Improving hospital systems for disadvantaged children and babies

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In this paper, I will discuss the importance of early intervention with vulnerable families where children and babies may be at risk of neglect and disadvantaged by their social circumstances in accessing appropriate, preventative support services. I will describe the Strengthening Families Program located in the Social Work Department of the Royal Children's Hospital, which provides a model for interdisciplinary and intersectoral (welfare and health) collaboration. The Program offers care management to individual families and is working towards systemic changes in the hospital's response to these families. Finally, I will illustrate aspects of the work of the Royal Children's Hospital Strengthening Families Program with a case study wherein a recent history of domestic violence impacted on the family's capacity to access health and welfare services for both mother and children.

Because neglect is an issue of *omission*, rather than one of *commission*, it has at times been considered less harmful to the child than abuse. However, persistent neglect may lead to serious illness, injury and death (Garbarino & Collins 1999). Further, the findings of neurological research point to the profound and lifelong effects of early deprivation (Perry & Pollard 1998).

Wolock and Horowitz (1984, cited in Garbarino & Collins 1999, p.12) define neglect 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.

A family's cultural context needs to be taken into account, but ethnic and cultural differences should not obscure the child's need for adequate care in each of these areas (Garbarino & Collins 1999; Stevenson 1998).

Monaghan and Buckfield (1981) observe that neglecting families tend to be families in constant crisis and also fairly isolated. They frequently have few supportive family members or friends on whom they can rely in times of difficulty and rarely actively participate in community organisations. For these families, neglect may be part of an intergenerational pattern wherein for a variety of reasons the families experience difficulty accessing and effectively utilising educational and preventative health services.

Research undertaken by Leventhal, Pew, Berg and Garber (1996) found that the children in neglecting families had disproportionately high rates of hospital admissions for both medical and psychosocial reasons and that the duration of hospitalisation was longer than that of other children. Further, foster care research has shown that children placed in alternative care as a result of neglect and/or abuse tend to have a range of unmet health care needs, which may lead 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).

While neglect is not caused by poverty, these factors often co-exist in families and would appear frequently to be linked to chronic intergenerational patterns of disorganisation. Also, the effects of poverty are likely to compound existing neglect in families. Neglect can be difficult to assess because aspects of poverty can resemble neglect and neglecting families tend to have disorganised patterns of accessing health care and social support (O'Neill, Hall & Miller 2002). Poverty can impact on the quality of nutrition, housing, health and dental care available to a family. Poor families may find it difficult to purchase medications promptly or to sustain stable housing so as to maximise continuity of local general medical care for their children.

While early intervention with neglecting families can help improve family functioning, provide more positive family experiences for children and better access to health and family support services, it cannot fully overcome socio-economic disadvantage. Stevenson (1998, p.4) observes that 'the evidence for success in intervention when there is serious neglect is shaky'.

Thus, support for these families is more likely to make a sustained and positive difference where early intervention occurs in situations of *potential* or *developing* neglect.

A focus group study involving welfare recipients found that health care providers were viewed as one of the most credible sources of welfare-related information (Lawton, Leiter, Todd & Smith 1999). Paediatricians generally have trusting and respectful relationships with families and it is likely that parents might therefore be more accepting of their recommendations.

Health care professionals offer relatively non-stigmatising and neutral services and so hospitals can be seen as highly appropriate venues for identifying vulnerable families where the children may be at risk of neglect. Hospitals are also likely to have a variety of services in one setting and thus offer many windows of opportunity for recognising vulnerable families and coordinating services to parents.

Through care coordination and case file documentation, hospital staff are potentially able to monitor possible signs of family stress or child neglect, such as a family's failure to attend appointments, delays in seeking medical attention or increasing numbers of presentations at the Emergency Department with vague symptoms or apparently minor health complaints. For young children, chronic health problems may be an indicator of developing neglect.

It can be seen that there is a compelling case for closer collaboration between the child welfare and health care systems.

THE STRENGTHENING FAMILIES PROGRAM

The Strengthening Families Program at the Royal Children's Hospital was funded by the Hospital in October 1998 to promote systemic change in the Hospital's response to families whose children are at risk of neglect by creating links across interdisciplinary and intersectoral (health and welfare) boundaries, with a view to facilitating more timely and effective communication and collaboration in work with families with young children at risk of neglect. The Program utilises a social work model for providing a formal link into the hospital for the network of community-based family support agencies and to coordinate relevant services within the Hospital. Referrals are accepted from community agencies, Hospital staff and from the families themselves. In collaboration with the community agencies, the model incorporates the principles of active outreach, comprehensiveness of service, professional and interagency collaboration, continuity of care and individualised interventions.

The following case study is presented to illustrate the work of the Royal Children's Hospital Strengthening Families Program with a family seeking to re-build their life in the aftermath of domestic violence. Names and other identifying information have been changed to protect the family's privacy.

SONIA AND HER FAMILY – A CASE STUDY

Sonia and her family of three children, Anna (14 years), Jack (4 years) and Katie (18 months) were referred to the Hospital Strengthening Families Program by the Hospital eye clinic. Four-year-old Jack had missed several consecutive outpatient appointments and the medical registrar had been concerned that without timely treatment, Jack was at risk of irreversible damage to his eyesight. All efforts to contact his mother had been unsuccessful. So when Sonia subsequently presented at the clinic with Jack and indicated that she was unable to afford the necessary prescription spectacles for her son due to the financial strains of escaping domestic violence, the clinic doctor contacted the Hospital Strengthening Families Program Coordinator.

In discussion with Sonia, it emerged that the family had been in and out of women's refuges for several months. Sonia had been concerned about her son's eyesight problems, but she had been overwhelmed by the stresses of the constant upheaval and disruption of her life. While her Refuge Workers had assisted Sonia to obtain safe housing and supported her through the Court processes, the enormity of the family's social situation appeared to have obscured the health and medical needs of the young children in the family.

Sonia described a lonely childhood wherein she had been the only child of a family who migrated to Australia as Polish refugees. She recalled that her family was quite isolated; her parents kept to themselves and she had few friends. The extended family were scattered across several countries and so there was only minimal contact with them. Sonia's mother missed her life in Poland prior to the political troubles and was unhappy in Australia; her father worked long hours in a factory and tended to drink heavily in the evening.

In adolescence, Sonia wanted to be like the Australian born girls she knew at school and so rebelled against her father's restrictions on her style of dress and activities outside the home. When at seventeen years of age, Sonia became pregnant with Anna, her father threw her out of the house. Sonia moved in with her then boyfriend, 22-year-old Craig. The relationship ended soon after Anna's arrival. Sonia felt unable to reconcile with her parents who remained angry and ashamed by their daughter's situation.

Sonia drifted in and out of numerous relationships and developed a heroin addiction. Eventually she managed to get herself onto a methadone program. She met Peter and they subsequently had two children – Jack and Katie.

Within this relationship, Sonia described episodes of physical assault wherein she sustained bruising and injuries requiring medical treatment. Child Protection authorities were notified and Sonia feared that her children would be taken from her. She separated from Peter, taking the children with her, but he continued to threaten harm and to stalk Sonia, with the result that the family were in and out of refuges and unable to settle in one place. Ultimately, Peter received a prison sentence in relation to the assault convictions. Sonia now found herself living alone with her children and in stable housing at last – but in yet another unfamiliar area of Melbourne.

While Sonia had had a succession of welfare agencies and workers in her life, it had been difficult for her to develop and sustain trust in working relationships because the instability of the family's housing and domestic situation meant that she was regularly withdrawing prematurely from sources of social, health and emotional support because she had moved out of the region or catchment area for the particular services. Sonia had reached the point where she no longer bothered to seek out community-based resources for herself and her family. She was relieved to learn that the Hospital Program did not have such regional boundaries that might disqualify her from accessing the Program Social Worker.

Sonia spoke of her concerns about her children. She experienced eighteen-month-old Katie as being very clingy, irritable and demanding of her attention. Katie suffered from recurrent colds and was unsettled at night. Her immunisations had fallen behind schedule.

Sonia was frustrated by four-year-old Jack's increasingly aggressive behaviour towards herself and his younger sister. She was bewildered by his behaviour and scared that he would 'end up like his father'.

Fourteen-year-old Anna's disrupted schooling combined with the emotional turmoil at home had led her to lose interest in attending school, and Sonia was worried that her daughter was mixing with older teenagers whom she believed were using illicit drugs. Anna would not talk with her mother and had begun staying out late at night.

Sonia expressed feelings of exhaustion and complained that she had no time to herself. She felt guilty about losing her patience at times and 'yelling at the kids'.

Sonia felt discouraged and acknowledged that the domestic violence experience had eroded both her sense of self worth and her self-confidence as a parent.

As we explored these feelings, Sonia was also able to gradually recognise her enormous strengths: her extraordinary resilience in the face of adversity; her persistence in overcoming obstacles such as drug addiction and homelessness; and her commitment to building a better life for herself and her children.

We drew on Sonia's experience to help determine which practical and emotional support services and resources would best assist her family and also her views regarding what ways of working she found helpful in a worker or a community agency.

In consultation with Sonia and in collaboration with both Hospital medical and allied health staff and the community-based agencies, the Hospital Strengthening Families Program coordinated the following intervention plan:

- Financial assistance was obtained to purchase the prescription spectacles required by Jack.
- Full paediatric assessments were obtained for both of the younger children and the family were linked to a general medical practitioner and dental service located within their local Community Health Centre.
- Katie's immunisations were brought up to date and a referral was made to the enhanced home visiting Maternal and Child Health Nurse to support Sonia in establishing routines for her younger children, and to provide her with information regarding areas such as nutrition and ways of supporting her children's developmental needs.
- A referral was also made to the Community Strengthening Families Program, which was able to provide in-home support with parenting skills and household management, to link the family to respite and childcare facilities and also to assist with furniture and other essential household items.
- At the Community Health Centre, the family was able to access financial guidance (including advocacy in relation to prior debts and Centrelink benefit issues) as well as, importantly, counselling services and a support group for women and children who have left violent relationships. A Youth Worker was also able to engage with Sonia's teenage daughter, Anna.
- The Hospital Strengthening Families Program Coordinator continued to support the family at their subsequent visits to the Hospital eye clinic and liaised with the community agencies and Hospital staff, as appropriate.

A recent evaluation (Contole & O'Neill 2000) of the Royal Children's Hospital Strengthening Families Program found that several key factors enhanced its service to families. These included the families' view of the Hospital as generally being a neutral setting without any negative connotation of 'welfare'; the non-statutory status of the Program and the considerable attention given to engaging parents in a collaborative way; and the consultation with families which involves the expertise of health and welfare professionals (both inside and outside the Hospital) working together to achieve positive outcomes for children and their families. ♦

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