Working together to protect children in cases of neglect: Complexity and the four 'Cs'

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Child neglect is one of the most insidious and damaging forms of maltreatment, having serious long-term consequences on the health and development of the child. It is also the second most frequent Child, Youth and Family child maltreatment investigation finding, with four out of every thousand New Zealand children identified as experiencing neglect in 2009 (Mardani, 2010). It is likely, however, that this under-represents the true extent of child neglect, as neglect is arguably the most complex form of maltreatment to identify (Stevenson, 2005). There are a number of reasons why assessing and intervening in child neglect is so complex. First, determining and then operationalising definitions of neglect is challenging. Neglect is usually perceived as a failure or an act of omission on the part of the carer to meet the needs of the child (International Society for Prevention of Child Abuse and Neglect, 2007). This is reflected in the recently published interagency guide *Working Together to Keep Children and Young People Safe* (Child, Youth and Family, 2010, p. 10) which makes reference to different forms of neglect including physical neglect, neglectful supervision, emotional neglect, medical neglect, and educational neglect.

The challenge, when operationalising such definitions, is that professional perceptions vary as to the degree to which particular acts become neglectful and harmful to the child. For example, Mardani (2010) highlighted the variability in the level of neglect that was considered referable to Child, Youth and Family. Moreover, professionals appear to tolerate behaviours that members of the public consider neglectful (Rose & Meezan, 1997; Rose & Meezan, 1996). Personal, professional, religious and cultural beliefs also influence perceptions of acceptable and neglectful behaviour (Department of Health and the Home Office, 2003).

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A second issue for practitioners attempting to identify neglect is that whilst neglect has cumulative and negative effects on the developmental needs of the child, it is very difficult to pin-point exactly when it becomes harmful. It is not surprising, therefore, that the more obvious and immediate physical neglect or safety issues tend to trigger neglect investigations rather than socio-emotional and behavioural concerns. For example, nearly 300 neglect-related offences are reported to the New Zealand police annually, with leaving a child aged under fourteen without supervision being the most common (Mardani, 2010).

Third, when assessing and intervening in cases of neglect, professionals hold different views as to what constitutes neglect. For example Davies et al (2009) found that some professionals tend to focus on the child and their unmet needs whilst others focus on parents' behaviour and culpability.

Finally, we tend to view neglect through a narrow lens. Whilst neglect is consistently associated with poverty and deprivation it can also exist amongst higher socioeconomic groups (Horwath, 2010) and yet because these parents do not fit the image of the stereotypical neglectful parent, neglectful behaviours may go unchecked.

Multidisciplinary practice is essential in order to address the multifaceted nature of child neglect. It is only through working together that it is possible to: 'join the dots' between parenting capacity, socioeconomic factors and the child's needs; and understand the lived experience of the neglected child and address any concerns. However, working together in these cases is not easily achieved. Whilst lack of shared ownership, inflexible organisational structures, conflicting professional ideologies, communication problems, poor understanding of roles and responsibilities, and mistrust amongst professionals have been recognised consistently as affecting the ability of practitioners to work together to meet the needs of children (Calder & Horwath, 1999; Milbourne, Macrea & Maguire, 2003; Doolan, 2004; Percy-Smith, 2006), additional issues exist in cases of child neglect that inhibit effective multidisciplinary working.

The purpose of this paper is to consider some of the specific issues practitioners and managers encounter when struggling with the complexity associated with neglect. These issues are explored in relation to four themes – the four 'Cs': collaboration; change management; consistency; and cultivation of good practice.

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Collaboration

One of the issues associated with collaboration or multidisciplinary working is that worker anxiety has a considerable influence on practice in cases of child neglect and can result in lack of focus on the child and their needs. The author found, in a study of professional practice in cases of neglect in the Republic of Ireland (for more information, see Horwath, 2007), that anxiety was particularly evident in relation to practitioners' decisions as to whether to refer cases of child neglect to other agencies such as child protection services. The anxieties described by the participants in the Irish study mirrored concerns raised by Mardani (2010), including:

- a fear of looking foolish if concerns are dismissed by social workers or other professionals as insignificant
- concerns that families will experience considerable distress with no gain because of lack of services. This led, in some cases, to practitioners failing to report and trying to manage potentially high-risk situations outside the formal child protection system. Mardani (2010, p. 74) also found professionals in New Zealand reluctant to refer
- fear of repeating previous negative experiences of intrusive interventions or concerns being ignored. This behaviour was also noted by Mardani (2010) with professionals attempting to find ways of circumnavigating the challenges of negotiating the neglect threshold
- lack of feedback leaving referrers living with uncertainty and not knowing what response they could expect from the carers. New Zealand professionals also reported frustration at the lack of feedback (Mardani, 2010)
- fear of verbal and physical aggression and intimidation from carers. This was most apparent amongst practitioners in routine contact with families, such as teachers
- concerns about the way in which the community will perceive the referrer. This was prevalent amongst practitioners who work and live in the same community or run private enterprises
- anxiety about hitting the headlines if a child dies and therefore referring all cases to 'cover one's back'
- worries that making a referral was not in the best interest of the practitioner themselves. Concerns included fear of complaints, going to court and damaging ongoing relationships with the carers.

These types of anxieties are likely to exist irrespective of statutory duties to report concerns. It appears that practitioners tend to use these

concerns and anxieties to justify to themselves, maybe implicitly, reasons for not making referrals to other professionals, particularly child protection services.

Creating an environment that promotes collaborative working can begin to address issues encountered by frontline practitioners (Laming, 2009). Although the literature on effective strategic collaboration concerning child maltreatment is sparse, four key areas have been identified as significant in promoting multidisciplinary practice, as outlined below (Horwath & Morrison, 2007; Percy-Smith, 2006):

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1. ***Strategy***: It may appear obvious that senior managers should reach some common understanding as to what they hope to gain through collaborative practice (Armistead, Pettigrew, & Aves, 2007). However, this is not necessarily the case, and even when managers recognise the need to agree on the purpose of collaboration, it is not easily achieved. For example, a diverse range of different organisations are likely to be involved in cases of neglect. The core business of these agencies will vary as will their perceptions of what should be, and indeed can be, realistically achieved through joint working. Moreover, funding, performance targets and other priorities will influence perceptions of what is to be achieved and how best to collaborate to achieve these goals (Lupton, North & Khan, 2001).

2. ***Governance***: In terms of creating the conditions necessary for effective frontline practice senior managers must accept that collaborative working involves some organisational give and take. Lowndes and Skelcher (1998) found, however, that senior managers do not always find these negotiations easy. They noted that distrust and tensions lead to disengagement and are particularly likely to exist between political and professional members of collaborations, as well as between representatives of statutory and voluntary agencies.

3. ***Systems and capacity***: Effective collaboration is dependent on systems and structures being in place to provide a framework for multidisciplinary practice (Percy-Smith, 2006). What is becoming increasingly apparent is that managers often make decisions about systems without engaging with frontline staff to establish what works and what issues need to be addressed. This leads to the development of inappropriate systems that do not necessarily meet the needs of practitioners, children and their families (Horwath & Morrison, 2011). Developing common systems across agencies may require compromises on work practices and styles of operation (Huxham, 1996). Moreover, agencies struggling with issues such as staff vacancies and a lack of resources may find it difficult agreeing to implement work practices that put a further strain on already stretched systems. The consequence can be tokenistic compliance to multidisciplinary working.

4. ***Outputs and outcomes***: Many of the performance indicators used to measure the effectiveness of agencies tend to focus on output measures. Whilst providing useful information on service throughput, they are limited, particularly in relation to multidisciplinary practice, as they do not capture the experiences and outcomes reported by staff and service users (O'Brien et a, 2009). Moreover, quality of service delivery does not of itself lead to better outcomes for children. For example, there may be a mismatch between users' needs and services provided. Hogan and Murphy (2002) have argued that for this reason it is important to measure outcomes. However, measuring outcomes is challenging because so many variables, over and above the services provided, impact on outcomes for children. Therefore, the focus tends to be on the *potential* for partnerships to improve outcomes rather than actually working collaboratively (Percy-Smith, 2006).

Consistency: singing from the same song sheet

In order for notifiers to have their concerns recognised and responded to by child protection, or indeed other agencies, there needs to be shared agreement of the concerns and their impact on the child. As described in the above, this is often not the case. Mardani (2010) for example, noted a lack of clarity amongst practitioners regarding acceptable standards of care and neglect thresholds. Whilst this is concerning, the issue is exacerbated because it is not just the information that is being shared between professionals about the child and their family that determines the thresholds for intervention, but also a range of subjective factors.

Reder and Duncan (2003) argue that both the information imparter and recipient give meaning to the content of an information exchange based on their personal values, beliefs and emotional state: '*I've received reports from her before, she always sounds anxious and it's usually nothing*'. In addition, agency context such as policies, workload and interagency relationships will also influence the communication: '*I'm up to my eyes in work – if I accept this referral I'll have to work late, besides it does not sound as if it meets our threshold*'. The tone of voice, past relationships, the time of day and day of the week, and the status of the referrer will also influence the way information is interpreted and, in turn, the thresholds: '*Typical, she waits until last thing on a Friday, I know she only wants to have an anxiety free weekend thinking she's passed her concerns on*'. Munro (2008) has also noted that if referrers are concerned about a case they emphasise the worrying features in order to try and ensure the case meets the thresholds criteria: '*I'm really worried about this one, but I bet she's thinking it's a Friday she's dumping on me, so I'll just point out my concerns, I won't mention that I think an auntie may be around*'.

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Even if the referral is accepted and a child protection assessment does take place, the Irish study referred to above highlighted significant inconsistencies in practice (Horwath, 2007). For example, the information gathered about the child and family, which in turn informed judgements, was determined by the ease with which workers could make contact with different professionals. They frequently placed the onus on professionals to return calls and provide the required information, on occasion not following up if this did not occur. Moreover, in the Irish study, some professionals, such as nurses, were routinely considered more important points of contact than others, irrespective of the concerns about the child. This can result in distorted decisions made on selective information rather than a holistic assessment of the situation.

Lack of consistency may also occur in relation to interventions and case closure. As one practitioner put it, the nature of intervention is decided by the response to the question '*Is the child safe?*' (Mardini, 2010) The notion of 'safety' is open to interpretation with different professionals taking different views: for example, do we mean physical safety, immediate safety, or longer-term safety from harm? Professionals in the Irish study had different views on thresholds for closing cases (Horwath, 2007). Some practitioners were so weighed-down by the complexity of a case that in their opinion small changes warranted case closure; others were prepared to accept low standards of care if carers lived in poverty and deprivation; whilst others closed cases because they did not feel they had the necessary expertise to work meaningfully with these families.

Change and multidisciplinary working

One of the greatest challenges encountered by those engaged in work with children and families is that they are attempting to meet the needs of children in a context of constant policy and

practice change and organisational restructuring. Change is usually accompanied by variations in roles and responsibilities. During periods of change, both managers and practitioners can feel as if they are in stormy seas in a boat with a captain who has no compass to navigate a safe route. Staff are likely to feel vulnerable, anxious and insecure. In addition, change may mean getting to grips with new cases and forming new multidisciplinary relationships. During periods of significant change the tendency is to focus on children who appear to have the most immediate need for protection with the insidious and longer-term effects of neglect becoming marginalised (Department of Health and the Home Office, 2003). Arguably this is neglect by agencies rather than carers.

The insecurity that staff feel during periods of change can impact on multidisciplinary work with families. Glissen and Hemmelgarn (1998) found that if practitioners are not confident and secure within their own agency setting and do not fully appreciate their roles and responsibilities then their ability to work effectively with other practitioners to meet the needs of children is compromised. Moreover, staff that lack confidence, are unsure of their roles, feel over-worked and stressed find it harder establishing meaningful relationships with children and families (Holland, 2004).

Against a backdrop of change in agency settings, practitioners are, in turn, working to bring about change in neglecting families. Behavioural change does not occur overnight: chronic neglect requires long-term solutions (Iwaniec, 2006). However, agencies are often geared-up for the 'quick fix'. Once the immediate presenting problem is resolved, the services are withdrawn with the underlying causes of the problem remaining. The consequence is that the family is likely to present again with further problems. According to Morrison (2009), if meaningful change is to take place both the family and practitioners should have a shared understanding of what interventions are planned, how they will contribute to improving the lived experience of the child, and how progress will be measured. Often plans are put into place containing phrases like '*Plunket nurse will monitor the situation*'. This leaves it vague as to what is meant by 'monitoring' (Mardini, 2010). If practitioners are not clear about ways in which other professionals are working with members of the family, they may be unaware of the demands placed on the parents. For example, the author recently became aware of a case involving a pregnant mother who was expected as part of the child protection plan to keep three separate appointments, on the same day in different parts of the town. In order to keep these appointments she had to bring a toddler along with her, having dropped her other child off at school and then had to ensure she was back to collect the child at the end of the school day.

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Good practice requires practitioners to agree on what is 'good enough' and to be clear with parents as to what they expect of them. All too often vague terms such as '*mother to bond better with baby*' are used (Mardini, 2010). But how will improved bonding be measured in terms of the impact on the child? Are practitioners agreed on what this would look like at a point when services can be withdrawn? Practitioners also need to be very clear and consistent in their messages to neglectful carers regarding the consequences of failing to meet the needs of the child. All too often neglectful carers are threatened with children being removed, but then a lack of sufficient evidence for court, or lack of out-of-home resources, means that the child remains at home and the case is allowed to drift (Brandon et al, 2008). In order to avoid this occurring, practitioners working with the family should agree on a viable contingency plan that will be put into place if the carers fail to change sufficiently to meet the needs of the child.

Cultivation of effective practice

If we are to improve collaborative practice in cases of child neglect, then it is essential

that collaboration between frontline staff and managers at all levels is nurtured and cultivated. There is a developing body of research that gives clear messages about the type of organisational culture that is likely to promote effective practice in relation to work with children and families. In a review of this research Hemmelgarn, Glissen and James (2006) concluded that if workers and managers feel positive about their job and their agency, collaborative working is likely to improve and in turn lead to positive outcomes for children. They found the following to be important in creating a positive organisational climate:

- organisations valuing quality improvements
- flexible organisational structures that can respond to change
- recognition of the impact of the work on staff through support systems and listening to staff concerns
- promoting an environment where errors can be expressed, mistakes acknowledged and solutions found
- clarity regarding workers roles
- manageable workloads
- workers feeling valued and positive about their job and organisation.

Glennie and Norman (2000) found that providing opportunities for practitioners from different agencies that work together to get together through, for example, network meetings and joint local training initiatives, played a key role in

Table 1: Questions for collaborative workers

Practitioners

These questions focus on working together once issues of neglect have been recognised but are also useful in terms of exploring thresholds at reporting stages:

- Is there agreement on the risk of harm, needs of the child and the family?
- Is there a shared understanding of the concerns regarding parenting behaviours and the changes required?
- Is there a shared understanding of the actions that need to be taken in relation to this family and the rationale for this approach?
- Are professionals clear about their own role and that of others regarding work with this family?
- Are there joint measures for acceptable and unacceptable change?
- Have practitioners agreed on timescales and contingency plans?

Frontline managers

- What are some of the challenges the worker/team are encountering in relation to collaborative working in cases of neglect?
- Are there areas of difference or conflict between the worker and team and/or other professionals?
- What strategies can we develop for managing differences and conflicts?
- What opportunities are available for local multidisciplinary relationship building?
- What changes are occurring within our organisation and in other organisations that may impact on practice?

Senior managers

- How have we reached a view about the quality of frontline practice?
- Are channels of communication in place that ensure common issues at the frontline are brought to our attention?
- Is the nature of the collaboration with other agencies built on trust and shared leadership at a senior level?
- Do we have systems in place at a senior management level for joint evaluation of practice and shared development?

developing effective and meaningful relationships between staff who then work together more effectively on individual cases. The respondents in the Irish study also noted the importance of opportunities for practitioners and frontline managers to physically come together for informal discussions (Horwath, 2007). This helps to establish relationships and allay many of the anxieties and misconceptions described above.

Effective practice does not occur overnight; it needs to be cultivated and nurtured. Listed below in table 1 are a series of questions for frontline practitioners, operational managers and senior managers, which are designed to enable the relevant personnel to begin to consider how they can improve collaborative practice in cases of neglect.

Summary

This paper has sought to draw attention to some of the subjective factors that make collaborative practice in relation to child neglect particularly difficult to achieve. I have attempted to demonstrate that subjectivity occurs at both a management and practitioner level. If practice is to focus on the child and their lived experience, which is so important in cases of child neglect, the first step is recognising that we all have prejudices that influence our work. The second step is cultivating an environment where these are acknowledged as influencing practice, and the third for both managers and practitioners is to have opportunities to explore these influences in safe and supportive surroundings in order to ensure that practice is child-focused. ■

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