Realising the potential
Tackling child neglect in universal services

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Introduction
Child neglect is a prolific and pressing challenge for policy makers, practitioners and society as a whole. It is the most common reason for a child to be on a child protection plan in England and can have a profound and long-lasting negative impact on a child’s development. There are currently substantial pressures on the child protection system and it is increasingly being required to act as an emergency service. We urgently need to find additional ways to get help to children as early and efficiently as possible.

Early help is about providing support as soon as a problem emerges at any point in a child’s life.
Providing effective early help can prevent children from suffering unnecessary harm, improve their long-term outcomes, allow child protection services to be more available to provide intensive support and interventions, and is more cost effective than reactive services. We have a large and skilled workforce in universal services who, given the right ingredients of clear role expectations, adequate resources and access to quality training and supervision, have the potential to play a leading part in tackling child neglect as soon as possible.

We draw on a large and unique data source comprised of the views of 893 health visitors, school nurses, GPs, midwives, teachers and early years practitioners in England, as well as 18 children and young people, to explore:

• How universal services practitioners see their role and responsibilities in providing early help;
• What early help is currently provided in universal services;
• What barriers practitioners face to providing early help; and
• How services can be better supported to provide early help

A model for the provision of early help in universal services
Drawing from this research, we propose a model for the way in which those working in universal services can provide early help for child neglect (see Figure 1).
Effective early help provision that tackles neglect at the earliest possible stage requires universal services practitioners to:

• Identify parental risk factors for neglect or neglect itself;
• Understand the child’s unmet need by talking to the child, their parents and other practitioners - this in turn requires practitioners to have the opportunity and be equipped to develop relationships;
• Assess the child’s and parents’ needs and formulate a plan through a formal or informal assessment, to identify which services might be best placed to help a child or family, within or external to universal services;
• Address the child’s needs through directly providing practical and/or emotional support where possible (continuing to develop and maintain relationships with the child and/or parent), and/or through signposting to other services or agencies if more specialist services are required;
• Monitor the child and/or parents throughout the period of concern, to assess whether problems escalate further or improve; and
• Review and reflect on progress, considering whether the child’s needs have been met. This process will depend on the age of the child and the context that has brought about the need for early help, and it must occur within the timeframe of the child. When the concern is low-level, a referral to children’s
social care should only be made when early help has not been successful within the child’s timeframe or when the concern escalates.

The research findings

What does the guidance say about universal services practitioners and early help?
Statutory and non-statutory guidance states that universal services practitioners have a role to play in providing early help for neglect. However, this requirement is often set out in vague and broad terms, and the guidance can fail to clarify what it means in practice. In addition, the guidance tends to focus on the responsibility of practitioners to identify neglect, share information and signpost families to other services; there is a lack of explicit guidance on how practitioners can directly respond to concerns.

Did the practitioners see early help as their responsibility?
All the practitioner groups in our study believed that they and other universal services practitioners have a responsibility to be able to both identify neglect and to provide early help in some way. On average, health visitors, school nurses and early years practitioners tended to see early help as more their responsibility than midwives, teachers and GPs, reflecting the extent to which their roles are more traditionally seen as early help providers. However, we found that there was often a lack of consensus within professions about their responsibilities to provide early help.

What early help did the practitioners say they provide?
We asked the practitioner groups to tell us how they would normally respond if they were concerned that a child they were working with might be experiencing low-level neglect and may benefit from early help. All groups said that they provide early help in a variety of ways. However, there were interesting differences between the groups, and while some of those differences related directly to the nature of the service that each practitioner group provided, others highlighted significant gaps in provision. The key findings were as follows:

- The most common way of providing early help across the practitioner groups was signposting families to other agencies. While signposting is an important component of early help provision, it needs be done alongside other aspects of early help, like taking time to understand a child and family’s needs, and developing a relationship with them that supports them to engage with other services. Other findings from this research show that this is not always happening, which raises concerns that signposting can sometimes be about ‘passing the buck’.

- Teachers and early years practitioners were less likely than those working in health services to contact other practitioners about an early concern. While between 82 per cent and 89 per cent of health practitioners said that they normally contacted other practitioners, only 64 per cent of education practitioners said that they did. Multi-agency working was considered to be a significant barrier to early help provision for those working in education services.

- The practice of routinely monitoring a child in response to early concerns about neglect was more commonly done in education settings than in health services, with 84 per cent of early years practitioners and 76 per cent of teachers saying that they routinely monitor children. The higher rate in
education settings is likely to be because monitoring is facilitated by the regular daily contact that they have with children. Nonetheless, health practitioners have a role to play in monitoring children, but, worryingly, only 20 per cent of midwives, 37 per cent of GPs, 52 per cent of school nurses and 66 per cent of health visitors said that they would normally monitor a child about whom they had early concerns.

• Talking to a parent about a concern was relatively common practice, with 90 per cent of health visitors, 83 per cent of GPs, 74 per cent of school nurses, 72 per cent of early years practitioners, 69 per cent of midwives and 66 per cent of teachers respectively saying they would do so. Providing practical and emotional support to these parents was very common for health visitors and early years practitioners, of whom 96 per cent and 79 per cent respectively said that they would do so. It was less common for GPs (67 per cent), school nurses (66 per cent), midwives (59 per cent) and teachers (53 per cent). There seems to be a missed opportunity here, particularly in relation to those practitioners who have the greatest contact with parents. The findings highlight the need to look at how GPs can be supported to build relationships with parents through, and following on from, talking about a concern. The findings also suggest the need to consider how to support midwives to both raise concerns and provide direct support to parents.

• When the concern is low-level, a referral to children’s social care should only be made when early help has not been successful within the child’s timeframe or when the concern escalates. However, we found that a high number of participants said that they would refer a low-level, early concern about neglect to children's social care. This included 75 per cent of midwives, 47 per cent of school nurses, 35 per cent of GPs, 32 per cent of health visitors, 31 per cent of early years practitioners and 29 per cent of teachers. These findings raise a number of issues for discussion: they may suggest a need to further support practitioners in understanding when a referral to social care is appropriate; they may reflect perceptions around responsibility to provide early help, and they also suggest that practitioners’ have low confidence in their own ability to respond to early concerns. Whatever the case may be, this finding highlights the need for clear role expectations, adequate resources and access to quality training and supervision to support the provision of early help.

• Relatively high percentages of early years practitioners (87 per cent), school nurses (73 per cent) and teachers (73 per cent) said that they would provide practical and emotional support to a child. However, we found strikingly low percentages of practitioners who said that they would normally talk to a child about an early concern: 88 per cent of early years practitioners, 69 per cent of teachers and 67 per cent of school nurses said they would not normally talk to the child about an early concern. This raises concerns about how child-centred practice is.

What are the barriers to the provision of early help in universal services?
The practitioners and young participants identified a wide range of barriers that can prevent the provision of early help or can reduce the effectiveness of that help.

• For health practitioners in particular, workload and time pressures were considered to be a significant barrier to providing early help. Staff shortages,
high caseloads and pressures to meet targets mean that practitioners have less time, for example, to consider the wellbeing of children in a more holistic way, to develop relationships with children and parents or to monitor children when they have concerns.

- Problems with multi-agency working and information sharing – historic but persistent barriers to providing effective safeguarding were again raised in this research. Specific examples given were practitioners not understanding one another’s roles and not valuing each others’ expertise and contribution, as well as simple physical barriers to multiagency working, like unreturned telephone calls.
- Having the opportunity and being equipped to develop constructive relationships with parents was also raised as a barrier to early help provision, particularly in the context of early help being non-statutory.
- Not all practitioners are receiving training on neglect, which may be hindering their ability to identify and provide early help for neglect. In particular, 18 per cent of health visitors, 15 per cent of midwives and 14 per cent of early years practitioners reported that they had not received training in the past three years.
- Practitioners also need to be aware of local thresholds for intervention. However, we found that many practitioners with specific safeguarding responsibilities had not read their Local Safeguarding Children’s Board (LSCB) threshold document; this applied to between 20 per cent and 50 per cent of GPs, teachers, midwives and health visitors.
- Most of the 18 children and young people we spoke to, who were aged between 14 and 24, said that they would not seek support for neglect from a universal services practitioner. Having a safe and trusting relationship with practitioners was crucial for young people, and many felt that their contact with universal services practitioners did not enable these relationships to develop.

What examples of promising practice and ideas for best practice were given?
Examples of promising practice and ideas for better practice from the professional participants included:
- Training that focuses specifically on neglect, its impact on child development and effective working with parents;
- Prioritising the provision of home visits in health visiting, midwifery and early years;
- Improving the provision of postnatal care;
- Enabling family support workers to provide early help through increased training and supervision;
- Establishing ‘contact windows’, during which practitioners make themselves available to answer telephone calls about safeguarding concerns;
- Holding regular internal team meetings and supervision;
- Government financial investment in early help in universal services (for example, a commitment to recruiting more school nurses) and in targeted early help provision; and
- LSCB-wide neglect strategies. For the young participants, service provision could
- be improved through a greater focus on building relationships with young people.
Recommendations
For an effective model for the provision of early help in universal services, we need:

1. **Adequate resources**: The UK government, local government and commissioners must ensure that there are necessary resources available to enable universal services practitioners to undertake early help. Therefore, there should be financial commitment to the provision of early help for neglect in universal services and targeted early help services. National and local governments should reduce the £17 billion ‘late intervention’ spending by 10 per cent by 2020 through better and smarter investment in early help. There should be a drive and commitment by the Department of Health to recruit additional school nurses.

2. **Clear role expectations**: Individual professions within universal services need to be clear about their role in providing early help for neglect. Therefore, government and professional membership bodies should clarify the role of universal services practitioners in providing early help for neglect and set out these role requirements clearly in statutory, professional guidance and professional job descriptions. More explicit guidance should be developed on how practitioners can provide direct support to children and parents.

3. **Clear pathways**: There needs to be clear and accessible pathways for the provision of early help, including between different universal services and between universal services, targeted services and children’s social care. LSCBs should develop a neglect identification and intervention pathway that helps practitioners identify and access targeted early help services. They should also lead a drive on awareness of the LSCB threshold document among practitioners with a specific safeguarding responsibility. LSCBs, Health and Wellbeing Boards, and Clinical Commissioning Groups (CCG) should recognise and draw on in-service planning and commissioning the role that universal services practitioners can play in responding to neglect.

4. **High-quality training, support and supervision**: Practitioners need to be confident and able to take early action before referring their concerns to children’s social care. LSCBs and safeguarding practitioners should ensure that all practitioners working with children receive specific training on neglect during their pre-qualification training and at least every three years while practising. This should include:
   -- the impact of neglect on child development, and how to articulate concerns about neglect to other practitioners;
   -- how to convey concerns to parents and challenge harmful behaviour;
   -- how to develop relationships with parents; and
   -- how to develop relationships and address early concerns with children and young people.
All practitioners should also receive training that actively encourages them to always share information with other practitioners where there is a legitimate purpose and with the child in mind. Safeguarding practitioners in school nursing, health visiting and midwifery should ensure that regular internal team meetings are held (at least every two weeks) to discuss early concerns about children and their parents, in which practitioners feel able to challenge one another and reach a consensus about appropriate responses. In addition, all practitioners should have regular supervision.
with their manager in which they are supported and encouraged to reflect on their day-to-day practice in providing early help to children and parents.

5. **Effective information sharing and multiagency working**: There needs to be open, professional and respectful dialogue and information sharing among different universal services practitioners, and between universal services practitioners and children’s social care (where in the child’s best interest). LSCBs should ensure that regular multidisciplinary meetings are held to discuss early concerns about children and their parents in the local area, in which practitioners feel able to challenge one another and reach a consensus about appropriate responses. They should introduce formal expectations of handovers at a non-statutory level when families move into a new area or their care passes from one professional to another, and should introduce ‘contact windows’, in which safeguarding practitioners within universal services agree a regular time slot during which they are contactable regarding safeguarding issues.

6. **Relational services**: Universal services need to be delivered with a focus on the importance of relationship building between practitioners and families. The government should support the development and promotion of community budgets, which allow providers of public services to pool their budgets. Postnatal services should be routinely available for all women, at an appropriate level of intensity and for as long as is required. Models of case allocation should facilitate continuity of care across all services. Further consideration should be given to the potential opportunities of employing adequately trained and well supervised family support workers in both health and education settings.
This figure, developed from the discussion group data and literature review, sets out a model for the provision of early help for neglect within health and education services/teams. Effective early help requires practitioners to have the opportunity and ability to develop relationships with children and/or parents. Provision of direct support to the child and/or parents includes practical and/or emotional support. This runs throughout the process, alongside monitoring the child and/or parents. At each stage, practitioners should refer to their LSCB threshold document. This process is time-limited and the time frame given for change to be evident will depend on the child’s age and their specific needs. A referral to children’s social care is positioned at the end point on the pathway when early help has not been successful. However, if a concern escalates at any point, a referral should be made to children’s social care. The early help activities that individual practitioners are able to carry out will depend on their role, the age of the child, and the particular context of the child and family.
Early help for neglect in universal services
Sample: 893 practitioners from universal services

We asked: What do you normally do if you are concerned that a child you are working with might be experiencing low-level neglect and may benefit from early help?

- **64%** of teachers and early years practitioners contact other practitioners to get more information, compared to **82%-89%** of health practitioners.
- **82%-94%** of health practitioners and **70%-76%** of education practitioners signpost to other services.
- **84%** of early years practitioners and **76%** of teachers monitor children, compared to **69%** of teachers, **67%** of school nurses, and **63%** of GPs.
- **20%** of midwives, **37%** of GPs, **52%** of school nurses, and **66%** of health visitors refer to children’s social care.

We asked: What barriers do you face to providing early help?

- **18%** of health visitors, **15%** of midwives, and **14%** of early years practitioners had not had training on neglect in the past 3 years.
- **50%** of GPs, **48%** of teachers, and **36%** of midwives with safeguarding responsibilities had not read their LSCB threshold document.

- **52%** of teachers, **59%** of school nurses, and **66%** of health visitors had a lack of early help services in their area.
- **37%** of GPs, **52%** of school nurses, and **66%** of health visitors did not know how to engage with parents.
- **37%** of GPs, **76%** of teachers, and **84%** of early years practitioners did not know their role and responsibilities.

- **Workload and time pressures**: 29% of respondents.
- **Difficulty working with other agencies and sharing information**: 27% of respondents.
- **A lack of early help services in my area**: 24% of respondents.
- **Difficulty engaging with parents**: 22% of respondents.
- **Not being sure about my role and responsibilities**: 20% of respondents.
- **Haven’t had training on neglect in the past 3 years**: 18% of respondents.
Tables

Graph 1: Length of time practising in profession

Graph 2: School nurses' early help responses to low-level neglect

- Graph 1 shows the percentage of participants in different length of time practising in their profession, categorized by profession (Health visitors, Early years practitioners, Teachers, GPs, Midwives).

- Graph 2 illustrates school nurses' early help responses to low-level neglect, with different categories such as contact professionals, direct support child, direct support parents, CAF, Sipposi, talk to the child, talk to the parent, monitor child, escalate concern, referral to social services, and other. The responses are categorized as average (n=89), safeguarding responsibility (n=41), and no safeguarding responsibility (n=48).