Neglect : Opportunities for collaboration between health and welfare

The Strengthening Families Program at the Royal Children's Hospital

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Persistent neglect is thought to be just as harmful to a child as abuse. However, neglect is often difficult to assess for two reasons: firstly it often resembles poverty; and secondly, neglecting families tend to have disorganised patterns of accessing health care and social support. This article looks at the importance of joint health and welfare input in interventions with families at risk of neglecting their children. The Strengthening Families Program at Melbourne's Royal Children's Hospital provides a model for interdisciplinary and intersectoral (welfare and health) collaboration, which offers care management to individual families and is working towards systemic changes in the hospital's response to these families.

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Neglect is an issue of *omission*, rather than one of *commission*, and is sometimes therefore considered to be less harmful to the child than abuse. However, there is considerable evidence to the contrary. Firstly, there is a substantial overlap between neglect and abuse and many professionals consider that they are part of a continuum for some children. Secondly, even without abuse, neglect on its own may lead to serious illness, injury and death (Garbarino & Collins 1999). Thirdly, the findings of neurological research point to the profound and lifelong effects of early deprivation (Perry & Pollard 1998).

Neglect has been defined as 'the failure of the child's parent or caretaker who has the material resources to do so, to provide minimally adequate care in the areas of health, nutrition, shelter, education, supervision, affection or attention, and protection' (Wolock & Horowitz 1984, cited in Garbarino & Collins 1999, p. 12). While a family's cultural context undoubtedly needs to be carefully considered (Garbarino & Collins 1999; Stevenson 1998), ethnic and cultural differences should not obscure a child's need for all these kinds of care.

NEGLECTING PARENTS AND THE HEALTH OF NEGLECTED CHILDREN

Neglect is likely to be part of a persistent intergenerational pattern (Stevenson 1998). In their description of neglecting families, Monaghan and Buckfield (1981, p. 29) state:

> they tend to be families in constant crisis and yet are remarkably isolated. They have fewer family members or friends on whom they can depend for help and are seldom members of community organistions. They seem less able to utilise educational and preventive health services. Frequently the parents were themselves unloved children, specifically children to whom very little was given but from whom much was demanded. Consequently, they suffer low self-esteem, their lives are remarkably joyless, and they cannot give love, because they have not themselves received it.

Children in these families have disproportionately high rates of hospitalisation (for both medical and psychosocial reasons) and longer lengths of stay in hospital than other children (Leventhal, Pew, Berg & Garber 1996). Research undertaken at Melbourne's Royal Children's Hospital (RCH) has also shown that these families take up a large amount of social work time in the health care system (Goodman & Miller 1996).

These findings are also echoed by foster care research, which has shown that children entering the alternative care system as a result of neglect and/or abuse tend to have considerable unmet health care needs, leading to chronic medical, dental and developmental conditions, as well as emotional problems (Blatt, Saletsky, Meguid, Church, O'Hara, Haller-Peck & Anderson 1997; Simms, Dubowitz & Szilagyi 2000; Simms, Freundlich, Battistelli & Kaufman 1999).

Simms et al (1999) cite research which shows that children in out-of-home care have nearly twice the length of stay in hospital as other children. Other US research has found that 22% of children

in out-of-home care were under-immunised; 43.1% presented to hospital with acute medical illnesses; 60.3% had chronic conditions; 57.1% had language delays; 33.4% had cognitive delays; and 31.2% had gross motor delays (Silver, DiLorenzo, Zukoski, Ross, Amster & Schlegel 1999).[1]

POVERTY AND HEALTH

Although it is important to understand that neglect is not caused by poverty, there are undoubted connections between them. Firstly, neglect and poverty co-exist in many families due to chronic intergenerational patterns of disorganisation. Secondly, the effects of poverty are likely to exacerbate existing neglect and abuse in families.

One of the complexities involved in assessing neglect is that some elements of poverty can resemble neglect. The links between poverty, poor health, chronic illness and disability are well recognised in the research literature (Bond 1999; Lawton, Leiter, Todd & Smith 1999; Logan & Spencer 2000; Meyers, Lukemeyer & Smeeding 1998; Roberts 1997).[2] Poverty is associated with low birth weights and domestic hazards, as well as inadequate nutrition, housing and health care (Rosman & Knitzer 2001). Poor families may also delay purchasing medication or they may change GPs frequently (Barnett 2000).

A child's chronic illness and disability may lead to poverty if parents are unable to work in paid employment. For example, recent US research shows that families who receive welfare benefits are more likely (than families not receiving welfare benefits) to be caring for at least one child with a chronic condition (Heymann & Earle 1999; Meyers, Lukemeyer & Smeeding 1998). Welfare 'reform' (decreasing families' reliance on welfare payments) is likely to put extra stress on already struggling families (Rosman & Knitzer 2001; Smith, Wise, Chavkin, Romero & Zuckerman 2000) and may therefore exacerbate the risk of neglect.

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INTERVENTION

Child welfare professionals inevitably see the vulnerability of neglecting parents. Monaghan and Buckfield (1981, p. 31) state:

> While such parents desperately need a close and trusting relationship, their life experiences have taught them that people are not to be trusted and a lifetime of emotional deprivation and disappointment in others will not readily be changed. If they are to be helped, enormous perseverance and understanding are required by all who reach out to them. They need nurturing and an irrational commitment from us.

However, providing family support services within a system which also investigates potential neglect and abuse is fraught with potential tensions (Faver, Crawford & Combs-Orme 1999; Frost, Johnson, Stein & Wallis 2000).

Maximising the possibility of changing family patterns of parenting failure and supporting parents to experience success are key goals of early intervention for the whole family. For the child, Roberts (1997, p. 1125) states:

> just as early trauma may have long term effects, early interventions enable children and young people to accrue some of the capital needed for good long term outcomes.

However, while it is important to recognise the positives of early intervention, it cannot fully overcome socioeconomic disadvantage (Roberts 1997). Stevenson (1998, p. 4) states 'the evidence for success in intervention when there is serious neglect is shaky'. Support to this group of families is therefore more likely to make a positive difference in situations of potential or developing neglect. Research has shown that a variety of intensive professional and volunteer interventions, both in and out of the home, lead to positive outcomes for children and parents (Campbell 1997; Frost et al 2000; Monaghan & Buckfield 1981; Olds, Henderson, Kitzman & Cole 1995; Siegel, Bauman, Schaefer, Saunders & Ingram 1980; Taggart, Short & Barclay 2000).

Important principles of intervention for families who neglect their children include (Anderson 2000; Belville, Indyk, Shapiro, Dewart, Moss, Gordon & Lachapelle 1991; Drotar 1999):

- outreach to at-risk families;
- a comprehensive service, involving a high level of professional initiative, structure and collaboration;
- individualised interventions to teach specific skills;
- coordination between community agencies; and
- intervention programs within the community.

WHAT THE HEALTH CARE SYSTEM CAN OFFER

Lawton et al (1999, p. 546) report on focus groups of welfare recipients 'who cited health care providers as one of the most credible sources of welfare-related information'. Similarly, 'pediatricians generally enjoy a trusting and respectful relationship with families ... and parents might therefore be more accepting of their recommendations' (Dubowitz 1990, cited in Wurtele 1999, p. 157). In addition, the life-changing nature of important health-related, developmental milestones, such as pregnancy and birth, are thought to facilitate increased openness to professional intervention at these times (Ayoub & Jacewitz 1982; Wurtele 1999).

Health care professionals offer relatively non-stigmatising and neutral services and hospitals are therefore seen as highly appropriate venues for identifying parents at risk of neglecting or abusing their children (Coppel,

[1] These children's unmet health care needs are also exacerbated by multiple placements within the alternative care system (Silver et al, 1999).

[2] This literature needs to be explored with some caution, as the US and UK research cited here relates to a very different context than that of Australia.

Packham & Varnam 1999; Lawton et al 1999; Scholte, Colton, Casas, Drakeford, Roberts & Williams 1999).[3] Hospitals are also likely to have a variety of services in one setting (Ayoub & Jacewitz 1982), and therefore offer many windows of opportunity for recognition of neglect and abuse and coordination of services to parents (Wurtele 1999).

For example, hospital staff are potentially able to monitor, through care coordination and file notes, possible signs of child neglect and abuse, such as closure (families withdrawing from contact with organisations) and covert warnings (disguised admissions of escalating abuse) (Reder & Duncan 1995).

For young children, chronic health problems may be one of the most obvious indicators of persistent neglect. There is therefore a compelling argument for a closer collaboration between the child welfare and health care systems.

THE STRENGTHENING FAMILIES PROGRAM AT THE ROYAL CHILDREN'S HOSPITAL

The Victorian Strengthening Families Program (SFP) was established by the Department of Human Services (DHS) in 1998 to identify families where there were concerns about neglect and to offer support to them, with the intention of preventing the need for later child protection intervention. Welfare agencies in all regions of Victoria have been funded to provide an average of 40 hours support to such families.

The Strengthening Families Program (SFP) at Melbourne's Royal Children's Hospital (RCH) was funded by RCH in October 1998 to promote systemic change in the hospital's response to families whose children are at risk of neglect; and to provide a formal link into the hospital for the SFP community agencies funded by DHS. The SFP is currently linked with five metropolitan agencies and two rural agencies.

It is important to distinguish between the DHS-funded program, which was set up to divert families from the child protection system, and the RCH-funded program, which has no direct links with the child protection system apart from making referrals to it when necessary.

The RCH program accepts referrals from community agencies, hospital staff and the families themselves. In collaboration with the community agencies, it incorporates core principles of active outreach, comprehensiveness of service, professional and inter-agency collaboration, continuity of care and individualised interventions. The SFP coordinator (located in the Social Work Department) within the hospital is central to this model.

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CASE STUDY

The following case study, with three alternative outcomes, is presented to illustrate not only what the RCH SFP program offers, but also what the health system in general has to offer the child welfare system in the assessment and treatment of neglect.

> A five year old girl, Kim, was treated for an acute illness at RCH as a toddler. Now in her first year of primary school, she is losing weight, not sleeping well and is generally slow to respond or irritable, both at home and school. Her teenage parents are worried about her and take her to a family support agency on a Friday. A social worker talks to the parents about the importance of a balanced diet and helps them plan a bedtime routine for Kim. The social worker is concerned about Kim's poor health and low energy, as well as her parents' seeming lack of understanding of Kim's basic needs. A further concern is that Kim does not seek comfort from either parent. An appointment is made for them to return to the agency early the following week and the social worker encourages the family to go to the local community health centre to have Kim medically assessed.

Outcome One

Over the weekend, Kim complains of a sore tummy and her parents take her to the RCH Emergency Department early on Sunday morning. They wait for some hours before being seen, Kim is treated with Panadol and the family return home. They may or may not return to the family support agency (or go to the community health centre) and staff there are unlikely to know that Kim has been seen at RCH. Given the busy nature of the Emergency Department, staff are unlikely to have referred Kim to the Social Work Department.

Outcome Two

When Kim is taken to the RCH Emergency Department, staff are concerned about Kim's health and arrange for her to be admitted to a General Medical ward for observation. During her one day stay in hospital, Kim may or may not have a full assessment including hearing tests, etc. The family support agency social worker sees Kim's mother down the street, asks how Kim is and is told that she is at RCH. The social worker rings RCH, finds out where Kim is and asks the nurse on the ward how she is. The nurse replies that 'Kim's doing fine and she'll be going home tomorrow'. Because the nurse doesn't know this social worker, she won't say 'Kim's parents haven't visited and we're a bit worried about her'.[4] As Kim is only in the hospital for 24 hours, a referral may not have been made to the SF worker or to Social Work.

[3] Schools are also seen as non-stigmatising – in contrast to some child welfare/family support agencies which families may view with some suspicion (Whyte, 1997; Wyatt & Novak 2000).

[4] An enquiry like this from an external social worker is likely to have the most informative outcome if the hospital Social Work Department is contacted, whether or not there is a program such as the SFP. Medical and nursing staff tend to be very wary in their communication with members of other professions external to the hospital.

Outcome Three

During the family's visit to the family support agency, the social worker tells the parents that Kim should probably be checked out by a doctor. As Kim's parents seem to have some reluctance about attending the community health centre and as they already seem to have had a positive relationship with RCH in the past, the social worker rings the RCH SF worker and talks to her about the centre's concerns for Kim and her parents. The SF worker organises for Kim to have a full assessment at RCH within the next week. She meets Kim and her parents when they arrive at the hospital,[5] alerts medical staff to Kim's possible needs and coordinates a full range of assessments for her. She also makes sure that the community agency staff are well informed about Kim and consults with them, as well as with Kim's parents, on possible referrals for the family.

The third outcome is clearly the most positive for Kim in that she will have a full range of assessments which may pick up underlying issues which are contributing to her poor health, lack of energy and irritability – hearing or vision problems, nutritional and iron deficiencies and various kinds of developmental delay. Identifying these issues is an important first step in understanding how they may be impacting on the relationship between Kim and her parents.

Any further outpatient or inpatient hospital appointments will be coordinated and supported by the SF worker. In addition, Kim's parents will have been offered support and referrals (in conjunction with the family support agency) within a non-stigmatising health setting.

Early intervention for children like Kim cannot completely overcome socio-economic disadvantage (Roberts 1997; Stevenson 1998). It does, however, maximise the possibilities for positive change in families and is incomplete without joint welfare and health input.

[5] If this family did not keep the RCH appointment, the SF worker would follow up with staff in the community agency.

One of the major strengths of the SFP at RCH is that it works across inter-disciplinary and intersectoral (health and welfare) boundaries. Within the welfare context, the social and psychological environment of a family is the primary concern and this can mask identification of underlying health issues which contribute to a family's functioning. Similarly, within the medical context, physical health is the primary concern and this can mask identification of social issues which contribute to poor health.

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A recent evaluation of the RCH program and its links with the SF community agencies found that there were several key issues which enhanced its service to families:

- the RCH program is not statutory and considerable commitment is given to engaging parents in a collaborative way. Engagement is seen as crucial to positive outcomes for the child;
- for most families, the hospital setting is relatively neutral, tending not to have the negative connotations of 'welfare'; and
- consultation with families involves the expertise of health and welfare professionals (both inside and outside the hospital) working together, rather than in isolation.

The evaluation made a number of recommendations concerning broad systemic change to facilitate support to this group of families (Contole & O'Neill 2000). One of the key recommendations was the desirability of establishing an outpatient clinic within the hospital to offer the detailed assessments often needed by this group of children, in collaboration with community agencies.

There are three main advantages in establishing such a clinic. Firstly, social work support would be further destigmatised as the SF worker would be an integral part of the care 'package' at the clinic. Secondly, families who are now frequent non-crisis users of the Emergency Department (ED) would be referred to the clinic, thus freeing ED resources. Thirdly, the clinic would actively facilitate interdisciplinary and intersectoral communication and collaboration.

CONCLUSION

Parents who neglect their children present challenges to professionals within both the child welfare and health systems. Boundaries between these systems are artificial and each domain has a considerable amount to offer the other. In particular, the health system provides a relatively non-stigmatising service to families and therefore offers potential windows of opportunity for positive intervention in the lives of these children and parents.

Closer collaboration between the welfare and health systems, in conjunction with families, seems an effective and obvious solution. While this kind of partnership is undoubtedly complex, due to the practicalities of time, resources and the challenges inherent in negotiating the interface between systems, it is ultimately likely to offer greater benefits to children and more cost-effectiveness for the community, than fragmentation of services.

The RCH Strengthening Families Program is an example of a service model which has established links across these boundaries in the interests of children at risk of neglect. ♦

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ACKNOWLEDGEMENTS

Ms Christine Minogue, Divisional Director (Nursing), COPAS Division, Royal Children's Hospital

Dr Julie Contole, Research Consultant

The Myer Foundaion