Childhood Neglect

Managing Neglect (option 1)

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child and family training

Department for Education

Childhood Neglect: A resource for multi-agency training is available to download from the Child and Family Training website www.childandfamilytraining.org.uk and on DVD-ROM from Bill Joyce, National Training Director, bill.joyce@childandfamilytraining.org.uk

Terms of use

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Exploring assumptions about assessment and decision–making in cases of neglect

Where a child may be experiencing neglect:

- when you consider the task of assessment and decision-making, what words come to mind;
- what feelings do you associate with assessment and decision-making;
- what helps with the process?

A model of assessment and analysis

Step 1 Consider issues of safety.

Step 2 Gather information.

Step 3 Organise information.

Step 4 Analyse processes affecting child's development.

Step 5 Predict outlook for child.

Step 6 Plan interventions.

Step 7 Identify outcomes and measures for interventions. (Bentovim et al. 2009)

Step 1 – consider issues of safety

Child neglect can be associated with:

- life-threatening levels of starvation;
- accidents in the home (poisoning, falls, electrocution, burns);
- accidents outside (traffic accidents, falls);
- exposure to dangerous adults (violent fathers, drug networks, child sexual abuse perpetrators);
- neglect of treatment regimes and medical care (disabled children, children with conditions requiring medication).

Step 2 – Gather additional information

A range of sources of information can be used to gather information about the child and family including:

- Interviews with child, parents, extended family members;

- use of scales and questionnaires;
- observations of the child and family in various settings;
- Information from professionals involved with/who know the family.

Use the Assessment Framework

- children's developmental needs
- parenting capacity
- family and environmental factors. (Department of Health, Department for Education and Employment and Home Office 2000)

Step 3 – Categorise and organise available information

- Use the Assessment Framework, also, to **organis**e the material and
- to identify important gaps in information, such as:
    - the chronology
    - lack of information about male figures
    - child or parental disability
    - parental mental illness, substance abuse, domestic abuse
    - child's wishes and feelings.

Step 4 - Analyse the processes influencing the child's development

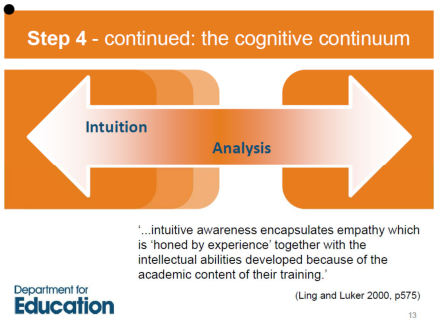
- What do the facts and opinions written in this assessment tell me?
- What does this mean for the child(ren) and the family?
- What needs of the child are being met – and how?
- What needs of the child are not being met – and why?
- What are the processes and patterns of factors?
- What is the impact of these processes? (Cox et al. 2009)

Questions to ask to assist analysis

- What evidence indicates this child/young person is being neglected?
- How does the parent(s) behaviours (acts of commission or omission) impact on their children's health and development?
- What are the pre-existing and current strengths?
- What are the child's views?
- What would need to change for the parent(s) to meet the child/young person's needs?
- Are there indications that the parent has the ability/motivation to make changes in timescales which meet the needs of the child? (Horwath 2007, p170)

Human factors that can affect judgements:

- confirmational bias
- failure to revise assessments of the likelihood of significant harm in the light of new information
- failure to engage with children and families
- problems in multi-disciplinary practice
- imprecision in communication relating to the likelihood of significant harm. (Helm 2010; Munro 2008)



'Sometimes where there are multi-faceted problems, assessments can become stuck and little progress made. The danger of assessment paralysis can apply…where the focus of attention becomes stuck on a particular diagnostic issue...' (Reder, Duncan and Gray 1993)

Anxiety can affect analysis and decision-making in many ways including:

- rushing into inappropriate intervention, for example, pushing for removal of a child from home to alleviate anxiety about risk of them suffering harm
- deferring to the views of a powerful member of the professional network, even when the views appear ill-judged
- avoiding contact with the child and family in order to avoid being faced with the reality of the circumstances.

Step 5 - Predict the outlook for the child

- Consider whether the child's development will be compromised if the current situation does not improve.
- Decide whether the child is suffering, or likely to suffer, significant harm. Royal Society (1992, p.2)

The process of trying to predict the outlook for the child can also provoke anxiety.

'High levels of emotion adversely affect cognitive functioning and capacity for information processing. This has particular relevance for child protection workers and the highly charged emotional content and context of their work.' (Anderson 2000, p841)

‘The common obstacle to reflection is anxiety…anxiety has a profound effect on our ability to think, feel and act.’ (Ruch 2002, p202)

Anxiety should not be ignored.

‘Practitioners need a secure relationship which will afford them a space where unthinkable experiences can be processed and made thinkable and manageable.’ (Ruch 2007)

Step 6 - Plan interventions

Absolute clarity is required about:

- how each unmet need is to be addressed
- who is to do what, and when
- what must change and by when
- the role of each practitioner involved
- how plans will be communicated to children and parents / carers
- how the pan will be monitored, by whom and when.

Step 7 - Identify outcomes and measures which would indicate whether interventions are successful

Assessment has to be an ongoing process, review is essentially re-assessment, focusing on:

- are the unmet needs now being met,
- can change be attributed to the services provided and
- what needs to happen next?

Conclusion

- There are rarely ‘quick fixes’ for neglect.
- Good assessment requires time and support.
- At the same time, assessment and decision-making should not be allowed to drift.
- Processes for review, that is, re-assessment, must be built into all plans.

Measuring outcomes for each child

What are outcomes?

The benefits or changes for participants that occur as a result of activities, such as:

- greater knowledge
- new skills
- different behaviour
- changes in attitude
- changes in population conditions. (Hoggarth and Comfort 2010)

Why have an outcome approach?

'There are downsides to the outcomes approach as there are to other systems of planning and evaluation. But the question of outcomes is a perfectly legitimate one.

The number of visits made to a family is beside the point if the risks are not picked up and appropriate interventions are not identified to begin to help people deal with the problems.

The number of counselling sessions provided is hardly important if in the end they made no difference for the person seeking help. We must address outcomes in order to improve services.' (Hoggarth 2010)

Measuring change

In working with children in need, and their families, the key outcome is the child's developmental progress. The aims are to assess:

- whether the child has progressed and in which dimensions
- how improvements or deteriorations have come about. (Child and Family Training 2009)

Measuring outcomes means collecting evidence about the effects of activities and assessing whether any change achieved is partially or wholly as a result of our activities or interventions and in respect of:

- the child's development
- the factors or dimensions of parenting capacity, or family and environment which are having an impact on the child's development.

Why measure change in day to day work?

- Helps all parties to clarify what we are trying to achieve - improves partnership working.
- Keeps us focused - prevents drift - when working on longer term basis with neglected children.
- Helps assess parents' ability to respond to a child's needs and identify what changes need to happen.

- Supports service users to understand why work is taking place and therefore interventions become more meaningful.

Evidence of change

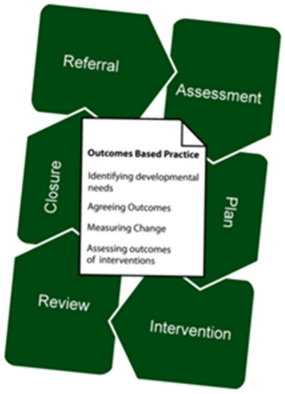
- Evidence is the information that demonstrates progress or improvement and the 'distance travelled'.
- This requires a baseline in order to be able to demonstrate that intervention has contributed to, or brought about, change or improvement.
- The important issue is that information must be recorded so that change over time can be measured and that judgments of outcomes can be validated.

Measures

- Recorded observations, for example, interaction between a parent and a child.
- Standardised assessment, for example, completion of a questionnaire or semi-structured interview.
- Testimonials, for example, a child says that they are happier at school.
- Numerical, for example, school attendance records.
- Objective, for example, child's health and developmental milestones, including height and weight.

5 critical points – direct work with children

- seeing children
- observing children in different situations
- engaging children
- talking to children
- activities with children.



Building it into practice

- Outcomes that we seek should arise from assessment of the developmental needs of a child, their parents' capacity, and family and environment factors.
- Only then can we state what we hope to change and the means by which we intend to do so.

Making use of research

- The outcomes we seek, and the interventions selected, should be grounded in professional knowledge and research findings.

- Research into neglect contributes to the interventions we provide to achieve the planned outcomes: the importance of building resilience; developing attachment; and reducing substance misuse.
- Research indicates that promising interventions include social network support, home visiting, and parent training.
- BUT outcomes should be grounded in the goals that parents and children want and can achieve.

Make them SMART

Specific what is it we are trying to measure?

Measurable will it be possible to tell if an outcome has been achieved?

Achievable don't set unrealistic outcomes - intermediate outcomes (distance travelled) are important.

Relevant the outcomes should regularly be derived from the assessment and professional knowledge and research

Time review progress

- An 'indicator' is a way of helping to measure progress towards achieving an outcome.
- In order to measure and demonstrate movement in relation to our outcomes, we need to:
- identify qualitative and /or quantitative indicators that will evidence progress and identify sources for this evidence;
- choose methods and tools for collecting this evidence.

Examples

Outcome

'There is an improvement in the physical living conditions of the child or young person'

Outcome Indicators - how will you know if there is change?

Improvement from the baseline assessment using Home Conditions Scale.

Parents no longer at risk of losing their tenancy.

Activity

Weekly home visits by volunteer befriender to support and motivate parents.

Parent training course on child safety in the home.

Measuring tools

- Our every day practice in assessing children's needs, recording and reviewing our activities to see if the planned outcomes are being met.

- Tools that are valid and reliable.
- Measuring Tools that are also interventions.
- Clinical Scales – largely focused on psychological outcomes, but also developed for areas including educational attainment and social functioning.
- Standardised questionnaires and scales.

Standardised questionnaires and scales (Department of Health, Cox and Bentovim 2002)

- Strengths and Difficulties Questionnaires.
- The Parenting Daily Hassle Scale.
- Home Conditions Scale.
- Adult Wellbeing Scale.
- The Adolescent Wellbeing Scale.
- The Recent Life Events Questionnaire.
- The Family Activity Scale.
- The Alcohol Scale.

Outcome stars

Child neglect and supervision

Support to practitioners

All those working with children in need or at risk of significant harm, whatever their agency or role, need someone who is not directly involved in the case to help them deal with the complexities and challenges of the work and to make sense of what they are seeing, hearing and feeling.' (Gordon and Hendry 2010, p8)

Important role of 'critical friend'/supervisor/ clinical supervisor/manager/mentor/ peer to:

- support practitioners
- help maintain focus on the needs of the child
- support process of analysis.

Guidance on supervision

Working to ensure children are protected from harm requires sound professional judgments to be made. It is demanding work that can be distressing and stressful.

All of those involved should have access to advice and support from, for example, peers, managers, named and designated professionals.' (HM Government 2010, p123)

Supervision should:

- help to ensure that practice is soundly based and consistent with LSCB and organisational procedures;
- ensure that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority; and
- help identify the training and development needs of practitioners, so that each has the skills to provide an effective service. (HM Government 2010, p12)

The role of supervision – messages from research

- Definitions and experiences of supervision vary across, and between, different professionals.
- Supervision is not common to all professionals.
- For those professionals where supervision is built-in, the quality and quantity may be variable.
- Role of both formal and informal supervision

Definition of supervision

Supervision is a process by which one worker is given responsibility by the organisation to work with another worker(s) in order to meet certain organisational, professional and personal objectives. These objectives or functions are:

- competent, accountable performance/practice
- continuing professional development
- personal support
- engaging the individual with the organisation. (Morrison 2005, p 32)

Purpose of supervision

Good quality supervision can help to:

- keep the focus on the child
- avoid drift
- maintain a degree of objectivity and challenge fixed views
- test and assess the evidence base for assessment and decisions; and
- address the emotional impact of work. (HM Government 2010, p123)

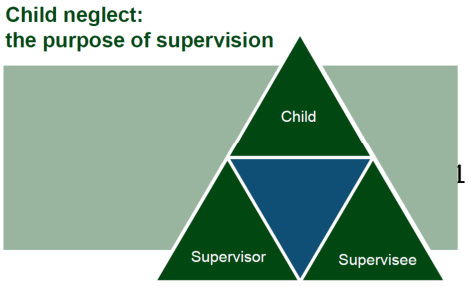
Good supervision should…

- Ensure supervisee is clear about roles, responsibilities and accountabilities.
- Ensure best interests of user are promoted.
- Ensure worker meets agency's objectives and standards.
- Ensure worker has appropriate and manageable workload.
- Develop a supportive and positive climate for practice and performance.
- Enhance the worker's professional development
- Support the worker in managing the demands (task and emotional) of their work.
- Promote clear communication between the organisation and the worker. (Morrison 2005, p30)

Child neglect and the role of supervision

'Supervision is an integral element of social work practice, not an add-on. Through it workers review their day to day practice and decision making, plan their learning and development as professionals, and work through the considerable emotional and personal demands the job often places on them.' (HM Government 2010, p2)

Effective and accessible supervision is essential to help staff to put in to practice the critical thinking required to understand cases holistically, complete analytical



assessments, and weigh up interacting risk and protective factors.' (Brandon et al. 2008, p326)

Keeping the child at the centre: the role of supervision

Possibly the single most significant practice failing throughout the majority of the serious case reviews was the failure of all professionals to see the situation from the child's perspective and experience; to listen to what they said; to observe how they were and to take serious account of their views in supporting their needs.' (Ofsted 2008, p18)

'There is plenty of evidence that front line staff who are in daily contact with parents often find it hard to sustain their suspicions about them. There is a vital role for managers to hold this awareness and to challenge and support staff to constantly review and update their opinion of children's safety.' (Social Work Inspection Agency 2005, p126)

Listening to children is central to recognising and respecting their worth as human beings…It cannot be taken for granted that more listening means more hearing.' (Christensen and James 2008, p264)

Appendix 1

A language of feelings

A child develops as a result of interaction with others. That interaction comes about through a process of communication, which might be verbal or non-verbal or both, depending on the stage of development of the child and his or her particular needs. Howe (2005) reminds us that children feel safe and secure when they are sensitively understood. Understanding insecurity in a child is about how both his or her body feels and about how his or her mind feels. To ensure full understanding, there is a need to check that the child has the language he or she needs to convey both experiences and that the meaning that the child attributes to the language is shared by the adult who is their primary caregiver.

Infancy

Children, it is suggested have sufficient language by the age of three. Before that, the infant brain struggles to understand and make sense of the world and is better at recognising, processing and remembering emotional states (Howe 2005).This includes the feelings and emotions conveyed in the adult's facial expression (especially the eyes); voice tone and body language. The infant's expectation is that any stress that he or she is experiencing will be managed for them (Gerhardt 2004). Emotional arousal, effectively conveyed by the infant prompts a response in the mother (in particular) in which she mimics the voice, facial expression and body movement of the infant, highlighting the emotion that the infant is experiencing and naming the feeling that they are aware of and how that feeling will be soothed. The message from the adult is that the distress is manageable; the infant will once again feel calm and comfortable.

Gerhardt (2004) reminds us that 'the very demanding needs of a dependent infant have a biological basis. They are demanding because they are continuous; sometimes hard to fathom without the aid of language and they make no concession to adult needs' (p.210). Interpreting these needs requires attentive caregiving. Where caregiving is compromised, whether by substance misuse; mental health issues or domestic abuse for example – the meeting of the needs of the infant may also be compromised and 'the caregiving might be experienced as essentially abusive, neglectful or most likely both' (Dunn et al. cited in Howe 2005, p.183) however much the infant tries to increase signals of need.

Comments regarding the particular temperament of an infant (having a temper – for example) should perhaps reflect on the urgency of their need and the significant implications for them of that need and other needs not being met.

The developing child

A child acquires language through interaction with others and needs his or her caregiver to anchor explanations for feelings – to ensure that the words accurately describe the feelings the child has and is experiencing. As the child reaches the age of 3 or 4 years, words start to play as big a part as looks. An attentive caregiver will develop a scripted interaction with the child which integrates the feeling that the child has with words which account for the emotion they are aware of. The child will then be able to develop his or her ability to recognise an emotion and link it with a particular feeling by rehearsing the script shared with the caregiver. For example, the child who has lost something is able to say that he or she feels sad. Earlier experiences in interpreting facial expressions will enable the child to begin to add an

appropriate visual representation of loss to the feeling that has been named. In this way, the child begins to use both words and looks to represent his or her emotional state.

Non-verbal feedback from other people's faces and body language is also still important in helping the child to communicate with those around him or her, especially in informing emotional responses, but verbal feedback now allows a caregiver who is tuned in to the child's emotional state to begin to acknowledge the child's state in words. These words can then form an emotional vocabulary (Gerhardt 2004, p.52) that can name feelings accurately and enable the child to begin to differentiate between different feelings; for example the difference between feeling sad and feeling tired.

Difficult feelings

If the caregiver does not talk about feelings – or represents them inaccurately – it is likely that it will be far more difficult for the child to express feelings and to negotiate around feelings with others. There is the possibility that the child will have a restricted emotional vocabulary which may not necessarily match with the facial expression that the child uses. The potential for such difficulties is increased where communication between the caregiver and child is limited. This is particularly so where the caregivers ability to communicate is affected by the effects of misuse of alcohol or drugs (prescribed as well as illegal); by mental health difficulties which impact on verbal interaction or by situations where the child's caregiver may themselves feel unsafe but determinedly tries to persuade the child that he or she should feel safe.

Impact on the child

When the faces and behaviours of others do not make sense, the child may become preoccupied because they find it difficult to make sense of this information and to respond to it in an appropriate way. Instead of the caregiver 'mirroring' the child's emotional state in a helpful way and making sense of it, the caregiver is unsympathetic and the child is left to try to make sense of emotions and feelings without understanding where they have come from or what they mean for him or her. The child may lack words for the feelings they are left with or they may struggle to connect the words they have with emotions that they are seeking to understand. Caught up in his or her own confusions, the child is unable to relate to others and either projects his or her distressed feelings on to others (being angry) or withdraws (becomes anxious). Howe suggests that children experience a rush of emotions and too many feelings to able to make sense of them without support. These children will also find it difficult to achieve a sense of calm. Living with confusion, the child might become hypervigilant – constantly aware of the need to look out for any danger or unknown threat but unlikely to be able to name, understand or ask for help to understand the feeling that underpins this instinctive response. Hormonal changes in the body as a result of the perceived threat from being alone ensure that the child who is alone, is not capable of changing their emotional state to regain a sense of comfort and to feel calm and may begin to feel overwhelmed.

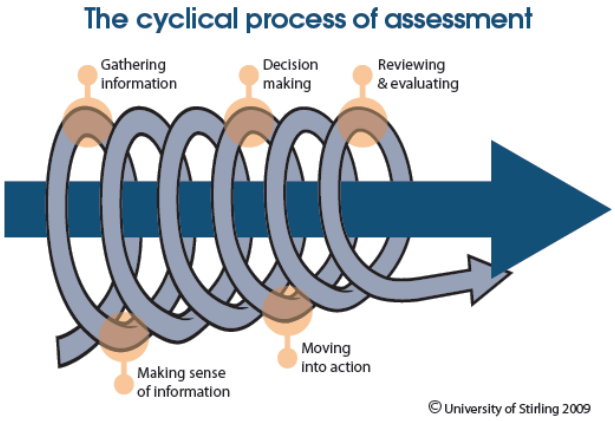
Alternatively a child whose needs have been neglected may exhibit passivity as a result of shutting down the range of needs they have, including emotional needs. A child whose needs have been neglected may also exhibit passivity because, as

Cairns and Stanway (2004) suggest, the effort of trying, on their own to make sense of and understand difficulties in interacting with others has itself exhausted them. In isolation from others, they are confused. The child may feel safe from others but also feel alone, in need of his or her caregiver but inhibited in making this demand.
Howe (2005) reflects on the hypervigilant or passive state of the child by underlining what he sees as their lived experience. He suggests that the child experiences hyperarousal in feelings; abandonment with feelings and helplessness because of the feelings. Given such an overwhelming experience for the child, it is not surprising that Horwath (2007) reflects on 'extreme moods' with children themselves struggling to articulate these emotions and name these feelings. The literature repeatedly makes reference to the 'anger' displayed by the child or their 'passive response' to neglect of their needs. A different perspective on the ability of the child to articulate their feelings would suggest that naming the child's feelings in this way might make them more explicit and more manageable for others but assumes that this is the child's lived experience.
Given that the child may not have the words they need to name the range of feelings they have, it is vital that assumptions are not made on behalf of the child, but that the child is helped to recognise; label and understand their feelings – a critical part, Howe (2005) would suggest in the process of enabling the child to let go of feelings which are damaging to their self and to their development.

Focussing on feelings

The difficulties outlined are significant. They have a particular significance when a child starts school. Cairns and Stanway suggest that 'children who find it difficult or impossible to put feelings into words are disadvantaged across the whole spectrum of school life.'
Nonetheless, school could potentially provide an opportunity for a child to begin to develop their own language of feelings which they can share with others and check with others to ensure that it is understood by them. In isolation from the home setting, this might create a different type of confusion for the child and caregiver - who may not recognise the range of emotions that the child is beginning to experience or the feelings that they can identify. Nonetheless, it might enable the child to begin to recognise a range of needs which he or she has; some of which can be met within the school setting. Howe (2005) suggests that 'experience and recognition of feelings is a first important step in helping children to get in touch with themselves' (p. 254)
Howe (2005) goes on to suggest that these children need to experience nurturing, trust, safety and security.
Nurture Groups within primary schools might be one way of achieving this for children – enabling them to begin to develop their language of feelings alongside peers in a playful, supportive and supported environment.

Appendix 2



Process of assessment

Research on assessment practice has demonstrated that assessments have too often been static and have been viewed by practitioners as one-off events. More recent models (for example Raynes (in Calder and Hackett 2003) have suggested a series of steps within the process of assessment. This has been very helpful in beginning to break down the complex process of assessment so that the individual parts of the process can be seen and understood more clearly.
Research has demonstrated that assessment should be viewed as a cyclical process. Many of the assessments considered in serious case reviews suffered from 'start again syndrome' where insufficient attention was paid to historical information and a 'clean sheet' approach was taken to each referral (Brandon et al 2008). Due to the chronic and cumulative effect, such weaknesses in assessment have lead to agencies failing to address the impact of neglect and not intervening at an early stage to prevent the child's difficulties from escalating (Ofsted 2008).

Neglect requires particular attention in assessment practice because it is rarely, if ever, that one incident will provide proof (Munro 2008). This means that information needs to be gathered from all relevant professionals and family members (Horwath 2007). We need to be able to recognise when information is significant for judgement and decision-making (Cleaver and Walker 2004). We need to pay attention to written information as this can be overlooked as our attention is caught by vivid and recently gathered information (Munro 2008). Finally, there is the challenge of knowing when we have enough information so that we do not end the search too early (Helm 2010) or get stuck in 'assessment paralysis' (Reder and Duncan 1993) where we can not move on from analysis to action.
All practitioners carry out assessment activity. Some of this activity is quick and informal assessment. For example, a police officer called out to a disturbance at a house will have to make a very quick judgement about the welfare of the children in the house. A school nurse may make an informal assessment of a young person's needs during a routine contact. If there are some nagging doubts they may spend a bit more time with the young person or seek further advice from a colleague. Whether the assessment is quick and impressionistic or lengthy and formal, it requires a level of skill and understanding on the part of the practitioner. If we can think of all this assessment activity as assessment, then we can view the professional networks around us as huge potential sources of relevant information.

Failure to revise assessments

Research into human judgement has revealed that humans are prone to error in some predictable ways (Plous 1993) and these human frailties are very important considerations when assessing neglect. In an effect known as ‘anchoring’ practitioners can find that deep-seated values about neglectful families can impact on their individual thresholds (Helm 2010). Although we may believe that the circumstances that we are assessing may not be acceptable for our own child, because our aspirational levels are so low for neglectful families (often characterised by intergenerational poverty) we do not reach a point where we recognise the benefits of intervention.

Conformational bias or verificationism (Helm 2010; Munro 1999; Scott 1998; Sheppard 1995) is widely recognised in the phrase ‘you find what you go looking for’. We are all prone to accept and discard pieces of information depending on whether they support our implicit beliefs. It is possible to weigh information selectively in assessment to support your inherent beliefs about children and families. This can result in a failure to recognise or accept the steady of accumulation of evidence which might provide the basis for intervention. This failure to revise our risk assessments (Munro 2008) in relation to neglect could result in a failure to act right across services. If a teacher does not see the rising tide of difficulty they may miss the opportunity to speak to the child’s family or offer further nurture and support. If a public health nurse does not view the family as in need of additional services, they may attribute health needs to organic causes and not neglectful parenting. If a social worker does not understand the impact of neglect on the 15 year old girl they could interpret behaviour as a feature of adolescent development.

Appendix 3

Child neglect and supporting workers

The significant role supervision and management plays in child welfare and protection has been commented on by a number of reports in the UK including Messages from Inquiry Reports (1980-89), Laming (2003, 2009), O' Brien (2003), Social Work Inspection Agency (2005).
In his Inquiry report in to the death of Victoria Climbié, Lord Laming (2003) commented: 'Effective Supervision is the cornerstone of safe social work practice. There is no substitute for it' (p. 211). The Eilean Siar (SWIA 2005) report considered the ongoing neglect and sexual abuse experienced by children within one family and highlighted the key role that managers have in enabling staff who are in direct contact with children and their families to maintain a focus on the needs of the child, and the capacity of parents to meet their children's needs. It stated

> ...there is plenty of evidence from previous child abuse inquiries that front line staff who are in daily contact with parents often find it hard to sustain their suspicions about them. There is a vital role for managers to hold this awareness and to challenge and support staff to constantly review and update their opinion of the children's safety in the home (p.126).

Following the death of Peter Connelly in Haringey and the publication of Lord Laming's 2009 report *The Protection of Children in England: A Progress Report* a Social Work Task Force was set up by the Secretaries of State for Health, and Children, Schools and Families to advise the government on social work reform. The Task Force reported in November 2009. Amongst their recommendations about pre- and post-qualifying social work education and training, they also considered the key role supervision played in contributing to high quality social work practice and improved outcomes for service users and carers. The Task force commented that:

> Supervision is an integral element of social work practice not an add-on. Through it social workers review their day to day practice and decision making, plan their learning and development as professionals, and work through the considerable emotional and personal demands the job often places on them (2009, p.29).

In their interim report the Task Force had identified three main functions of supervision. These were:

- **line management- including managing team resources, workload management, performance appraisal, duty of care, support;**
- **professional (or case) supervision - reflecting on and responding to the challenging questions thrown up by practice, including implications for the practitioner's welfare or safety; reviewing roles; evaluating the impact of actions and decisions; learning from day to day practice;**
- **continuing professional development - ensuring social workers are developing the skills, knowledge and experience necessary to do their job well and progress in their careers. Observation of practice and constructive feedback should be part of the process.**

Following the publication of the interim report over 1000 social workers were surveyed, and one of the findings was that many did not get access to the full range

of supervision types, rather supervision tended to focus on case management (Baginsky et al. 2010). The Task Force (2009) recommended that there should be a 'clear national standard for the support social workers should expect from their employers in order to do their jobs effectively' (p. 32). The Laming report (2009) had also recommended that guidelines should be established to guarantee supervision times for social workers, and that the then Department of Children, Schools and Families should set out the elements of high quality supervision.

Laming recommended that this needed to include case planning, constructive challenge and professional development.

Relevant Models

The definition (and functions) of supervision varies within the literature and within different policy documents and inquiry reports. Morrison (2005) defined supervision as the process by which one worker is given responsibility by the organisation to work with another worker(s) in order to meet certainorganisational, professional and personal objectives. These are:

- „ competent accountable practice;
- „ continuing professional development;
- „personal support;
- „ engaging the individual with the organisation.

Pritchard (1995) identified 6 tasks of supervision:

- „maintaining and developing unit operations;
- „clarifying staff roles and responsibilities;
- „facilitating a climate for good and imaginative practice;
- help people cope with stress;
- „assisting creative professional development;
- „providing feedback to organisation on policy and practice.

How supervision should look is a subject of ongoing debate. Some commentators have suggested that the supportive and management functions of supervision can be separated (Stanley and Goddard 2002) while others (Hughes and Pengelly 2002) highlight some of the difficulties of doing this in terms of accountability. Dependant on the organisation in which practitioners work, it may be that the different functions of supervision are carried out by one person, or that the different tasks are performed by different individuals. If the tasks are separated one area which practitioners and those who have supervisory responsibility will want to consider is the potential that this may cause tasks to be replicated, or alternatively for assumptions to be made that 'someone else is taking responsibility' and consequently that things can fall down the middle. Practitioners are likely to work to different thresholds which affect when and how they intervene with or on behalf of children and young people who are experiencing neglect. Where case management

rests with more than one individual, there is the potential that each may hold a different threshold for intervention. Dalgleish (2003) developed a model that enables workersto reflect on the difference between the threshold for assessment, and their personal threshold for action.

Practitioners and supervisors may want to look at this in more depth within the supervisory relationships to help explore where there are differences / similarities in thresholds for intervention, why these differences exist, and what the potential impact is for the child and young person who is experiencing neglect.

Keeping the Child at the Centre

Those in a supervisory role can keep the child at the centre throughout their assessment and intervention particularly given concerns that at times the needs of parents and carers can obscure the needs of children and young people.
Ofsted (2008) carried out an evaluation of serious case reviews from April 2007-March 2008.The report commented that 'Possibly the single most significant practice failing throughout the majority of the serious case reviews was the failure of all professionals to see the situation from the child's perspective and experience; to see and speak to the children; to listen to what they said, to observe how they were and to take serious account of their views in supporting their needs' (p. 18).
Ofsted's findings are mirrored by much of the literature on child welfare and protection which highlights that children's experiences are not always at the centre of assessment and intervention, despite good intentions and legislative and policy drivers (Holland 2004; Cleaver and Walker 2004; McLeod 2008; Munro 2010 and 2011). One of the reasons for this may be that in order to keep children and their needs at the centre professionals have to engage with children and young people about difficult or uncomfortable subjects.
There is some evidence that professionals avoid talking about difficult areas to protect themselves, and that child and young people avoid sensitive or difficult subjects because they know workers will find it difficult to hear them (Killen 1996; Mudaly and Goddard 2006; Morrison 2007). There is also some evidence to suggest that an unintended consequence of professional efforts to work in partnership with parents is that the needs of children can become secondary (Stanley and Goddard 2002; Laming 2003; SWIA 2005). Where there is a concern that children and young people are experiencing neglect, supervision (informal and formal) can play a key role in helping workers unpack and unpick their engagement to help them to ensure that the child/ young person remains at the centre. One model that can assist supervisors to focus on the needs of the child and ensure that the child is' brought in to' supervision, is the supervision triangle (Hughes and Pengelly 2002).
One exercise practitioners and supervisors may want to complete is to look at how they could 'bring' the child in to supervision to think about what neglect might mean for the child. For instance, is there an empty chair which symbolises the child or young person? Does the supervisor ask the practitioner to look at the chronology from the perspective of the child? In the chronology a professional might note that the child has had untreated head lice for 3 months. However, if a child were to write about the impact of on her/him this s/he might mention how itchy it is, how it makes it difficult to concentrate, how no other child wants to sit next to her/him and that s/he was the only person not invited to a classmate's bithday party.

Within supervision, one area which should be explored is how the practitioner is applying relevant theory to practice. For neglect, it will be relevant for practitioner and supervisor to consider the attachment strategies a child may have developed to try and ensure that his or her needs were met, and whether these might prove maladaptive in the longer terms. Here practitioners can be encouraged to consider what children and young people may have missed as a consequence of neglect. Hughes (1998) coined the term the ‘ trauma of absence’ to describe the impact of children missing day to day experiences that children and young people who are not experiencing neglect might take for granted. Another area which should be explored in supervision is how professionals can build on resilience. If resilience is understood as both an outcome and a process, the impact of neglect can be seen as significant (Davies 2004).

The three building blocks of resilience are having a secure base, self-esteem and self-efficacy (Gilligan 2009) and within supervision practitioners can be encouraged to reflect on the impact neglect has on each of these building blocks. For instance, self-esteem can be described as appreciating one’s own worth, and being able to be act responsibly towards others. Daniel and Wassell (2002) identify that the roots of self esteem are based on early experiences of being and feeling loved within attachment relationships. Garbarino (1980) argued that a focus on the physical aspects of neglect, and practical interventions misses the real significance of neglect for the child or young person’s developing sense of self, and that neglect always carries an emotional message. When considering neglect within supervision, the ‘meaning’ of neglect for the child needs to be the focus, and the link made to feelings of self esteem. There is some evidence (Brandon et al. 2008, Hicks and Stein 2010) that practitioners can experience difficulty engaging with teenagers who are experiencing neglect, and that the impact of neglect on teenagers has been underestimated.
Hart (in Daniel and Wassell 2002) identified that for adolescents their feelings of self esteem and self worth can be linked to five different areas, all of which can be affected by neglect. These are:

- **scholastic competence;**
- **athletic competence;**
- **social acceptance;**
- **physical appearance;**
- **behavioural conduct.**

Within supervision, practitioners can be encouraged to think critically about the impact of neglect on these five areas.

Appendix 4

Introduction

Once a person has decided on their favoured explanation they are likely to selectively seek evidence which confirms their preferred explanation and unlikely to select information which might challenge their explanation (Snyder cited in Arkes and Hammond 1986). This is now recognised to be one of the most important human failings to be aware of in assessment. It is often referred to as 'verificationism' (Scott 1998; Sheppard 1995) or 'confirmatory bias (Munro 2008; Plous 1993). We have a tendency to form our views fairly early on in proceedings and then unconsciously select and weigh the information emerging in a way that ensures that our early beliefs will be supported rather than tested (Munro 2008).

Inquiries and serious case reviews have highlighted some of the ways in which this confirmatory bias can feed into ineffective and damaging judgements and decision making in child welfare. In terms of neglect, verificationism may result in agencies not taking action when they should. Brandon et al. (2008) commented on the management of caseloads under pressure and noted that in one instance 'the current climate in (local authority) would have put pressure on staff to keep as low as possible the numbers of children looked after' (p. 87). In a climate of limited resources and high caseloads, confirmatory bias may allow practitioners to conclude that a neglected child or young person is not at risk or does not met a threshold for intervention when, in fact, a more balanced examination of the evidence would reveal evidence which disconfirms this initial belief that no further action is required. Munro (2008) advises that we may unconsciously use a number of techniques to avoid seeing challenging evidence:

- **avoidance;**
- **forgetting;**
- **rejecting;**
- **reinterpreting.**

Guarding against confirmational bias

There is little psychological research in the literature on decision-making on how to avoid such confirmational errors (Plous 1993). However, one strategy shown to be effective in research is to focus on motivational factors (Snyder et al. 1982 cited in Plous 1993). In practice we may benefit from approaching all interviews and discussions with clients and other professionals with the belief or mind-set that whoever we are speaking to may think that we have already made our minds up and are just going through the motions. Deliberately concentrating on open-minded and non-judgemental questioning may result in practitioners gaining more balanced views.

To avoid confirmatory bias (i.e. only seeing the evidence that supports your explanation and not the evidence which challenges you) it should be embedded in practice that you should always consider the opposite and try to seek evidence which disconfirms your favourite explanation (i.e. if your main explanation is that the child's difficult behaviour is linked to the parent's volatile nature then you need to explore the possibility that the difficult behaviour is not linked to the parent's

temperament). For example, instead of carrying on questioning about anger and irascibility, explore the possibility that the parent is patient and calm when feeding the child.

Reframing our hypotheses and seeking disconfirming evidence does not come easy and simply considering that you may be wrong is not in itself enough to overcome tendencies toward confirmatory bias (Plous 1993). However, techniques can be learned and this way of questioning judgement needs to become ingrained in practice.

Simply saying to yourself “I must not be biased” is simply not enough. Being aware of a tendency towards bias can help avoid it; it has been shown that overconfidence in decision making can be reduced if decision makers can consider why their judgements might be wrong (Koriat et al 1980; Lord et al 1984).

However, the confirmatory bias is such a strong tendency that it needs attention at all levels.

Strategies for Avoiding Verificationism

Individual – be aware of tendency, accept that your judgement may be wrong, seek disconfirming evidence.

Agencies - demand good quality supervision, come prepared to supervision to explore judgement, seek “devil’s advocates” and “critical friends” to help see other perspectives and test your thinking.

Organisations - accept the uncertainty in practice and teach the skills required to think in this environment, create and maintain supervision policy, build checks for conformational bias into points of review.

Reference and further reading

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Tools and resources

Assessing families in complex child care cases using The Family Assessment (training course)
http://bit.ly/GVpmcQ

Assessing parenting and the family life of children (training course)
http://bit.ly/17yoH7P

The Family Pack of Questionnaires and Scales (Department of Health, Cox and Bentovim 2000)
http://bit.ly/1cR9mX4
http://bit.ly/H5ppU2

Strengths and Difficulties Questionnaires
http://bit.ly/H1RJq1
www.sdqinfo.org

Organisations

Research in Practice
www.rip.org.uk

Social Care Institute for Excellence (SCIE)
www.scie.org.uk