

Child neglect:

what does it have to do with general practice?

Child protection and the wellbeing of children are inextricably linked in the provision of an adequate child health service. GPs, with access to extensive privileged information about families, have a central, though often misunderstood, role. Child health generally, and child maltreatment in particular, have nevertheless rarely featured in recent UK general practice policy development.

Child maltreatment may be dichotomised into acts of abuse or neglect. Abuse is less problematic conceptually and practically because of its focus on physical evidence. GPs can follow clearly defined referral pathways into the child protection system, confident that they are supported by comprehensive services and a robust legal and administrative framework. However, child neglect is more challenging. It is essentially an act of omission and its detection requires an interpretation of parental behaviours, parent-child interactions and observation of children themselves.

There is no accepted standard definition of child neglect, so a shared understanding between professions is difficult to achieve. Furthermore, collecting reliable data on an ill-defined phenomenon is a great challenge. Depending on the method of data collection and the definitions used, prevalence estimates have ranged from 3%¹ to a lifetime rate as high as 37%.²

From the perspective of children and society, neglect is more important than abuse. We know that neglect is more prevalent than abuse³ and least likely to be dealt with by child protection services.⁴ Harsh or abusive parenting is also generally less damaging than severe neglect in terms of cognitive⁵ and behavioural⁶ outcomes. The negative and pervasive long-term effects of neglect, such as poor educational achievement, addictions, mental health problems, and criminal behaviour, ultimately affect children's life chances and contribute to early mortality⁷ and the impact of neglectful parenting persists into second and subsequent generations.⁸

In a study linking child protection and

behavioural data among 1308 at-risk US children, Kotch *et al*⁶ found that neglect accounted for two-thirds of all reported cases of maltreatment. Neglect was defined as failing to provide for basic needs or emotional support, or leaving a child unsupervised or with an inappropriate carer. Only early neglect (before 2 years of age) significantly predicted aggression. Abuse at any age and neglect after age 2 years were not significantly predictive of aggressive behaviour, in a controlled model.

Child neglect is not simply a social construct. Neglected children display persistent abnormalities of brain function^{9,10} and the hypothalamic-pituitary-adrenal axis,¹¹ as well as persistent cognitive, behavioural and emotional problems.^{12,13}

Therefore, early child neglect has major public health implications. Only two professions in the UK have near-universal contact (albeit episodic) with young children: GPs and health visitors. These two professions have extensive but complementary knowledge of families and their problems, although the level of knowledge varies between families. A primary care team with GPs and health visitors working together is therefore ideally placed to identify children at risk of long-term harm and offer appropriate support.

IDENTIFYING NEGLECT

What might lead GPs to suspect neglect? The article in this issue by Hølge-Hazelton and Tulinius¹⁴ suggests that GPs construct their understanding from everyday interactions with children and their parents, and tend to focus on predominantly parental factors. The family is the GP's 'unit of analysis.' The initial trigger for suspicion may be an ill-defined sense of discomfort in witnessing interactions between a parent and child. Examples might include lack of verbal or non-verbal interaction, rough handling, or negative comments about the child. Sometimes children's behaviour gives a clue: one example is indiscriminate friendliness when a young child seeks proximity to a stranger, such as the GP, rather than the

normal caregiver. Indiscriminate friendliness is an important manifestation of insecure parent-child attachment.¹⁵ It is now considered an adaptive behaviour among children experiencing severe neglect — allowing them to receive attention from alternative caregivers — although this is clearly fraught with danger in many circumstances.

Sometimes there may be other objective indicators in children such as failure to thrive,^{16,17} language delay,¹⁸ or concerns about cleanliness or state of dress.¹⁹ In parents we may identify factors, such as addiction, depression, learning difficulties, or adverse early experience.^{20,21} It is often very difficult to establish whether there are damaging patterns of parent-child interaction, and this reflects the fallibility of a reductionist-diagnostic approach. General practice, nevertheless, has much to offer in terms of identification of problems. Although most GPs offer 10-minute consultations, we have the benefit of longitudinal relationships with families and therefore acquire enormous knowledge of patterns of family behaviour and of the trajectories of child development. We also know a great deal about the real circumstances of families and generally have their trust. Hølge-Hazelton and Tulinius present a series of vignettes illustrating some of the ways in which this knowledge can be used by GPs to identify 'the child in need'.¹⁴

Families are adaptive systems and parent-child interactions are at least partially determined by economic and cultural factors. For example, in circumstances of extreme external threat to the integrity of the family, such as poverty, war, or transnational flight, sensitive parenting may be particularly difficult. We must understand both the family's circumstances and our own social expectations of parental behaviours before concluding that a parent is neglecting a child.

INFORMATION MANAGEMENT

To allow children's services to develop locally, but in keeping with national frameworks, GPs may be asked to share information from case records with various other agencies. The aim

is to ensure an inclusive and supportive service in child protection, working to provide a seamless electronic tagging system for 'vulnerable' children accessible across health, education, and social services. Defining vulnerability is, however, far from straightforward in relation to child neglect. There is clear guidance concerning disclosure of information, even without consent, if a child is believed to be at risk of serious harm or a child is in danger, but it remains unclear how serious harm or danger is constituted within the context of neglect prevention.²²

Sharing information and working within multidisciplinary teams is nothing new for GPs. Sharing sensitive information with agencies not attached to the practice and collating information from child and parental records is new and creates many challenges. These issues are repeatedly cited in significant child protection inquiries and illustrate the lack of shared understanding of the concept of child neglect.

The RCGP chose not to support full implementation of the recommendations of the Climbié report on wider information gathering on children. We think that this decision may reflect a conceptualisation of child neglect in terms of specialist knowledge rather than being embedded in the fundamental elements of family medicine. It may also reflect a predominantly adult discourse taking precedence over a child-centred approach.²³ The RCGP's *Grasping the Nettle* report²⁴ specifically recommended that there should be no compulsion to gather information about a child's social and developmental issues at a new patient medical. It also considered that patient information could not be shared without consent unless there was a serious risk of harm or death. This response highlights the real difficulties that general practice has in sharing such information with other agencies and emphasises the crucial importance of gaining parental consent for information sharing. It also brings into focus potentially conflicting ethical responsibilities to children and parents. The RCGP guidance may be challenged in light of recent child protection cases, such as that of Baby Peter.

A WAY FORWARD

Child neglect is underreported and therefore we do not have accurate data on which to

base service planning and provision to create an adequate service for dealing with vulnerability in families. High-quality needs assessment is therefore crucial in the development of local services.

General practice should acknowledge its central role in the management of child neglect. Our principal responsibility lies in the identification of problems and in effective communication with families and with other professionals. We need to be better informed about the social, emotional, and cognitive development of young children and we need a language to describe problems in these domains which will be understood by other professionals. Adoption of a common conceptual framework, such as the 'Solihull approach' to infant mental health,²⁵ is a good starting point and training is currently being offered in Glasgow as part of its developing comprehensive parenting support strategy. Supervision groups for GPs, as described by Hølge-Hazelton and Tulinius¹⁴ could also prove valuable in establishing a shared understanding within the profession. We need clarity about which information can and should be shared with other agencies. Finally, the attachment of health visitors to general practices, a working relationship which is threatened or already lost in many parts of the UK, should be reaffirmed and consideration given to shared records.

The effective management of child neglect will draw on interventions from a number of perspectives: the treatment of parental mental health or problem substance use, improving parental resilience, encouraging social support, and improving parental knowledge about parenting and child development. Structured parenting programmes involving parents and children can also markedly increase parental sensitivity and child attachment security.²⁶

General practice can help to prevent the 'intergenerational cycle of neglect',²⁷ in which parents may replicate their own adverse childhood experiences.²⁸ Many GPs have an intuitive understanding of this familial pattern. GPs and health visitors provide a universal service to these vulnerable families in terms of identification, referral, and non-stigmatising supportive therapeutic relationships. This work receives scant official acknowledgement. For example, the most recent policy document dealing with child protection in Scotland²⁹

does not mention general practice at all. GPs must become full partners in the planning and delivery of services to neglected children or we shall continue to be part of the 'neglect of the neglected'.³⁰

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Provenance

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NICE work: how NICE decides what we should pay for

The National Institute for Health and Clinical Excellence (NICE) is responsible for providing guidance on the promotion of good health and the prevention and treatment of ill health in the UK. Fundamental to the decision-making process is the need to make recommendations based on the best available evidence with input from all stakeholders in a transparent and collaborative manner.¹ Health technologies considered by NICE include pharmaceuticals, medical devices, diagnostic techniques, surgical procedures, other therapeutic technologies, and health promotion activities.

The budget for the NHS is fixed by a political process and decisions about which health technologies to recommend are based on a combination of clinical effectiveness and cost-effectiveness, taking into account the opportunity cost of technologies displaced by new, generally more expensive, technologies. Evidence regarding clinical effectiveness often comes from randomised controlled trials (RCTs) because they have high internal validity. However, RCTs generally estimate efficacy in a much narrower population than the target population and may be conducted over much shorter time periods relative to how long the health technology will be applied in clinical practice. Consequently, when assessing the relative cost-effectiveness of two or more health technologies it is usual to make decisions based on an economic model to capture the expected lifetime costs and benefits.

Drug regulatory authorities define a

confirmatory trial as an adequately controlled trial in which the hypotheses are stated in advance.² Such trials are predominantly designed and analysed using a frequentist (or classical) approach to statistics in which a hypothesis to be tested is specified (that is, the null hypothesis), the sample size necessary to generate sufficient information to reject the null hypothesis if it is false is determined, and the strength of evidence against the null hypothesis is calculated (that is, the *P*-value).

Trials are typically designed either as superiority or non-inferiority trials. In superiority trials, a minimum effect that has clinical relevance is specified. In non-inferiority trials, a non-inferiority margin is specified such that if the effect of the new intervention were no worse than this, then the conclusion would be that it was clinically non inferior to the standard. At the design stage, the sponsor's risk, or power of the test, is the probability that we will reject the null hypothesis if the true treatment effect equals the effect size of interest. Power is conventionally set at 80% or 90%, which means that the sponsor is prepared to accept probabilities of 0.20 and 0.10 of not rejecting the null hypothesis respectively.

At the analysis stage the *P*-value, or significance level, is the regulator's risk of wrongly approving a drug as efficacious, usually set at 0.05 (5%) or less, and represents the probability of obtaining a result at least as extreme as the one observed on the assumption that there is no true difference. Any effect can be shown to

be statistically significant given enough information, although such differences may not be clinically relevant.

The RESPECT trial team³ designed the RESPECT trial to estimate the effect of pharmaceutical care for older people, shared between GPs and community pharmacists in the UK, relative to usual care. The primary outcome measure was the UK Medication Appropriateness Index (UK-MAI). Following conventional trial design considerations for a superiority trial, they defined the treatment effect to be detected as a difference of 0.4 of a standard deviation in UK-MAI, a significance level of 5%, and a power of the test of 80%. At the analysis stage, the *P*-value can be regarded as a decision rule and, because the *P*-value for the effect of the intervention was estimated as 0.402, the authors concluded that 12 months of pharmaceutical care delivered by community pharmacists to older people did not affect the appropriateness of repeat medication as assessed by the UK-MAI.

However, absence of evidence is not the same as evidence of absence and it is helpful to supplement *P*-values with 95% confidence intervals which provide a range of plausible values for the true treatment effect. Unfortunately, the authors found it necessary to transform the data prior to their analysis and, as a consequence, an appraisal committee would find it difficult deciding whether important treatment effects are plausible on the original scale.

Most submissions to NICE will usually include strong evidence for the clinical