Barriers to health visitors identifying child neglect

Abstract

Child neglect poses a significant issue in the UK with enduring repercussions for the health and wellbeing of children. Health visitors are responsible for safeguarding and promoting child welfare and play a pivotal role in identifying and addressing neglect, but a multitude of barriers can hinder this. This article explores the complex landscape of health visitors identifying child neglect, outlining the significance of early intervention, with a particular focus on health visiting in Scotland. Challenges faced by health visitors are examined, including organisational barriers, family/carer disguised compliance, and varying professional thresholds for when to intervene. The importance of leadership support, enhanced training and clear thresholds in safeguarding work are highlighted. The concept of 'respectful uncertainty' is advocated as an approach for health visitors to navigate the challenges they encounter when protecting and promoting the wellbeing and safety of children in the UK.

KEY WORDS: Barriers · Child neglect · Health visitors · Disguised compliance · Thresholds

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Children who face neglect have a high risk of negative outcomes in adulthood, including engaging in neglectful behaviours towards their own children (Bartlett et al, 2017; Avdibegović and Brkić, 2020). The responsibility for identifying and safeguarding children lies with education, social care and health professionals. Reporting concerns to relevant services for assistance can help to address this (Hood et al, 2016), with prevention a more effective approach than intervention (Rooke, 2015; Glasgow Child Protection, 2022).

Health visitors support interventions from birth to pre-school, and play a crucial role in identifying children at risk of neglect (Scottish Government, 2012; Coles et al, 2016; Peckover and Appleton, 2019). Nonetheless, there are many barriers to identifying and safeguarding these children, both in the workplace and households in which they live (Jarrett and Barlow, 2014).

This article explores the barriers health visitors and other professional practitioners face when identifying children at risk of neglect. Identifying such barriers, and how to address these, can provide valuable insights into the professional role health visitors have in contributing to the prevention of child neglect in Scotland.

Searching the literature

A search of literature published between 2015 and 2023 focused on westernised healthcare provision, excluding hospital or care home settings. The inquiry used the terms 'health visitor', 'specialist public health nurse', 'family nurse', 'child abuse', 'maltreatment', 'neglect', 'infant ill treatment', 'home setting', 'household', 'residence' and 'living environment', with Boolean operators 'OR' and 'AND'. The databases CINAHL, MEDLINE, Education Source, and Health Source: Nursing/Academic Edition were searched. Grey literature, including government policy documents, was also explored. Articles identified in the search and referenced in this paper are relevant to the themes discussed below.

Defining child neglect

An estimated one in 10 children in the UK experience neglect, making it a significant issue (NSPCC, 2021). The exact number is difficult to determine due to under-reporting and lack of recognition (Herendeen et al, 2014; Azizi and Shahhosseini, 2017). Child neglect can be considered a form of child abuse (Hills, 2019; Riley and AlQahtani, 2020; Child Protection Scotland, 2022) with National Guidance for Children in Scotland (2023: 12) defining child neglect and abuse as ' inflicting harm or failing to act to prevent harm', resulting in impairment of the child's health and/or development.

It has been proposed that this definition should be broadened from addressing current neglect to the probability of future neglect (Scottish Government, 2012), while recognising that the impact of neglect on individual children must be identified early and interventions prioritised to prevent further harm.

To meet this, both public and professional practitioners need to be vigilant and report any suspected cases of neglect (Donelan-McCall, 2009; Ammerman et al, 2014). As such, it is crucial for health professionals, specifically health visitors, to understand the complexity of child neglect and its implications for a child's development and their health and wellbeing.

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GIRFEC and the health visitor role

In the UK, a health visitor is a postgraduate registered nurse or midwife, who leads an assessment and intervenes, if necessary, in the wellbeing of children aged 0–5 years (Institute of Health Visiting [iHV], 2017). Health visitors have a broad and significant role in promoting children's health and wellbeing. Their role in identifying and safeguarding children at risk of neglect is crucial (Rooke, 2015; iHV, 2024); nevertheless, there are challenges that health visitors face in fulfilling this role. In many areas of Scotland, there is evidence of deprivation and persistent health inequalities. To address this, the Scottish Government (2015) implemented strategies to make Scotland a place where children can thrive. Health visitors play a significant role in implementing these strategies, with a key focus on the health and wellbeing of pre-school (0–5 years) children.

In 2015, the Scottish Government introduced *Get It Right For Every Child* (GIRFEC). The GIRFEC framework plays a vital role in ensuring the wellbeing of pre-school children in Scotland. Health visitors advocate for children by gathering information from their families and sharing a robust understanding of the child's needs with relevant statutory and non-statutory services. The GIRFEC model has eight indicators that can show how a child is thriving in the present and for them to thrive in the future. If the indicators identify unmet needs and/or concerns for the child, the health visitor can use the National Practice Model and its associated tools, 'My World Triangle' and 'Resilience Matrix' (Scottish Government, 2015) to further assess the child's needs and identify potential risk of harm occurring.

Despite this, some suggest that health visitors have gaps in their understanding of the GIRFEC framework (Coles et al, 2016) and that different health visitors interpret the 'frameworks' they use differently to support their assessment (Raman et al, 2012), resulting in children's needs not being identified early enough to prevent harm. Different interpretations made by health visitors can be influenced by their professional experiences, anxieties and their beliefs and attitudes to the GIRFEC framework (Coles et al, 2016; Welsh, 2019). This can lead to health visitors experiencing uncertainty over the sharing of information and managing confidentiality, as well as challenges in balancing children's wellbeing with maintaining their safety.

Organisational barriers, clinical supervision, leadership and support

Home visiting services are a universal service employed to identify vulnerable children and those at risk of harm (Rooke, 2015; Kim, 2019). One of the biggest challenges experienced by health visitors when attempting to identify child abuse are organisational barriers (Azizi and Shahhosseini, 2017). Barriers can start in the workplace and not necessarily in a child's family home. Barriers that originate from the health visitor's workplace, such as the absence of professional or peer support and/or unsupportive leadership, can have an impact on a professional's work while engaging with families in the community (Herendeen, 2014; Jarrett and Barlow, 2014). Additionally, due to 'lone working' practices or having to make what can often be rapid safeguarding judgements, health visitors are exposed to high levels of stress and anxiety (Devereux, 2023). Little (2017) asserts that good support from leaders and work colleagues can control and mitigate this.

Peer and emotional support from colleagues and managers, as well as improved role recognition from wider professionals in the multidisciplinary team, are necessary for health visitors to provide a quality service that addresses the needs of children and their families. Health visitor leaders and colleagues play a significant role in supporting one another in their safeguarding capacity to protect children and families (Rooke, 2015; Riley and AlQahtani, 2020).

It is crucial that leaders of healthcare teams have the ability to support the emotional wellbeing of their practitioner colleagues should they encounter professional challenges when engaging with the families of children in their clinical care (Busch et al, 2021). Recognising, acknowledging and addressing emotions allows practitioners to ask peers for support, which can lead to increased self-confidence when experiencing challenging or difficult home visits (Naughton et al, 2018). However, Appleton (2011) and Naughton et al (2018) also suggest that, as well as the health visitor role becoming increasingly complex, it is often misunderstood. Misconceptions are held by many, including other professional disciplines linked to childcare and welfare. Some health visitors believe their role and professional responsibility is perceived by others as limited to weighing babies, chatting with parents, and drinking tea. Moreover, managers who have no health visiting caseload experience can fail to appreciate the workload demands health visitors experience and the day-to-day challenges they encounter (Jarrett and Barlow, 2014).

These misunderstandings and/or inactions by leaders can cause health visitors to feel emotionally unsupported and have a negative impact on their health and wellbeing or, conversely, cause them to suppress how they feel at work for fear that their colleagues and peers will think they are unable to cope (Naughton et al, 2018; Rooke, 2015). As Taylor et al (2019) point out, the role is emotionally complex. Leaders need to ensure emotional support is available in the workplace. Without this, professional practice and personal wellbeing can be affected. The provision of clinical supervision can assist with mitigating against this.

Clinical supervision is confidential, protected time for practitioners to reflect on their practice, gain professional support and discuss any professional concerns they have about families they engage with (Corey et al, 2020). While clinical supervision is recognised as a valuable aspect of health visiting, its effectiveness can be undermined if not carried out at planned times or interrupted by other tasks (Burton, 2009; Jarrett and Barlow, 2014; Appleton, 2015). Reflective and critical thinking by supervisor and supervisee are essential for clinical supervision

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to be effective (Taylor et al, 2019). Health visitors who receive effective clinical supervision, even from a different professional discipline, provide a significantly better quality of service to families when the supervisor has had training in relevant supervision tools (Snowdon et al, 2017).

Disguised compliance

The number of children in Scotland being placed on the child protection register for abuse or neglect continues to rise (Child Protection Committee, 2020). When a child is suspected or known to be suffering from abuse or neglect and subsequently dies or experiences significant harm, a multi-agency review is conducted to identify potential weaknesses in the statutory agencies' collaborative practices. In Scotland, these reviews are carried out by the Child Protection Committees (NSPCC, 2021). A recurring theme across several previous case reviews is the presence of 'disguised compliance' (Scottish Government, 2015). Despite disguised compliance being frequently identified when investigating child abuse or neglect, in the recent past across the UK, little has been done to implement the findings and recommendations from such reviews in professional practice (NSPCC, 2019). It is essential, then, for practitioners to have a thorough understanding of disguised compliance and to consider and assess for this when working with families.

Disguised compliance involves the primary caregiver appearing to comply or engage with professional agencies to downplay or dismiss safeguarding concerns and avoid further engagement (Reder et al, 1993; NSPCC, 2019). Therapeutic relationships between professionals and families are critical when supporting families and their children; yet, as Vincent (2013) notes parents may say and appear to do the 'right things', or engage 'just enough' to satisfy professionals, or offer justifiable excuses for when not fully engaging.

Evidence from case reviews elsewhere in the UK (NSPCC, 2019) suggests that professional practitioners can be accepting of information provided or presented by a child's family rather than explore further for corroboratory information. Brandon et al (2014) suggest that it can be difficult for professionals to know whom to trust and whose explanation is truthful. Such actions (by families and professionals) can result in disguised compliance.

Thresholds

Effective safeguarding work requires expert professionals who work collaboratively with other agencies (Hood et al, 2016; Azizi and Shahhosseini, 2017). Despite this, professional decision-making can be influenced by a person's education, opinions and experiences, which shape the individual's 'thresholds' (Taylor et al, 2019) to such a degree that similar 'cases', with similar characteristics, can result in different outcomes depending on the 'thresholds' of the professionals involved (Ben Natan et al, 2012).

Thresholds are the point at which decisions should be made to prevent exacerbation of risk or harm, or to protect the child's welfare. Thresholds can change outcomes for children depending on the professional 'leading the case'. As individual thresholds can differ, in Scotland, the Children (Scotland) Act 2020 (section 11) provides threshold criteria for the professional to identify the stage at which (legal) interventions can be taken to protect children from harm. This can, however, be hindered when different professional agencies set local or personal threshold points. For example, a small study by Hood in 2017 explored the 'threshold' decision-making in nursing, education and social work professionals when safeguarding children and found differences in approach. Nursing practitioners demonstrated a reluctance to refer on for further assessment citing past negative experiences where they have done so or that not enough 'red flags' were evident justifying an onward referral. Similarly, Hood noted that education practitioners refrained from making onward referrals on safeguarding grounds for fear of damaging relationships with the families of children they educated. Social work practitioners, on the other hand, did make onward safeguarding referrals, although there was a difference between more and less experienced practitioners.

More experienced social work practitioners reflected on past professional experiences to assist with decision-making, while less experienced practitioners tended to gather more inter-agency information and then sought guidance from more experienced colleagues before reaching a decision. Health visitors in Scotland can use the 'My World Triangle' to help subjectively assess the level of risk of a child (Scottish Government, 2015), but perhaps health visitors should also routinely seek out second opinions from colleagues and supervisors to check thresholds are not crossed and safeguarding actions takes place at the correct time.

Respectful uncertainty

In Scotland's health visiting services, it is not mandatory for parents to accept the health visiting programme (Scottish Government, 2015). It is therefore crucial for the health visitor to adopt an approach of 'respectful uncertainty' (Laming, 2003; Heron and Black, 2023) and not be too trusting with families (McNicoll, 2017). If there is evidence of non-engagement, health visitors should seek further information to assess whether there are other issues indicating disguised compliance (Akehurst, 2015). For instance, not attending health appointments, nursery attendance, how the nursery reports on the children's health and wellbeing, and whether the family is known to, and how they engage with, other statutory and non-statutory services.

When such information or evidence is limited, or the complexities and myriad of issues experienced by families can appear overwhelming, health visitors should trust their instincts and act when something does not feel right (Desai et al, 2017). As mentioned, regular case reviews and supervision can assist with this, offering a fresh perspective from a professional peer (Jarrett and Barlow, 2014)

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and an opportunity to talk through the concerns and the evidence that support this. It is essential that information gathered from significant case reviews need wide dissemination to ensure that professional practitioners involved in safeguarding children are aware of patterns of disguise compliance and other factors that impact on child protection and welfare.

Conclusion

Child neglect is a pressing issue in the UK, with long-lasting consequences for the wellbeing of children and their futures. Health visitors, as crucial figures in safeguarding and promoting child welfare, play a pivotal role in identifying and addressing neglect. Nonetheless, numerous barriers hinder their efforts in this regard. Organisational challenges, such as unsupportive leadership, place undue stress on health visitors. Additionally, disguised compliance by caregivers when engaging with health visitors further complicates the identification of neglect cases. Moreover, differing professional thresholds for intervention can lead to inconsistent responses to similar cases, potentially putting children at risk.

To improve the effectiveness of health visitors and other practitioners in safeguarding children from neglect, there is a need for clear and consistent support from health visitor leaders, enhanced training on disguised compliance, and the alignment of professional thresholds. Moreover, maintaining respectful uncertainty when engaging with families — even in the face of limited information — can help identify and address child neglect more effectively.

It is essential for leaders to provide emotional support to their team, recognise the complexity of the health visitor role, and encourage practitioners to express their emotions freely, without fear of judgment, to improve their wellbeing and provide better care to children and families. This will allow professionals to be more confident in the workplace, and approach their team leader for any education they may need to help with their quality of care delivered to families. JFCH

CPD

- How can health visitors work collaboratively with their leaders and other professionals to overcome the barriers they face in identifying and addressing child neglect, such as disguised compliance and differing professional thresholds for intervening?
- How can the approach of 'respectful uncertainty' be integrated into the practice of health visitors to ensure the wellbeing of children, while respecting the autonomy of families, some of whom may be masking neglect?
- What steps can be taken at a systemic level to improve training, support and the dissemination of information from significant case reviews to enhance the effectiveness of health visitors and other professional practitioners involved in safeguarding children from neglect?

Akehurst R. Child neglect identification: The health visitor's role. Community Pract. 2015 Nov;88(11):38-42

Ammerman RT, Putnam FW, Teeters AR, Van Ginkel JB. Moving Beyond Depression: A collaborative approach to treating depressed mothers in home visiting programs. Zero to Three. 2014;34(5):20-27

Appleton JV. Safeguarding and protecting children: where is health visiting now? Community Pract. 2011 Nov;84(11):21-5

Appleton JV, Sidebotham P. The Child at the Centre of Care. Child Abuse Review. 2015;24:77-81

Avdibegović E, Brkić M. Child Neglect - Causes and Consequences. Psychiatr Danub. 2020 Oct;32(Suppl 3):337-342

Azizi M, Shahhosseini Z. Challenges of reporting child abuse by healthcare professionals: A narrative review. J Nurs Midwifery Sci. 2017;4(3):110-116

Bartlett JD, Kotake C, Fauth R, Easterbrooks MA. Intergenerational transmission of child abuse and neglect: Do maltreatment type, perpetrator, and substantiation status matter? Child Abuse Negl. 2017 Jan;63:84-94. https://doi: 10.1016/j.chiabu.2016.11.021

Ben Natan M, Faour C, Naamhah S, Grinberg K, Klein-Kremer A. Factors affecting medical and nursing staff reporting of child abuse. Int Nurs Rev. 2012 Sep;59(3):331-7. https://doi: 10.1111/j.1466-7657.2012.00988.x

Brandon M, Bailey S, Belderson P. Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? https://tinyurl.com/37uemw4u (accessed 13 August 2024)

Burton S. The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information? 2009. https://childprotectionnorthayrshire.info/cpc/download/?file=575 (accessed 13 August 2024)

Busch IM, Moretti F, Campagna I, Benoni R, Tardivo S, Wu AW, Rimondini M. Promoting the Psychological Well-Being of Healthcare Providers Facing the Burden of Adverse Events: A Systematic Review of Second Victim Support Resources. Int J Environ Res Public Health. 2021 May 11;18(10):5080. https://doi: 10.3390/ijerph18105080

Glasgow Child Protection. Keeping Children & Young People Safe. 2024. https://www.glasgowchildprotection.org.uk/article/8459/Keeping-Children-Young-People-Safe (accessed 13 August 2024)

Coles E, Cheyne H, Rankin J, Daniel B. Getting It Right for Every Child: A National Policy Framework to Promote Children's Well-being in Scotland, United Kingdom. Milbank Q. 2016

Key Points

- Child neglect is a pressing issue in the UK, with a significant risk of long-lasting negative outcomes for affected children
- Health visitors play a crucial role in identifying and addressing child neglect, particularly among pre-school children
- Health visitors encounter various barriers in their efforts to safeguard children, including organisational challenges, disguised compliance by caregivers, and varying professional thresholds for intervention
- Effective leadership support, training on disguised compliance, and the establishment of clear and consistent thresholds for intervention are essential to improve the effectiveness of health visitors in safeguarding children and reducing childhood neglect
- Maintaining a stance of 'respectful uncertainty' when engaging with families and health visitors trusting their instincts is a valuable approach to help identify and address child neglect

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Jun;94(2):334-65. https://doi: 10.1111/1468-0009.12195

Corey G, Haynes R, Moulton P, Muratori M. Clinical Supervision in the helping professions: a practical guide, 3rd edition. Wiley & Sons; 2020

Desai C, Reece JA, Shakespeare-Pellington S. The prevention of violence in childhood through parenting programmes: a global review. Psychol Health Med. 2017 Mar;22(sup1):166-186. doi: 10.1080/13548506.2016.1271952

Devereux E. Survey shows half of Health visitors in England intend to quit. Nursing Times 2023. https://tinyurl.com/25jrmxsx (accessed 13 August 2024)

Donelan-McCall N, Eckenrode J, Olds DL. Home visiting for the prevention of child maltreatment: lessons learned during the past 20 years. Pediatr Clin North Am. 2009 Apr;56(2):389-403. doi: 10.1016/j.pcl.2009.01.002

Health Improvement Scotland. A guide to Getting it right for every child. 2012. https://ihub.scot/media/1512/a-guide-to-getting-it-right-for-every-child.pdf (accessed 13 August 2024)

Herendeen PA, Blevins R, Anson E, Smith J. Barriers to and consequences of mandated reporting of child abuse by nurse practitioners. J Pediatr Health Care. 2014 Jan-Feb;28(1):e1-7. https://doi: 10.1016/j.pedhc.2013.06.004

Heron G, Black K. The Role of Uncertainty in Professionals' Thinking about Children Who Harm Other People British Journal of Social Work. 2023;53(5):2922–2939

Hood R, Price J, Sartori D, Maisey D, Johnson J, Clark Z. Collaborating across the threshold: The development of interprofessional expertise in child safeguarding. J Interprof Care. 2017 Nov;31(6):705-713. https://doi: 10.1080/13561820.2017.1329199

Hood R, Gillespie J, Davies J. A conceptual review of interprofessional expertise in child safeguarding. J Interprof Care. 2016 Jul;30(4):493-8. https://doi: 10.3109/13561820.2016.1173656

Institute of Health Visiting. State of Health Visiting, UK survey report. London: iHV; 2024

Jarrett P, Barlow J. Clinical supervision in the provision of intensive home visiting by health visitors. Community Pract. 2014 Feb;87(2):32-6

Kim H. To Prevent Child Maltreatment, Home Visiting Programs Are One Part of a Complete Response. Am J Public Health. 2019 May;109(5):653-655. https://doi: 10.2105/AJPH.2019.305043

Laming L. The Victoria Climbe Inquiry- Report Of An Inquiry - CAIPE. 2003. https://tinyurl.com/32pnh98 (accessed 13 August 2024)

Little M, Baker T, Jinks A M. A Qualitative Evaluation of Community Nurses' Experiences of Child Safeguarding Supervision. Child Abuse Review. 2017;27(12):150-157

McNicoll A. Baby P: Social work's story. Community Care. 2017;12(8):17-21

Naughton A, Perkins L, McMinn B, Kemp A. Using an observation tool (Parent-Infant Interaction Observation Scale) to assess parent-infant interaction in the first 2 weeks of life: A feasibility study. Child Care Health Dev. 2018 Mar;45(2):271-285. https://doi: 10.1111/cch.12637

NSPCC. Disguised Compliance: Learning from case reviews. 2019. https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/disguised-compliance (accessed 13 August 2024)

NSPCC. A summary of the Care Inspectorate's triennial review of initial case reviews and significant case reviews in Scotland: CASPAR briefing. 2021. https://learning.nspcc.org.uk/research-resources/2021/care-inspectorate-triennial-review-case-reviews-in-scotland-caspar-briefing (accessed 13 August 2024)

NSPCC. Statistics Briefing: Neglect. 2021. https://tinyurl.com/bd5xbya5 (accessed 13 August 2024)

Peckover S, Appleton J. Health visiting and safeguarding children: a perfect storm? J Health Visit. 2019;7(5):232-238

Raman S, Holdgate A, Torrens R. Are our frontline clinicians equipped with the ability and confidence to address child abuse and neglect? Child Abuse Rev. 2012;21(1):114-130

Reder P, Duncan S, Gray M. Beyond Blame, 1st edn. London: Routledge; 1993

Riley A, AlQahtani S. Identifying and responding to child abuse and neglect. 2020. https://www.rdhmag.com/resources/contact/14167580/sakher-alqahtani-bds-mclindent-phd (accessed 13 August 2024)

Rooke J. Exploring the support mechanisms health visitors use in safeguarding and child protection practice. Community Pract. 2015 Oct;88(10):42-5

Scottish Government. A Guide to getting it right for every child. 2012. https://girfec-ayrshire.co.uk/wp-content/uploads/2018/03/Guide-to-GIRFEC-1.pdf (accessed 13 August 2024)

Scottish Government. Getting it right for every child: The national practice model. 2015. https://www.gov.scot/policies/girfec/national-practice-model/ (accessed 13 August 2024)

Scottish Government. National Guidance for Child Protection in Scotland 2021 – updated 2023. https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021-updated-2023/documents/ (accessed 13 August 2024)

Snowdon DA, Leggat SG, Taylor NF. Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review. BMC Health Serv Res. 2017 Nov 28;17(1):786. doi: 10.1186/s12913-017-2739-5

Taylor J, Smith P, Taylor J. A hermeneutic phenomenological study exploring the experience health practitioners have when working with families to safeguard children and the invisibility of the emotions work involved. J Clin Nurs. 2017 Feb;26(3-4):557-567. doi: 10.1111/jocn.13486

Vincent S. Preventing child deaths: Learning from review. Edinburgh: Dunedin Academic Press; 2012

Welsh I. Getting it Right For Every Child: Practice Development Panel. https://dera.ioe.ac.uk/id/eprint/34224/1/getting-right-child-practice-development-panel-final-report.pdf (accessed 13 August 2024)

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