Child Abuse Review Vol. **17**: 313–330 (2008)
Published online in Wiley InterScience
(www.interscience.wiley.com) DOI: 10.1002/car.1043

The Preoccupation with Thresholds in Cases of Child Death or Serious Injury through Abuse and Neglect

Marian Brandon*
Pippa Belderson
Catherine Warren
Ruth Gardner†
David Howe
Jane Dodsworth
School of Social Work and Psychology, University of East Anglia, UK

Jane Black
Designated Nurse, Safeguarding Children, NHS Norfolk, UK

Thresholds into and between services emerged as a significant theme in the biennial analysis of cases of child death and serious injury through abuse and neglect 'serious case reviews' carried out in England for the (then) Department for Education and Skills between 2003–05. The preoccupation with thresholds was one of a number of interacting risk factors and many children's cases were on the boundary of services and levels of intervention. In most cases child protection did not come 'labelled as such' which reinforces the need for *all* practitioners, including those working with adults to be alert to the risks of significant harm. Policy makers should acknowledge that staff working in early intervention are working *within* the safeguarding continuum and not in a separate sphere of activity. The emotional impact of working with hostility from violent parents and working with resistance from older adolescents impeded engagement, judgement and safeguarding action. In the long term neglect cases that were reviewed, the threshold for formal child protection services was rarely met and some agencies and practitioners coped with feelings of helplessness by adopting the 'start again syndrome'. Adequate resources are essential but not sufficient to redress the problems. Effective and accessible supervision is crucial to help staff to put into practice the critical thinking required to understand cases holistically, complete analytical assessments, and weigh up interacting risk and protective factors.

KEY WORDS: thresholds; fatal child maltreatment; neglect; hostility and non cooperation

'Many children's cases were on the boundary of services and levels of intervention'

'Effective and accessible supervision is crucial to help staff to put into practice the critical thinking required'

* Correspondence to: Marian Brandon, School of Social Work and Psychology, Elizabeth Fry Building, University of East Anglia, Norwich NR4 7TJ, UK. E-mail: m.brandon@uea.ac.uk
† Ruth Gardner is also employed by the NSPCC.

 Accepted 14 July 2008

The debate concerning levels of intervention and thresholds into and between services has been part of a long standing twin pronged drive to encourage prevention and the efficient use of resources within child welfare services (Hardiker *et al.*, 1991; Mesie *et al.*, 2007; Frost, 1997). One of the objectives of the Quality Protects Programme launched in 1998 was 'To ensure that referral and assessment processes discriminate effectively between different types and levels of need and produce a timely service response' (Robbins, 2001). Yet, there continue to be problems in relation to thresholds for children who need safeguarding. Two linked studies into the work of eight Area Child Protection Committees in England (Joint Chief Inspectors, 2002, 2005) found that pressures on resources in children's social care were continuing to raise the threshold for services for children where there were concerns about their welfare. Threshold criteria applied by adult services have been similarly found to create tensions between agencies and stop help getting to parents when they need it (Commission for Social Care Inspection, 2006).

'Recent national policy initiatives in England aim to curb the persistent problem of tightly guarded thresholds between services'

Recent national policy initiatives in England aim to curb the persistent problem of tightly guarded thresholds between services. *Working Together* (HM Government, 2006a) sets out in chapter 3 the Local Safeguarding Children Board (LSCB) functions which include specifying:

> 'The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention. . . . Clear thresholds and processes and a common understanding of them across local partners may help to reduce the number of inappropriate referrals and to improve the effectiveness of joint work, leading to a more efficient use of resources' (p. 78).

Rectifying problems with thresholds and improving the effectiveness of joint work are important but challenging imperatives. Most children who die from abuse or neglect are not at the child protection end of the safeguarding continuum at the time of the incident. Rather they are children known to have additional or complex needs who do not always come within the ambit of children's social care (Brandon *et al.*, 2002; Reder and Duncan, 1999; Sinclair and Bullock, 2002). As Lord Laming said in the Inquiry into the death of Victoria Climbié, 'child protection cases do not always come labelled as such' (Lord Laming, 2003, para 17.106). His view was that preventative and supportive services in the community that are sensitised to safeguarding children are the most effective way to prevent child death through abuse. Hence, safeguarding children must be 'everyone's responsibility' (HM Government, 2006c). This means that lead professionals (LPs) and Common Assessment Framework (CAF) workers practising at the lower levels of intervention will be working with children who need safeguarding. Yet the national evaluation of the CAF and LP working (Brandon *et al.*,

DOI: 10.1002/car

2006a, 2006b) found that there is not always a good join-up between services for early intervention and safeguarding, so that children's need for protection may continue to go unnoticed.

'There is not always a good join-up between services for early intervention and safeguarding'

Reder and Duncan have enumerated the ways in which problems with communication could, arguably, militate against 'agreeing thresholds' and achieving 'a common understanding' (Reder and Duncan, 2003, p. 96). They make the case for a communication 'mindset' as a core skill that takes into account the psychology of communication because 'individuals and groups create their own boundaries based on beliefs, attitudes, work pressures, and so on'. They, like Cooper (2005), Cooper *et al.* (2003), Ferguson (2005) and Munro (2004) recommend that supervision has a key role to play in taking into account the psychology of practice. In order to achieve this, supervision needs to go beyond accountability and back to its roots as part of a reflective learning process where practitioners can be encouraged to think systemically and to hold in mind other professionals who are relevant to the case (Reder and Duncan, 2003, p. 96).

'Supervision needs to go beyond accountability and back to its roots as part of a reflective learning process'

Ferguson has also argued the need for a more subtle understanding of the psychological and emotional aspects of this work and particularly the challenges of working with resistant and hostile people (Ferguson, 2005). Bureaucratic procedures, thresholds and eligibility criteria often serve to distance, or even, to protect, practitioners from the children and families they are working with. Workers may be 'traumatised' through working with hostile families (Ferguson, 2005) and may take unconscious refuge in the safety of eligibility criteria to avoid working with violent or emotionally disturbing families.

The remainder of the paper discusses the way in which thresholds appear as an interacting risk factor in a national study of all cases of child death or serious injury through abuse which became serious case reviews between 2003 and 2005 in England. Serious case reviews are carried out in England when abuse and neglect are known or suspected factors when a child dies (or is seriously injured or harmed), and there are lessons to be learnt about inter-agency working to protect children (HM Government, 2006a). The purpose of the review is to establish what improvements can be made to the way in which professionals and agencies work together to safeguard children and to identify how these will be acted upon. The English government requires that a two yearly overview analysis of serious case reviews in England is commissioned to draw out themes and trends so that lessons learnt from the cases as a whole can inform both policy and practice.

This is the third such analysis and the first English study of a (near) full cohort of serious case reviews commissioned by the Department for Education and Skills (now the Department for Children, Schools and Families, DCSF). The fourth analysis of

'This is the third such analysis and the first English study of a (near) full cohort of serious case reviews commissioned by the Department for Education and Skills'

DOI: 10.1002/car

serious case reviews notified between 2005–07, also funded by the DCSF, is also being undertaken by the same team.

The Study

Methodology

The overall aim of the study was to use learning from the serious case reviews studied to improve multi-agency practice at all levels of intervention. The study objectives were to provide descriptive statistics from the agreed full sample (i.e. 161 cases) illustrated by some examples from the reviews; to scrutinise a sub sample of cases (i.e. 47) and in so doing to chart thresholds of multi-agency intervention at the levels specified in *Every Child Matters* (HM Government, 2003); to identify interacting risk factors within the sub sample; and finally, to provide practice tools and identify lessons for policy and practice, including examples of good practice.

'The study was made up of two inter-connected samples of serious case reviews'

The study was made up of two inter-connected samples of serious case reviews. The first was the 'full sample' of 161 cases for which only minimal information was available, primarily from the child protection database, which held brief notification information about the original incident which prompted each of the serious case reviews from the two year period between 1 April 2003 and 31 March 2005 (Commission for Social Care Inspection (CSCI), 2005). The second, 'intensive sample' comprised a sub sample of 47 cases, drawn from the full sample of 161 cases. In constructing the intensive sample, the aim was to find a comparable sub set to include a representative spread of age, ethnicity, incident (including neglect), family factors, and a mix of cases which had and had not been known to children's social care at the time of the incident. When tests were applied, the two samples showed a high degree of comparability, as the full report shows in detail.

A mixed methods approach was used for the analysis. Primarily quantitative methods were employed to describe and chart the background characteristics of the children, their families and multi-agency practice in the full sample of 161 cases. A coding framework was drawn up selecting variables and categories from a number of sources. The data were then loaded and analysed in Statistical Package for the Social Sciences (SPSS).

Qualitative methods, drawing on fuller information from the overview reports and the stories of the cases, were used to identify and analyse themes which emerged from the intensive sample. The first stage of the analysis involved the construction of brief analytical chronologies and a review of the history of each case by a member of the research team adapting the scheme for mapping a chronology in Reder and Duncan (1999, p. 13). Family events were

DOI: 10.1002/car

Table 1. Themes emerging from the 47 cases

Child factors and experiences	Family and environmental factors	Practice/professionals, agency factors
Very young babies	Domestic violence	Agency context, capacity and 'organisational climate'
Illness in babies	Substance misuse	Preoccupation with thresholds (e.g. CP threshold not met)
Older child, hard to help	Mental ill health	Professional anxiety and reluctance to act
Sexual exploitation	Fathers, hostility, criminal convictions	Understanding and dealing with neglect, 'start again syndrome'
Going missing	Patterns of hostility and compliance	Professional challenge
Bullying	History of neglect	Supervision
Suicide	Previous child death	Ethnicity challenges
Disability, chronic illness	Poverty	Communication
	Poor living conditions	Keeping track of families
	Frequent house moves	Child not seen/heard
	Accidents	

listed alongside services that had been offered to the family. Thus it was possible to map thresholds for services and see evolving patterns of support or protection and legal status over time, and match these to family incidents and relationships, life events or patterns of harm to the child.

The theory used to inform the analysis was the ecological transactional perspective (Cicchetti and Valentino, 2006) which requires a dynamic not a static understanding and assessment of children and their families and is compatible with the ecological roots of the Assessment Framework (Department of Health, 2000). Regular research analysis meetings were held to discuss, cross check and validate the themes which emerged. Findings were further explored at local and national advisory groups. Major themes to emerge from the analysis of the intensive sample were assembled in a three column table to represent child factors, family and environmental factors and practice and agency factors (see Table 1 which is discussed later).

'The theory used to inform the analysis was the ecological transactional perspective'

Two thirds of the 161 cases concerned children who died and a third were of children who suffered serious injury. The story of each child's death or serious injury makes very powerful reading and as a result, one feature or theme can take on a disproportionate significance. While it was important to acknowledge the individual differences of each child or young person, it was also essential to consider each case objectively as part of a larger whole of 161 or 47 reviews. The analytical approach adopted took account of the researchers' emotional reaction to the cases and allowed the children and their circumstances to be studied respectfully, but systematically.

Findings

The paper is concerned, primarily, with the findings from the intensive sample of 47 cases, which as already described, were

'The paper is concerned, primarily, with the findings from the intensive sample of 47 cases'

DOI: 10.1002/car

representative of the full sample of 161 cases on key characteristics. Table 1 charts the inter-linking themes which emerged from the qualitative analysis of the sub sample of 47 case reviews. The emphasis here is on a key theme, 'preoccupation with thresholds' and on those themes listed in the three columns in Table 1 which influence thresholds. The relationship between thresholds and 'patterns of hostility and compliance' is explored in some detail. The other sub themes arising from the analysis will be described in a narrative form, illustrated with quotes from the overview reports. More detail is available from the full report (Brandon *et al.*, 2008). It is important to stress that these themes illustrate the circumstances that surrounded the death or serious injury of the children but do not necessarily link to their death or injury.

Thresholds and Agency Context

'Frequent reference to staff absence through ill health or staff vacancies, a backlog of unallocated work and very high case loads'

The state of 'health' and capacity of agencies providing services for the children at the centre of these reviews provided an important contextual backdrop to the discussion of thresholds. There was frequent reference to staff absence through ill health or staff vacancies (front line and managerial), a backlog of unallocated work and very high case loads, all of which contributed to serious lapses in safeguarding. In children's social care this was exemplified by cases being closed without core assessments completed and cases which reached the threshold for children's social care but which remained unallocated, or were kept out of the child protection system: 'In deciding that this case was not to be followed up under child protection arrangements, it became one of, at the time, eighty 'child welfare' referrals awaiting attention' (extract from serious case review overview report).

Every Child Matters acknowledged the contribution of high vacancy rates to practitioners' pressures and promised workforce reform, better working conditions and more resources (HM Government, 2003, pp. 85, 86). These improvements were not in place when these reviews took place in the immediate aftermath of the Victoria Climbié Inquiry nor have they been instituted at the time of writing. This is despite staff skills development being one of the main planks of the *Every Child Matters* programme.

The dearth of local staffing resources also meant that manager absence or unavailability often contributed to a lack of support and oversight for hard pressed practitioners. In these circumstances supervision fell by the wayside, despite its key role in maintaining consistency: 'Supervision has a key role in monitoring and overview of case progression when unpredictable day to day events can distract involved professionals' (extract from serious case review overview report).

DOI: 10.1002/car

Thresholds, Levels of Involvement and Degree of Family or Child Cooperation

Families' and young people's engagement with services and patterns of cooperation had an impact on the way that services were delivered and thresholds were considered. To shed more light on the way in which thresholds between agencies and services were interpreted and the part that cooperation (or its absence) played, all 47 cases from the intensive sub sample were plotted on a chart to represent the level of service offered at the time of the incident and the way in which families or the child cooperated or resisted services (Figure 1). Levels of intervention will be discussed first and the examination of patterns of cooperation will follow.

'Families' and young people's engagement with services and patterns of cooperation had an impact on the way that services were delivered and thresholds were considered'

There was a spread of agency involvement across all four levels of intervention. Although 26 children were receiving high level services above the threshold for intervention from children's social care (top two quadrants at levels three to four), for 21 children, only additional needs or ordinary universal needs had been recognised (bottom two quadrants at levels one to two). Similar proportions were found in the full sample of 161 cases where 45 per cent of children were not known to children's social care at the time of the incident. Only a small proportion of the 55 per cent of children who were known to children's social care were listed on the child protection register (15%) at the time of the incident which prompted the serious case review. It was clear in this study that in most cases child protection did not come 'labelled as such'. This reinforces the need for *all* practitioners to be alert to the risks of significant harm (including death and serious injury) across all levels of need and intervention.

'In most cases child protection did not come "labelled as such"'

The additional information provided for the 47 cases plotted in more detail in Figure 2 illustrates that many clustered just below

	Lack of cooperation	Cooperation
Levels 3 and 4 (Children in need, and regulatory/ restoratory services)	23	3
Levels 1 and 2 (Universal services and early needs)	9	12

Figure 1. Threshold map of level of intervention and degree of family or child cooperation with agencies at time of incident n = 47

DOI: 10.1002/car

Note: Deaths highlighted by an asterisk.

Figure 2. Findings from threshold mapping exercise (*at time of incident*): Position of cases in relation to key thresholds. Deaths are highlighted by an asterisk

the threshold for services at level three (the 'eligibility criteria' for children's social care, *Children Act 1989*, HMSO, 1989, s 17, or 'child in need'). Cases also grouped at the boundary of level three and four, reflecting a hesitancy about whether or not this was a 'child protection' case. There was often a preoccupation with these boundaries and which professional group was 'responsible' for the child so that: 'There appears to be confusion and disagreement between agencies over what services can be offered and are appropriate to be offered' (extract from serious case review overview report).

Figure 2 provides more detail about the relationship between thresholds and cooperation. Each small box represents an individual case and cases are placed in each cell to reflect their fit in relation to the level of intervention at the time of the incident which prompted the serious case review. Thus cases nearer to the top of each cell were at the threshold for the next level of intervention.

'Thus cases nearer to the top of each cell were at the threshold for the next level of intervention'

It should be noted that in keeping with other similar studies, 47 per cent of the children at the centre of the review were under one year of age, and many were only a few weeks old. Figure 3 provides details of children's ages and also shows that a quarter of the children were aged over 11, and a small minority of nine per cent were over 16 years of age. There were only small numbers of

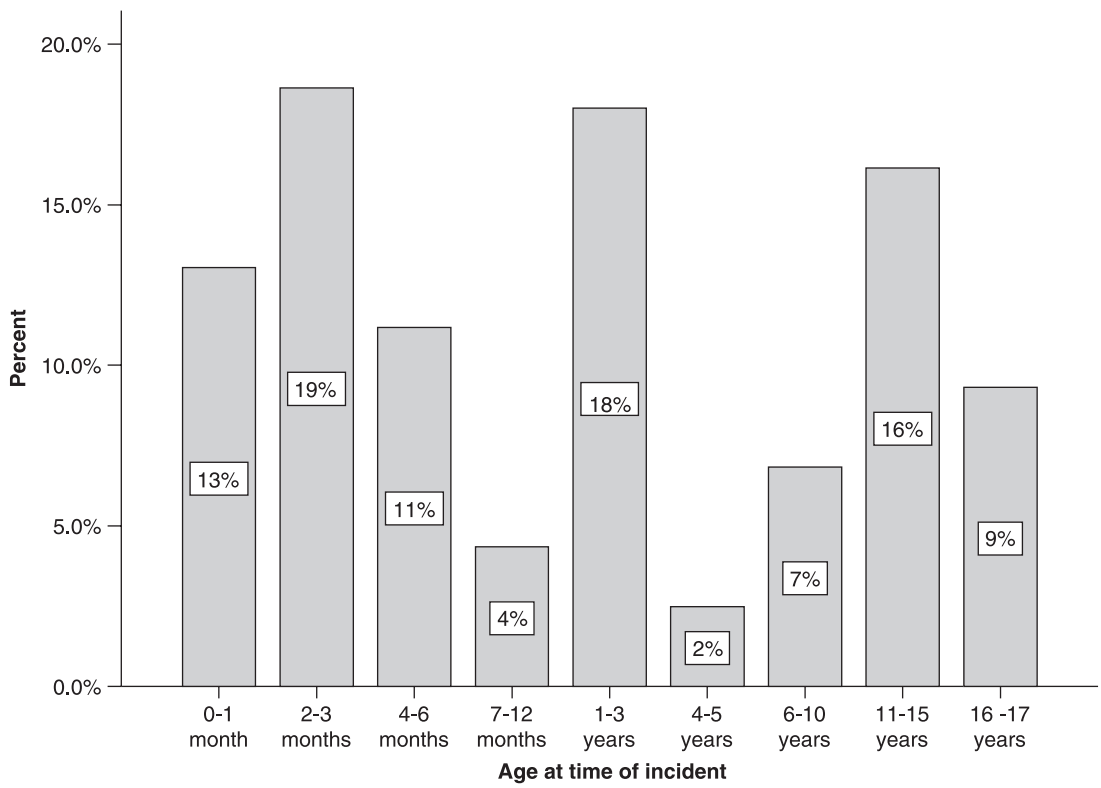

Figure 3. Child's age at time of incident

DOI: 10.1002/car

'Many of the cases grouped at the threshold of level three, involved younger children'

children in their middle years. There was a spread of involvement with children of all ages across all levels of intervention, but numbers are too small to draw any firm conclusions from this. However, many of the cases grouped at the threshold of level three, knocking at the door of children's social care, involved younger children.

The older young person whose circumstances are mentioned below was receiving only 'universal', level one, services.

> 'A young person who was the subject of bullying both at school and outside of school committed suicide. The parents had brought concerns about their son to the attention of several agencies but the risks were not taken seriously enough and there was no indication of working together, sharing information or implementing any plan of action' (researcher summary of extract from Child Protection Database Report information).

'Many of the young people in the 16 to 18 year age band died as a result of suicide'

The decision to call a serious review on cases of older children reflects the increase in Area Child Protection Committees' (now LSCBs) willingness to acknowledge deficits in safeguarding for this group and shows that much older children are dying or being harmed through maltreatment or neglect. Many of the young people in the 16 to 18 year age band died as a result of suicide. Although for some like the young person above, their problems had never been acknowledged, many others had a long history of high level involvement (level four) from children's social care and other specialist agencies, including periods of local authority care (often as the subject of a care order) and some had spent time in a secure unit or other highly supervised setting. The theme of older adolescents who were very difficult to help, with a history of rejection and loss and severe maltreatment over long periods of time, emerged powerfully from the findings, 'G had been repeatedly abused over time by several family members, but no-one in her family was willing or able to look after her' (extract from serious case review overview report). While there may have been pockets of excellent practice in past years, by the time of the incident, help for many had slipped to the lower levels of intervention, with little or no help being offered either because the young person refused it and/or because agencies appeared to have exhausted their helping strategies. Some young people, for example, had been discharged home because of persistent running away with very little help now offered to support them or the family where their problems had originated.

Patterns of Cooperation and their Effects on Workers

The 'lack of cooperation' apparent in more than two thirds of the 47 cases is charted in Figures 1 and 2. This included hostility, avoidance of contact, many missed appointments, disguised or partial

DOI: 10.1002/car

Table 2. Parental characteristics: intensive sample

Characteristics of parents/carers	Intensive sample (n = 47)
Mental health problems/personality disorder	26 (55%)
Domestic violence	31 (66%)
Substance misuse	27 (57%)
Learning disability	5 (11%)
Care history	14 (30%)
Childhood abuse	20 (43%)
Criminal record	25 (53%)
Violence	33 (70%)
Sex offender	4 (9%)
Offender posing a risk to a child	3 (6%)
Previous child death	4 (9%)

compliance and ambivalent or selective cooperation. At the extreme end, it included overt hostility and sometimes threats towards staff. 'Cooperation' included neutral cooperation, a willingness to cooperate or engage and persistent help seeking. Patterns of parental cooperation need to be understood within the context of other parenting characteristics. Domestic violence was present in two thirds of the 47 cases (66%) and the word 'volatility' occurred frequently in relation to many of these families. Parental substance misuse was apparent in 57 per cent of families and mental ill health in 55 per cent. In over a third of reviews (16) there was evidence that all three factors—domestic violence, substance misuse and mental ill health—co-existed. This is a higher level of co-morbidity than Cleaver *et al.*'s (2007) recent study of 357 referrals to children's social care. Other parenting characteristics are shown in Table 2.

'Parental substance misuse was apparent in 57 per cent of families and mental ill health in 55 per cent'

Many factors influence the way that families engage with services. The way that professionals respond to parents can promote cooperation or hostility. A recent government policy review found that families who suffer from problems that hamper their ability to parent effectively may be reluctant to engage with services and not trust the support offered (HM Treasury/Department for Education and Skills, 2007, p. 85). In the current study, there were similar findings of families 'in denial' or not owning up to problems, and of disguised or partial compliance where families were 'good at keeping things from professionals'.

Where there was parental hostility, in cases for example where the father was described as 'always violent' or where there was 'violence with weapons', there was evidence that workers often became frozen. This hampered their ability to reflect, make judgements and act clearly, 'Workers can become paralysed by their own fears and anxieties, which can lead to the assessment process remaining incomplete' (extract from serious case review overview report).

'Evidence that workers often became frozen'

Disguised or partial parental compliance also wrong-footed professionals and could prevent or delay the understanding of the severity of harm to the child.

DOI: 10.1002/car

'The role of managers and particularly the conference chair is critical in ensuring that these cases do not drift'

> 'In this situation of "apparent compliance" it is extremely difficult for professionals directly involved in the family to sustain an objective view of a lack of progress in safeguarding children's welfare. The role of managers and particularly the conference chair is critical in ensuring that these cases do not drift' (extract from serious case review overview report).

The reasons for not seeing or hearing children can be bound up with parental patterns of engagement and cooperation. Where the needs of the parents overshadowed those of the children, the focus of professional engagement was parents and children were missed. This particularly applied to pre-verbal or non verbal children, who were not yet able to speak for themselves and could be ignored:

> '[The baby] was too young to express an opinion about his care but it was known that he had been described as "constantly crying". Opportunities to examine him, to check for any other indications about his well-being, were not taken. The opinion of his mother, who was known to have been unable to care for her first child, was accepted. At a time in his life when it was known that he had not been taken to four planned appointments with health, and that his mother had failed to be in when she knew the health visitor was due to call, a further attempt to see him was abandoned despite the sound of a crying baby being heard at his address' (extract from serious case review overview report).

Professional Avoidance of Neglect and the 'Start Again Syndrome'

'Agencies appeared to avoid or rebuff parents through closing the case, re-assessing, referring on, or through offering a succession of different workers'

The problems of struggling to achieve the threshold for child protection were particularly acute in working with neglect, and many of the families where neglect featured in the serious incident were well known to children's social care and to other agencies over many years. In these cases, although the threshold for *intervention* (from many agencies) had been reached, there was evidence of workers neither fully engaging with families, nor addressing the serious harm to the child. Agencies appeared to avoid or rebuff parents through closing the case, re-assessing, referring on, or through offering a succession of different workers. The consequence of these displacement practices was a systemic failure to engage with the parents' fundamental problems in parenting and the child's experience of direct or indirect harm: 'When a Health Visitor failed to gain access to a family she referred the case to a voluntary organization and Sure Start who also failed to gain access and closed the case' (extract from serious case review overview report).

The histories of these families were complex, confusing and often overwhelming for practitioners. Neglect is notoriously difficult to work with in a clear, systematic fashion (Gardner, 2008) and the chaos and confusion apparent among the families can be mirrored by the practitioners working with the family (Mattinson, 1975).

DOI: 10.1002/car

Another way of dealing with the overwhelming information and the feelings of helplessness generated in workers by the families, was to put aside knowledge of the past and focus on the present in the 'start again syndrome'. In this respect a new pregnancy or a new baby presented the opportunity for a fresh start. Escalating family difficulties tended to be ignored, downgraded or screened out, for example, 'as the family increased in size, so too did the parents' abilities to cope become increasingly strained' (extract from serious case review overview report), but this was not acknowledged.

Referral on to short term programmes, like parenting classes, was another possible coping mechanism for practitioners and managers feeling overwhelmed by families. However, these programmes are unlikely to produce the long term changes needed to protect children from the harmful impact of serious neglect. There is a growing evidence base indicating that short term programmes are not likely to succeed with families with long standing, complex problems (Howe and Hinings, 1995; Utting *et al.*, 2007). '[The father's] lack of interest in attending [parenting classes] was clear evidence of his continued unwillingness to address the issues causing professionals concern but this evidence appeared to be ignored' (extract from serious case review overview report).

'Short term programmes are not likely to succeed with families with long standing, complex problems'

The strategy of starting with a clean slate could be prompted by a worker leaving and a new practitioner starting afresh to form an 'unprejudiced' view of the case, thus losing the opportunity to learn from the family's history. Similarly, a worker being absent through long term sick leave could prompt the 'start again syndrome'. In one case, worker absence resulted in the removal of the child's name from the child protection register and care proceedings being halted in an attempt to manage workload problems.

The 'start again syndrome' should not be confused with the benefits of a fresh perspective on a case, where professionals are well supported and feel able to think differently, reconsider, revise earlier judgements and act with what Ferguson has called 'respectful uncertainty' (Ferguson, 2005, p. 793). Reder and Duncan note Munro's point that reviewing judgements is hard, not only intellectually, but emotionally (Reder and Duncan, 2004, p. 97). Revising professional opinion in these difficult, long term neglect cases often means acknowledging that enough is enough and that the child or children should not remain at home.

Discussion

The findings illustrate the struggle that practitioners and managers faced in trying to deal with overwhelming workloads and cope under pressure. The additional impact of having to work with distress, volatility, hostility and violence often contributed to

DOI: 10.1002/car

'Besieged workers, however, may feel they have nothing left to give'

paralysis in the workers. To work effectively with hostility and notice potentially damaging patterns of cooperation like disguised compliance, it is arguable that practitioners need to be self-aware, flexible and sensitive to the factors underlying their own and the family's behaviour and emotions (Cooper *et al.*, 2003; Glisson and Hemmelgarn, 1998). Besieged workers, however, may feel they have nothing left to give.

A practice mindset is needed not only of how and whether or not the parents or young person are cooperating, but *why* they might be behaving in this way, at this time, with this particular professional? Psychosocial and developmental theories can help to explain why, for example, young people who have never learnt to trust, will test workers (and carers) who, in turn, need to prove their reliability and responsiveness. Why families might be avoiding or cancelling appointments needs to be thought through in the context of other aspects of their lives.

'Robust supervision can help the worker to recognise and cope with the impact of hostility and guard their own safety'

These findings add weight to the arguments that effective and accessible supervision is essential to help staff to put into practice the critical thinking required to understand cases holistically, complete analytical assessments, and weigh up interacting risk and protective factors. Robust supervision can help the worker to recognise and cope with the impact of hostility and guard their own safety. Help in coping with the emotional demands of work with children and their families is needed at all levels of intervention, not just in social work. Without supervision or accessible professional consultation, practitioners working with children and families with early needs may also struggle to cope. Yet the skills of supervision are rarely developed or maintained by child welfare agencies.

'Effective early intervention will uncover *early* risks of harm'

The spread of cases at all levels of intervention, reinforces the need for *all* practitioners to have a holistic understanding of children and families and to be aware of the way in which separate factors might interact to cause increased stresses in the family and increased risks of harm to the child. Guidance and training for the CAF and LP roles in England stress the voluntary nature of these lower level intervention services and emphasise that where there are child protection concerns, child protection procedures must be followed (HM Government, 2006c). However, effective early intervention will uncover *early* risks of harm, some of which, but not all, will not need to be referred to children's social care. It is logical that all staff working with children with additional needs should understand that they are working *within* the safeguarding continuum and not in a separate sphere of activity. Training and guidance should reflect this so that staff can be helped to understand when it is safe to work with early, low level concerns where parents are giving their consent, and when to follow LSCB procedures without delay (HM Government 2006b and 2006c).

DOI: 10.1002/car

Lack of parental cooperation raises problems for interventions below the threshold of formal safeguarding procedures, where the state has no mandate to intervene compulsorily and families must agree to agency involvement. If a family fails to attend appointments that are necessary to safeguard the child's welfare or safety, or refuses to take up a service that the child requires, this should arguably be taken into account as part of the assessment. As a consequence, the level of concern may raise the case to a higher threshold. This is often the case in continental Europe where lack of cooperation can justify compulsory intervention, and those parents who cannot or will not change will come within the more formal court-based systems (Scottish Executive, 2002, Annexe B). This report shows, however, that support without coercion and accessible skilled helping relationships are more readily available in continental Europe, and families are more likely to seek voluntary help. This is a more controversial managerial issue in England where families, as we discussed earlier, may have good reasons to be suspicious of services (HM Treasury/Department for Education and Skills, 2007, p. 85).

'In continental Europe where lack of cooperation can justify compulsory intervention'

The government emphasis on prevention and early intervention (precisely to make accessible non stigmatised help available) poses problems in some respects for the long term planning needed for 'later intervention' cases (for example with complex neglect cases). The influential document *Reaching Out: Think Family* includes statements like 'it's never too late to act preventatively' (Cabinet Office, 2007, p. 32). While this is valid advice in respect of most families in difficulty, it is not always so in cases of entrenched long term neglect where the hard decision that 'enough is enough' may be necessary. This document's specific example of childbirth providing an opportunity for families to be more receptive to services could, arguably, be encouraging a 'start again' mentality. This approach can be a stumbling block, preventing practitioners thinking and acting systematically in cases of long standing neglect.

All of the hard to reach young people had experienced long term, high intensity, level three or four services. However, for some of the neediest young people, services were being withdrawn or scaled down in the period before their death through suicide. Local authorities' pressures on resources (and targets) often lead to a push for a reduction in the numbers of children looked after. This makes it difficult for workers to provide services for hard to help young people who tend to spurn help. These very vulnerable, hard to help young people need more creative, more responsive, individually tailored services that extend into their adulthood and which can address root cases and not just respond (or fail to respond) to their distress. In addition, it is important that there is a clear transition from children's services to effective and responsive adult services. Since these young people are often extremely

'For some of the neediest young people, services were being withdrawn or scaled down in the period before their death through suicide'

DOI: 10.1002/car

'Developing a set of specialist skills to support these young people and their families is, however, highly resource intensive'

challenging to help, excellent support is needed for those providing their care. If vulnerable young people return home, both the young people and their parents or carers need a high level support service not a minimal service. Developing a set of specialist skills to support these young people and their families is, however, highly resource intensive.

The problems of struggling to achieve the thresholds for intervention to protect children from harm were widespread and increased the risks for hard to reach young people leaving them isolated and without help. Arguing about which agency is responsible for which service and whether thresholds are met must be replaced by a shared commitment to children and young people and clear, well-coordinated multi-agency involvement. LSCBs have a key, but challenging, role to play in rectifying the long standing problems with thresholds. Establishing clarity and a common understanding of thresholds is a formal responsibility of LSCBs (chapter 3 in *Working Together*, HM Government, 2006a). Their success in relation to thresholds will be an important measure of their effectiveness.

Key policy and practice points:

- Since child protection does not come 'labelled as such', *all* practitioners, including those working with adults need to be alert to the risks of significant harm to children.
- Policy makers should acknowledge that staff working in early intervention are working *within* the safeguarding continuum and not in a separate sphere of activity.
- The emotional impact of working with distress and hostility from parents and working with resistance from older adolescents can impede engagement, judgement and safeguarding action.
- In long term neglect cases, some agencies and practitioners will cope with feelings of helplessness by adopting the 'start again syndrome'. This can prevent practitioners thinking and acting systematically; Effective and accessible supervision is crucial to help staff to put into practice the critical thinking required to understand cases holistically, complete analytical assessments, and weigh up interacting risk and protective factors.

'This can prevent practitioners thinking and acting systematically'

References

Brandon M, Howe D, Black J, Dodsworth J. 2002. *Learning How to Make Children Safer Part 2: An Analysis for the Welsh Office of Serious Child Abuse in Wales.* University of East Anglia/Welsh Assembly Government: Norwich.

Brandon M, Howe A, Dagley V, Salter C, Warren C, Black J. 2006a. *Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation in 2005–6.* Research Report 740. Department for Education and Skills/University of East Anglia.

Brandon M, Howe A, Dagley V, Salter C, Warren C. 2006b. What appears to be helping or hindering practitioners in implementing the Common Assessment Framework and Lead Professional Working? *Child Abuse Review* **15**: 396–413. DOI: 1002/car.951

Brandon M, Belderson P, Warren C, Howe D, Gardner R, Dodsworth J, Black J. 2008. *Analysing Child Deaths and serious injury through abuse or neglect; what can we learn. A biennial analysis of serious case reviews 2003–2005.* Research Report DCSF RR023. Department for Children, Schools and Families: London.

Cabinet Office. 2007. *Reaching Out: Think Family, analysis and themes from the Families at Risk Review.* Social Exclusion Task Force: London.

Cicchetti D, Valentino K. 2006. An ecological transactional perspective on child maltreatment: Failure of the average expectable environment and its influence upon child development. In *Developmental Psychopathology: Risk, Disorder and Adaptation (2nd ed.) (Vol. 3)*, Cicchetti D, Cohen DJ (eds). Wiley: New York.

Cleaver H, Nicholson D, Tarr S, Cleaver D. 2007. *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. Jessica Kingsley Publishers: London.

Commission for Social Care Inspection. 2005. Guidance on Handling Serious Child Care Incidents, Quality, Management, Performance and Methods Directorate, CSCI QPM Document No: 24/05.

Cooper A. 2005. 'Surface and depth in the Victoria Climbié Inquiry Report', *Child and Family Social Work* **10**: 1–9.

Cooper A, Hetherington R, Katz I. 2003. *The Risk Factor: Making the Child Protection System Work for Childre*n. Demos: London.

Department of Health. 2000. Framework for the Assessment of Children in Need and Their Families. The Stationery Office: London.

Ferguson H. 2005. 'Working with violence, the emotions and the psycho-osocial dynamics of child protection: reflections on the Victorian Climbié case' *Social Work Education* **24**(7): 781–795.

Frost N. 1997. Delivering family support: issues and themes in service development. In *Child Protection and Family Support: Tensions, contradictions and possibilities*, Parton N (ed.). Routledge: London.

Gardner R. 2008. *Developing an Effective Response to Neglect and Emotional Harm.* University of East Anglia/National Society for the Prevention of Cruelty to Children: Norwich. Available: http://www.nspcc.org.uk/Inform/research/NSPCCResearch/CompletedResearch/DevelopingAnEffectiveResponseToNeglect_wda56702.html [Accessed on: 1 November 2007].

Glisson C, Hemmelgarn A. 1998. The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse & Neglect* **22**(5): 401–421.

Hardiker P, Exton K, Barker M. 1991. *Policies and Practices in Preventive Child Care.* Avebury: Aldershot.

HM Government. 2003. *Every Child Matters*, Cm 5860. The Stationery Office: London.

HM Government. 2006a. *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.* The Stationery Office: London.

HM Government. 2006b. *The Common Assessment Framework for children and young people: Practitioners guide.* The Stationery Office: London.

HM Government. 2006c. *What To Do If You Are Worried A Child Is Being Abused*. The Stationery Office: London.

HM Treasury/Department for Education and Skills. 2007. *Policy review of children and young people—A discussion paper.* The Stationery Office: London.

HMSO. 1989. *The Children Act 1989*. London: HMSO.

Howe D, Hinings D. 1995. Reason and Emotion in Social Work Practice: Managing relationships with difficult clients. *Journal of Social Work Practice* **9**(3): 5–14.

Joint Chief Inspectors. 2002. *Safeguarding Children*: *A Joint Chief Inspectors' Report on Arrangements to Safeguard Children.* Department of Health: London.

Joint Chief Inspectors. 2005. *The Second Joint Chief Inspectors' Report on Arrangements to Safeguard Children.* Commission for Social Care Inspection: London.

Lord Laming. 2003. *The Victoria Climbié Inquiry*. Report of an Inquiry by Lord Laming. Cm 5730. The Stationery Office: London.

Mattinson J. 1975. *The reflection process in case work supervision.* Institute of Marital Studies: London.

Mesie J, Gardner R, Radford L. 2007. *Towards a Public Service Agreement on Safeguarding*. Research Report No 829. Department for Education and Skills/ NSPCC.

Munro E. 2004. The impact of child abuse inquiries since 1990. In *The Age of the Inquiry: learning and blaming in health and social care*, Stanley N, Manthorpe J (eds). Routledge: London.

Reder P, Duncan S. 1999. *Lost Innocents: A Follow-up Study of Fatal Child Abuse*, Routledge: London.

Reder P, Duncan S. 2003. Understanding Communication in Child Protection Networks. *Child Abuse Review* **12**: 82–100. DOI: 1002/car.787

Reder P, Duncan S. 2004. From Colwell to Climbié: Inquiring into fatal child abuse. In *The Age of the Inquiry: Learning and blaming in health and social care*, Stanley N, Manthorpe J (eds). Routledge: London.

Robbins D. 2001. Transforming Children's Services: an Evaluation of Local Responses to the Quality Protects Programme, Year 3, Department of Health: London.

Scottish Executive. 2002. *It's Everyone's Job to Make Sure I'm Alright*, The Stationery Office: Edinburgh.

Sinclair R, Bullock R. 2002. *Learning from Past Experience; A Review of Serious Case Reviews.* Department of Health: London.

Utting D, Monterio H, Ghate D. 2007. *Interventions for Children at Risk of Developing Anti-social Personality Disorder*, Report to the Department of Health and Prime Minister's Strategy Unit. Policy Research Bureau: London.