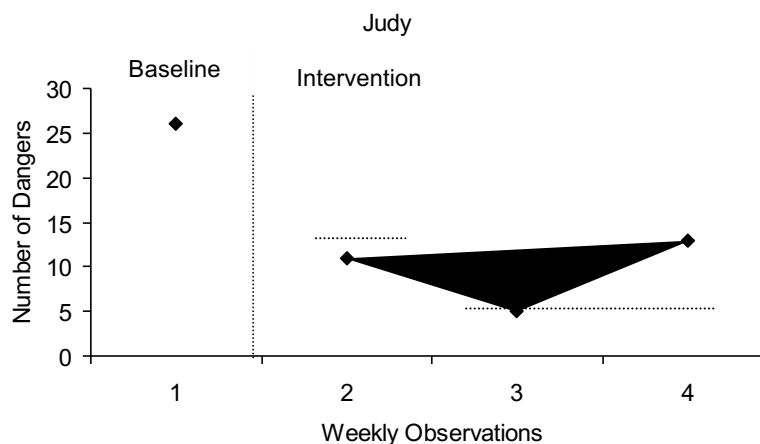
Results

Figure 3.1 Results for Judy for baseline and intervention for combined categories of hazards. Broken horizontal lines show criterion levels.

Judy

Figure 3.1 illustrates the effects of intervention on the total number of dangers present. Figure 3.2 shows dangers across each category. Judy reached criterion scores for two observations following baseline, however this was not maintained at the fourth observation.
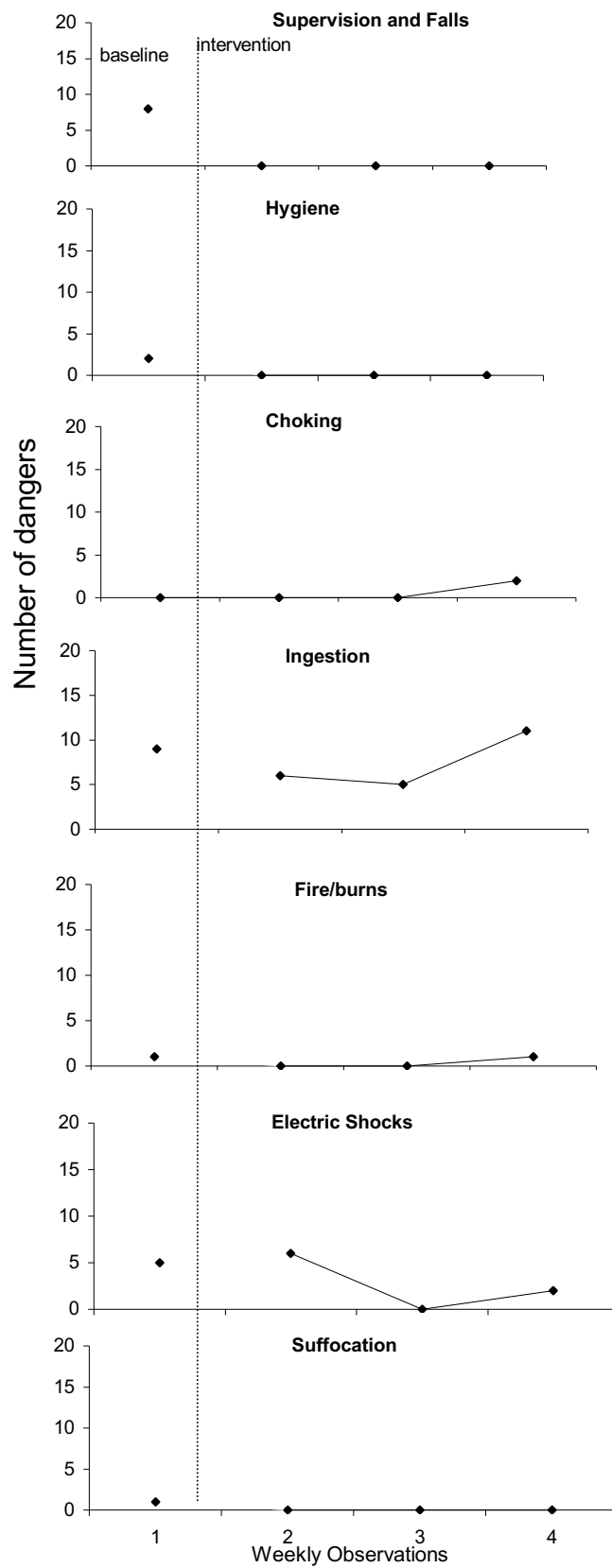
Figure 3.2 results for Judy during baseline and intervention for all categories of dangers.

The main category where dangers were present was 'ingestion' and consisted of cosmetics, shampoos and medicines that were within her child's reach in the bathroom. Judy had identified the potential consequences of her child swallowing any of these items, and included 'keeping them out of reach' in her plan for reducing dangers, but had not done this. Follow-up data were not available as Judy moved into her own house and further observations were not feasible due to the distance from the project. However family support services reported that the improvement in overall standards in the home was maintained in the community and Judy's child's name was removed from the Child Protection Register soon after discharge from the project.
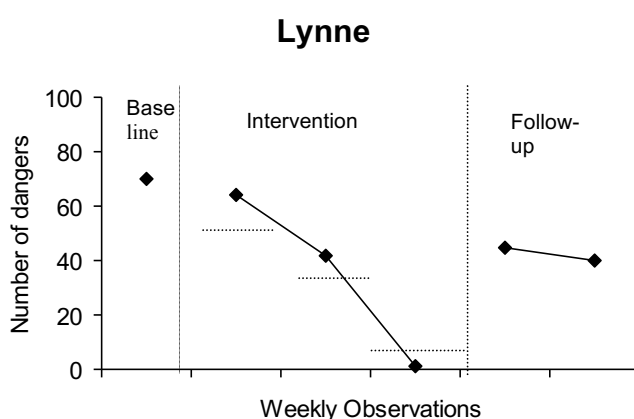
Lynne

Figure 3.3, results for Lynne for baseline, intervention and follow-up for combined categories of danger. The broken horizontal line represents criterion levels.

Lynne

Lynne had difficulty reaching criterion scores as shown in Figure 3.3; however, she did remove all dangers prior to the fourth observation. Lynne moved into the community after the fourth observation and follow-up observations were undertaken in her new home. Figure 3.4 shows dangers across categories. The greatest numbers of dangers were in the categories 'supervision', because of ornaments and sharp objects within reach and 'ingestion' due to medication and cosmetics within reach. Reductions in the overall number of hazards were not maintained as shown in Figure 3.3. The increase in the number of dangers at follow-up was due to the lack of child proof areas in Lynne's new accommodation, for example she did not have a bathroom cabinet, a lockable cupboard, or high shelves in her living room. As Lynne was living in privately rented accommodation she needed her landlord's permission to make any alterations. She could identify all dangers that were present, and planned to address this with the landlord.
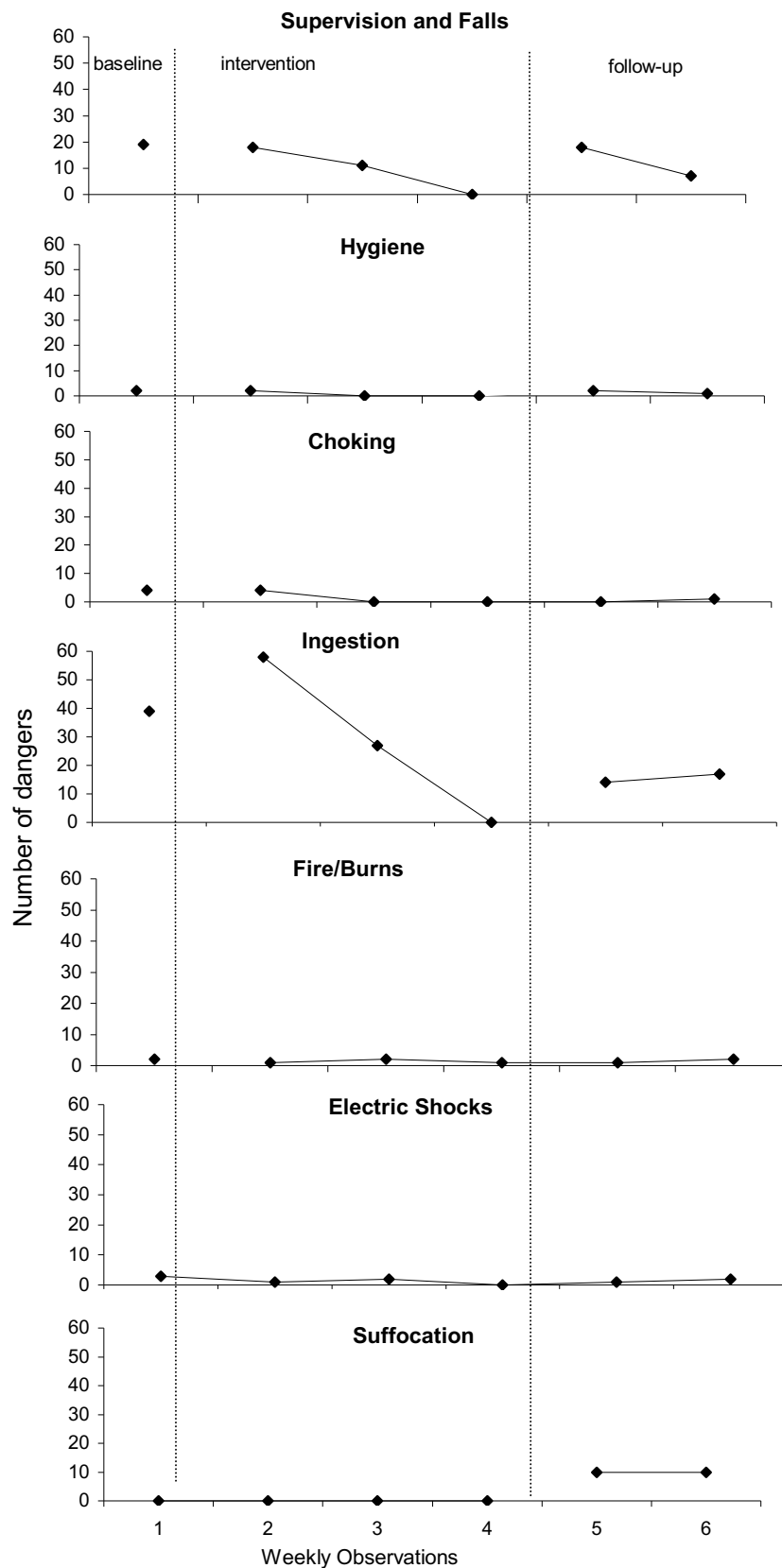
Figure 3. 4, results for Lynne for baseline, intervention and follow-up phases across all categories of dangers.

Discussion

Intervention was effective in raising each mother's awareness of potential dangers; however, counting individual items does not give a realistic picture of the levels of safety in each of the flats. Although both mothers succeeded in reducing the numbers of dangers present in their homes; this is not fully reflected in the results. One difficulty was that counting each item as a separate hazard gives an inflated sense of how unsafe homes were. For example, the increase in the number of hazards following intervention for both mothers was caused by cosmetics being within reach in the bathroom, although both mothers had made significant progress in reducing hazards in other rooms in their homes. As very young children are more likely to experience accidents in other rooms this is not a true reflection of risks to both children. For example, none of the children included in Alwash and McCarthy's (1987) review of 481 children attending an Accident and Emergency department following injuries in the home, were injured in the bathroom. This is likely to be linked to two factors. First children are likely to spend more time in other rooms in the home and second, young children are more likely to be with a parent when in the bathroom. In Part Two of the study dangers are categorised across rooms, to reflect areas of the home where accidents are most likely to happen.

The use of a multiple baseline design across categories of danger as used by Tertinger, Lutzker and Greene (1984) was not appropriate for this study because the numbers of dangers in some categories were minimal. This was mainly due to the high standard of accommodation, and health and safety procedures followed by the project. As mothers participated in the completion of the checklist, and were therefore aware of all dangers in all categories, it would not have been possible to obtain extended baseline measures for any categories. Using a changing criterion design for the total numbers of dangers was a simple way to ensure that mothers were clear about target scores; however data gathered across all categories were useful in pinpointing specific categories where dangers existed.

The reinforcers identified by mothers were extremely effective, but also expensive in terms of resources and staff time. Lynne identified a meal cooked by a member of staff, while Judy requested a night out with a member of staff. It was noticeable that following the delivery of the reinforcer that the numbers of dangers present in Lynne's home increased suggesting that the use of a fixed ratio schedule, using smaller amounts of reinforcement more frequently would be more effective.

Feedback from the two mothers who participated in the preliminary study indicated that they found the procedure useful. They also highlighted issues that will be addressed in Part Two. These included:

1) The scoring method was confusing for mothers. Scoring was done on the total number of dangers present, and therefore a high score indicated a high number of

dangers, while in other assessment instruments as used in Studies One and Two, a high score indicated progress.

2) Mothers also suggested that counting the total numbers of dangers in each category, for example counting the total numbers of sharp knives, gave unrealistic scores. A child could just as easily be injured if they had access to one knife, as opposed to several.

Part Two

Participants

Karen

Karen was twenty years old when admitted to the project with her two sons aged one and two years. Karen had learning difficulties and problems with literacy. Karen was taking medication for depression. Karen's oldest child was very active, and although big for his age had global developmental delay, and behaviour problems. In contrast the younger child presented as a quieter, less demanding child.

Karen had been living in a hostel with a partner who was violent towards her. Following the break up of this relationship, professionals became concerned about the quality of care that Karen was able to provide for the children on her own. In particular Karen had difficulty managing daily routines, her eldest son's behaviour and hygiene and safety standards in the home. Karen had little understanding of the children's developmental levels, for example she had not begun any toilet training with her eldest son although he was almost three. Karen often underestimated her children's ability, for example, she was unaware that her eldest child would be able to lock himself in the flat, although she had previously seen him playing with the lock. Karen had difficulty carrying out more than one task at a time, which raised difficulties in supervising the children. For example, the children often were often unsupervised if Karen was using the telephone. Both children's names were on the Child Protection Register under the category of potential neglect.

Karen was selected for the study because of concerns about safety and supervision that had arisen during her placement. Her youngest son had fractured his arm on two occasions while climbing on furniture. Her eldest son had almost been hit by a car while walking beside the pram.

Cathleen

Cathleen was admitted to the project with her two sons. Cathleen was nineteen on admission; her sons were aged one and three years. Before admission Cathleen's children had been in foster care because of concerns which included domestic violence with a former

partner; Cathleen's drug and alcohol misuse; the children's contact with Schedule One sex offenders and Cathleen's ability to maintain standards of care for the children. Cathleen had been diagnosed as having depression and was taking prescribed medication.

Cathleen's eldest son was a very articulate child, who was advanced in all areas of development. Cathleen's youngest child was passive compared to his brother and demanded very little attention from his mother or other adults. Both children were on Care Orders, and on the Child Protection Register under the category of potential neglect.

Since admission a number of concerns had arisen about the standard of care that the children were receiving. These included failing to attend the children's medical appointments, not giving the children prescribed medication, and the youngest child being put in his cot for long periods of time. Cathleen did not provide many opportunities for play or stimulation, and the children became increasingly difficult for her to manage. Her eldest son often swore at and kicked his mother. Cathleen believed that her youngest child was rejecting her, and described him as not liking to be cuddled. Both children were affectionate, responsive and easy to engage when project staff looked after them. Cathleen's depression appeared to improve as her placement progressed and she became more outgoing with staff and other residents. Her behaviour towards the children however did not change, their diets continued to be poor, routines fitted around Cathleen's activities, and because of additional time spent with other residents Cathleen interacted less with the children.

Cathleen was selected for the study because of concerns about the number of minor accident resulting in injuries and bruises that the children had experienced since admission.

Consent
Consent was obtained as outlined in Part One of this study. Both mothers agreed that observers could check all areas.

Materials & Procedure
The home safety checklist was revised to measure dangers across rooms in each flat (Appendix 3d). The categories and subcategories of dangers used in the previous version remained the same, with some additional items identified by the two mothers who participated in Part One of this study. The observation procedure remained the same. As both mothers had two children, measures were taken of the eldest child in each family to ascertain which objects could be classed as within reach.

Research Design

A multiple baseline across rooms design was combined with a changing criterion design. Criterion levels increased on a weekly basis to a maximum of 90% based on the score for the previous observation.

Measures

Each room was scored under all categories and included all hazards in subcategories that were applicable to that room. If the hazard was present no score was given, and a score of 1 when hazards were not present. A percentage score for each room was calculated by dividing the total score obtained by the maximum possible score for that area multiplied by 100. When hazards were present a score of zero was given, the actual number of hazards did not affect the score.

Intervention

Intervention remained the same as part one, with the exception of target scores, which were measured for each room rather than the total number of hazards present. As Karen had some problems with literacy the 'dangers in my home sheet' was completed verbally with her, and the observer recorded her responses. Mothers were awarded vouchers following each observation if criterion levels were reached, and could use these to 'buy' a range of items. Any room that scored below 80% during baseline observations was selected for intervention. Kitchens and living rooms were addressed first as these were areas where families spent most time and therefore accidental injury is more likely to happen than in other rooms. Intervention continued until a score of 90% or above was achieved over three observations.

Results

Karen

Figure 3.5 shows that Karen easily met and surpassed criterion levels in all target areas. As Karen was involved in completing the sheets during observation she was aware of the desired changes in the bedroom and bathroom and behaviour generalised without further intervention. Karen was able to identify potential negative outcomes from any existing hazards for her children and ensure that these were removed or fixed. For example during baseline observations matches had been left within the children's reach. Karen removed them and this item did not occur again during any subsequent checks. Karen had been unaware of the potential risks of many items which were identified as choking hazards and took steps to remove these. For example, Karen had not been aware that toys that were suitable for the oldest child could be classed as hazards for the younger child due to small parts, and took steps to store these appropriately.

Reductions in the level of home hazards were maintained at follow-up. The final two observations were undertaken following Karen's move to a hostel with a lower level of staff

support. The slight decrease in scores during the final observations were mainly due to the layout of the new hostel, for example not having a locked cupboard for cleaning materials. Karen was able to ask the staff at the hostel to provide safety equipment.
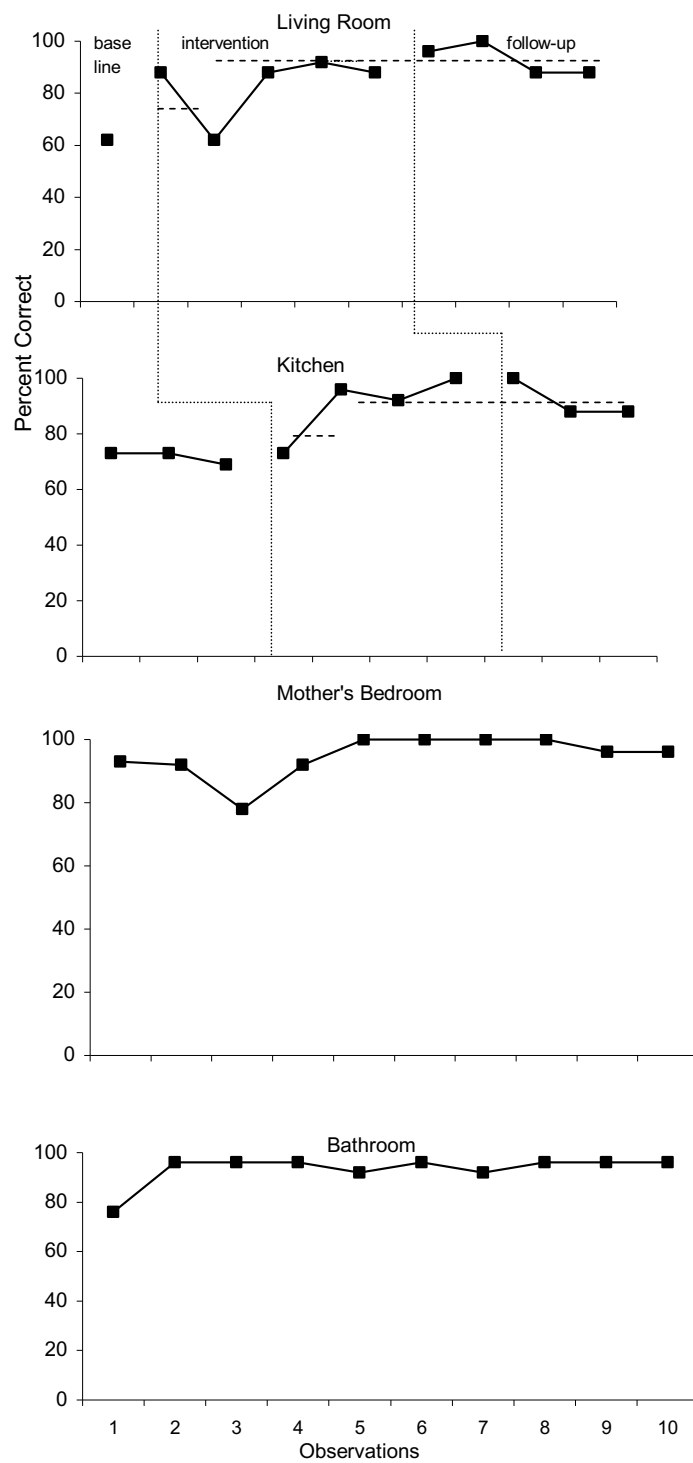
Figure 3.5, results for Karen for baseline, intervention and follow up in living room and kitchen, baseline scores for bedroom and bathroom. The dashed horizontal lines represent criterion levels.
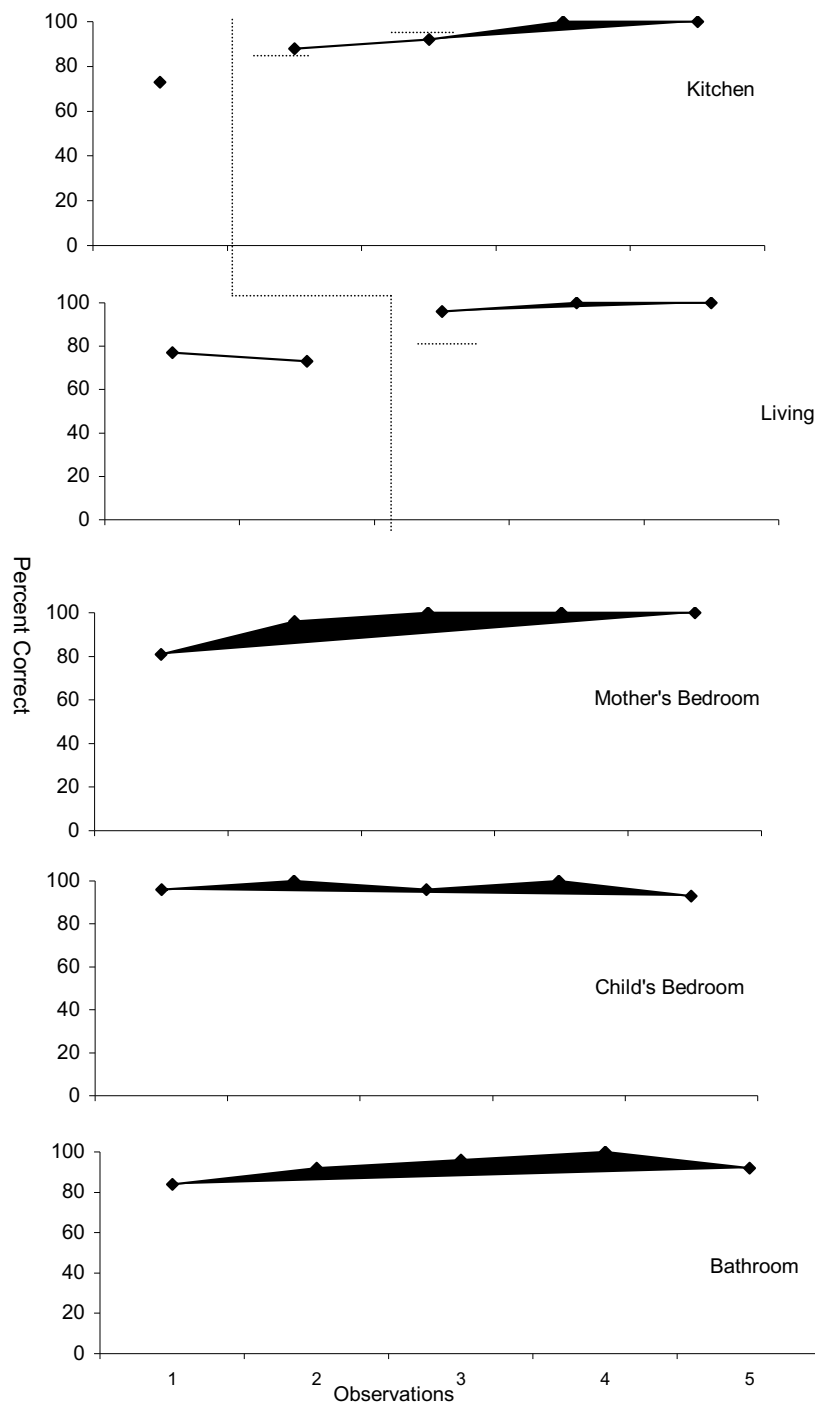
Figure 3.6, results for Cathleen during baseline and intervention for kitchen and living room. The remaining rooms remain at basline. The dashed horizontal lines represent criterion levels.

Cathleen

Figure 3.6 shows that Cathleen also easily reached criterion levels in both the kitchen and living room. No intervention was required for the remaining rooms. Cathleen was able to identify the potential outcomes for the children of being exposed to specific hazards.

Cathleen's scores, even at baseline, were almost at the maximum criterion level. One of the reasons for this was the lack of personal possessions in the flat for either Cathleen or the children. Cathleen's flat was sparse, with few items other than those provided by the project. No follow-up data was available for Cathleen as she decided to place the children in care following the last observation.

Although Cathleen scored highly during checks her children continued to suffer ongoing minor bruises and injuries, for example her eldest son cut his foot by jumping off a bed onto a large toy when she was not present. Cathleen did not increase her supervision of the children following injuries, and the children experienced further injuries.

Discussion

The procedure was effective with both mothers in reducing the levels of dangers in each flat, however, an increased awareness of dangers in the home did not generalise to improved supervision of children. Both mothers had a number of factors that are likely to have influenced their ability to maintain levels of supervision. Karen and Cathleen had both been diagnosed with depression, and were socially isolated with few contacts outside the project. Both mothers had recently separated from long term relationships, and although these has both been violent at times, their partners had offered a level of practical support in caring for the children. Karen had learning difficulties, which resulted in problems with literacy and numeracy, making daily tasks more of a challenge. In addition each mother had to balance the demands of two very young children who were close in age. This was particularly difficult for Karen as her oldest child was extremely active, had behaviour problems and required constant supervision, meaning that her youngest child was at times unsupervised. Children with behaviour problems have been found to be at increased risk of accidental injury (Tremblay & Peterson, 1999). However in this case Karen's younger child was at increased risk. Both of Karen's children began to attend nursery during the intervention period which allowed Karen time to complete household tasks without the children present.

Cathleen also had difficulty maintaining levels of supervision for both children; however this was more often linked to Cathleen being unavailable to the children. For example, on several occasions Cathleen left both children alone in the flat while she was visiting other residents. Cathleen's children often presented as bored and unhappy, while in contrast Karen's children presented as lively and happy children. Cathleen was provided with a nursery placement for her eldest child, to allow her time with her youngest child.

This was in part to ensure that the eldest child received adequate stimulation, and also to allow Cathleen time to build her relationship with her youngest child through increased interaction and play. Cathleen spent the time that her eldest son was at nursery with other residents, largely ignoring her youngest child.

Although results may indicate that intervention effects have generalised across rooms in the flats, this was in part due to mothers being aware of the desired changes in other areas because of their involvement in completing the checklist. However, follow-up data indicate that intervention effects also generalised to Karen's new home. Generalisation across settings is of vital importance as mothers need to be responsible for safety standards in their own homes.

General Discussion

The families who participated in this study shared similarities to the families who took part in Tertinger, Greene and Luzker's (1984) study in that there were concerns about standards in the home. There were however, considerably fewer hazards during baseline observations, mainly because the families who participated were living in temporary accommodation, and had few possessions with them. The families had been living in the project for a matter of months and did not have an accumulation of possessions built up over years. The flats are fully furnished and equipped, and any damaged or dangerous equipment is removed and replaced immediately by staff. In addition the project conforms to very strict health and safety guidelines which ensure that all equipment conforms to the highest safety standards. Few parents would be able to maintain these standards in their own homes.

This procedure was effective in reducing the occurrences of home hazards with each of the mothers. Each mother would fall within the categories of families who are seen to be at greatest risk of high rates of accidental injury, yet their homes even at baseline had relatively low levels of risks. This demonstrates that a good standard of accommodation removes many risks and suggests that responsibility for child safety should not be placed only on parents. Lynn, for example, made good progress while in the project but was unable to maintain this because of the difficulties of making changes to private rented accommodation.

Each parent consistently used any safety equipment that was provided for example, socket guards and stair gates. The provision of safety equipment was an important part of intervention, which may not have happened if parents had to buy items themselves, because of their limited financial resources. For example, each flat has a lockable cupboard for the storage of poisonous items such as cleaning fluids. Young parents in their own accommodation are unlikely to have such safety items and may be deterred by either not having the skills to put on a lock, or the finances to purchase one or pay someone else to do it. Overall where safety equipment was provided it was used.

The procedure could be viewed as invasive as observers looked in cupboards and drawers; however mothers did not identify this as a problem, and stated that they viewed the process

as a useful exercise. All of the mothers showed a willingness to participate in the work and none avoided any arranged observations. This is in part due to working in partnership with parents, through parents' involvement in completing the observation sheets, and also because staff shared responsibility for the safety of the flat, for example through the provision of socket guards.

Cathleen stands out because of her lack of interest in the children's welfare, and unwillingness to engage even when given supports to give her the opportunity to do so. This fits with Iwaniec's (1995) description of emotionally neglectful parents' unavailability to provide care and protection through 'the passive ignoring of a child's emotional needs' (p.5). In contrast, the other parents may have lacked knowledge about their children's ability and development, but once given this information were willing to act on advice. As the children who participated in this study were older and more active than those in the previous studies, the impact of parental care was more evident. Cathleen's children's presentation contrasted starkly with the other children involved, and showed the impact of emotional neglect. They presented as unhappy, bored and angry and showed little interest in their mother or other adults. Following their admission to foster care the children settled immediately, and showed no negative effects. The oldest child never asked for his mother. The children in the other families in contrast presented as lively sociable children, who enjoyed contact with other adults but showed a preference for their mother.

The standard of hygiene in the home was not fully addressed through this procedure, although observers identified this as an issue for some of the parents who participated. This will be addressed in Study Four.

Study Four- The Home Hygiene Programme

Introduction

Adequate shelter is a basic need for all children; components of shelter include safety as addressed in the previous study, and the child's hygiene which was included in Studies One and Two. A further aspect is the standard of hygiene in the home. Poor hygiene can have a direct negative effect on children's health and development (Howarth, 2001; Watson-Perczel, Lutzker, Greene & McGimpsey, 1988). The impact is likely to vary depending on the child's developmental level and can range from mild effects to serious threats to health. Children, for example, may be infected through exposure to bacteria from dirty kitchens and toilets, this is particularly pertinent for very young children who are crawling and exploring as they may come into direct contact with unclean floor surfaces or toilet bowls. Younger infants may experience fungal infections and diarrhoea as a result of unhygienic preparation of formula. Very young children are therefore at greatest risk of serious illness as a result of poor home conditions. The main risk areas for infection are wet areas such as the kitchen or bathroom (Jones 1998).

Although older children may have a greater tolerance to bacteria, and therefore experience fewer effects on their health, the experience of poor personal or home hygiene is likely to adversely affect self esteem. Children who live in extremely dirty home environments, and who have poor personal hygiene are likely to be rejected by peers and are less likely to be by accepted the wider community due to poor hygiene (Bifulco & Moran, 1998). Other parents are unlikely to want their children to visit homes that could be a health risk, and less likely to invite children who are perceived as dirty into their homes. In an action research project commissioned by Nottingham ACPC looking at 25 long-term cases of neglected children, the home conditions were described by professionals as 'smelly, dirty, infested and often unsafe, leading in many cases, to social isolation and ostracism within the immediate neighbourhood, or even from the professional community' (Glennie, Cruden & Thorn, 1998, p. 15).

Social workers may be anxious about making value judgements about the state of the home; however they have a professional responsibility to decide at what point the condition of the home is likely to have an adverse effect on the child's wellbeing. In fact, a home that is excessively clean is also now believed to be potentially harmful because children do not have the opportunity to build up resistance to bacteria. A sterile environment is not necessarily a healthier one, for example the increase in asthma and rhinitis is thought to be linked to having less contact with microbes in the home, and eating more sterile food (Matricardi, Rosmini, Riondino, Fortini, Ferrigno & Bonini, 2000). While some parents are

untidy, and standards in all homes vary widely, it is when these standards are harmful for the child, either physically or emotionally that this constitutes neglect.

In reviews of professionals' definitions of neglect both Howarth (2001) and Stone (1998) include hygiene problems and poor housing as components of neglect. Examples included by professionals in both studies tended to be extreme; for example, human or animal faeces on the floor, or rotting food. These problems often occur as the result of parental problems such as mental health, drug or alcohol abuse (Clever Unell & Aldgate, 1999). Hygiene problems at their most severe are reported in the case of Paul (The Bridge Child Care Development Service, 1995) who died as the result of neglect. Over a fifteen year period of involvement with Paul's family professionals repeatedly reported extremely poor conditions in the house, as well as poor hygiene for the children.

Clearly a difference needs to be made between inadequate living conditions caused by poverty and those caused by other factors. Minty and Pattinson (1994) suggest that what differentiates poverty and physical neglect is the element of emotional neglect present in the latter. They state that emotional neglect is present when parents are unable or unwilling to recognise children's basic needs. In order to assess the quality of parenting it is necessary to find out if parents have the necessary knowledge and skills to meet their children's needs. If these skills are present, or can be learned, assessment needs to focus on whether or not parents can consistently put these skills into practice.

Greene and Kililli (1998) highlight the lack of any acceptable measurable standards for parenting in general; this includes standards within the home. They point to the need for baseline measures that can demonstrate progress over time. Existing checklists, for example Minty and Pattinson's (1994) Neglect Questionnaire, or The Childhood Level of Living Scale (Polansky et al., 1981) include items that reflect the level of hygiene in the home at a given time, but do not give any quantifiable measures that could demonstrate progress, nor do they offer any directions for intervention.

Some mothers living in the project have been found to have extreme difficulty maintaining hygiene standards in the home. On occasion, the condition of the flats has been so poor that industrial cleaners have been employed to clean the flats when the placement ends. Mothers in the project who have has severe difficulties in maintaining their homes have also had problems in all aspects of childcare.

Findings from the implementation of the Family Cleanliness Scale establish correlation between children's development and the overall state of the home. Children whose families scored positively on the scale had better language and intellectual development than families

who obtained low scores (Davie, Hutt, Vincent & Mason, 1984). It is likely therefore that the overall standard of the home is indicative of the quality of care a child receives.

The aims of this study were:

1. To develop an instrument to measure standard of hygiene in the home.
2. To assess if mothers have the skills to maintain standards of hygiene in their homes.
3. To develop these skills if needed, through prompting, modelling and positive reinforcement.
4. To enable mothers to develop regular cleaning routines.

The study is presented in three parts to reflect development of the instruments used.

Participants

Five mothers took part in the study. All were selected because of ongoing concerns about the levels of hygiene in their homes and the potential affect of this on their children. Four mothers had participated in previous studies. Seven children were involved in the study. The children's ages ranged from two weeks old to three years old. All children except one were on the Child Protection Register under the category of neglect.

Consent

Written consent was obtained as outlined in Studies One to Three. All mothers gave consent that observers could examine the inside fridges and check bedding.

Training for Observers

Observers were trained through discussion of each of the items on the check lists and practice observations consisting of observers completing the check list independently in each room in a resident's flat. Agreement between observers was above 91%. This was calculated using the formula:

$$\frac{\text{Number of Agreements}}{\text{Number of Agreements} + \text{Number of Disagreements}} \times 100$$

(Sulzer-Azaroff & Mayer, 1991).

Part One

Susan

Susan previously took part in Study Two addressing routines. While undertaking work on daily routines it became evident that Susan was having difficulty maintaining hygiene standards in her home, and that further work needed to be undertaken to address this. This study took place two weeks after work commenced on routines, and continued for two weeks after Susan stopped recording her daily routines. Intervention stopped because Susan's baby was removed from her care under an Emergency Protection Order.

Susan's baby was five weeks old at the start of the study and had experienced diarrhoea which was possibly linked to poor hygiene. Susan had been able to maintain her flat at the beginning of the placement, however as standards of overall childcare decreased, so did standards of hygiene in the flat.

Materials

The Checklist for Living Environments to Assess Neglect (CLEAN) (Watson-Perczel et al., 1988) was adapted for use in a residential project. The checklist measured the standard of the entire home in terms of cleanliness, inappropriately stored items and clutter. Each room was divided into item areas, and these were observed to measure levels of cleanliness, clutter and inappropriately stored clothing (appendix 4a). These were defined as:

- *Clean or dirty*: the presence of organic matter on surfaces in each area
- *Clothing*: accumulations of clothing, towelling, bed clothes in each area
- *Clutter*: objects out of place in each area, for example plates on the floor

A list of tasks to be undertaken for each area was devised as a visual prompt and self-recording tool for mothers (appendix 4b).

Procedure

The same procedure was used throughout all parts of the study with slight variations which will be described in the relevant sections. The procedure was introduced to the mother as a way to help her to keep her flat clean and tidy. Observations were undertaken in the mother's flat on a weekly basis at a prearranged time. Mothers accompanied observers during scoring and discussed each item as it was scored. Following an initial baseline observation the observer helped the mother to clean one room. This allowed the observer to see if the mother had the necessary cleaning materials, and skills to complete the task. If mothers did not have cleaning materials, they were provided by the observer on the first occasion and the observer and the mother discussed and agreed which products she should purchase. If the mother was unable to perform the task, the observer offered verbal prompts followed by modelling if necessary.

Following the initial session, a target room was selected for the following observation. The mother was given the task list for the relevant room although this was not included in the scoring. Staff also discussed with the mother the importance of a hygienic living environment for the child's health and development. On subsequent observations if the target room scored above 80% in all categories the observer arranged to undertake an activity with the mother, for example going out for coffee. If the target score was not reached, the observer and the mother undertook the cleaning of that area, using the checklist as a guideline. Intervention continued on each room until a target level of 80% had been obtained.

Measures and Research Design

Each item of the checklist was given a numerical value based on the CLEAN procedure. A score of 10 was given if an area was clean, and 0 if it was dirty. The number of clothes inappropriately stored, and the number of items constituting clutter were scored from 5 for no items down to 0 for more than twenty items. A percentage score for each of the three categories was calculated by the total score obtained divided by the total possible score multiplied by 100.

The research design used was a multiple baseline across rooms design.

Results

Figure 4.1 shows the results of intervention in the living room and kitchen, and baseline scores for the remaining rooms across the three categories. Although Susan scored above criterion levels in the categories of clutter and inappropriately stored clothing throughout all phases; she had difficulty maintaining levels of hygiene. Following the initial baseline observation for the living room Susan scored 100% in the category of cleanliness, however subsequent observations indicated that improvements were not maintained in this area. Soiled nappies and used baby wipes were often left on the floor or table tops, and dirty ashtrays were spilt on the floor. There was some improvement in the category of cleanliness following intervention in the kitchen; Susan maintained a score of 80% during the two subsequent observations. This was partly due to staff cleaning the kitchen between observations as they were concerned about the potential impact on the baby's health. As Susan's placement ended no further observations were undertaken.

Discussion

By the time intervention ended Susan was having difficulty in maintaining her day to day routines for herself and the baby, as outlined in Study Two. Susan demonstrated during the very early weeks of the placement that she had the skills to maintain hygiene levels in her flat but was unable to sustain these. One difficulty was the amount of time Susan spent away from her flat, either out of the unit or with other residents, leaving her very little time to clean or tidy her flat or carry out childcare tasks.

This instrument was effective in assessing the level of hygiene throughout the flat, however the measures of clutter and clothing out of place did not reflect standards in the flat realistically. For example four soiled nappies on the table would have resulted in a decrease of only 6% in the score on clutter for the living room, leaving this well above the 80% criterion level, although this was a considerable health risk to both Susan and her baby. Informal observations by staff during this period often described the flat as very untidy, although this is not reflected in the results.
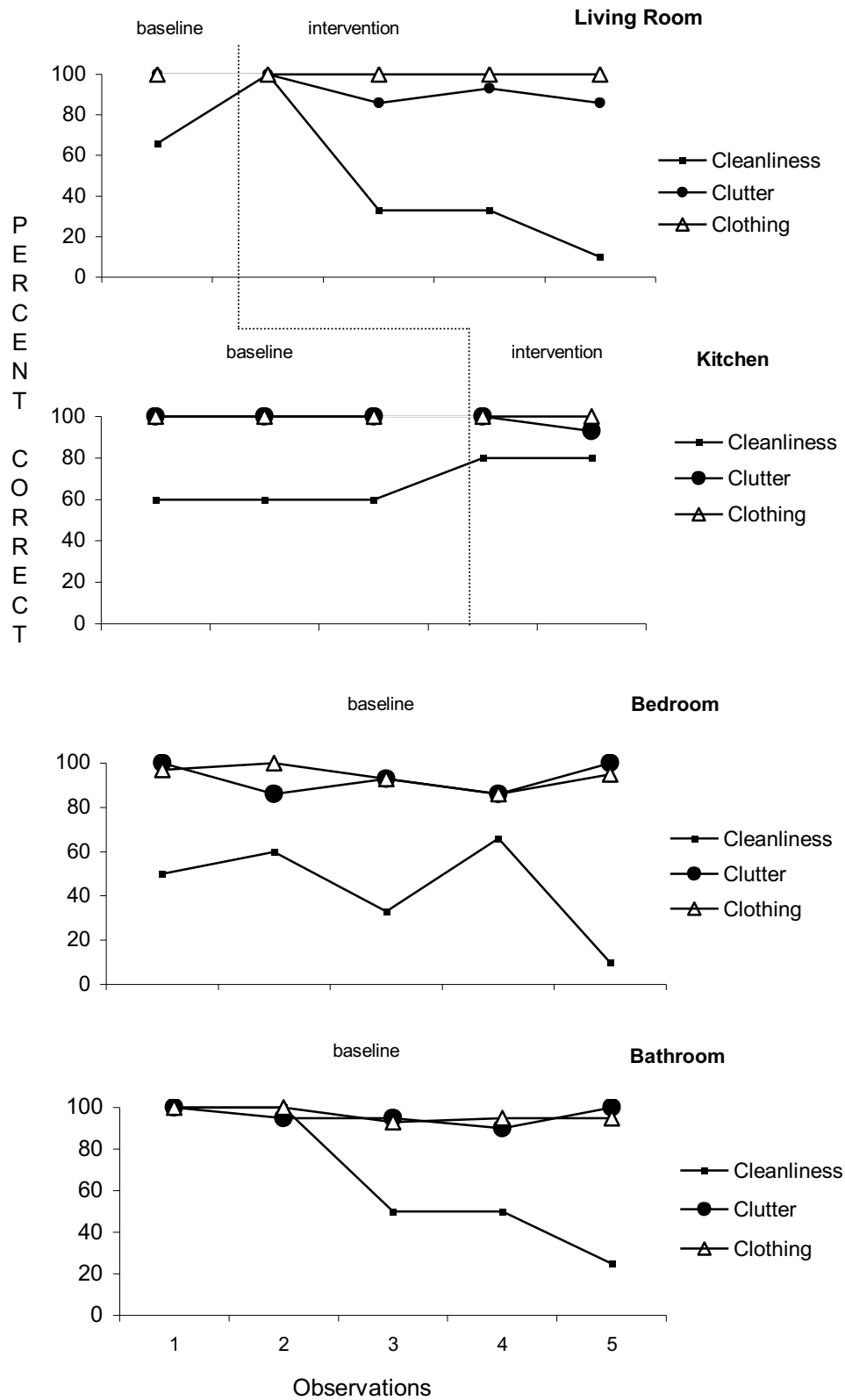
Results

Susan

Figure 4.1 results for Susan for the categories of cleanliness, clutter and clothing during baseline and intervention for living room and kitchen, and baseline scores for bedroom and bathrom

The high scores under the categories of clutter and clothing were mainly because of the temporary nature of the accommodation provided by the project, which means that parents only have a limited number of possessions, and are provided with adequate storage.

Feedback from observers indicated that it would be useful if the checklist gave more specific information on what families need to do to improve hygiene standards. The scoring was also believed to be too complex, making it difficult to fully involve some parents in completing the checklist. The checklist was modified as described in Parts Two and Three of this study.

Part Two- Ruby

Ruby participated in Studies One and Two. Ruby's child was 6 months old at the start of the study and spending time on the floor, often with minimal supervision. The floors and furniture in Ruby's flat were often covered with old food. Soiled nappies and dirty plates were frequently left on the floor. Ruby blamed her son for her flat being untidy or dirty claiming that he did not like her to clean the flat and cried when she tried to do this. Although her son had begun to roll Ruby often refused to lift plates or cups off the floor, insisting that her son 'knew' not to touch them.

Materials

The original checklist was revised and specific items were added each room. These included areas that needed to be cleaned or tidied at least weekly (Appendix 4c). Items included on the checklist were those that could pose health risks for example floor surfaces, toilets, fridges and bins. Other items were included that staff had observed to contribute to the overall standards in resident's flats. The main emphasis was on cleanliness, with only a few items relating to clothing or clutter. These items were included in the overall score, and not measured separately. This checklist allowed six observations to be completed on each sheet, so that results in specific areas could easily be compared. Mothers were also given the list of tasks that needed to be completed daily for each room (Appendix 4b).

Procedure

The procedure was the same as described in part one. Intervention continued in each room until the criterion level of 80% had been reached during two observations.

Measures and Research Design

Measures were taken of the number of items of the checklist that had been completed in each room. A percentage score was calculated by the total number of items scored divided by the total possible number of items multiplied by 100. If any item did not apply, for example if the family did not use face cloths, this was omitted from the checklist and the final score. A multiple baseline across rooms design was used.
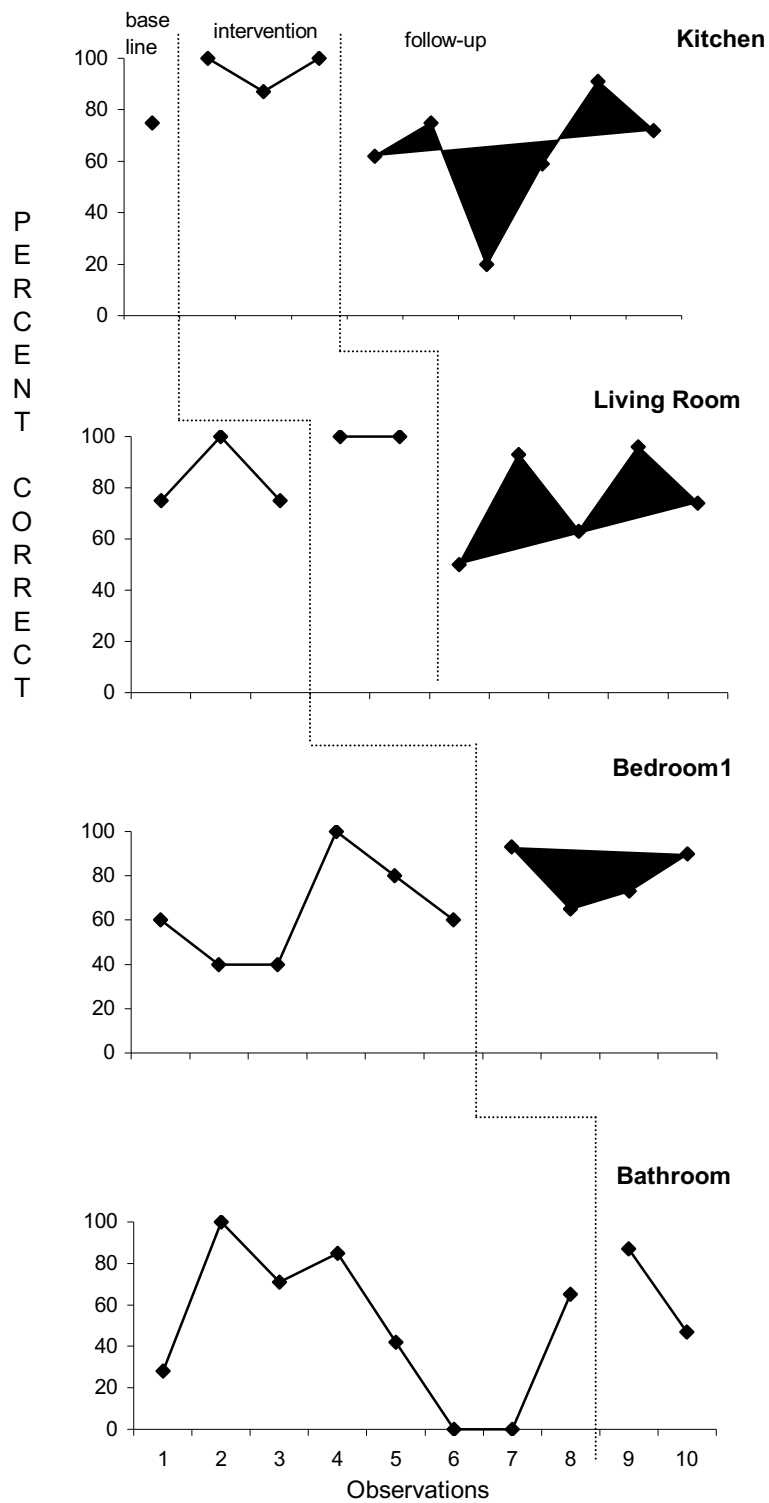
Results

Ruby

Figure 4.2 results for Ruby for basline, intervention and follow-up for kitchen and living room, and baseline and intervention for bedroom and bathroom

Intervention was initially successful in all rooms as shown on Figure 4.2; however this was not maintained at follow-up. Ruby's scores indicate that she had the skills to clean and tidy her flat, but was unable to sustain this. During the intervention phase for the living room Ruby scored 100% on two occasions, this decreased immediately during follow-up. Behaviours that competed with cleaning the flat were similar to those that prevented Ruby from following her planned routine as outlined in Study Two, mainly spending time out of the flat or with other residents. Areas where Ruby had repeatedly had difficulty were washing dishes, keeping worktops clean and cleaning food spillages off her furniture. In the bedroom Ruby frequently had dirty washing on the floor. As Ruby's placement ended further data were not available.

Discussion

The revised instrument gave a more realistic overall picture of the condition of the home, and specific areas that needed intervention. The use of vouchers, praise and potential outings with staff acted as reinforcers for some areas but not others. The condition of Ruby's flat reflected how she was coping with childcare, on days when this was disorganised, so were conditions in the flat. The main risks to Ruby's baby at this stage were the potential bacteria from the kitchen, dried in food on the furniture and carpet and her child having access to dirty cups and soiled nappies on the floor. These risks were increased because Ruby did not always supervise her baby.

Data follow a similar pattern in all rooms, for example on the second observation, although this was the intervention phase for the kitchen only, the bathroom, and living room both improved to 100%. The reverse is also true, for example results from the seventh observation show low scores for both the kitchen and bathroom. In general standards were similar in all rooms regardless of the intervention phase. This indicates that targeting each room in sequence is unnecessary as results generalised throughout the flat, and therefore a simple AB design targeting all rooms in the flat simultaneously would be effective. This is explored further in Part Three.

Part Three

Karen, Cathleen and Hannah

Karen and Cathleen also participated in Study Four.

Cathleen was included in the study because she had difficulty in maintaining standards in her flat. When Cathleen had been living in the community, prior to the children being admitted to care, there were serious concerns about the standard of hygiene in her home. Reports indicate that there was rotting food strewn on the floor, along with used nappies.

When Cathleen left her home many items including furniture and carpets had to be burned because they were in such poor condition.

Cathleen often left the children unattended while eating, and as a result her youngest child frequently spilled food on the floor and over his highchair, which was often left for several days before being cleaned.

Karen

Although Karen cleaned her flat on a regular basis, the flat often presented as untidy and dirty, particularly with spilled food. Karen had been attempting to toilet train her eldest son for several weeks, and he had several accidents on the carpet in the flat. Karen's youngest son had asthma and regularly had to take an inhaler.

Hannah

Hannah was seventeen when she was admitted to the project prior to the birth of her baby. Hannah had spent most of her life in care, most recently in a children's home. Although she had some contact with her parents this was sporadic and not always supportive. Hannah was referred to the project because of her young age, and inexperience in looking after children.

Initially Hannah maintained high standards within the home; however these dropped significantly following the birth of the baby. Hannah was assessed in caring for her baby using the assessment methods and tools as outlined in Study One and required no further intervention in these areas.

Materials and Procedure

The same checklist as described in part two of this study was used along with the daily cleaning task list. The procedure as outlined in Part One was used, with the following changes:

1. Instead of having individual rooms as target areas the entire flat was classed as a target area. Data were also divided into rooms so that individual areas could be monitored.
2. Two baseline observations were undertaken. Mothers were helped to clean one area following the second baseline observation.
3. Follow-up data were collected weekly throughout the duration of the placement.

Measures and Research Design

Measures were taken as in part two of this study. An ABA design was implemented for two mothers. An AB design was used for Karen as no follow up data were available as she was unable to reach criterion levels for two observations in all rooms during the placement.
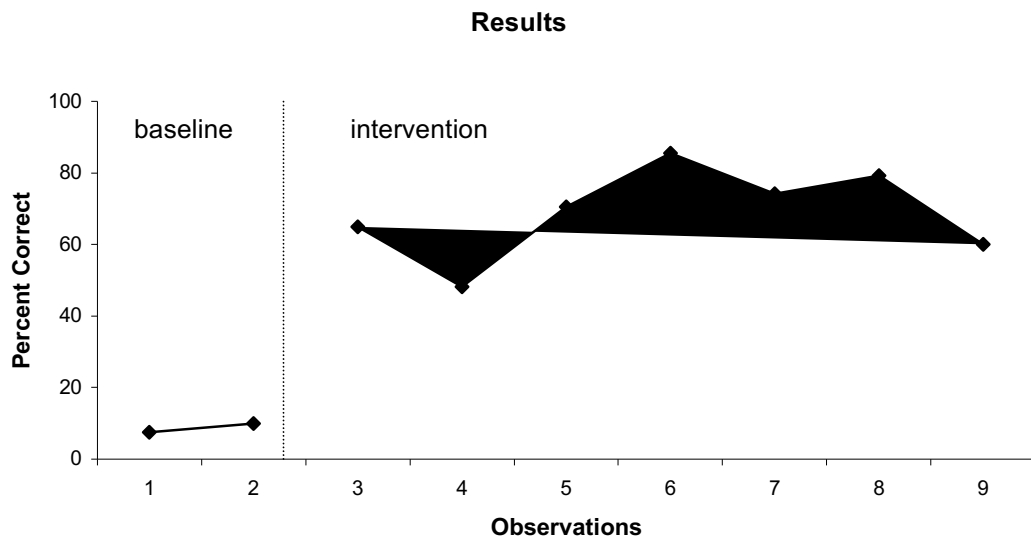
Results

Figure 4.3 results for Cathleen for baseline, intervention
and follow-up for all rooms.

Cathleen

During baseline observations Cathleen had no cleaning products in her flat and did not know
what to buy. Figure 4.3 shows that Cathleen scored above criterion levels on two occasions
during intervention, and once during follow-up, but did not sustain these consistently. Each of
these high scores coincided with Case Conferences, when Cathleen was aware that
professionals would be making decisions about whether or not to the placement should
continue because of childcare concerns. Figure 4.4 shows progress across rooms. As in
parts one and two of this study, data follow a similar pattern, high scores in one area are
generally replicated in other areas for example the fourth observation. Low scores are also
generalised.

The area that Cathleen made most progress in was the living room, reaching 100% during
two observations. The children's comfort was not always a concern for Cathleen, for
example Cathleen rarely had clean towels for the children, which meant that after baths they
were often dried with damp towels. The children's bedding was often soiled and unchanged.
As Cathleen's children were both mobile, they were under increased risk of infection though
touching items which were dirty for example the toilet, particularly as the children were at
times unsupervised. The toilet continued to be unclean during 33% of observations during
intervention. Cathleen reported that she found it difficult to clean the flat and supervise her
children; however when a nursery placement was provided for her eldest child standards in
the home did not improve. During follow-up standards in the flat deteriorated; this coincided
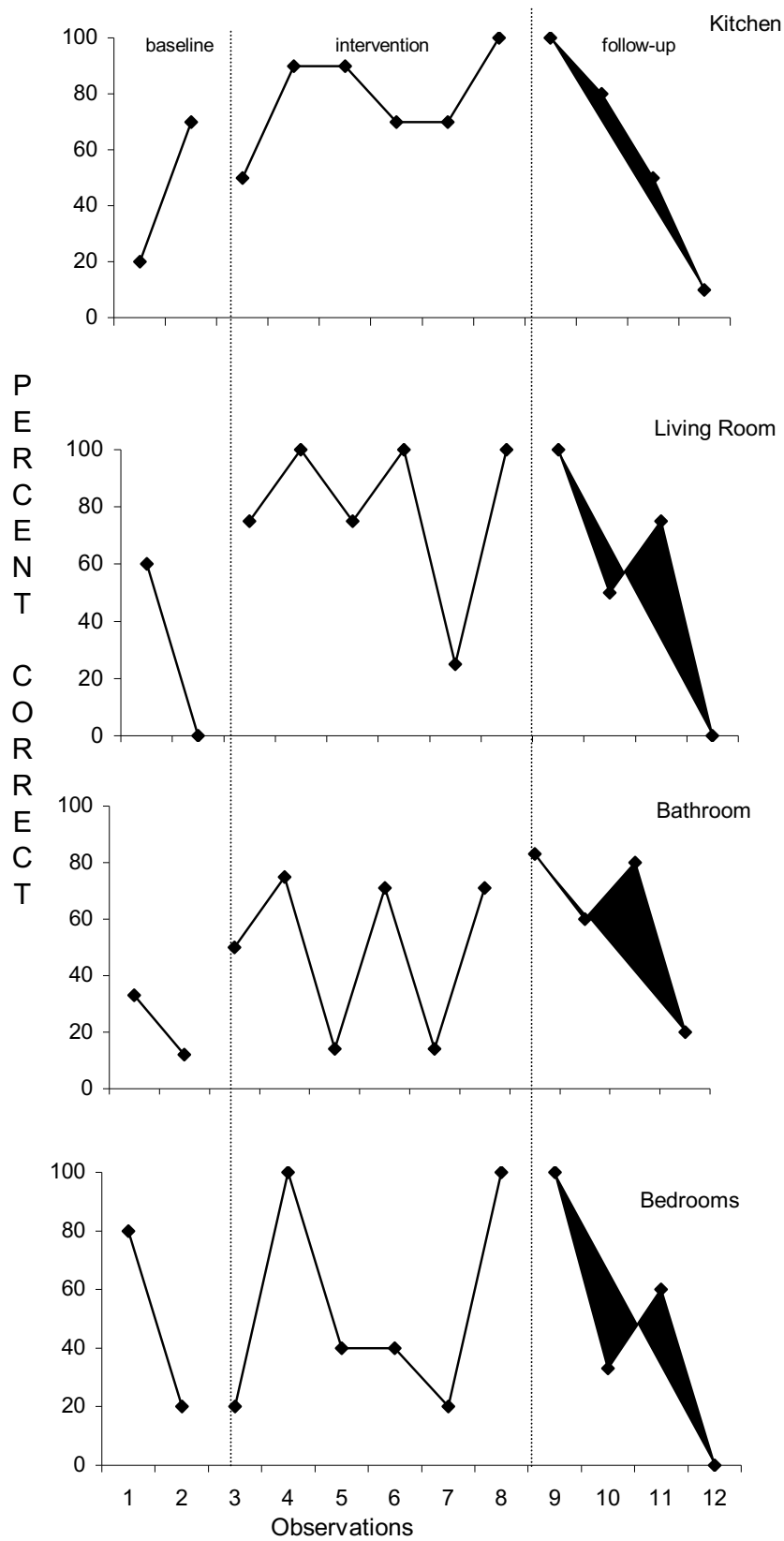with Cathleen' decision to place the children in foster care.

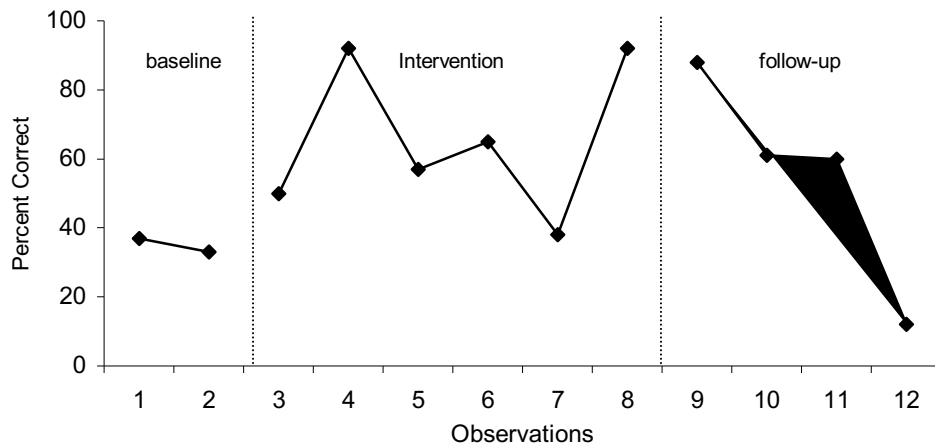Figure 4.4 results for Cathleen broken down
across rooms

Karen

Figure 4.5 results for Karen for baseline and intervention for all rooms.

Although Karen's scores increased following baseline observations as shown in Figure 4.5, intervention continued because Karen reached criterion levels in all rooms on only one occasion. Figure 4.6 shows Karen's progress across rooms. Progress was maintained in the bedrooms. Specific items that Karen had the most difficulty with included having the washing up done and having bins emptied and cleaned. The bins posed a risk to both children because of the risk of infection and also because the children were unsupervised at times and could gain access to these items. Like Cathleen, Karen found it difficult to clean her flat and supervise the children, however she did make improvement to the flat when her eldest son began attended nursery, this coincided with the start of intervention. Scores dropped again during the fourth observation. This observation coincided with Karen's son being off nursery on his mid term break, and highlights the difficulty Karen had in maintaining standards in flat when she had both children with her. Karen had learning difficulties, which meant that she found it difficult to carry out more than one task a time. Karen managed this by completing her cleaning at times when her youngest son had a nap. During the final observation Karen's scores decreased. This was during the period that she was packing to move to new accommodation.
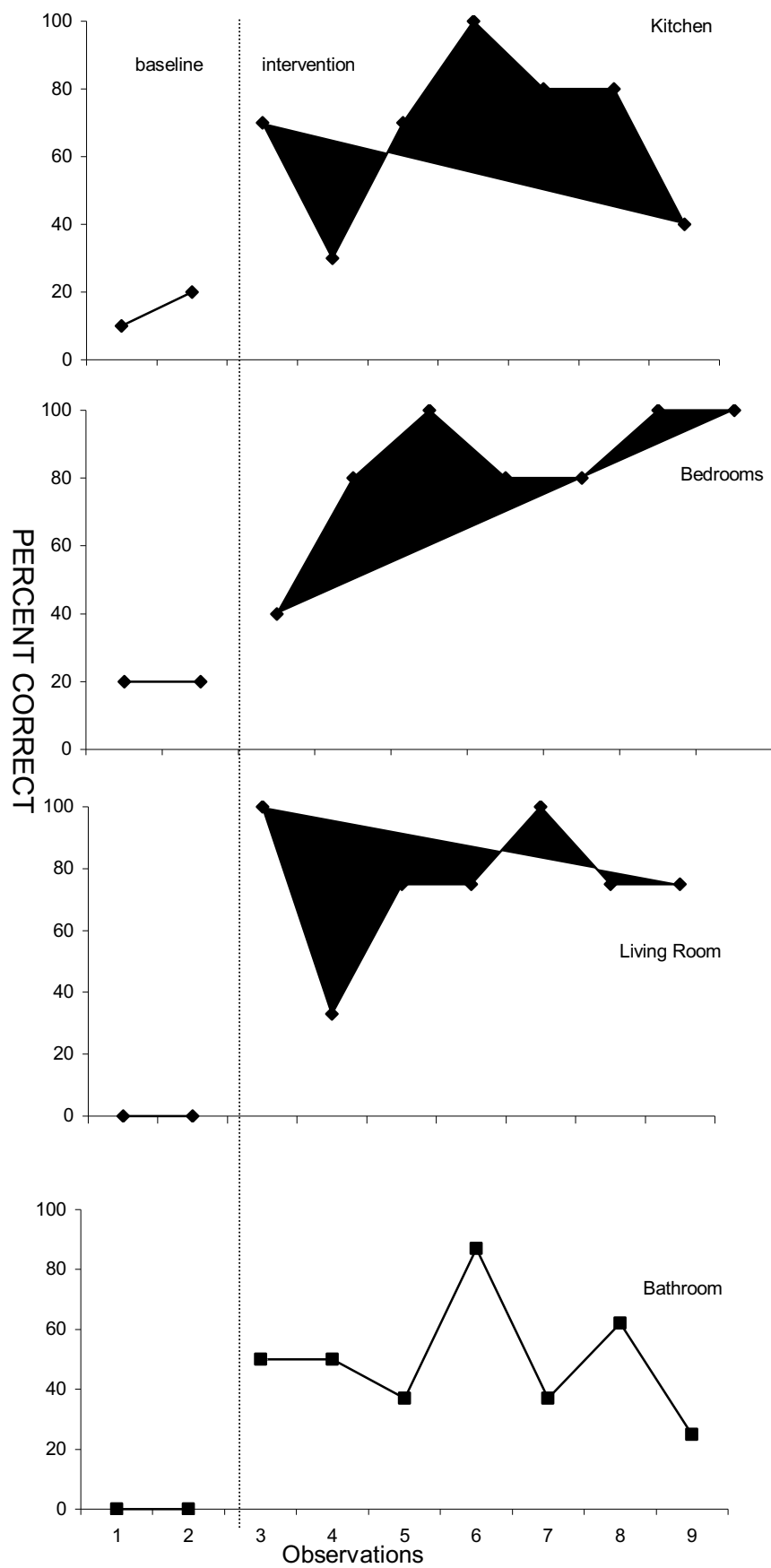
Figure 4.6 results for Karen during baseline and intervention broken down across rooms
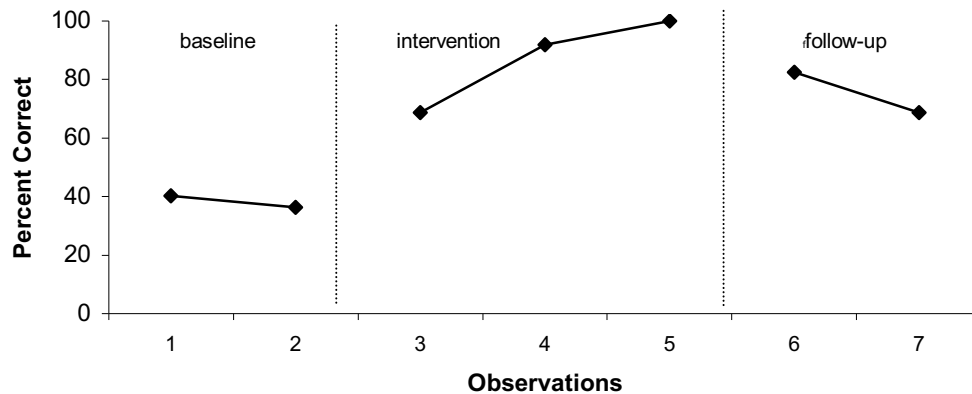
Hannah

Figure 4.7 results for Hannah for total scores for all rooms during baseline, intervention and follow-up.

Hannah surpassed criterion levels during intervention as shown in Figure 4.7, but did not maintain these at follow-up. The scores for individual rooms shown in Figure 4.8, show that the kitchen was the area that Hannah had most difficulty maintaining. Hannah often had dirty dishes and worktops in the kitchen, both of which could pose a health risk to her baby when making up feeds. The area where Hannah made most progress was the living room. Although scores for this area dropped during follow-up these were still at the 80% criterion level.

Discussion

Each of the three mothers reached criterion levels for all rooms on at least one occasion, however none were able to sustain this. Cathleen and Karen needed to clean their flats more frequently than Hannah because they each had two children who were older and more mobile. Their children were exposed to a higher risk of infection than Hannah's baby because of direct contact with areas that were unclean throughout the flats. Older children may actively contribute to any untidiness in the flat, for example by pulling out toys from cupboards, or leaving pieces of food around the flat. Although Karen had difficulty reaching criterion levels, the increase in scores reflect the attempts Karen made to maintain her flat. Had intervention continued it is likely that Karen would have eventually have reached criterion levels, however this was not possible as Karen moved out of the project.
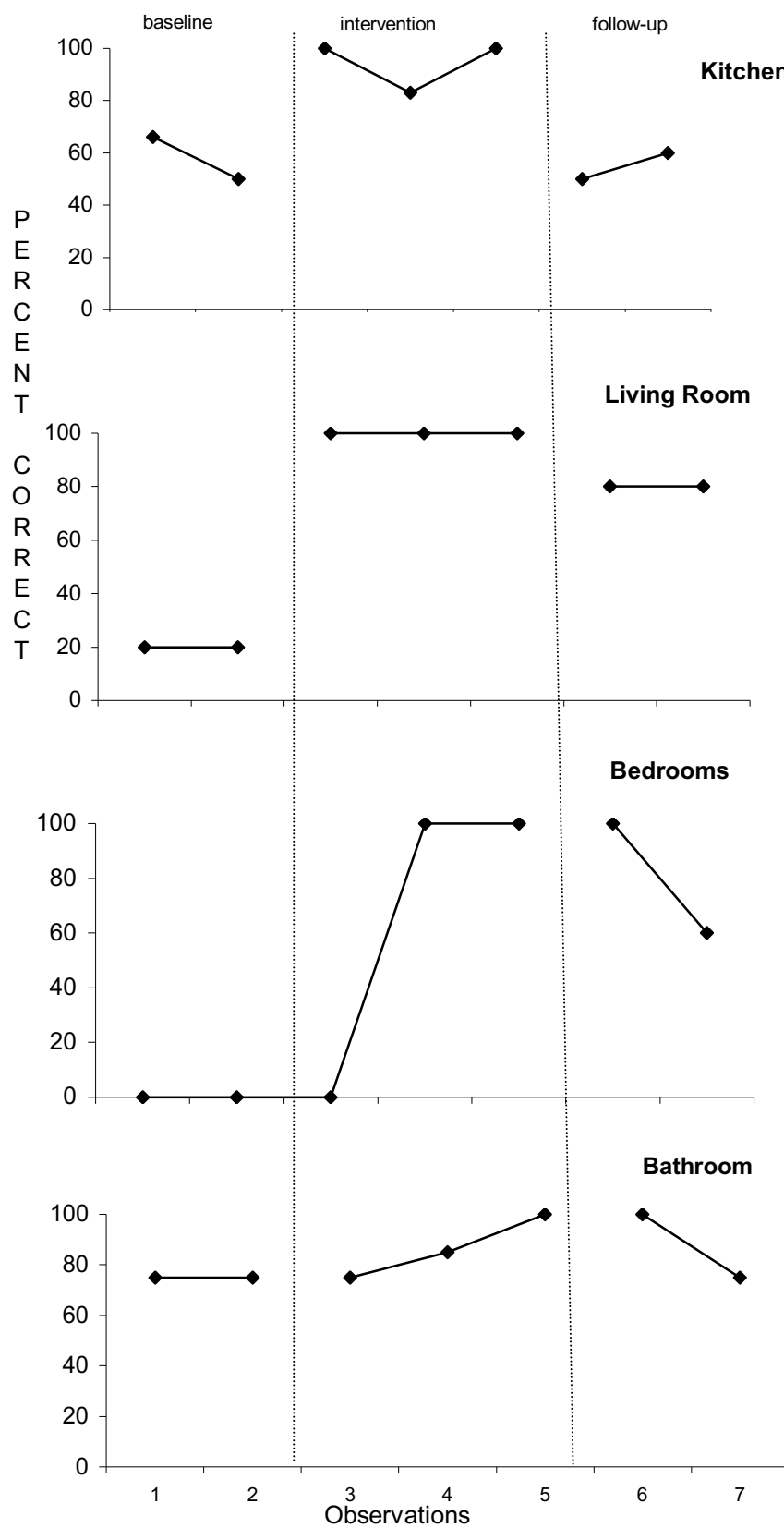
Figure 4.8 results for Hannah during baseline, intervention and follow up, broken down across rooms.

General Discussion

Although concerns existed about the levels of hygiene in each of the homes of the parents who participated in this study this was not fully reflected using the CLEAN checklist. The first checklist used was effective in measuring the levels of cleanliness; however the measures of clutter and clothing were not relevant for temporary accommodation because the parents had fewer possessions than they would have if living in their own homes. Three of the mothers had very young babies and as a result had fewer toys, and books in their flats than the mothers with older children had. The revised checklist gave a more realistic score, and was explicit in what parents needed to do.

The revised checklist differs from other existing measures of home conditions because it was based completely on positive statements. Minty and Pattinson's (1994) neglect questionnaire the Childhood Level of Living Scale (Polansky et al., 1981) both contain statements that would be perceived by parents as critical, for example 'there are food scraps on the floor and furnishing' (Polansky et al. 1981, p 246). Both these instruments are designed to be completed by workers, and not with parents. The emphasis on positive statements is likely to make the procedure more acceptable to parents who are less likely to feel judged than they would by negative descriptions of their homes. Using the checklist allowed observers to explore hygiene throughout the house with parents, something that can be difficult for social workers to access during routine visits.

Parents were aware when visits were going to take place, and although it could be argued that as parents were prepared that this would not reflect the standard of the home, it does address one of the aims, which was to encourage parents to clean their homes thoroughly at least once per week. Staff had ongoing contact with parents between observations, and could address hygiene issues if necessary.

Social outings or other activities with staff as reinforcement had a limited effect, and it appears that staff helping mothers to clean if tasks were not completed provided equal reinforcement. This means that the prospect of staff helping mothers to clean may have been acting as a reinforcer for not cleaning the flat.

All mothers were able to reach criterion levels during the intervention phase, suggesting that any skills deficits that did exist were addressed through modelling and verbal instruction. Difficulties arose for all mothers in maintaining progress. As all mothers could on occasion score highly on the checklist this suggests that standards were not unrealistic. It is significant that Hannah's scores increased more steadily overall than other parents as she was the mother who also appeared to be providing the best overall standard of care for her child. Hannah was the only parent whose child was not on the Child Protection Register. The mothers who scored lowest both in total scores and in individual rooms were also the

mothers who had most difficulty in caring for their children. This would indicate that very poor standards of home hygiene are linked to overall standards of childcare.

Although risks through poor home hygiene need to be considered in the context of the current age and developmental ability of the child, future risks to the child also need to be considered. Ruby for example was unwilling to accept that a baby who could roll would be able to reach items on the floor. This highlights the need for parents to have an understanding of their child's development.

Poor hygiene in the home is often attributed to poverty and low standards of housing, however as the accommodation provided in the project is of a high standard this is not the case. Other factors that had an influence on the condition of the flat included mothers spending time away from their flats and so not having the opportunity to clean flats and the difficulty of completing household tasks while supervising two children. Karen's learning difficulties may have slowed down her rate of progress, although this needs to be looked at alongside other potential factors that impacted on all the mothers who participated.

One of the difficulties in assessing the level of hygiene in the home is that risks may not always be obvious. For example, a work surface in the kitchen may appear to be clean, but may in fact be a high risk area if it has been cleaned with a dirty cloth. Cleaning the home alongside parents allowed this to be assessed. It was also important that education of parents was included to ensure that parents were aware of potential risks.

Although professionals may view unhygienic home conditions as neglectful when they are most severe, even conditions that would not be described as extreme need to be considered in terms of the direct risk to the child, depending on the child's age and developmental stage. Hannah's flat for example would have been considered adequate, but could have been a source of infection for the baby because of the condition of the kitchen. This would however have depended on the length of time dirty dishes had been left, if they were left from the last meal or had been there for several days.

As in Study Two the child's wellbeing was not acting as a reinforcer for some of the parents in this study, nor was the child's discomfort aversive. For example, although Susan was aware that her baby's diarrhoea could have been caused by unhygienic conditions in the flat, she was unwilling to address this. Cathleen continually used damp and dirty towels on her children although this was frequently addressed with her. For Susan, Ruby and Cathleen as in Study Two social contact was a more powerful reinforcer than those provided by their children or staff.

Study Five Parent-Child Interaction

Studies One and Two highlighted parental difficulties in recognising and responding sensitively to infant cues. Studies Three and Four showed that some parents had problems in ensuring safety and hygiene standards in the home. In some cases, the child's wellbeing did not appear to be acting as a positive reinforcer for parental caretaking behaviour, and children's distress or discomfort was not acting as an aversive stimulus to punish behaviour that was incompatible with childcare tasks. This study aimed to increase the positive reinforcement value of infants, by training parents to interact contingently, and observe their child's responsive behaviour. Increasing the rate and quality of interaction aims to enhance the overall reinforcement value of the child's behaviour.

The potential difficulties that both neglectful parents and parents with learning difficulties may have in interacting with their children have been highlighted in the literature review. For example, Crittenden reports that neglectful parents are unresponsive to cues from their children (1988). High levels of stress in parents' lives have been shown to have a negative impact on parent-child interaction (Feldman et al., 1997; Tymchuk & Andron, 1992). Difficulties in interaction are likely to increase the risk of children experiencing emotional neglect and developmental delay, particularly in the area of language development (Gaudin, 1993; Tymchuk, 1992; Keltner, Wise & Taylor, 1999; Glaun & Brown, 1999).

Many of the mothers in the residential project have had limited experience of appropriate parenting during childhood and often have not had exposure to positive role models. Subsequently parents may lack many parenting skills including those needed for interaction. This study aimed to prevent later difficulties by intervening at an early stage with parents who are at risk of having difficulties interacting with their children, and offer parents the opportunity to begin to develop the skills to shape and manage their children's behaviour.

Existing measures of interaction are often complex and require intensive staff training. Crittenden's CARE Index (1988), for example, is useful in categorising attachment, and identifying problematic parental behaviour. The complexity of this procedure makes it difficult for parents to fully understand, this is particularly true of parents who have learning difficulties or limited reading skills.

This study developed methods devised by Feldman (Feldman et al. 1986, Feldman et al. 1993) to improve interaction between parents and children, and subsequently improve parents' ability to read their children's cues. This method keeps a focus on positive parental behaviour in a way that is easily understood by parents of all levels of ability. The study is reported in two parts to reflect the development of the instrument used.

Evelyn

Evelyn was twenty-four years old when referred by Social Services for an assessment of her ability to parent her new baby. Evelyn had learning difficulties and had not previously lived fully independently. Evelyn attended a special school until the age of twelve before transferring to mainstream education. This baby was Evelyn's first child. Evelyn had a brief involvement with Social Services following allegations of physical abuse by her stepfather when she was ten years old. Evelyn remained in the family home following the investigation.

Evelyn's partner also had learning difficulties and attended the same residential college. Although he was keen to be involved in childcare he was unable to participate in the work undertaken in the project due to college commitments. Evelyn had regular contact with some family members, but was estranged from her mother. Evelyn's father died when she was six years old.

Family and professionals had concerns about Evelyn's ability to care for herself and her baby. The baby's name was placed on the Child Protection Register under the category of potential neglect.

Evelyn attended the project for two full days per week initially while waiting for a residential place to become available. Evelyn spent the rest of the week in her own home with a wide range of daily supports from professionals and extended family. Observations took place within the communal living room in the project. Prior to and during the time of the study Evelyn was offered advice and training in other childcare skills that were not targeted in this study; these included weaning, nutrition and cooking.

Initial observations had been undertaken with Evelyn using checklists as outlined in Study One. These assessed Evelyn's ability to perform basic childcare tasks, including cleaning and preparing bottles, feeding, changing and bathing. Evelyn required intervention on bathing skills, as outlined in Study One. Evelyn was performing all other skills at the target level of 80% of steps correct and therefore required no further intervention in these areas.

Consent was obtained as in previous studies.

Identification of Target Behaviours

Observations of childcare tasks previously undertaken with Evelyn, using the procedure outlined in Study One, indicated that the steps 'talking and maintaining eye contact' with the baby happened at low rates while completing tasks. Project staff noted through informal observations that Evelyn rarely talked to the baby unless she was crying or Evelyn was carrying out a childcare task that involved direct contact with the baby. Informal observations

also identified that Evelyn had difficulty in attending to more than one task at any one time, for example if the baby began crying while a member of staff was talking, she waited until the member of staff had stopped talking before responding to the baby. During the initial weeks spent in the project the baby was very unsettled and cried frequently.

Definitions of target behaviour were based on Feldman's definitions (Feldman et al 1993, p. 391-392). Target behaviours were defined as:

- *Mother praises child*- any positive comment directed to the child that expresses approval contingent on something the child does.
- *Mother prompts child to play*- mother provides verbal or physical prompts to encourage her child to play, or any interactional play.
- *Mother talks to child*- verbalisations directed at child, in a gentle or playful tone, including rhymes or songs. This does not include any critical comments.
- *Mother looks at child*- mother faces the child for at least two seconds.
- *Mother imitates child vocalisation*- mother repeats, approximates or expands any noises that the child makes, within 5 seconds.
- *Mother gives physical affection*- any hugs, kisses, strokes, or tickles.

The baby's behaviour was also recorded to measure responsiveness to the mother. The baby's behaviour was not directly targeted during intervention, but was used as a method of providing feedback to mothers. These behaviours included:

- *Child vocalises*- any vocal sound coming from the child except crying, burping or screaming.
- *Child plays*- child uses toy for intended purpose or any interactional play.

In addition to Feldman's definitions the following behaviour was added to assess the responsiveness of the baby during interaction:

- *Child looks at parent*- Child faces and looks at mother for at least 2 seconds.

Maternal behaviours were targeted at a mean score of 30% during intervention for observation for praise, imitation and physical affection, and at a mean of 80% for the remaining behaviours. Mean scores were used rather than actual scores to reflect the natural variations in rates of maternal behaviour during interaction. This was based on Feldman's findings that this was the mean rate for these behaviours for a comparison group of parents without learning difficulties (Feldman et al., 1986).

Recording and Reliability

Observations were recorded on video and scored using a partial-interval recording schedule at twenty second intervals. Each behaviour was scored as present if it occurred during the twenty second interval without any prompting from the observer. Observers were trained by observing and scoring a video recording of another resident, not included in this study, interacting with her child. Observations were recorded on a sheet based on the Step by Step Childcare Manual (Feldman & Case, 1993) (See Appendix 5a).

Interobserver agreement was calculated on 48% of observations by two observers across all behaviours. Mean overall agreement was 87%, and ranged from 75-95%. This was calculated using the formula:

$$\frac{\text{Number of Agreements}}{\text{Number of Agreements} + \text{Number of Disagreements}} \times 100$$

(Sulzer-Azaroff & Mayer, 1991).

Procedure

The process was explained to Evelyn as a way of working to help mothers and babies to communicate with each other. A Residential Social Worker, who had previously been trained in the procedure, recorded all observations on video. The worker was already familiar to Evelyn and had undertaken previous observations of childcare tasks. Observations took place for five minutes twice a week over period of three months, starting when the baby was ten weeks old. These were scheduled when the baby was alert and settled, if the baby became unsettled during an observation, the observation was postponed.

Baseline measures were taken of the following maternal behaviour: praising the baby, prompting play, talking to the baby, looking at the baby, imitating the baby and giving physical affection. Infant behaviour recorded included: vocalising, playing and looking at parent.

During the initial baseline phase Evelyn was asked to play with the baby in the way that she normally would. No prompting, modelling or feedback was provided during the baseline phase other than thanking Evelyn for participating. The observer did not interact with Evelyn or the baby during observations. After a baseline had been established for each behaviour, those that did not reach criterion levels during baseline were targeted in sequence.

Intervention involved modelling, rehearsal, discussion and feedback on the target behaviour. The worker discussed why each particular behaviour was important, modelled the behaviour, asked Evelyn to demonstrate the behaviour, and praised Evelyn for a correct response. Evelyn was advised on the use of developmentally appropriate toys and rhymes. Evelyn received a homework chart to act as a prompt to remind her to practice the behaviour

between sessions at home. She was prompted regularly while in the project to practice the specific target behaviour during the intervention phase for that behaviour and praised for any correct performances. When a behaviour reached mean criterion scores over three observations, intervention stopped. During the follow-up period if behaviour fell to zero rate, booster sessions were implemented, using the same intervention strategies. The baby's rate of response was used as feedback for Evelyn. This was done by drawing Evelyn's attention to, and praising her for increases in the baby's vocalisation, eye contact, and play behaviour immediately following sessions, and prior to commencing the next observation.

A multiple baseline across behaviours design was used; each behaviour was targeted in turn once criterion levels had been reached.

Results

Figure 5.1 shows results for all behaviours. Imitation increased from zero during baseline recordings to reach a mean criterion of 33% during the intervention phase. This was not maintained during the follow-up phase when the mean score fell to 12.5%. As the behaviour fell to zero on two observations a booster session was undertaken, after which Evelyn maintained a mean of 31%, just above the target level of 30%. During later observations when the baby's vocalisations became more complex, Evelyn continued to imitate using sounds that resembled those that the baby had been making during the early observations.

Praise was the second target behaviour and increased from a rate of zero during baseline to a mean rate of 46% during intervention. During the initial follow-up period Evelyn's mean score was 29%. Although this was close to the target level of 30% for this behaviour, as the behaviour fell to zero rate during the 16th observation a booster session was provided. During the second follow-up phase Evelyn maintained a mean score of 34%. Evelyn had difficulty ensuring that praise was contingent on the baby's behaviour, and at times praised her non-specifically, for example telling her she was a 'great girl'. During some observations although praise was contingent on the baby's behaviour it appeared excessive, and Evelyn was encouraged to reduce the level of praise.

The third behaviour to be targeted was prompting play. Evelyn was encouraged to use the baby's own toys, and age appropriate play was modelled. Evelyn knew a range of interactive rhymes and was able to use these appropriately. Although Evelyn's performance in this skill improved from a baseline mean of 8% to 30% during intervention, Evelyn was unable to reach the criterion level of 80%. Intervention continued on this behaviour until Evelyn's placement ended.

Evelyn graph 5.1 in here

The behaviours 'mother talks to child', and 'mother looks at child' required no intervention as both surpassed the 80% criterion level. 'Mother shows physical affection' also exceeded the mean criterion of 30%. This behaviour appears to have been linked with praise as the data follow a similar pattern.

During the initial baseline phase the baby did not vocalise, her rates of vocalisation increased in line with Evelyn's imitation. It is difficult to separate the effects of maturation on the child's vocalisation overall, however the baby was making no attempts to vocalise until Evelyn received training on imitation, and vocalised at low rates during observations when Evelyn responded at low rates.

The rates of the baby looking at Evelyn increased after the first two observations. During the tenth observation when Evelyn did not imitate vocalisations, the baby did not look at Evelyn. During later observations the baby was becoming more active and able to roll, and at times became distracted by the camera and the observer.

Although Evelyn stated that she was completing her homework charts she did not return them to the main observer, so it seems unlikely that these were completed.

It was evident during intervention that external environmental factors impacted on Evelyn's interaction with the baby, for example, Evelyn was having difficulties with her extended family on the day when the tenth observation was being completed. Observations on this day showed no imitation, or physical affection. The child responded by vocalising less and failing to look at Evelyn throughout the observation. On occasions where Evelyn did not perform the target behaviours she was able to identify the things she had 'forgotten to do' immediately after the observation.

Discussion

Although this procedure shows an increase in target behaviours and child responses it does not address the quality or sensitivity of Evelyn's responses. For example, during some observations Evelyn responded very sensitively to the baby, talking to her in a quiet way, with gentle movements when the baby was tired and ready for a nap. During observations when Evelyn was responding appropriately to the baby, she described the baby's behaviour, making comments like 'oh you're tired', or asking questions like 'do you want to play with that?' when the baby looked at a toy. On other occasions Evelyn was intrusive in her interaction, trying to stimulate the baby and encouraging her to play when the baby was clearly tired, and was averting her gaze from her mother. Although this was discussed with Evelyn at the time it was not reflected in the data. This is addressed in part two of this study.

It is possible that the presence of an observer acted as a discriminative stimulus for performing behaviours, and that the behaviours did not generalise to other times of the day. Although Evelyn had agreed to self-record she did not do so, and it is unclear whether or not she practiced between sessions. It seems likely that given the fluctuating rates of performance of each skill, and the need for booster sessions that she did not.

Part Two

Two mothers participated in part two of this study.

Mary

Mary was referred to the project four weeks prior to the birth of her son. Mary was 18 years old on admission. Mary had spent most of her life in care following physical and sexual abuse by her parents. Mary had stopped contact with her parents for a number of years; however contact resumed when she was pregnant. Mary experienced further physical abuse by her mother during her pregnancy. As the baby's father had sexually abused young children he was not allowed any contact with the baby. Mary's baby was placed on the Child Protection Register at birth under the category of potential neglect.

Mary was referred to the project because of concerns about her nomadic lifestyle and difficulty in looking after herself. Mary had difficulty settling in previous accommodation, often not unpacking her possessions and living out of carrier bags. Professionals were concerned about Mary's vulnerability within relationships, and the risks posed by Mary's family. Mary had a support network of friends and professionals who she saw regularly.

Although Mary was initially reluctant to come to the project, after the first two weeks she appeared to settle into the project and began to form relationships with project staff. Throughout her placement Mary stated that she wished to live independently in the community with her child, however Mary's behaviour indicated that she was extremely anxious about the move. This behaviour included avoiding any work addressing the move into the community, and at one stage accepting accommodation that was unsuitable in the knowledge that professionals would advise her not to move.

Mary's baby was three months old at the beginning of the study. Mary had previously been assessed in basic childcare skills as outlined in Study One and was easily reaching criterion levels for all skills. Mary had well established routines for her son. Mary was due to move into her own accommodation during the period when observations took place, and agreed that observations could continue in her own home. Mary was enthusiastic about completing

observations, often asking when the next one would be done, and keen that other members of staff who were not involved in observations watched videos.

Informal observations by project staff highlighted that Mary was at times insensitive in her interaction with the baby, for example throwing him in the air in a way that appeared to frighten the baby, then laughing at his reaction. Mary appeared to be unable to read the baby's responses if he was frightened or distressed. At times, Mary said that she felt uncomfortable talking to the baby, and the baby was not yet beginning to vocalise. Mary had difficulty comforting the baby when he was unsettled and often asked staff to comfort him, saying that she could not cope and was frightened that she might hurt him if he did not stop crying.

Alice

Alice was eighteen years old when she was admitted to the project with her new born baby. Alice experienced physical abuse and neglect during childhood. Alice lived in her family home until she was thirteen, when she left home and lived with various members of her extended family. During this time Alice disclosed sexual abuse by a family member that had been happening since she was a young child. Although Social Services were involved, no action was taken and Alice now states that no one believed her. Alice became involved in solvent and alcohol misuse, began to self mutilate and took a number of overdoses. At one stage Alice was hospitalised for depression. Alice had experienced severe domestic violence within relationships. Her last two partners had assaulted her so severely that she was admitted to hospital.

Alice was referred to the project mainly because of concerns about her ability to protect herself and her son. Alice stated clearly that she intended to continue her relationship with her partner in spite of the violence, and would not accept that he could pose a risk to her child. Alice's moods were unpredictable, at times she presented as extremely angry while at other times she was elated. Professionals were concerned that her baby was being exposed to her anger. Alice did not share these concerns. Alice had been diagnosed with depression, but did not comply with her medication.

Alice had no difficulty in meeting her baby's physical needs and could perform all childcare tasks to a high standard. Alice's baby presented as withdrawn and difficult to engage. Although the baby was three months old at the start of the study he rarely vocalised, and was often irritable. Alice was selected for the study to assess the quality of her interaction with the baby, and to give her the opportunity to see how her behaviour impacted on baby's responses.

Alice's baby was on the Child Protection Register under the categories of neglect and potential physical abuse and was also subject to an Interim Care Order.

Definitions of Target Behaviour

Definitions of target behaviour included those used in Part One of this study. The following behaviours were added:

Child positive expression- Child's mouth turns up at the corners, either open or closed.

Mother reads the baby- mother appropriately describes baby's state, e.g. you're tired, hungry, bored etc. or mother gives the baby an appropriate dialogue e.g. 'you're telling me that you want to play'.

'Child positive expression' was added to give feedback to mothers on their child's enjoyment of interaction and strengthen the positive reinforcement provided by the baby for any parental behaviour resulting in smiles or laughs. This was added as the data collected in the first part of the study did not reflect the baby's overall mood.

'Mother reads baby' was added to improve the parent's ability to read the baby's overall mood, and therefore strengthen cues from the baby. During the first part of the study, at times Evelyn was at times able to identify and react to the baby's state, for example when the baby was tired, but on other occasions appeared to misinterpret the baby's state. As this behaviour was not present in Feldman's original study no pre-existing criterion was present, however based on observations during the first part of the study as this behaviour happened at a low rate criterion levels were set at 30%, along with other lower-rate behaviours including praise, imitation and physical affection.

Each observation was given an overall score for sensitivity, using a summarised version of Ainsworth's Sensitivity Scale (Ainsworth, Bell & Stayton, 1974). This rating was given on all maternal and child behaviour during observations and allowed the inclusion of behaviours not included on the observation sheet.

Sensitivity is said to be 'the mother's ability to perceive and to interpret accurately the signals and communications implicit in her infant's behaviour, and given this understanding, to respond to them appropriately and promptly' (Ainsworth et al., 1974, p. 127). Ainsworth (et al., 1974) states that in order to respond sensitively the mother needs to be a) aware of the signal, b) interpret them accurately and c) respond appropriately and promptly. The summarised version of the scale used the following measures:

<u>9 Highly sensitive</u>
Mother responds promptly and appropriately to her baby's signals

<u>7 Sensitive</u>
Mother responds promptly and appropriately to her baby's signals, but sometimes becomes distracted and misses the baby's cues.

<u>5 Inconsistently sensitive</u>
Mother is prompt and responsive to infant cues on some occasions, but either inappropriate or slow at other times

<u>3 Insensitive</u>
Mother is inaccessible or misinterprets the baby's signals. Responses are often delayed or inappropriate, but if the baby's mood and activity match the mother's she shows some sensitivity.

<u>1 Highly Insensitive</u>
Mother is geared almost exclusively to her own wishes. Her response to the infants signal is delayed and inappropriate

Recording and Reliability

Interobserver agreement for Mary's behaviour was calculated on 70% of observations by two observers across all behaviours. Mean overall agreement was 94%, and ranged from 92-97%.

Interobserver agreement was calculated on 80% of observations for Alice. Mean agreement was 94.5% and ranged from 93%-97%. This was calculated using the same formula used in the first part of the study. Interobserver agreement on the sensitivity scale was 100% for both mothers.

Procedure

Observations following the same procedure as the first part of the study took place with each mother, starting when each baby was three months old. Maternal behaviour recorded at baseline included: praise, prompting play, talking to the baby, looking at the baby, imitation, showing physical affection and reading the baby. Infant behaviour recorded at baseline included: child vocalising, child playing, child looking at parent and child positive expression. Each session was given an overall rating on sensitivity.

Intervention was undertaken using the same methods outlined Part One of this study, and included modelling, rehearsal, discussion and feedback on the video recording. In addition mothers also reviewed the videos with the observer, and were encouraged to observe the target behaviour and the baby's responses. Intervention to address reading the baby took the form of encouraging mothers to give the baby a dialogue while watching videos. Mothers were asked 'if your baby could speak what would he say?' If mothers were unable to do this, the observer modelled the behaviour. Alice and Mary were not given homework charts to complete as these were ineffective during the first part of the study.

A multiple baseline across behaviours design was used.

<div align="center">**Results**</div>

Mary

Figure 5.2 show the results for Mary, during baseline, intervention and follow up for imitation, baseline and intervention for reading the baby and praising the baby. Imitation increased from zero rate during the baseline phase to a mean of 59% during intervention. The other behaviours remain at baseline. As the baby was vocalising during the baseline phase there were opportunities for imitation. This was not maintained at follow-up when rates fell to zero, and therefore a booster session was undertaken. During the final two follow-up sessions the rate remained at zero.

Reading the baby was the second behaviour to be targeted. During baseline observations Mary performed this skill during the second observation. During intervention Mary scored 20% on two occasions. When reviewing videos Mary had some difficulty giving the baby a dialogue, and although this was modelled by the observer Mary was unable to consistently put this into practice.

Praise was the third behaviour to be targeted, and although Mary could rehearse this, and participated in discussions about the importance of this behaviour, she did not perform this behaviour during observations.

Sensitivity ratings ranged from 1 to 5, the mean score was 3. Behaviours resulting in a low sensitivity score included failing to comfort the baby when he was unhappy; continuing to playfully bite the baby's feet or tickle the baby when he was unhappy and not responding to this interaction; pulling the baby's hands out of his mouth when he was teething and wanted to chew them; ignoring the baby's attempt to lift toys, and presenting him with alternative toys chosen by Mary. When reviewing the videos Mary identified some of her inappropriate responses to the baby. These tended to be the most obvious responses, which resulted in the baby crying, rather than the more subtle incidents when the baby showed discomfort. In spite of being able to identify inappropriate responses Mary did not change her behaviour.

Looking at the baby, prompting play and talking to the baby all reached criterion levels and required no intervention. Showing physical affection towards the baby also required no intervention, and had a mean score of 36%. Physical affection appears to be linked to the baby's positive expression, as the data follow a similar pattern.The baby's vocalisation showed an initial increase in line with Mary's increase in imitation; however, this behaviour decreased as the rate of maternal imitation decreased. The reduction in the rate of in 'child looks at parent' are partly caused by Mary prompting the baby to play during observations as the baby's attention was focused on the toy presented. It also seems likely that the baby lost

interest in Mary because of the lack of contingent attention from his mother. There is also a noticeable downward trend in scores for child positive expression.

Figure 5.2 Mary in here

After ten observations Mary moved with her baby into the community, however it was not possible to continue with observations in the community as planned as Mary placed the baby in care on a voluntary basis after two days. This followed a disclosure from Mary that she had allowed the baby to have contact with a person who was known to have sexually abused children.

Discussion

Overall the results show very little increase in target behaviours. Mary was due to begin a phased move into the community during the period when the last four observations took place. The results reflect the wider concerns expressed by the staff team about the baby's general presentation during this period. Informal staff observations at this time indicate that the baby became gradually withdrawn and frequently appeared to be unhappy. Previously high standards of day to day childcare slipped. It seems likely Mary's willingness to participate in the videos, yet unwillingness to change her inappropriate behaviour was Mary's way of showing project staff that she was not yet ready to move from the project.

Although talking to the baby and prompting play required no further intervention to increase the rate of these behaviours, the lack of sensitivity was highlighted in both behaviours. Mary frequently ignored cues from the baby in relation to play, removing him from toys he was showing an interested in, to play with toys that she selected.

Intervention was not successful in increasing and maintaining target behaviour, however, it provides useful assessment data on the quality of interaction between Mary and her baby, in particular the difficulties with sensitivity. Encouraging Mary to give the baby a dialogue allowed her to recognise some her non-contingent responses to the baby; this was further strengthened by encouraging Mary to notice the child's positive responses. Results reflect wider concerns expressed by project staff about the quality of child care prior to Mary's move to the community.

Alice

Results

As Alice participated in only five observations before withdrawing from intervention no follow-up data were available. Figure 5.3 shows results for Alice during baseline and intervention for praise and imitation, all other behaviours, including the child's remain at baseline. Praise was the first target behaviour. Alice reached criterion scores following two observations. During discussion Alice displayed a prior knowledge of the importance of praise in managing children's behaviour, stating that she had observed her sister using praise with Alice's three year old nephew.

Figure 5.3 Alice here

Although imitation occurred during the first two baseline observations, scores dropped to zero rate prior to intervention. In reviewing the video Alice was able to identify the decrease in her son's vocalisation when her rate of imitation decreased. Alice scored a mean of 47% during the intervention phase for this behaviour. Data on the child's behaviour reflect the increases in imitation, and follow a similar pattern.

Alice scored 100% during baseline for 'looking at the baby', and had mean scores of 32% for physical affection, 95% for talking to the baby, and 32% for reading the baby. As each of these scores was above the target score for that behaviour no further intervention was required. Observers praised Alice for her performances of these behaviours.

Alice scored the maximum score of 9 throughout all observations on sensitivity. Alice was very responsive to her baby, and responded immediately to any signs of boredom, or frustration by distracting the baby, for example, moving the baby or presenting a different toy. This was also shown in Alice scores in 'reading the baby'. She made frequent appropriate comments that showed an understanding of the baby's state such as 'you're fed-up' or asking 'do you want to play with that?' when the baby looked at a toy.

Discussion

Although Alice's results show positive interaction with the baby, Alice frequently cancelled arranged observations if she was feeling angry or depressed, usually following arguments with her partner. Informal observations at these times indicated Alice interacted very little with the baby when she was preoccupied with external events. Increases in target behaviours maintained between sessions suggest that Alice was able to retain the skills learned. Alice clearly enjoyed the procedure, and often asked other members of staff to watch her videos. Alice eventually completely withdrew from intervention when she was having difficulties in her relationships with her family and her partner.

General Discussion

Results from this study need to be treated with caution because of the small number of mothers involved. However a number of common themes emerge from each participant. These include possible explanations for low rate behaviours and the effect of the wider environment on parent child interaction.

This study looked at the effects of parent child interaction training on the behaviour of mothers and children using a procedure specifically developed for parents with learning difficulties. The findings of the first part of the study match Feldman's findings that parents with learning difficulties praise and imitate at low rates (Feldman et al. 1986). The other two mothers who participated did not have learning difficulties and also had low baseline rates of

these behaviours. It is necessary, therefore, to consider other factors that may have prevented mothers from learning these behaviours.

All three mothers had difficult childhood experiences. Each mother had suffered maltreatment by one or both of their parents, and continued to have ongoing difficulties in their relationships with their parents. It seems likely that each mother's lack of opportunity to observe or experience consistent positive parenting while growing up may have contributed to later difficulties in interaction with their own children.

Evelyn and Mary both had few opportunities to care for younger siblings or other young children. For example, Evelyn had very limited opportunities to look after any children as her mother did not believe that Evelyn was capable of looking after herself, and would not have allowed her to care for any child. Mary spent most of her life in care, largely in children's homes, where she would have had little contact with young children or their carers. In contrast Alice had an older sister with a young child, who would have given her opportunities for observational learning; this is reflected in Alice's baseline scores for all behaviours, which are higher than those of the other two mothers.

This study demonstrates that interaction skills can be learned if parents do not have the skills in their repertoires, but also shows how stress can impact on parent-child interaction. For example Mary's fears about moving resulted in her becoming increasingly withdrawn from her child. Evelyn's scores dropped for all behaviours on a day when she had difficulties in relationships with her wider family. Evelyn's difficulties were resolved by the time of the following observation, and scores again increased. Alice withdrew from the procedure when she was having difficulties, so it is not possible to explore the effect of this on her interaction.

The first part of the study shows increases in targeted maternal behaviour, and the subsequent impact on child behaviour, but does not address the overall sensitivity of the interaction. The addition of the sensitivity scale in part two of the study addresses this, and although it gives an overall score rather than one addressing specific behaviours, the high interobserver agreement indicates that this is a useful tool in assessing sensitivity. Because of the range of potential behaviours that could be included on this list, it would not be possible to include these behaviours individually on the checklist. There would appear to be a link between overall sensitivity and the mother's ability to 'read the baby'. Alice was consistently sensitive to her child during all observations, and also scored well on 'reading the baby' without intervention. Mary in contrast obtained low scores on sensitivity, and only 'read the baby' during two observations, in spite of intervention.

The addition of the child's positive expression was a useful tool for providing feedback to Alice, and strengthened any reinforcement offered by the child, as Alice was praised when

her child smiled. This does not appear to have been effective with Mary, who appeared to receive little reinforcement from any of her child's behaviour after the first four observations.

The impact of the mother's behaviour on the child's development is relation to vocalisation is evident with all participants. Evelyn's and Alice's babies both increased their rate of vocalisation when maternal imitation increased. In contrast Mary's baby showed a decrease in the rates of vocalisation as the rate of imitation decreased.

Mothers selected for this study already had the basic skills necessary to physically care for their children. Although many mothers who participated in other studies would have benefited from this intervention, this was not possible because it was essential that intervention primarily focused on ensuring the basic physical and safety needs of the child were being met. For these mothers it would only be possible to undertake this work if the child's physical needs were being met by another carer, for example if the child was in care.

Chapter 6

Main Discussion

Introduction

This discussion will consider the overall findings of the studies in relation to the stated aims outlined in Chapter Four. Outcomes of studies will then be considered in the context of some of the issues raised in the literature review. Finally future recommendations for practice, policy and research will be presented.

The overall aim was to develop and evaluate a behavioural programme to prevent neglect with young mothers in a residential assessment project. The assessment procedures were based mainly on instruments used in Project 12-Ways, and The Surrey Place Center. A range of interventions were designed to increase parental skills in areas of childcare that can be linked directly to neglect. These areas were selected based on common difficulties experienced by mothers in the project, and specific areas of assessment frequently requested by professionals when referring mothers to the project.

As the findings of individual studies have been discussed in the relevant chapters, a brief summary of each study will be given followed by an overall evaluation of the studies.

Overview of Studies

Study One aimed to increase parental skills needed for the basic physical care of children using childcare checklists. Skills included in this study were those needed for bathing and feeding. Seven mothers participated. Results for bathing showed that all mothers improved and maintained their skills at or above criterion levels. Feeding had less defined results; all mothers could reach criterion levels, however this progress was only maintained by two mothers. This study notes that mothers who had difficulty with feeding often failed to talk to or look at their babies while undertaking feeds.

Routines for children were explored in Study Two, in particular, parental planning of and adherence to routines. This intervention aimed to help mothers to create a stable and predictable environment for their children. Three mothers participated in this study. Results showed that all mothers could outline a routine for their children but had difficulty adhering to this plan. The main difficulty in managing routines was that other activities, particularly those involving social contact, took priority over planned childcare tasks.

Study Three looked at the development and implementation of a programme to improve levels of safety in the home. The procedure entailed a checklist for dangers in the home,

combined with advice on developmental expectations of children, and supervision. Four mothers participated in this study; two of the mothers each had two children. Results showed that intervention was effective in reducing the number of dangers in the home. The importance of supervision is outlined in this study, in particular the difficulties for lone parents with more than one very young child in providing adequate levels of supervision.

Study Four describes the development of a programme that aimed to improve levels of hygiene in the home. Mothers were helped to develop the necessary skills to maintain their homes in a clean condition. Five mothers participated in this study. Results showed that all mothers could reach criterion levels during intervention; however, none of the mothers maintained this during follow-up. The mothers who had the lowest scores overall were also having difficulties in all areas of childcare.

Finally, Study Five aimed to improve the frequency and quality of mother-child interaction to improve mothers' skills in recognising and responding to their babies' cues. Three mothers participated in this study. Results showed that one mother was able to reach and maintain criterion levels during intervention. The second mother made little progress with any of the target behaviours. The third mother made good progress in all behaviours targeted, but withdrew from the procedure before any follow-up data could be collected. This study highlights the importance of sensitivity in interaction.

The relatively low success rate in some studies may raise questions about the appropriateness of the method of intervention, however results show that intervention was effective when mother's difficulties were caused by a skills deficits directly related to the specific childcare task. Intervention was less effective when mothers had the necessary skills, but were distracted from the task by other events. Skills that required mothers to respond to their babies' cues, for example, feeding, maintaining routines, or interaction were more challenging for some mothers than tasks that could be performed at times selected by mothers, such as bathing the baby, or cleaning the flat.

When intervention was not effective useful assessment data was provided that highlighted specifically where the children's needs were not being met, and the quality of care that the child was receiving. The varying outcomes of studies demonstrate that criticisms that behavioural methods are overly powerful, and can force people to change their behaviour, are unwarranted. It is impossible to control all aspects of the natural environment, and the contingencies created were not as powerful as the naturally occurring ones.

Children

All of the children included could be classed as vulnerable because of their young ages and levels of dependency. The effect on the children of the quality of care provided by mothers was clearly evident. In general, the children of mothers who maintained change following intervention presented as contented, responsive babies who were meeting all their developmental milestones. Children, whose mothers were at times unavailable to them, and who received inconsistent care, became passive and difficult to engage during interaction with any adult. One older child often shouted at and hit his mother, although he was well behaved with other family members and staff.

Although staff ensured that most of the children's physical needs were met, some children did experience what appeared to be the physical effects of neglect, for example, repeated diarrhoea or poor weight gain. Each of these, if left untreated, could have had serious long term consequences for children. The negative effects of poor childcare practices were evident in the children who went into care, and it was noted that their presentation improved considerably following removal from their mothers.

Babies, who were mobile, were in some cases at risk of accidental injury because of poor supervision. Supervision is a basic need for children, and the level needed depends on the age and developmental ability of the child. The difficulties of supervising two very young children were highlighted in the home safety study. Unlike other childcare tasks such as feeding or changing, which could be performed by staff if necessary, supervision for young children needs to be almost constant, and must be provided by the adult who is with the child.

Most mothers learn about appropriate levels of supervision through a combination of education and experience. This was effective with one mother, after she was provided with a nursery placement, which allowed her time to complete household tasks. Another mother did not improve her levels of supervision when provided with the same supports. She did not appear to learn through experience, even though her children suffered repeated minor injuries, which were linked to poor supervision.

Routine is of central importance in childcare, and necessary to prevent neglect. It is clearly not enough that mothers can perform tasks; they also need to do them repeatedly at appropriate times. Assessment in a residential setting meant that mothers could be observed at normal times for tasks, so that a picture of the quality of care at all stages of the day could be obtained. Inconsistency in performance of tasks was a difficulty for some mothers highlighted in Study One; frequency and timing difficulties with childcare tasks were outlined in Study Two.

The overall wellbeing of children is likely to be negatively affected if they receive unpredictable care. Physical effects may include nappy rash through infrequent nappy changes, this is likely to worsen if a baby is not washed regularly. Unpredictable environments can have an effect on children's social and psychological development. For example, if mothers respond calmly to a baby's cry on some occasions, and on other occasions respond in an angry manner, they may inadvertently reinforce and punish the same behaviour so that the child is confused about what cues to give, and following an initial display of anger, the child is likely to become withdrawn (Crittenden, 1999).

Programme Design

The difficulty in reaching a working definition of neglect has been highlighted in the literature review. Problems arise because of the wide range of behaviours that can result in neglect, which may not be directly related to childcare, for example substance misuse (Mattaini et al., 1996). Other dimensions need to be included such as frequency, chronicity and severity of neglect as well as the age and developmental needs of the child. Stone (1998) states that neglect is 'a loosely defined category indicative of professional concerns about standards of care' p.49. Rather than trying to reach one single definition of neglect, this research focussed on a range of specific parenting behaviours, to promote positive childcare practices.

There are no universal standards by which parenting can be judged. It is unlikely that any one standard could be set, because standards are likely to change over time with increased knowledge about what is harmful for children and differences in childcare as a result of cultural practices (Garbariono & Collins, 1999). It is necessary for professionals to have some idea of basic standards by which to assess individual mothers.

A number of authors report that mothers from differing socioeconomic groups and cultures have been able to reach agreement about childcare practices that constitute neglect (Dubowitz et al., 1998; Craft & Staudt, 1991; Rose &Meezan, 1996). Birchall and Hallett (1995) report that professionals, in contrast, have had lower levels of agreement about neglect. If mothers can consistently define which childcare practices are neglectful, it seems reasonable to assume that the reverse can be true, that mothers will also be able to identify basic standards of childcare that are acceptable.

Mothers who participated in studies set their own standards of childcare, for example, in outlining routines. Mothers had no difficulty in identifying acceptable and safe practices, even those mothers who had difficulties meeting them consistently. When standards were not set directly by mothers, for example in the checklists used in Study One, they were based on observations of other mothers in the project, and discussed before use with participating mothers. Discussing and defining standards with mothers meant that mothers

were not being asked to meet standards that were too high or based on the value system of workers.

All studies use behavioural methods based on clearly defined measures, which allowed work to be subjected to ongoing review and evaluation. Behavioural interventions were chosen because of their demonstrated effectiveness in targeting the specific areas outlined in the studies. Many of these models were originally designed for mothers with learning difficulties; however, the methods used were applicable to other mothers who also lacked basic childcare skills, and shared similar backgrounds. Intervention aimed to build on existing skills or develop new ones, rather than focusing on any negative attributes of mothers.

The basis of each intervention was direct observation in the natural environment. This allowed the observer to gain a picture of the target behaviour and explore the immediate antecedents and consequences related to that behaviour. It was necessary to undertake a number of observations to ensure that measures were taken of typical behaviour for that mother, and to demonstrate changes that occurred as the result of intervention. Any assessment based on single observations is in danger of reflecting a 'bad day' for the mother, and not their normal behaviour.

Although a range of behaviours were targeted, it would be impossible to include all behaviour relevant to parenting. However, those included do give a picture of the quality of physical and emotional care a child is receiving. Steps that involved interaction with the child, either when completing childcare tasks or specifically addressing interaction provided a useful bench mark for the overall quality of the mother's relationship with her child.

Parental Involvement

Designing a behavioural programme to address areas of childcare related to neglect did not mean that each component was automatically suitable for all families. A key feature was that all instruments could be individualised, for both mothers and children. Mothers' individual preferences about how and when childcare tasks would be carried out were included in the development of each instrument used. For example, in Study One steps could be added or taken away from the checklist as needed. The age and development of the child also dictated which interventions were appropriate. The Home Safety programme described in Study Three was not used with mothers of very young babies as it was not relevant until children were mobile. Plans for intervention were agreed and planned with individual mothers and checked for acceptability at all stages.

Mothers were encouraged to ensure that interventions were tailored around their child's needs. In Study Two, mothers outlined their child's routine based on their child's normal rhythms to ensure that it was sensitive to their child's cues, rather than being based on any

preconceived ideas from mothers or staff about how a routine should be followed. It is important that many childcare practices are based on contingency shaped behaviour as this is sensitive to signals given by the child. Childcare that is entirely rule governed may be insensitive to the individual child.

The format of forms and methods of intervention were easily understood by mothers and provided a transparent way of working. As the content of each procedure was agreed with mothers, they were clear about expectations in relation to each procedure. Feedback given was constructive and linked to specific behaviours, rather than any criticism of the mother. Parental involvement in assessment ensured that mothers were clear about the basis on which decisions were made.

Mothers shared or completed recording that formed a basis for their own assessment. An example was mothers participating in observations and scoring of the Home Safety and Home Hygiene procedures, or recording routines. Parental involvement in assessment and intervention was important to ensure that improvements were maintained following discharge from the residential unit. If changes were made to parenting behaviour based only on the expectations and goals of professionals, it is unlikely that such changes would be maintained when professionals were no longer present.

Shared responsibility with mothers also increased the chances of skills being transferred or generalised when workers were no longer present, as mothers could use the same checklists in their own homes. Positive changes in behaviour may be affected by a range of factors when mothers leave the project. This could include the influence of friends or families, or personal difficulties such as stress, depression or social isolation (Sanders & Dadds, 1993). Ideally work would have continued when mothers moved into their own home to promote generalisation, unfortunately resource restraints and time restrictions limited where this could happen.

At times involving mothers may have influenced the robustness of the research, for example, mothers were aware of the desired changes in the environment as they were involved in scoring the checklists for both home safety and hygiene. However, parental participation was important as it promoted a sense of partnership and shared responsibility.

The focus on positive reinforcement aimed to make the process acceptable to mothers. Reinforcement took the form of verbal praise and vouchers. Vouchers were selected as they could be given immediately following the desired behaviour, and could be exchanged for a range of reinforcers. It was planned that each intervention would move to naturally occurring contingencies provided by the children's behaviour. The child's cues would act as antecedents and their responses would positively reinforce caretaking behaviour. This did

occur for mothers who were able to maintain progress following intervention, but did not happen where mothers were having difficulties. Further exploration of the role of both positive and negative reinforcement will be undertaken in the outcomes section below.

Practice Implications

The straightforward layout of forms and procedures meant that staff required only one training session on each procedure prior to use. Staff training consisted of the following:

• An introduction to the overall assessment programme
• Direct teaching, practice exercises, discussion and a written test on basic behavioural principles and using single case designs.
• Examples, and discussion of the routine procedure
• Practice scoring of checklists on video for basic childcare skills, and interaction
• Live scoring in specifically arranged flats, for home safety and hygiene

Feedback from staff following training indicated that staff believed that the working methods were suitable for the setting and service user group, and felt confident about using the procedures.

Stone (1998) explored the personal feelings of professionals when working with neglect. Many of the feelings reported are said to mirror those expressed by mothers in neglectful families; these included helplessness, and being overwhelmed. Some workers also reported feeling protective and sympathetic towards families.

Using the checklists provided objective measures to guide decision making and could avoid the feelings generated by families from dominating assessment. Prior to implementing these procedures, staff at times found it difficult to remain objective. For example, as some mothers were very young and vulnerable, staff had protective feelings towards the mother. This could have resulted in the needs of the mother being prioritised over those of the child. The use of clear measures removed many of these difficulties and could demonstrate progress, or show where improvements needed to be made.

Working in a residential setting offered opportunities for ongoing direct observation, and full exploration of the contingencies that were maintaining behaviour. It allowed close working relationships to be to be formed between staff and residents. One drawback to undertaking research in this setting was the difficulty in separating the effects of the intervention described in each study from other work undertaken by staff. All mothers were offered individual sessional work addressing a range of issues. This included work on: general childcare; protecting children; dealing with issues from the past; support in obtaining benefits; and practical support in securing future accommodation. Each family also had contact with staff every two hours during the day while in the project. This often took the form

of advice and discussion about childcare. All mothers had additional informal support, above that detailed in each study. It seems likely that this did not affect the outcomes of intervention; in spite of additional supports mothers with the greatest difficulties with childcare continued to struggle to meet their children's needs. These mothers also tended to avoid any structured individual work. Mothers who were coping best with day to day childcare were more likely to participate in work on a range of other issues,

Effectiveness of Intervention

Intervention in each study aimed to increase parenting skills through the use of positive reinforcement. Vouchers and verbal praise acted as a positive reinforcer for some mothers; however for others vouchers and praise were only effective in the short term. Mothers who could manage childcare tasks maintained progress after vouchers had been discontinued as their behaviour was being reinforced by naturally occurring contingencies, such as their child's responses or developmental progress. These mothers received ongoing praise from project staff and more formal praise from a range of professionals during reviews or case conferences.

When intervention was not effective other naturally occurring contingencies impacted on the effectiveness of planned reinforcers. Some of the mothers in the project were subject to coercive control through negative reinforcement. Many childcare tasks were undertaken to escape aversive consequences. This could have been to avoid disapproval from staff, or to stop a baby crying. In extreme cases, the consequence was the removal of the child from the mother's care. This form of control was likely to result in mothers avoiding contact with project staff or their field Social Worker. Avoidance was likely to be viewed by professionals as a lack of motivation to parent.

Mothers, who complied with advice from staff about childcare to escape such aversive consequences, were unlikely to carry out tasks when staff were not present as there was no reinforcement to maintain the behaviour. This is similar to the coercion trap between support workers or family members described by Wahler (1980). Staff's advice giving was positively reinforced when mothers complied with the advice; mothers were negatively reinforced by termination of advice. Childcare, therefore was not undertaken by mothers as a result of cues from the child, nor was caretaking behaviour reinforced by positive changes in the child's wellbeing or behaviour.

Feelings towards staff also affected the value of reinforcement, for example, if mothers felt threatened by the assessment process, and viewed staff as part of a system that was likely to remove their child; this would also devalue any positive reinforcement offered. Some mothers sought out staff's company when their children were not with them, for example

when babies were asleep, but took steps to avoid contact when completing childcare tasks, for example, feeding babies away from the project so that staff could not be present.

Artificially constructed reinforcers were unable to compete with external contingencies, such as social contact with friends, which offered social reinforcement and temporary escape from the assessment process. Mothers who had very low levels of social contact were susceptible to any opportunities to socialise. Some mothers had few friends and difficulty maintaining relationships, which resulted in a limited social network. Friends and family members controlled when they had contact with mothers, and were often unreliable, changing or cancelling arrangements at the last minute. This meant that mothers were deprived of social contact. When positive reinforcement from social contact occurred intermittently, a powerful contingency was created.

Contributory Factors

Contributory factors that impacted on the ability to parent will be considered in this section. Many of the stresses often associated with neglect were temporarily removed while mothers were living in the project, for example the effects of poverty and poor housing. However, it is important to note that these stresses were likely to impact on mothers when they returned to the community, and need to be fully considered in planning future supports.

The mothers who participated all had background factors which made them vulnerable to parenting difficulties. These included experiencing abuse and neglect; growing up in care; being young mothers raising a child alone and poor educational achievement. More recent stresses included depression, domestic violence and social isolation. As all of the mothers had similar backgrounds, it is necessary to look more closely to ascertain why some mothers managed better than others.

All of the mothers who made good progress during intervention had at least one positive, supportive relationship. This was with a partner, family member, friend or former foster carer who could provide ongoing practical and emotional support plus additional help in times of stress. What differentiated these contacts from those described in the previous section, was that they were reliable and predicable, and responded to the needs of both mothers and children. Many were positive role models for childcare, and positively reinforced mother's parenting skills. As these relationships were voluntary, coercive exchanges were avoided.

It is not surprising that these supports had such a positive effect; most mothers have a support network, and share the responsibilities of childrearing. Many parents have a range of people who can offer ongoing assistance (Booth & Booth, 1998). Supportive relationships with reliable adults have been shown to promote resilience in children (Newman, 2002); it appears that this is also a protective factor for adults. Although many mothers had some

family contact, this was not necessarily supportive. Many mothers had been maltreated by their families, and even as adults could not rely on their families for support

The mothers who had most difficulty had similar backgrounds to the other mothers, but the main difference evident during the time that studies were completed, was that they were socially isolated, with very limited family support. Socially isolated mothers had less opportunity to learn parenting skills from many of the sources available to other parents. Their mothers were unlikely to be positive role models, and they had few other opportunities for observational learning.

Social isolation has been linked to depression and low self esteem (Roberts & Pless, 1995) and can also have an immediate impact on childcare. This is clearly illustrated by the two mothers with two children who participated in the home safety study. Both mothers had difficulty carrying out necessary tasks, as there was no other adult present who could supervise their children.

As suggested in the literature review social isolation is a commonly associated with neglect. Many mothers who are isolated find it difficult to access supports, and may view available supports as unhelpful (Coohey, 1996; Polansky et al. 1985; Wahler, 1980). This was also true for participating mothers who were having difficulties; for example, some mothers would not attend mother and toddler groups, or other groups available in the community as they felt that they did not fit in, and viewed other parents as unwelcoming. They reported that they felt different to other parents in groups, because they were younger or did not have a partner. In some cases mothers lacked very basic social skills; and as a result were not readily accepted into groups.

Parenting groups can be important supports for mothers. They provide models of appropriate childcare and can offer social reinforcement for adhering to community rules about childcare. When mothers are socially isolated they are unlikely to come under such influences, and may be part of an environment where neglectful childrearing is the norm (Lutzker, 1990).

Various groups in the community can offer opportunities for observational learning, however as learning works best when the model is perceived to be similar to the observer; this was unlikely to be effective. Mothers were more likely to be receptive to models from their own peer group. Many of their friends, who did not have children, modelled and offered reinforcement for behaviour that would be considered normal for adolescents and young adults. This included drinking alcohol, and staying out late at night. Often this behaviour was incompatible with childcare. In contrast, mothers who had positive supports, attended groups in the community, and received further support from them.

Individual factors in mothers, such as learning difficulties may have slowed down the acquisition of new behaviours, but did not prevent mothers from caring for their children. Mothers with learning difficulties were assessed using the same standard as other mothers, the only difference was that some of the working methods were adapted, for example completing forms verbally for mothers with literacy problems. The three mothers with learning difficulties, who participated in the studies all responded well to intervention, and moved into the community with their babies. Each had a high level of support from their families, and a comprehensive package of professional support. Some mothers with learning difficulties took slightly longer to learn skills, however once skills were learned they were maintained.

Many of the difficulties these three mothers experienced were due to lack of experience because mothers had been over protected and prevented by their mothers from carrying out normal daily tasks in the home environment. One of the mothers was managing childcare in spite of being faced with a range of stresses, including depression, domestic violence and social isolation. These were similar to difficulties faced by other mothers who did not have learning difficulties.

Categories of Neglect

Literature suggests that neglect can be divided into two categories, recent and long term/ chronic neglect (Nelson et al. 1993; Fitzgerald, 1997; Stone, 1998). Chronic neglect is suggested to be persistent, and unresponsive to intervention. The results from the studies presented here also indicate that neglect can take two forms. The first type occurs when mothers lack knowledge or skills, and the second happens when mothers can complete necessary childcare tasks, but do not do this consistently.

When neglect takes the first form, lack of knowledge or skills, then the programmes outlined here are effective, and may require only short term intervention to ensure that mothers have acquired the necessary skills. It could be argued that this is a temporary difficulty, and does not therefore constitute neglect, however without intervention Gaudin (1993) suggests that minor difficulties could escalate and develop into chronic or long term neglect. For example, feeding difficulties with a baby can have an impact on the relationship between mother and child and may result in the child being rejected.

Minty and Pattinson (1994) suggest that emotional neglect can occur in isolation; however, an emotional component is always present in physical neglect. Although the mothers who responded to intervention were initially not fully meeting their children's physical needs, they did have close emotional bonds with their children, and were keen to improve their childcare. This would suggest that it is the emotional quality of parenting that differentiates between the two forms of neglect.

When neglect took the second form, when mothers have the necessary knowledge and skills and are unable to parent consistently, the effects of intervention were not sustained. Some mothers had very young babies, so the length of time that neglect had been present was not a factor. This form of neglect had a strong emotional element, as mothers often overlooked or were unresponsive to their children's needs.

Parental cooperation has been suggested to be a crucial aspect in identifying cases of neglect (Stone, 1998). Although the mothers who provided inconsistent childcare were willing to become involved in the assessment process, they were less cooperative with professionals, and reluctant to accept concerns about their childcare. This was evident by the numbers of children who were on Care Orders, mainly because of mothers being unwilling to work with professionals.

Placement Outcomes

Following the residential assessment, nine (60%) of the mothers who participated in this research moved into the community with their children. Of the remaining six families, three (20%) had children freed for adoption, a further two families (13%) have children in long term foster placements, yet to go through the freeing process. One family is undergoing a further period of assessment, with plans for permanency if the assessment outcome is not positive. The mothers who no longer have their children living with them are those that made least progress in all interventions.

Six (40%) of the mothers who participated may eventually have their children adopted. Although this figure seems high, it is indicative of the levels of concern held by court or professionals that originally caused the families to be referred to the project. Mothers would not be allowed to live independently with their children until they have successfully completed a residential assessment.

Freeing for adoption is the process that is used by the courts to give adoption agencies the right to place children for adoption. It was originally developed to prevent children growing up in public care (Kelly & Ince, 2000). Neglect concerns are the most common reason for freeing applications in Northern Ireland (Kelly & Ince, 2000).

The total figures for contested adoption applications in Northern Ireland give some indication of the severity of problems present in some of the families in the studies, for example, in 2000 only 11 contested adoptions occurred, while in 2001 only 16 took place (NI Court Services, 2001).

A study by Kelly and Ince (2000) of 50 Northern Irish families who had children freed for adoption reports that mothers came from disadvantaged backgrounds. Like the mothers is this study, they were likely to have experienced abuse and neglect in childhood, been in care and had low educational achievement.

Delay is reported to be common in the early stages of the adoption process, when childcare professionals are slow to make decisions about permanency for children following the initial admission to care (Kelly & Ince, 2000). As neglect is generally shown through the build up of minor events over a period of time, gathering evidence may further slow down the process, possibly resulting in the child being left in a difficult home situation. Using assessment tools that clearly demonstrate any progress made by mothers may shorten the delays experienced by children. Following the short term residential assessment described here, final decisions were often made about children's futures.

Conclusion and Recommendations

This study has several limitations. First, it is a small scale study of fifteen families with very young children. Many of the interventions would not be suitable or necessary for families with older children. With the exception of the first study which was used to screen all families, families were selected for each study based on difficulties with specific areas of parenting. This restricted the numbers available and meant that the sample sizes in each study were small, so although the results obtained offer useful information about the individual families who participated, the specific results of each study cannot be generalised.

However, as described in the previous section a number of common threads ran through the studies. In particular the importance of ensuring that parents have the social skills needed to permit access to wider community supports, and the need to strengthen the positive reinforcement provided by the child, so that caretaking behaviours will be cued and maintained by the child's behaviour.

A second limitation is that placements in the project last an average of four months, so any progress described is of limited duration, and linked mainly to the care of very young children. Although the majority of parents moved into the community with their children, they continue to face a range of stresses which leaves them vulnerable to further difficulties in childrearing. As children grow up, the challenges facing parents become more complex and families are likely to need support in a range of areas. As neglect is often a long term problem for families, further research is needed to ascertain how families manage following discharge from the residential unit, and if there are key stages that are particularly stressful for parents when additional support may be needed.

The majority of children in the studies were on the Child Protection Register under the category of neglect. In some cases registration was due to concerns about the mother's ability to protect the child from other family members rather than concerns about standards of day to day childcare. However, having a child on the register ensured that families received a range of support services when they left the project, and case conferences ensured that progress was reviewed in a multidisciplinary forum. (Boushel, 1994; Farmer, 1997) found that the child protection process tended to focus on specific incidents, and overlook the wider needs of the family. This was not the case for mothers in the studies. Although risks to the child were priority, case conferences were also a useful forum for agreeing the range of supports needed by a family.

In contrast the two families who did not have children on the Child Protection Register received fewer resources and support services on leaving the project. Case reviews were called only when there were concerns and were not always attended by a range of professionals. While most mothers would have preferred not to have their children on the Child Protection Register, registration did ensure better coordination between disciplines, and more comprehensive support services. As suggested by Fitzgerald (1997) if neglect cases are to be treated as family support, rather than child protection, better interagency agency and inter disciplinary communication is needed to ensure that if concerns arise about children, these are addressed at the earliest possible stage.

The quality of the relationship between mother and child, and the mother's emotional availability are central issues in neglect. The instrument described in Study Five offers a simple method of assessing, and intervening with parent-child interaction. A further limitation of this study was that this was not fully tested with the mothers who may have benefited most from this intervention. However, the level of support needed to ensure that mothers were meeting the child's basic physical needs to ensure survival meant that this was not possible.

Children in families facing a number of stresses are at risk of developing behaviour problems. As parent training has been found to be less effective with families facing a range of difficulties (Wahler, 1980; Sutton, 1992; Kazdin, 1990) it is vital that preventive intervention is undertaken before these problems emerge. Early intervention addressing parent-child interaction may help parents to understand how they influence and shape their child's behaviour, and equip parents with the skills needed to address behavioural difficulties at a later stage. Education and support with basic childcare skills needs to be undertaken at an early stage, and may prevent later difficulties from emerging.

Parents who are facing multiple stresses including social isolation are likely to either drop out or fail to attend group based supports. Daro and Donnelly (2002) suggest that home visiting

services can offer a useful starting point for hard to reach families. These services need to directly address social skills training, so that mothers can eventually access supports in their wider community. Further research is needed in identifying the effectiveness of components of such services. The background of ideal home visitors should be decided in conjunction with families to ensure that they are acceptable to families.

Undertaking work in a residential setting provided more opportunities for observing daily patterns of childcare than would be available in other settings. However it is important that direct observations of the parent and child are incorporated into any assessment. Although parents may be able to describe positive childcare practice, or perform tasks, without direct observation it is difficult to know how consistently this is done.

In some cases parents will be unable to make the necessary changes in their behaviour within a realistic timescale for the child. In such cases current policy is to plan for permanence. While this may be the only option for some children, detailed assessment and appropriate intervention needs to be undertaken to achieve a clear prognosis about the mother's ability to change and adapt her behaviour towards her child before such decisions are finalised.

Social workers may have a range of difficulties in working with neglect. They may not recognise the serious impact it can have on children, because a picture of neglect is likely to be a build up from possibly minor concerns over a period of time (Minty & Pattinson, 1994). The range of factors that need to be considered when assessing neglect add to the difficulty of the task. Social workers may have strong feelings of hopelessness when working with neglect that make it difficult to make objective assessments (Stone, 1998). All of these issues highlight the need for training for social workers in dealing with neglect. In addition one of the recommendations of the Paul inquiry is for social workers to be provided with clear practice guidelines to help identify neglect, and its effects on children (Bridge, 1995).

Final Remarks

The research presented here shows that skills training could enable some mothers to provide care for their children; in spite of a range of background factors which made them vulnerable to parenting difficulties. For other mothers, past events and current stressors impacted on their relationship with their children, and prevented them from providing appropriate care at this stage.

The application of behavioural methods in social work offers a number of advantages for families and practitioners. First, the emphasis on building strengths through positive reinforcement makes intervention acceptable to families. Second, shared goals and clear working methods promote participation and partnership. Third, the range of genetic and

environmental factors that shape and maintain behaviour are considered as the main causes of behaviour, rather than any specific characteristic of the individual. A full exploration of these factors points towards appropriate treatment strategies, and recognises that people can change their behaviour when they have the necessary supports.

For practitioners behavioural methods offer a theory base that is directly linked to practice. The empirical base for behavioural work means that working methods described in research reports can be replicated in other settings, and the emphasis on evaluation ensures that the effectiveness of any intervention can be demonstrated.