Do you see what I see?
*Multi-professional perspectives on child neglect*

Working with cases of child neglect in the North Eastern Health Board

Developing systems for effective practice under *Children First*

by Jan Horwath
Senior Lecturer in Social Work Studies and Teela Saunders Research Assistant The University of Sheffield
The Child Care Act 1991 places the statutory responsibility on health boards to promote the welfare of children who are not receiving adequate care and protection. *Children First – National Guidelines for the Protection and Welfare of Children (1999)* sets out a national framework for the delivery of child protection and welfare services. These guidelines require consistent and standard approaches to children in need across all sectors and geographical areas.

Child neglect continues to be the most prevalent form of child maltreatment reported to the North Eastern Health Board (NEHB). In 2003, 551 reports were received by the Board concerning child neglect which constituted 41% of all child abuse reports. The significant number of referrals, plus the potential for child neglect to damage children’s development in profound ways, provided the impetus for the NEHB to seek to learn about its practice with these children and their families. This learning contributes to our commitment to develop and plan our services in line with evidence-based research.

*Do you see what I see? Multi-professional perspectives on child neglect* is the second study on child neglect carried out in the NEHB region. It is a follow-up study to the 2001 report, *Child Neglect – Is my view your view?*, which examined social work practice, views and responses to cases of child neglect in the NEHB and identified the need for further exploration of other professionals’ attitudes to child neglect.

*Do you see what I see? Multi-professional perspectives on child neglect* explores a broad range of professionals’ responses to child neglect and examines how professionals in the Board and in partner agencies view their role in working with cases of child neglect. The study was commissioned by the Child Care Advisory Committee of the NEHB, which is a statutory committee established under the Child Care Act 1991 to advise the Board on the performance of its responsibilities under the legislation. The committee reflects a broad range of professionals from both inside the NEHB and colleagues in education, the Garda Síochána, probation and welfare, and the voluntary sector. Their advice in this regard is warmly welcomed and appreciated.

The report confirms that there is a great deal of effective and innovative practice taking place in terms of protecting neglected children. It also highlights areas of challenge for development in both policy and practice. The challenges are ones which will require the energy and commitment of all professionals and core agencies involved in working with children. We look forward to meeting that challenge and taking a lead in harnessing the multi-disciplinary and inter-agency processes required.

This work is in line with the objective in *A Health Strategy for the People of the North-East (2003)* where we are committed to strengthening links and partnerships with key statutory, voluntary and community agencies to deliver better outcomes for the people of the north-east. It is also strongly aligned to *Leaps and Bounds, A Strategy for Children and Families in the North-East (2004)* whose primary goals include, ‘respecting, listening to and supporting children and families’ and ‘building alliances and partnership both inside and outside the organisation to ensure integrated services for children and families’.

In conclusion, I would like to pay tribute to the researchers who carried out the work so professionally, to the large number of staff who made the time to contribute and participate in the research, to the Steering Group and to the commissioning committee for its foresight in progressing our learning and understanding of this important area of work.

Paul Robinson  
Chief Executive Officer
We would like to thank the following members of the Steering Group for this research project. They provided us with valuable advice and guidance throughout the project.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position &amp; Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Richard Byrne</td>
<td>Divisional Inspector, Department of Education and Science</td>
</tr>
<tr>
<td>Ms Liz Coogan</td>
<td>Child Care Training Manager, NEHB</td>
</tr>
<tr>
<td>Ms Rose Cullen</td>
<td>Child Care Development Officer, NEHB</td>
</tr>
<tr>
<td>Ms Cathleen Curry</td>
<td>Public Health Nursing, NEHB</td>
</tr>
<tr>
<td>Ms Nuala Doherty</td>
<td>Director of Governance, Planning and Evaluation – Children and Family Services, NEHB</td>
</tr>
<tr>
<td>Mr Alan Doran</td>
<td>Clinical Psychology, NEHB</td>
</tr>
<tr>
<td>Dr Maeve Doyle</td>
<td>Child and Adolescent Psychiatry Service, NEHB</td>
</tr>
<tr>
<td>Ms Monica Doyle</td>
<td>Community Mental Health Nurse, NEHB</td>
</tr>
<tr>
<td>Inspector Pat Gannon</td>
<td>The Garda Síochána</td>
</tr>
<tr>
<td>Ms Mary Gordon</td>
<td>Child Psychology, NEHB</td>
</tr>
<tr>
<td>Dr Fenton Howell</td>
<td>Department of Public Health Medicine, NEHB</td>
</tr>
<tr>
<td>Ms Mary G Killion</td>
<td>Child Psychiatry Department, NEHB</td>
</tr>
<tr>
<td>Ms Ann Leahy</td>
<td>Consultant Paediatrician, NEHB</td>
</tr>
<tr>
<td>Ms Siobhan McCormack</td>
<td>Pre-school Inspector, NEHB</td>
</tr>
<tr>
<td>Ms Marie McGinn</td>
<td>Primary Care Unit, NEHB</td>
</tr>
<tr>
<td>Ms Bernie McMahon</td>
<td>Area Manager, Naonrai</td>
</tr>
<tr>
<td>Ms Kerry Mullen</td>
<td>Principal Social Worker, NEHB</td>
</tr>
<tr>
<td>Ms Margaret Reidy</td>
<td>Family Therapist, Adult Mental Health Service, NEHB</td>
</tr>
<tr>
<td>Ms Yvonne Ridley/MsSiobhan McArdle</td>
<td>Speech and Language Therapy, NEHB</td>
</tr>
<tr>
<td>Ms Joan Walshe</td>
<td>Regional Director, National Educational Psychological Service, Dublin</td>
</tr>
</tbody>
</table>

Special thanks are also given to Finbarr Marsden (NEHB) for his assistance throughout the whole project, especially with questionnaire distribution. In addition, thanks to Sue Plummer (University of Sheffield) for her help with the focus groups and Emma Clare for her assistance with the final preparation of the report.

Jan Horwath and Teela Saunders
January 2005

© The copyright to this Child Neglect study is jointly held by the North Eastern Health Board and Jan Horwath, The University of Sheffield. Complete or large-scale reproduction, or inclusion of extracts in publications, may be done only with written permission from the North Eastern Health Board and Jan Horwath, The University of Sheffield.

Every effort has been made to ensure that the information in this study was correct at the time of publication. The North Eastern Health Board, its officers, employees and advisors, Jan Horwath and The University of Sheffield disclaim all responsibility for such facts and opinions which should not be relied upon in the absence of independent verification.
## Contents

Foreword i  
Acknowledgements ii  
Executive summary 1  
Chapter 1 Introduction 8  
Chapter 2 Child neglect: Lessons from the literature 12  
Chapter 3 Research design and methods 34  
Chapter 4 Questionnaire findings 42  
Chapter 5 Qualitative results from the focus groups 65  
Chapter 6 Discussion of findings 80  
Chapter 7 Conclusion and recommendations 106  
Bibliography 112  
Appendix: The postal questionnaire 121  

For correspondence contact:

Jan Horwath  
Senior Lecturer in Social Work Studies  
Department of Sociological Studies  
The University of Sheffield  
Sheffield S10 2TU  
United Kingdom  

Phone (from Ireland): 0044 114 222 6442  
Fax (from Ireland): 0044 114 276 8125  
E-mail: J.Horwath@Sheffield.ac.uk  

Copies of this report are available from:  
Regional Child Care Office  
Aerbridge House  
Dunshaughlin Business Park  
Dunshaughlin  
Co Meath  
Phone: 01 825 0907  
Fax: 01 825 0695
EXECUTIVE SUMMARY
Executive summary

Background

It is generally recognised by both policy makers and professionals that child neglect is more prevalent in the Western world than other forms of maltreatment (Tomison, 1999; Thoburn et al., 2002; American Humane Association, 2001). Ireland is no exception. For example, 600 child neglect referrals were made to the North Eastern Health Board (NEHB) in 2002. By contrast, there were 247 reports focusing on physical abuse, 310 on sexual abuse and 231 concerning emotional abuse.

Not only is child neglect prevalent but it also damages children in ways that are not immediately visible but may have long-term consequences for both emotional and physical development (Law and Conway, 1992; Kurtz et al., 1993; Gaudin, 1999). Despite the evidence that child neglect can have a profound effect on the development of a child, research into child neglect is limited. It is against this background of limited research that professionals struggle to assess children’s needs in cases of child neglect.

Recognising the issues for practitioners, the NEHB commissioned a study, Child neglect – Is my view your view? (Study 1), of social work practice in cases of child neglect. Study 1 was completed between 2000 and 2001. Its findings showed that the NEHB has a skilled social work workforce which is committed to identifying and addressing issues of child neglect.

The findings, however, also indicated that there is a lack of common understanding among staff as to the meaning of child neglect and perceptions vary between teams and from worker to worker. This in turn influences the way in which cases of child neglect are

---

1 Reference will be made in this section to Child neglect – Is my view your view? (Horwath and Bishop, 2001). It will be referred to as Study 1. This is a study completed between 2000 and 2001 by the NEHB which explored social workers' perceptions of child neglect and social work practice when assessing potential cases of child neglect.
managed, from the initial reporting through to intervention and decision-making regarding case closure. In addition, although both managers and practitioners recognise the importance of working in partnership with children and carers, evidence on case files indicated that this does not always happen and children in particular are marginalised.

One of the important findings from Study 1 related to multi-disciplinary practice in cases of child neglect. Information gained from questionnaires and focus groups demonstrated that multi-disciplinary work is highly valued by social work practitioners and managers. Respondents, however, indicated that more needed to be known about multi-disciplinary practice in cases of child neglect.

The Child Care Advisory Committee of the NEHB consequently commissioned a second study, *Do you see what I see? Multi-professional perspectives on child neglect* (Study 2), aimed at firstly exploring the attitudes of professionals towards identifying and assessing child neglect and, secondly, identifying factors that influence effective multi-disciplinary collaboration in cases of child neglect.

**Methodology**

The University of Sheffield research team completed the study in collaboration with a Steering Group formed of a sub group of the NEHB’s Child Care Advisory Committee and consisting of 20 managers and practitioners from health, education and the Garda Síochána. An anonymous questionnaire was sent to 800 professionals who are responsible for reporting child neglect to the Community Care social work team, including general practitioners, who completed a shortened version of the questionnaire. There was a 49% response rate (n=390, including 59 general practitioners). To assist in the interpretation of the findings from the questionnaire and to gain more information on professionals’ experiences of working with child neglect, 10 focus groups were held and were attended by 85 participants.

**Aims and objectives of the research**

The aims of Study 2 are to:

- Identify professionals’ understanding of neglect as defined in Section 3.2 of *Children First – National Guidelines for the Protection and Welfare of Children (1999).*

- Understand factors which currently inform decisions made by professionals to notify Community Care social work teams of a potential case of child neglect.

- Explore professionals’ and organisational needs in view of new national guidance regarding multi-disciplinary assessment and intervention in cases of child neglect.

- Make recommendations to the NEHB regarding ways of developing a standardised multi-disciplinary approach towards assessment and intervention in cases of child neglect.

The objectives of the study are to:

- Provide opportunities for professionals to explore their understanding of neglect through case scenarios and discussion.

- Enable professionals to consider ways in which they could work together to promote better outcomes for service users.

- Identify policy and practice developments that would enable the NEHB to work more effectively with cases of child neglect within the *Children First* national guidance.

2 The term professionals is used throughout the report to refer to all practitioners and managers who come into contact with children and families.

3 This national guidance document is referred to as Children First throughout this report.
Key findings and recommendations

The study highlighted that there is a great deal of effective and innovative practice taking place in terms of protecting neglected children. In the main, professionals in both children’s and adult services share a common understanding of neglect. They recognise that it is about more than focusing on the physical and safety needs of the child. The majority of professionals in the study are also aware of their responsibility to identify and report cases of child neglect to Community Care social work teams.

There are, however, areas for development in terms of both policy and practice. These are considered below and suggested recommendations for improving practice in order to promote better outcomes for neglected children and their families are presented.

Thresholds

This study has highlighted that there is no common agreement among professional groups, or indeed between professionals within the same group, as to the types of neglect that should be referred to Community Care social work teams or managed by professionals working with children and families. Unless some agreement is reached regarding thresholds for referral, children and families are entering a lottery with the same needs being addressed differently depending on the professional or group of professionals who come into contact with the child and family.

Practitioners from all professional groups, including social workers, are not using the same baseline or sharing a common language. For example, professionals could not agree on the key factors of a neglectful environment. That is, individuals placed a different emphasis on different factors. They also interpreted terms such as ‘good enough parenting’ in very different ways.

The study also highlighted that professionals focus on gathering information about the family rather than making sense of that information in light of theory, current research and practice developments. If professionals do not make explicit when communicating with each other the reasons why they consider that certain factors are a cause for concern, then they can be overlooked or ignored by other professionals. An evidence-based approach towards cases of child neglect could improve communication and understanding between professionals.

Recommendation: Professionals from all disciplines need a common assessment framework, guidance and training to enable them to make a holistic assessment of the impact of neglect on the child and his/her developmental needs. All professionals should use the Framework for Assessing Child Neglect developed as part of Study 1. A common assessment framework should begin to standardise the approach taken by practitioners towards the assessment of child neglect.

Recommendation: All professionals should use the national standard reporting form for referrals introduced by the NEHB in line with Children First guidelines.

Recommendation: An evidence-based approach towards practice should be reflected in all referrals and assessments and should be an integral part of training and case management.

Recommendation: All child protection guidance should include a glossary of common terms used in the context of work with vulnerable children by practitioners in different disciplines.
The child protection process

Professionals who referred cases to Community Care social work teams have varying degrees of understanding about the way in which the child protection system operates in terms of assessing, planning and intervening in cases of child neglect. Lack of clarity was notable in regard to:

- The types of cases that should be reported to Community Care social work teams.
- Contributions to multi-disciplinary assessments following a report of child neglect.
- The purpose and functioning of case conferences.
- Appropriate interventions to meet the needs of children and families.

Recommendation: Local guidance is required that clarifies the assessment roles and responsibilities of professionals involved in cases of child neglect.

Recommendation: Community Care social work teams should use protocols introduced in Children First clarifying both the assessment and planning process.

Recommendation: The Child Protection Conference policy and protocols developed by the NEHB in 1999 should be used for all conferences.

Recommendation: All child protection and family support plans for children should use a standardised format such as the Children First guidelines. The plans should include aims and objectives designed to safeguard children and promote their welfare. If monitoring by professionals is considered appropriate, exactly what should be monitored, why, how and by whom should be clearly recorded.

Perceptions of Community Care social work teams

Professionals recognised the pressure placed on Community Care social work teams resulting from high staff turnover and heavy demand for services. Although respondents to the study were able to cite positive experiences of working with social workers, many focused on the negative experiences and the consequences of these experiences for children and families.

The consequence causing most concern was that professionals, particularly those in contact with children, were referring cases of child neglect to Community Care social work teams as a last resort. The professionals expressed concerns that referral did not necessarily lead to any action that would ensure the needs of the child were met. As result of this, many professionals were trying to find ways of meeting the needs of the child by referring to other services or monitoring the situation themselves.

Referral to other services and monitoring may be an appropriate response in many cases. However, it may be placing children in vulnerable situations. Based on the information gained from Study 2, it is difficult to ascertain whether this is the case.

Recommendation: Senior managers within the NEHB region need to audit the cases of child neglect that are ‘monitored’ or worked on by professionals other than social workers. The purpose of the audit should be twofold. Firstly, it should identify whether professionals are managing appropriate cases bearing in mind their areas of professional expertise and secondly, it should establish whether the level of service provision is commensurate with the needs of the child.

Professionals also highlighted the problem of accessing social workers, particularly out of hours. This lack of availability could lead to cases being managed inappropriately.
Recommendation: Consideration should be given at national level to developing an out-of-hours service run by experienced social work staff trained in managing crisis childcare situations.

Working with children and families

One of the most striking findings from this study is the impact of verbally and physically aggressive parents or carers on workers’ practice in cases of child neglect. The respondents acknowledged that fear of aggression or intimidation by parents can influence thresholds of concern and act as a barrier to referral to Community Care social work teams.

In addition, the presence of aggressive or intimidating parents at case conferences can inhibit discussion. Many respondents cited incidents of actual aggression and intimidation by parents after concerns had been expressed about their parenting ability.

Recommendation: The agencies may wish to consider implementing some of the strategies adapted from initiatives taken by the New Zealand Government department responsible for child protection. These include:

- Establishing teams/coordinators that can act as a resource for workers in terms of guidance and support. These people can also be used to debrief staff following an incident.
- Regular review of situations of violence and threat to workers.
- Training on personal safety strategies.

Recommendation: Professionals need written guidance and training regarding the diverse ways in which children and families can be engaged in the assessment process in order to ensure that the assessment is child focused and identifies parenting strengths and weaknesses. Particular attention should be paid to ways of working with families where aggressive and uncooperative behaviour on the part of a carer impacts on a professional’s ability to assess the needs of a vulnerable child.

Professionals also highlighted issues associated with living and working in the same community. These issues centred on obtaining a negative reputation for reporting families to Community Care social work teams and the consequences for their relationships with community members.

Recommendation: Consideration needs to be given to ways of both developing the skills of practitioners and also providing them with the support that will enable them to manage the tensions of reporting child abuse when working and living in a close-knit community.

Only a small minority of professionals placed any emphasis on consulting with children to ascertain what life is like for the child and ascertaining their wishes and feelings about their situation.

Recommendation: Professionals should make a point of communicating with children in the family in a way that takes account of the age, ability and circumstances of the individual child. Professionals should seek to gain an understanding of the child’s wishes and feelings and an understanding of what a day in the life of the child is like.

Although professionals recognised the challenges of assessing children from minority groups, the focus was on ethnicity. No mention was made of disabled children and their specific needs.

Recommendation: All professionals who come into contact with children and families should receive training regarding the identification and impact of neglect on vulnerable groups of children.

The majority of professionals associated neglect with poor mothering. This marginalises the role and influence of the father and makes the mother responsible for protecting her children without any interventions that address the father’s behaviour.
Recommendation: Professionals should have opportunities through training and case management to explore issues associated with completing assessments of child neglect that emphasise the role and responsibilities of the mother as the primary caretaker and minimise the role of the father or male partner.

Multi-disciplinary practice

Lack of communication, particularly feedback from social workers to other professionals, was a theme of this study. The respondents highlighted the importance of establishing effective ongoing relationships with colleagues from different disciplines in order to discuss concerns about a child and family. They recognised that building these relationships was particularly difficult with social work colleagues as staff turnover was high and they believed that formal and informal systems should be developed to promote multi-disciplinary practice. All staff groups identified the pressures placed on them through high workloads as a result of understaffing and sickness. In some settings, staff were working with families where the individual worker did not feel they had the knowledge and skills to meet the needs of the family.

Recommendation: Social work services should have a standardised feedback procedure ensuring that professional referrers are informed in writing of the outcome of their referral.

Recommendation: Managers should ensure that professionals have a caseload commensurate with the experience, knowledge and skills of the worker.

Recommendation: The senior managers in the NEHB and other agencies may wish to identify the structures and systems acknowledged within the literature and also those operating within the region that promote multi-disciplinary practice.

Training

Respondents identified a number of areas for knowledge and skill development, which are incorporated into the recommendations above. In addition, respondents emphasised the advantage of joint training initiatives. Multi-disciplinary training events can be particularly useful if delivered on a locality basis, as they bring work colleagues together for training.

Recommendation: Multi-disciplinary training is an effective method for developing multi-disciplinary practice and should be given priority by senior and middle managers and front-line staff. The training where possible, should be provided on a locality basis. This means that those who train together will go on to work together. The training should be informed by research, theory and practice developments on child neglect. The following topics for training have been identified through this study:

- Working with aggressive and uncooperative service users.
- Effective communication with children regarding the impact of child neglect on their lives.
- Identifying and assessing child neglect among members of vulnerable groups.
- Assessing parenting capacity of both parents rather than focusing on mothers.
- Issues regarding working with child maltreatment when working/living in small communities.
CHAPTER ONE
INTRODUCTION
Introduction

Background

It is generally recognised by both policy makers and professionals that child neglect is more prevalent in the Western world than other forms of maltreatment (Thoburn et al., 2000; American Humane Association, 2001). Ireland is no exception. For example, in their study of Irish child protection practice, Ferguson and O’Reilly (2001) found that neglect is the most common form of abuse referred to the Health Boards. Commenting on the nature of the cases, they note that they are multi-referred, high-risk cases where ‘the single biggest deficit in meeting identified need [of the child] lies in the area of parenting skills’ (op. cit. p. 22).

Buckley (2002), reporting on the findings of a series of small-scale studies into child protection, notes both a high rate of child neglect referral to the Health Boards and a system that tends to filter these cases out without provision of services. Graham, cited in Buckley, concludes from his small-scale study of neglect cases that social workers are either ‘over-whelmed’ by the enormous and impervious problems presented by neglectful families or ‘under-whelmed’ to the point of normalising neglect.

Neglect is prevalent in reports of child welfare and protection concerns to Community Care social work teams within the North Eastern Health Board (NEHB). In 2002, although 45% of referrals (1,123) reflected such welfare concerns as children with emotional and behavioural problems, children abusing drugs and alcohol, and parents unable to cope, 24% (600) of reports related to child neglect. This may be an under-representation as it is difficult to ascertain to what extent the welfare concerns are associated with neglect. Referrals for child neglect were significantly greater than for other forms of maltreatment, with 10% (247) of
Introduction

Reports focusing on physical abuse, 12% (310) on sexual abuse, and 9% (231) concerning emotional abuse.

Not only is child neglect prevalent but it also damages children in ways that are not immediately visible but may have long-term consequences for both emotional and physical development (Law and Conway, 1992; Kurtz et al., 1993; Gaudin, 1999). The Irish Department of Health and Children defines child neglect as: ‘an omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, or medical care’. (Children First – National Guidelines for the Protection and Welfare of Children, 1999, paragraph 3.2.1.)

The Children First guidelines stress the cumulative nature of neglect and state that: ‘The threshold of significant harm is reached when the child’s needs are neglected to the extent that his or her well-being and/or development are severely affected.’ (1999, paragraph 3.2.3.)

Despite the evidence that child neglect can have a profound effect on the development of a child, research into child neglect is limited and most studies have been restricted to the United Kingdom or the United States of America (Iwaniec and McSherry, 2002). It is against this background of limited research that professionals struggle to assess children’s needs in cases of child neglect. As in most countries, if family members, the community or other professionals in Ireland are concerned that the needs of a child are not being met as a consequence of neglect, then the child is likely to be referred to social work services for an assessment of the needs of the child and the parents’ ability to meet these needs. Social workers, therefore, have a key assessment role and are usually responsible for coordinating the assessment through working with the child, the family and other professionals.

Study 1: Child neglect – Is my view your view?

Recognising this key role of social workers and the lack of research into how cases of neglect are assessed and managed, the NEHB commissioned Child neglect – Is my view your view? (Study 1), a study of social work practice in cases of child neglect. This was completed between 2000 and 2001. The aims of Study 1 were to gain greater insight into social work practitioners’ and managers’ understanding of child neglect and to identify factors that influence decision-making among social work personnel in cases of child neglect. Study 1 included an analysis of case files, focus groups and postal questionnaires to social work personnel.

Social work practice

The findings of Study 1 showed that the NEHB has a skilled social work workforce which is committed to identifying and addressing issues of child neglect. However, the findings also indicated that there is a lack of common understanding among staff as to the meaning of child neglect. In addition, perceptions vary not only between teams but also from worker to worker. This in turn influences the way in which cases of child neglect are managed by Community Care social work teams. Furthermore, although managers and practitioners recognise the importance of working in partnership with children and carers, evidence on case files indicated that this does not always happen and children in particular are not consulted.

Multi-disciplinary practice

One of the important findings from Study 1 related to multi-disciplinary practice in cases of child neglect. Information gained from focus groups and questionnaire respondents demonstrated that multi-disciplinary work is highly valued by social work practitioners and managers. However, findings from Study 1 indicated that multi-disciplinary practice could be more developed.
For example, although *Children First* emphasises that all professionals should understand their roles and responsibilities, a review of case files indicated differences in perceptions among professionals regarding their roles and responsibilities in cases of child neglect. These differences appear to have an effect on referrals, with a minority of referrals made to the NEHB by professionals who are in direct contact with children such as teachers and public health nurses. As *Children First* emphasises the importance of a multi-disciplinary approach to both assessment and interventions in child protection, it is important firstly to understand the factors that promote and inhibit effective multi-disciplinary practice within the NEHB region and, secondly, to consider strategies that will improve multi-disciplinary practice.

**Aims and objectives of Study 2**

The aims of Study 2 are to:

- Identify professionals’ understanding of neglect as defined under Section 3.2 of *Children First – National Guidelines for the Protection and Welfare of Children* (1999).
- Understand factors which currently inform decisions made by professionals to notify the Community Care social work teams of a potential case of child neglect.
- Explore professionals’ and organisational needs in view of new national guidance regarding multi-disciplinary assessment and intervention in cases of child neglect.
- Make recommendations to the NEHB regarding ways of developing a standardised multi-disciplinary approach towards assessment and intervention in cases of child neglect.

The objectives are to:

- Provide opportunities for professionals to explore their understanding of neglect through case scenarios and discussion.
- Enable professionals to consider ways in which they could work together to promote better outcomes for service users.
- Identify policy and practice developments that would enable the NEHB to work more effectively with cases of child neglect within the *Children First* national guidance.

---

4 Section 7 of the Child Care Act 1991 requires each Health Board to establish a Child Care Advisory Committee to advise the Board on the performance of its responsibilities under the legislation. The committee is comprised of persons with a special interest or expertise in matters affecting the welfare of children and includes three members of the Health Board nominated by the Health Board, three officers of the Health Board and representatives of voluntary bodies providing childcare and family support services. The advice of the committee is transmitted in writing to the chief executive officer who then submits it to the Health Board for consideration. A minimum of four meetings of the committee are held per year.
CHAPTER TWO
CHILD NEGLECT: LESSONS FROM THE LITERATURE
Lessons from the literature

The context

Wolock and Horowitz (1984) documented the ‘neglect of neglect’ nearly 25 years ago. More recently, the Lancet (2003) highlighted that neglect continues to be low on the agendas of social and medical scientists, policy makers and practice professionals. Wolock and Horowitz (1984) offer some suggestions as to why neglect has been marginalised by these groups of professionals. They conclude that these professionals believe:

- That neglect does not have as serious consequences as other forms of maltreatment.
- It is inappropriate to judge parents involved in poverty-related neglect.
- The issues associated with neglect are insurmountable.
- Neglect is a vague and ambiguous concept.

Sullivan (2000) confirms that these attitudes towards neglect still exist and explains why neglect continues to receive little priority in Western society.

There are pragmatic reasons why neglect is neglected while other forms of abuse are tackled head on. Garbarino and Collins (1999) point out that in situations where children are being physically harmed, the response to protect them can be an act, sometimes singular. In a case of neglect, the response needed is often a long-term intervention, which supports and enables the parents to care adequately for the child. Intervention in neglect cases is both costly and complex, and therefore a challenge for professionals who are overloaded with cases and constrained by limited resources.

---

5 This chapter builds on the work of Beverley Bishop.
From an Australian perspective, Dingwall et al. (1983) suggest there are two reasons why professionals often sidestep neglect. First they refer to ‘cultural relativism’ as an attitude among professionals that enables them to discount certain situations as not neglectful but alternative cultural practice. The second method used to minimise neglect is the ‘rule of optimism’, i.e. that there is innate natural love between a parent and child which can overcome most problems.

Corby (1999) argues that there has not been a change in the level of neglect occurring but rather a change in how neglect is perceived and defined at particular times. For example, neglect was the primary focus of social work practice in the 1950s but awareness of the ‘battered baby syndrome’ in the early 1970s shifted attention to physical abuse. By the late 1980s the focus shifted again as attention moved to child sexual abuse (Scourfield, 2000). As the Bridge Child Care Consultancy (1995, p.1) states in the opening of its report on the death of baby Paul: ‘Society’s response to neglect, as with other forms of child maltreatment is shaped by and occurs within the context of relative cultural, economic and ideological values.’

The social construction of neglect therefore reflects the current understanding and profile of neglect and is influenced by the media and specific incidents (Reder et al., 1993). For instance, Scourfield (2000) documents the ‘rediscovery of neglect’ in the 1990s and notes that it brings with it a redefining of what constitutes neglect and what practitioners should be assessing. Scourfield (2000) explains how child death tragedies such as the death of Paul have a striking effect on how professionals view neglect and redefine the boundaries of how neglect is understood.

Defining neglect

One of the biggest challenges for professionals working with children and families is defining neglect. As highlighted in the NEHB’s Study 1 on child neglect, how does one professional know if their perception of child neglect is the same as their colleagues or that of a professional from another discipline? In this section, consideration is given to the different features of neglect that are used to inform definitions of neglect and the range of issues and questions that complicate defining neglect, such as:

- What are the indispensable, minimal types of care that children require?
- What acts of omission or commission constitute neglect?
- Is neglect the result of an intentional action or omission on the part of the carer?
- What are the effects on the child’s development?
- There is a lack of consensus over what is ‘good enough parenting’.

In Defining Child Abuse, Giovannoni and Bercerra (1979) surveyed professionals about the definition of child maltreatment. Based in Los Angeles, 71 lawyers, 113 social workers, 50 police officers and 79 paediatricians were asked to comment on a range of examples. The researchers found a degree of consensus among professionals within the same group regarding the seriousness of different incidents, but there was considerable disagreement between professional groups over what constituted neglect. However, Giovannoni and Bercerra argue that unanimity is not necessarily desirable as disagreement resulting from different organisational and occupational perspectives can be useful in decision-making and planning interventions. At the same time, they recognised that too much disagreement could lead to professional paralysis.

The differences between professionals’ definitions of child neglect may not be affected by whether the professional is located in a rural or urban area. Craft and Staudt (1991) conducted a study in the USA among professionals in different geographical settings and found a large degree of consensus on what they considered to be neglectful behaviour. However, Rose and Selwyn (2000), evaluating multi-disciplinary research on child maltreatment, conclude that
persons from different occupations hold disparate definitions of child neglect because of their various societal roles. They highlight that the point of view of the definer is influenced by:

- Professional occupation.
- Societal role.
- Relationship to the community and individual children and families.

In the UK, Fox and Dingwall (1985) conducted a small-scale study exploring the perceptions of child maltreatment among health visitors and found there was clear agreement about the seriousness of incidents. However, the literature suggests that there is a lack of consensual understanding of what constitutes child neglect among different professional groups and therefore a lack of consistent practice (Stone, 1995). For instance, Rose and Selwyn (2000) suggest that in the US and in Britain there are disparate definitions of neglect among occupational groups. Hallett (1995) notes that these differences can place considerable strain on the relationship between social workers and other professionals involved in the care of children.

**Focus on the child or the parents?**

Dubowitz (1999) advocates an ecological perspective that focuses on the basic needs of children that are not met rather than the intentions or behaviour of parents. Dubowitz (1999) argues that the child’s needs and developmental state should be at the centre of any judgement about the occurrence of neglect. However, Schumacher et al. (2001, p. 232) reviewed the literature on neglect and concluded: ‘Neglect occurs when there is a deficiency in appropriate parenting behaviour, rather than when an inappropriate parenting behaviour occurs.’ Gabarino and Collins (1999, p. 12) focus on the carer’s failure to meet the needs of the child: ‘Neglect is an act of omission; abuse is one of commission.’

Minty and Pattinson (1994, p. 736) state that neglect is a ‘...persistent failure to meet a child’s essential needs by omitting basic parenting tasks and responsibilities. The basic needs that are not usually met are those for adequate food, clothing, shelter, cleanliness, stimulation, medical care, safety, education and love and control, in spite of parents having the resources to meet these needs at a basic level.’

Defining neglect as an omission on the part of the carer is written into the Irish Department of Health and Children’s guidelines: ‘Neglect is normally defined in terms of an omission, where a child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, or medical care.’ (Children First – National Guidelines for the Protection and Welfare of Children, 1999, chapter 2.)

Minty and Pattinson (1994) suggest that parental ‘resources’ are at the heart of determining whether neglect is apparent. It is this differentiation between actions and omissions that distinguishes neglect from other forms of abuse, with neglect being characterised by acts of omission and abuse being characterised by acts of commission (Stevenson, 1998; Schumacher et al., 2001).

**The role of the mother**

Research into child neglect has tended to focus on mothers, mainly because it is the woman who is the primary caregiver, or only caregiver, in many families. However, if we consider the abandonment of children in terms of financial, psychological and physical care by their fathers, then the degree of neglect by fathers must outweigh that of neglectful mothers. Parton et al. (1997) analysed case notes from social workers in the UK and Australia and found that the focus of attention is on mothering and this is assessed according to a standard set by the worker. Scourfield (2000) used an ethnographic approach in a social work office in Britain to examine the discourses on child neglect and concluded that there were two influential themes among social workers. Firstly, there was a ‘scrutiny of mothering’ and a consensus that neglect was due to maternal...
failure. Secondly, he found that the state of children’s bodies was the focal point for gathering evidence.

Early definitions of neglect were personalised and gendered and ‘seen as failure of individual mothers to carry out their mothering responsibilities’ (Swift, 1995, p. 72). Swift (1995) suggests that this over-focus on mothers has been at the expense of an understanding of, and efforts to change, the social and economic context in which child neglect occurs. Turney (2000) argues that because care is so strongly associated with femininity, women are always held responsible. Tanner et al. (2000) note that discussions of neglect involve criticisms of mothers so therefore stereotypical ideas of ‘mother blaming’ can lead to inappropriate interventions. However, social workers interviewed by Scourfield (2000) explain that there is little choice but to focus on the mother because normally she is the primary caregiver who is available during home visiting times as the father is at work or is absent.

### Types of neglect

Reid et al. (1994, p. 12, cited in Sullivan, 2000, p. 9) claim that: *In effect, neglect is a residual category composed of all instances of child maltreatment other than those explicitly defined as sexual, physical or emotional abuse.* Hegar and Youngman (1989) suggest a causal typology of neglect based on three major categories: physical, developmental and emotional neglect. *National Incidence Studies* (Garbarino and Collins, 1999) breaks the concept of neglect into the failure to provide for children’s physical, educational and emotional needs. Giovannoni and Becerra (1979) distinguish the neglect of children using four categories: educational neglect, abandonment, failure to provide and fostering delinquency. This final category is redefined by Minty and Pattinson (1994) in a British context to mean the lack of supervision of children, allowing them to play truant and allowing them to become involved in crime. In this section, some of the key types of neglect reported in the literature are explored in detail.

### Lack of supervision

Leaving a child unsupervised is the most common form of reported neglect in the USA (Hildyard and Wolfe, 2002). This was also found to be the case in the review of NEHB cases by Horwath and Bishop (2001). Jones (1997) defines five types of ‘lack of parental supervision’:

- Child left unattended.
- Child left in the care of an unsuitable caregiver.
- Child inadequately supervised.
- Child left with someone without planning or consent.
- Child permitted or encouraged to engage in harmful activities.

### Emotional neglect

As definitions of neglect have evolved, emotional abuse has become included in the overall concept of child neglect. Iwaniec (1996, p. 5) provides a definition of emotional neglect as ‘hostile or indifferent parental behaviour which damages a child’s self esteem, degrades a sense of achievement, diminishes a sense of belonging, prevents healthy and vigorous development, and takes away a child’s well-being’. Some scholars believe that emotional maltreatment is at the root of all major forms of abuse and neglect, or that it is difficult to distinguish between emotional abuse and neglect in particular (Iwaniec, 1997; Stevenson, 1998). Encouragingly, Minty and Pattinson (1994, p. 746) found that social workers on a British child protection team recognised that physical neglect was related to emotional neglect.

### Focus on uncleanliness

Neglect has traditionally been associated with dirt and lack of cleanliness. Douglas’s (1966) work on the anthropological and social meaning of ‘dirt’ explains how mess is considered to challenge social boundaries and values. This would appear to influence perceptions of neglect. For example, Swift (1995), exploring the construction of neglect in Canadian cases, found that dirt and disorder were constant reference points in case notes. Scourfield (2000, p. 372) states that the social
work team he observed in Britain, shortly after a child in their area died of neglect, had a ‘preoccupation with dirt, mess and smell in the identification of neglect’. This led to the ‘domestic environment’ and ‘home conditions’ being cited as the primary grounds for implementing child protection inquiries. However, the concentration on ‘dirt and mess’ was explained by social workers as evidence that the child’s health was at risk. Scourfield (2000, p. 377) points out that the culturally specific meaning of ‘dirt’ cannot be divorced from understanding why dirt, smell and uncleanliness are the focal point of decisions regarding the care of a child.

Multi-type maltreatment
Evidence suggests that child maltreatment often manifests itself as more than one form of abuse. In their consideration of types of abuse that occur together, Ney et al. (1994) found that only 5% of cases occurred in isolation. In many cases, neglect was often a precursor to other forms of abuse. Oliver (1988) collated data over a 20-year period from 560 children from families with two generations of documented child maltreatment. From the sample, 513 had been maltreated and of these 499 had experienced neglect. Higgins and McCabe (2000) studied the existence of multi-type maltreatment and also found that it was usual for children to experience more than one form of abuse (physical, sexual, psychological, neglect and witnessing family violence). In a community sample of 175 adults, there was a high degree of overlap between the types of abuse reported. These caused long-term adjustment problems in adulthood. Emotional abuse is often an aspect of other forms of maltreatment but goes overlooked as other forms of abuse are prioritised. As Iwaniec (1997, p. 371) states, ‘emotional abuse is a key feature of most child maltreatment’.

Parental processing of information
Definitions of neglect often emphasise socio-economic factors. Crittenden (1999) has taken a cognitive approach to defining neglect and argues that a focus on the socio-economic causes of neglect is not sufficient to explain child neglect. Crittenden argues that the way in which parents mentally process information about relationships may be significant in terms of who experiences neglect and who does not.

She defines three types of neglect based on the way that parents manage information and ultimately construct their parenting behaviour and relationship with their children. ‘Disorganised neglect’ is when the parenting is entirely inconsistent, with the parent going from crisis to crisis amidst multiple problems. ‘Emotional neglect’ occurs when the parent is unable to share feelings, especially extremes of negative or positive emotions. The third category is ‘depressed neglect’ where the parent is withdrawn, passive and helpless and therefore does not respond to either the physical or emotional needs of the child.

Crittenden claims that the way in which information is processed during everyday interactions determines how the parent can or cannot respond to the child’s needs. Ultimately, a failure to process information adequately results in some children experiencing inappropriate care.

Prevalence of neglect
It is difficult to establish the real prevalence of child neglect for a number of reasons. When looking at statistics of neglect cases, Tomison (1995) reminds us that systems such as registration (in Ireland this would be equivalent to confirmed notifications of child abuse) reveal more about the changes in perceptions of maltreatment than the real incidence of neglect. Rose and Selwyn (2000) explain why it is difficult to estimate the level of neglect in a society noting:

• The lack of common reporting standards.
• Differing societal explanations for what constitutes inadequate care.
• A lack of common definition parameters.
Concerns have also been raised regarding the level of maltreatment that is not reported because of the observer’s bias, the observer’s lack of faith in the child protection system or a lack of information about how to report (McDevitt, 1996). Indeed, Zellman (1990), exploring reporting patterns of child maltreatment among mental health professionals, found that the nature of the maltreatment and whether individuals believed the referral would benefit the child or family were the key determinants in decisions to report. Fisher et al. (1995, p. 205) reflect on the under-reporting of neglect in a British context: ‘Physical abuse remains the most likely area for professional disgrace in the event of a child’s death. Neglect and emotional abuse may seem to be less immediately dangerous to children and to professionals, so it may be that consideration of danger has come to dominate professional thinking and considerations of psychological well being of the child, relatively speaking, neglected.’

However, despite these reservations regarding official statistics, data on the prevalence of neglect in the USA, Australia and Britain indicates that neglect is the most frequently reported form of maltreatment. In Australia, 23% of all maltreatment cases were officially labelled neglect (Tomison, 1995). However, aboriginal families were over-represented in neglect cases, with 40% of cases labelled so. In Britain, the number of cases of child neglect has risen from 13% of all cases in 1988 to 25% in 1993 (UK Department of Health quoted in Rose and Selwyn, 2000, p. 180). In England, statistics for the number of children registered on the Child Protection Register in March 2001 showed that 12,900 were registered for neglect, 7,300 for physical abuse, 4,500 for sexual abuse, 4,800 for emotional abuse and 500 for other forms of maltreatment (UK Department of Health, 2001). Wilding and Thoburn (1997) studied three social services departments in England and analysed 349 child protection referrals of children under the age of 8. They found that 64% of referrals were for neglect, while a further 23% were for physical abuse including neglect.

The findings from other Western countries regarding the reporting of types of maltreatment are comparable with Irish statistics. Of the 8,269 cases of suspected maltreatment that were referred to Health Boards in Ireland during the year 2000, 40% (3,301) were suspected neglect cases. Of these 3,301 cases, 44% (1,453) were later confirmed as actual neglect. In line with the literature described above, which documents the difficulties of collecting evidence, 21% of cases resulted in an ‘inconclusive assessment’.

Factors that contribute to neglect

This section summarises the literature regarding factors that are believed to contribute to incidents of child neglect. They include socio-demographic influences, parental characteristics and behaviours, as well as characteristics of children. These are explored under the following headings:

- Family dynamics.
- Parental social networks.
- Parenting.
- Poverty.
- Alcohol and substance misuse.
- Inter-generational patterns.
- Mental health.
- Violence.
- Ethnicity.
- Child disability.
Family dynamics

Psychological and socio-psychological studies conceptualise neglect in terms of disordered relationships between parent and child (Stone, 1998). The functioning of the family as a whole and how different members relate to each other have been examined as key causal factors of neglect (Gaudin et al., 1996; Campbell, 1997; Gauthier et al., 1997). Family structure has also received attention when considering the contributing factors to child neglect. For example, children in single-parent households – in effect children reared by single mothers – are highlighted as being at significant risk of experiencing neglect compared to children living with long-term couples (Stone, 1995). This is attributed to the stress of parenthood on one person and the added financial burdens for single-headed households.

Sullivan (2000) notes that gender is an important factor as there is a tendency for mothers to have a lack of nurturing knowledge and experience role rejection. In addition, many have experienced poor nurturing themselves. However, as described above, these characteristics overlook the father’s role in neglect and his input into the parenting of children and stability in the household. Feminist scholars challenge the emphasis on mothering in child protection assessments stating that fathering is not scrutinised in the same way (Turney, 2000).

Other research findings contest that single-parent householders are more likely to be neglectful. Egan-Sage and Carpenter (1999) reviewed the family composition of those referred to an English social services department. Of the 2,069 children referred, 373 (18%) were added to the child protection register. Interestingly, they found fewer single-headed families than was expected. Less than one third of children lived with a lone or unmarried mother. However, of the children who were registered, half of the mothers were below the age of 21.

These findings support the hypothesis that young mothers are at risk of perpetrating maltreatment: 43% of mothers referred were aged 21 or less at the birth of the child, while this increased to 45% for those children registered. They found that the natural mother was a significant figure in almost all of the children’s lives, and that a stepfather/mother’s cohabitee was apparent for those registered. The most important finding from Egan-Sage and Carpenter’s (1999) study is that there were few members of extended families involved with children who were placed on the protection register.

Lagerberg et al. (1979) found a basic set of characteristics among families with neglected children in Sweden. The life careers of these families were marred by:
- A lack of structure and continuity, such as no long-term employment.
- Unrest in the home.
- Health problems.
- Social isolation.
- Feelings of worthlessness.

Large family size is positively correlated with the occurrence of neglect. This is not necessarily because large families are unplanned, with the children therefore being undesired additions. In fact, logistic regression analysis on a group of 198 low-income, female-headed families found that unplanned childbearing increases the risk of child abuse but not of neglect (Zuravin, 1999). Family size, of course, impacts upon the resources available for each child. Egan-Sage and Carpenter (1999) found that children placed on the child protection register for a range of maltreatments were more likely to have two or more siblings. However, they warn practitioners that while their findings do suggest there can be links between certain family characteristics, they are not advocating a checklist response to the assessment of neglect. Rather, they guard against making assumptions regarding the relationship between lone parenthood and...
abuse, but suggest that ‘an understanding of the associations between structural family characteristics and child abuse is an addition to, but not a substitute for, the knowledge and skills required of practitioners in making an assessment of the extent of risk in an individual family’ (op cit., 1999, p. 312).

Parental social networks
Egan-Sage and Carpenter’s (1999) review of the literature indicates that the evidence of how family networks influence child maltreatment is contradictory. Some findings suggest that parents who are neglectful are isolated from their own parents or relatives, while other findings suggest that extended families are far more prevalent in modern times than research has recognised. However, most empirical findings suggest that an absence of support networks is a risk factor in cases of maltreatment and that the presence of family and friends is a protection factor (Jack, 1997; Gilligan, 1999).

Polansky et al. (1985) conducted a study of 152 neglectful mothers and 154 non-neglectful mothers who were matched by race, economic status and other life circumstances. They found that neglectful mothers reported less support available from informal networks, they appeared to be in socially impoverished neighbourhoods and were considered deviant by other families who were therefore unlikely to offer any help.

The incidence of neglect has been linked to the number of contacts with others, the parents’ perception of such contacts and whether the parent has received support in the past. Coohey (1998) found that neglectful mothers exchange fewer resources with their parents and their partners. Therefore, these findings suggest that the social networks of parents can be a focus of effective intervention. For instance, Garbarino and Collins (1999) suggest that in some African families the presence of extended family can act as a protection from neglect as the wider kinship network can stand in for the parent.

Parenting
In his book Damaged Parents: an Anatomy of Neglect, Polansky (1981) was among the first writers to suggest that the root cause of child neglect is to be found in the psychological and developmental deficits of the parents. Based on two studies in low-income areas on the east coast of America, Polansky focused his hypothesis on the pathology of the mother. However, other ecological factors were found to contribute to the onset of child neglect, particularly poor informal support networks.

Drotar et al. (1990) suggest that maternal interactional behaviour is significant in non-organic failure to thrive and is therefore a possible cause of neglect. They examined maternal interactional behaviour as a causal factor in babies who have non-organic failure to thrive. Over a period of one month, 47 mothers and their 6-month-old babies were observed and compared with another group of healthy babies. The mothers were found to have less adaptive social interactional behaviour, less positive affective behaviour and demonstrated more arbitrary termination of feeding. However, no group differences were found in the flexibility or sensitivity of maternal feeding or in the environmental circumstances such as other people present, noise level or level of activity. Black et al. (1994) studied the parenting styles of parents with children with non-organic failure to thrive and compared them to a match-controlled adequate-growth group. Parents with children with non-organic failure to thrive were less nurturing and more neglectful than the parents in the control group.

The parent-child relationship can be neglectful when the emotional needs of the child are not recognised or met. Iwaniec (1996) describes the features of a hostile parent-child relationship.
that constitute emotional neglect. The following eight forms of interaction can lead to several forms of maltreatment:

- Little or hostile physical contact and the lack of appropriate touching.
- Lack of eye-contact or smiling at the child.
- Limited verbal contact – communication tends to be commands, shouting and criticising.
- Ignoring the child’s presence or avoiding the child.
- Rejecting.
- Physically neglecting (no feeding, dressing or supervising, etc.).
- Harming the child.
- Inflicting psychological pain (threatening, provoking anxiety, inducing fear, deprivation of love).

Together, these various research studies indicate that the interactions between a parent and child, especially in the early stages of life, can be influential in the onset of neglect.

Poverty

It is difficult to untangle the debate on poverty and child neglect as it is rooted in the definition of neglect (Stone, 1995, p. 39). If neglect is partially defined in terms of poor material conditions, then it leaves the gate open for all children in households below the poverty line to be classified as neglected. Chronic child neglect cases are certainly influenced by sustained financial disadvantage (Nelson, Saunders and Landsman, 1993), yet not all families who are poor or disadvantaged neglect their children. Nevertheless, child maltreatment is far more likely to be recorded among low-income families (Gaudin et al., 1996) and is more closely associated with neighbourhood poverty than physical and sexual abuse (Drake and Pandey, 1996). Tomison (1995) claims that the environmental factors associated with low incomes, multi-problem families, families receiving government benefits, poor housing and living conditions, and low educational and employment levels are predictors of neglect.

It is often suggested that being poor means that a family is more likely to be subject to the attention of the authorities and thus neglect is more likely to be discovered among poor families (Minty and Pattinson, 1994). Furthermore, police officers, medical professionals and social workers are likely to have built up ‘mental inventories’ of characteristics of typical abusers as, among other things, poor and under-educated. So when they encounter a case of a person who does not appear to fit the stereotype of a child maltreater, they may be less likely to classify him/her as such (Gelles, 1999).

This cannot explain, however, why neglect appears to be related to degrees of poverty (Pelton, 1985; Gaudin et al., 1996). Pelton (1980) observes that even if middle-class parents are neglectful, the consequences for their children are less severe. For example, even if a middle-class mother is poor at budgeting, she is still unlikely to run out of money, whereas if a welfare recipient fails to very tightly control her spending, her children might well go hungry. Similarly, middle-class children left alone at home are less likely than their extremely poor counterparts to come to harm, as there are generally fewer hazards in a middle-class home.

Other scholars warn against equating poverty with neglect. DiLeonardi (1993, p. 562) claims that ‘Poverty is not a predictor of neglect: it is a correlate of neglect.’ In reality, it is probably both. Minty and Pattison (1994) point out that poverty attracts the attention of the authorities, but also that poverty forces parents into choices which are simply not an issue for the better off. There is also the possibility that in some cases the link between poverty and child neglect may be correlative rather than causal. That is to say, those with personal problems could be more likely to drift down the social scale and also to neglect children in their care. Furthermore, unhealthy foods are cheaper and a poor child’s growth and health may suffer because of this (Hobbs et al., 1993).
Minty and Pattinson (1994) clarify the dangerousness of equating neglect to poverty. Poverty cannot be the main factor that causes neglect as not all poor families are neglectful, and also severe forms of neglect are concerned with more than dirty children. They also highlight that poor families who ask for financial assistance from the state open themselves up to greater state scrutiny than families who privately provide for themselves.

When considering the impact of poverty on the incidence of neglect, distinctions also need to be made between material poverty and emotional poverty (Rosenberg and Cantwell, 1993). Crittenden (1999) also states that poverty, unemployment, limited education, social isolation, large families and unmarried parents are significant but are not the whole story that explains why neglect occurs in some families and not others. She reflects on this by arguing that the policies and programmes to improve the low socio-economic status of poor families in the USA have not altered the level of neglect. Instead she argues that neglect is a result of severe difficulties in sustaining interpersonal relationships (see Mental health section on p.23).

**Alcohol and substance misuse**

While there is some evidence that the relationship between substance use and neglectful behaviour in parents is not a simple cause and effect relationship (Sheridan, 1995), the two are strongly correlated (Nair, 1997; Nelson et al., 1993; Egami et al., 1996). Substance abuse is usually considered to be a risk factor for disruption in primary care giving or neglect among children born to substance-using women (Nelson et al., 1993; Egami et al., 1996).

In one study, Nair (1997) found that 43% of infants born to substance-using mothers experienced a maternal inability to provide care at some point in the first 18 months of their lives. While all children born to substance-using women are disproportionately at risk, this is particularly true of children born to young female heroin users, to women who have had two or more children, to women who have had other children in care and to women who have had symptoms of depression (Nair, 1997).

Dube et al. (2001) make a detailed examination of the association between parental alcohol abuse and multiple forms of child abuse and neglect. From a questionnaire completed by 8,629 individuals, those whose parents did abuse alcohol were between two and 13 times more likely to score higher in each category that indicated experiences of abuse, neglect or adversity in childhood.

In Britain, Fisher et al. (1995) reviewed the reasons why 138 children were placed on the child protection register and found that 89% of children who were registered came from families whose parents misused alcohol and/or drugs. Also in the UK, Forrester (1995) found that among 50 families with 95 children on the child protection register, parental substance misuse was considered to be the main cause of concern. Despite such concerns and the consequence of increased care proceedings, very few substance misuse professionals were involved with families.

The correlation between substance misuse and parental failure is, however, disputed by Harrington et al. (1996). They found that maternal substance use was unrelated to neglectful parenting, and that neither of these factors was correlated with children’s cognitive and motor skills or their expressive language development.
Lessons from the literature

Inter-generational patterns
There is a significant level of evidence to suggest that some aspects of neglect are inter-generational. Buchanan (1996) examines the inter-generational transfer of behavioural patterns, looking particularly at physical abuse, neglect and emotional abuse, and found that although most families do not replicate the maltreatment suffered in their own childhood with their own children, many do maltreat. Weston (1993) found that 80% of mothers whose children had non-organic failure to thrive reported that they had been abused in childhood, the majority having been victims of violence. However, Sullivan (2000) criticises the theory of inter-generational transmission of maltreatment by advocating that the factors that keep families in poverty – such as parental unemployment, general disorganisation and lack of support networks – perpetuate neglect.

Mental health
Although most people with psychiatric disorders do not report abusing or neglecting the children in their care, a lifetime history of any mental illness has been associated with both child neglect and abuse. The balance between the two varies with the parent’s diagnosis.

Anxiety disorders (phobias, panic disorder and obsessive-compulsive disorder) are more strongly associated with neglect than abuse (Egami et al., 1996). They found that neglectful mothers tend to exhibit higher levels of depression. In the UK, Coohey (1998) found that mothers who inadequately supervised their children were less motivated, had fewer problem-solving and social skills, and were more likely to be homeless than others mothers. Ethier (1995) used various psychological scales to test the levels of parental stress among 80 families and found that among neglectful mothers there were high levels of depression. Mothers had often also been the victims of violence and sexual abuse, but they were not prone to relationship break ups any more than non-negligent mothers.

Violence
There is a growing trend to correlate violence within the home with the maltreatment of children. Iwaniec (1997) notes that evidence of the negative impact of domestic violence on children is slowly emerging and illustrates that violence in the home can impair children’s cognitive and social problem-solving behaviour, as well as their emotional functioning.

Kanto and Little (2003) debate whether domestic violence leads to parental failure to protect children from potential physical harm and psychological and emotional distress. Gibbons, Conroy and Bell (1995) found that children who are registered for protection concerns are likely to have a history of violence in the family. In 38% (59) of 155 cases of confirmed child maltreatment in Oregon, domestic violence had also occurred (McGuigan and Pratt, 2001). In most cases (78%), they found that the domestic violence had occurred prior to maltreatment of the child. In the UK, Egan-Sage and Carpenter (1999) analysed characteristics of 378 children placed on the child protection register in England. They found that lone parenthood was not a determinant factor but domestic violence from a male in the household was common.

The high level of violence in neglectful families may also relate to levels of criminality among parents. Hobbs et al. (1993) make reference to an NSPCC study which found that 15% of mothers and 41% of fathers in cases reported to them between 1983 and 1987 had criminal records prior to a diagnosis of abuse or neglect.

Ethnicity
Cultural differences in what is considered acceptable child-rearing practices have been well documented in the social science literature (Ferrari, 2002; O’Hagan, 1999). Ferrari (2002) describes the impact of culture upon child-rearing practice and consequently definitions of maltreatment, while O’Hagan (1999) advocates the need for cultural sensitivity when working with children and families. Definitions of child
neglect are culturally bound and there is always a risk that the dominant white patriarchal culture will impose its own understanding of neglect on other cultures. However, there are also a number of studies that highlight the cross-cultural consensus as to what constitutes child neglect (Stone, 1995). Despite this, there is ever-growing concern regarding the over-representation of black children who are removed from their families in Britain (Chand, 2000).

In the USA, research has attempted to dispel the commonly held belief that African-American families are prone to inadequate childcare practices. Saunders, Nelson and Landsman (1993) studied 182 families that had been referred to the state child protection team for child neglect in Pittsburgh. Despite the stereotype that deems there to be more neglect in African-American families, there was no significant difference in the incidence of neglect between ethnic groups. They concluded that while African-American families are substantially poorer than Anglo-American families, they have learned to cope with severe conditions and have built up resilience.

Child disability

Disabled children are at greater risk of maltreatment than other children (Hobbs et al., 1993). Garbarino and Barry (1997) explain how children with special needs or disabilities are disproportionately represented among those who are maltreated. Neglect has also been found to be more prevalent than physical abuse in children with chronic illnesses. This neglect includes medical care neglect, educational neglect, abandonment, emotional neglect and physical neglect (Jaudes and Diamond, 1986).

This could be because disabled children have special needs that their parents are unable to meet. Or this could be partially due to the fact that the disability may reduce the child’s ability to communicate and therefore increases their vulnerability.

Short- and long-term effects of neglect

The social, cognitive and emotional consequences of neglect can be severe, and can be considered apart from the serious injuries, death and failure to thrive that result from parents’ lack of attention. Often professionals divide the consequences of neglect into the medical/health-related issues or the social, behavioural impacts. Either way, research across the disciplines and countries suggests that neglect produces long-term detrimental effects (Tomison, 1995). Such consequences will be discussed under the following headings:

- Attachment and interactions.
- Failure to thrive.
- Development.
- Illness, morbidity and death.
- Poor academic performance.
- Delinquency.

Attachments and interactions

Crittenden (1993), using attachment theory, illustrates how children who are neglected suffer ‘anxious attachment’ which determines child-parent interactions. Children whose mothers were not psychologically available to them manifested angry, disobedient behaviour, yet were highly dependent on their mothers. A lack of parent-child interaction, therefore, is more likely than physical abuse to result in dysfunctional attachment styles in psychological functioning.

If a carer is inaccessible or unresponsive, the child is likely to develop an anxious and insecure relationship with their primary care provider and become clingy and whining. This anxiety means the child will not feel sufficiently secure to explore his or her surroundings and to develop feelings of competence. Disordered attachments can persist into later childhood: neglected children are disproportionately likely to be socially withdrawn, socially rejected and/or to have feelings of incompetence (Finzi, Cohen and Sapir 2000).
Iwaniec and Sneddon (2002) conducted a follow-up study on children who were identified as suffering from non-organic failure to thrive between 1977 to 1980 and who received social work intervention. Each individual attachment style was compared with the initial attachment with the mother. Several cases showed changes from insecure to secure attachments styles. The findings suggest that when appropriate interventions are received, they can have a positive impact on attachment.

**Failure to thrive**

Failure to thrive is widespread and accounts for 1% of all patients admitted to US paediatric hospitals (Bithony et al., 1991). The term has been used for the last 50 years to describe an infant or young child whose growth falls substantially behind that of his peers, often resulting from caloric and/or maternal deprivation.

Operationally, health visitors in the UK tend to define children whose weight is on or below the third centile as failure to thrive. However, as there is a large deviation in ‘normal weight’, a more significant measure is a downward deviation from the expected growth curve (Stone, 1995). Caution is advised, however, as there are also many pathologic or organic reasons why a child may suffer from failure to thrive, including coeliac disease, cystic fibrosis, cow’s milk intolerance, central nervous system disease, severe cardiopulmonary disease, tuberculosis, renal failure, diabetes mellitus and diabetes insipidus (Hobbs et al., 1993).

Generally, a differentiation is made between organic failure to thrive, where children are adequately cared for but still fail to grow, and non-organic failure to thrive, where children would grow if there was adequate care (Bithoney et al., 1989). Some academics are moving away from the emphasis on non-organic failure to thrive as an important manifestation of neglect (Stone, 1995). Sidebottom (2000) suggests that only a minority of failure to thrive cases have significant child protection issues.

Nonetheless, either alone, or in combination with/as a result of neglect, failure to thrive can have serious long-term effects. Children who have been diagnosed as suffering from both neglect and failure to thrive are more likely to show significant deficits in cognitive functioning than children who experience only neglect or only failure to thrive (Mackner and Starr, 1997). Children with non-organic failure to thrive have also been reported as suffering from delayed mental development (Wolke et al., 1990). A failure to thrive in infancy is associated with a higher occurrence of depression, reduced reading scores, poor language development, low social maturity and low verbal intelligence in later life (Hobbs et al., 1993).

Iwaniec (1997) reviews the research in order to make links between failure to thrive and emotional neglect. Interactional problems between mother and child are common where failure to thrive is diagnosed, which has led some scholars to determine that failure to thrive is a relationship disorder. Iwaniec (1997) describes the physical manifestations of emotional neglect in terms of growth and developmental retardation. Manifestations of disturbed behaviour include self-harming (e.g. headbanging), bizarre eating habits, disturbed toileting behaviour, destructiveness and attachment difficulties.

**Development**

Hildyard and Wolfe (2002, p. 679) have summarised the literature concerned with the impact of child neglect and concluded: ‘Child neglect can have severe, deleterious short- and long-term effects on children’s cognitive, socio-emotional and behavioural development.’ They found that if neglect occurs early on in life then the consequences could be more severe and irreversible. For instance, during the first two years of life the brain is particularly sensitive to stimulation and individuals who are deprived of stimulation during this time suffer irreversible problems in cognitive, emotional and behavioural development (Sullivan, 2000). Hildyard and Wolfe (2002) also found that the
effects of neglect often cause more severe cognitive and academic deficiencies compared to the effects of physical abuse. Children often internalise problems, have little social interactions and withdraw from peer groups.

Kerr et al. (2000) conducted an examination of the relationship between failure to thrive, maltreatment and four aspects of child development: cognitive performance, adaptive functioning at school, classroom behaviour and behaviour at home. The sample included 193 6-year-old children and their families. The results illustrated that children with a history of failure to thrive and maltreatment (defined as at least one report to the child protection service for neglect) had more behavioural problems, worse cognitive functioning and worse school performance than children without these risk factors.

Drotar and Sturm (1992) compared 48 children with early histories of non-organic failure to thrive with a sample with similar socio-demographics except health status. Non-organic failure to thrive children displayed deficits in behavioural organisation, ego control and ego resiliency compared to the control group. Deficiencies in problem-solving and personality development, and increased levels of behavioural symptoms in pre-school children with early years histories of non-organic failure to thrive may affect their future socio-emotional development and learning.

Iwaniec (1997) conducted a comprehensive overview of the literature on emotional maltreatment and concluded that the psychological development of children with failure to thrive was often impaired. Iwaniec collated data on the impact of witnessing violence within a family setting and found that studies indicate that such factors affect children’s psychological and cognitive development, as well as their coping and emotional functioning. Infants who witness spousal violence were characterised by poor health, erratic sleeping habits, excessive screaming and attachment disorders. Toddlers exposed to domestic violence were frequently ill, had acute shyness, low self-esteem and relationship difficulties in day care.

Illness, morbidity and death

The typical neglect fatality is a male child under 3 years of age, living with his mother and two or three brothers and sisters. In the overwhelming majority of deaths from neglect, the caregiver was simply absent at a critical moment when the child was exposed to a hazard (Margolin, 1990). In the United States, the Department of Health and Human Services calculated that during 1999, of the 1,100 children who died from abuse and neglect, 38% were attributed to neglect rather than any other form of maltreatment. In the USA, Rosenberg and Cantwell (1993) found that mortality arising from neglect cases is often due to lack of supervision, or, to a lesser extent, medical or nutritional neglect. However, official recording categories of ‘accidental, natural or undetermined death’ obscure these figures.

In the UK, a professional and political interest in child neglect was renewed through the death of Paul (Bridge Child Care Consultancy, 1995). Paul and his brothers and sisters had suffered gross neglect by their parents that had spanned over a 15-year period. At the age of 3, Paul died following severe nappy rash caused by being left lying in the same nappy for several days. Professionals such as social workers, health care workers (including a health visitor, a general practitioner and a paediatrician), and the neighbourhood office had been in contact with the parents over a long period, yet their persistent lack of cooperation meant that assessments and interventions were not achieved. The report on the case history and professionals’ actions highlights that despite an occupational cultural desire not to impose class-bound value labels associated with low-income families, factors such as poverty and non-cooperation must be seriously considered in cases of neglect.
Lessons from the literature

Child abuse and neglect have been associated with Sudden Infant Death Syndrome (SIDS) (Hobbs and Wynne, 1996). Investigations of SIDS children in Leeds, for example, found issues of abuse or neglect associated with more than 50% of cases (Hobbs, Wynne and Gelletlie, 1995). However, the American Association of Pediatrics’ Committee on Child Abuse and Neglect challenges this view, arguing that parents of SIDS victims typically ‘...are anxious to provide unlimited information to professionals involved in death investigation or research. They also want and deserve to be approached in a non-accusatory manner’. (American Association of Pediatrics, 2001, p. 437).

Poor academic performance
Child neglect is even more likely than other forms of child maltreatment to be predictive of poor academic performance (Kendall-Tackett, 1997), resulting in neglected children performing at a lower level, being absent more often and having more disciplinary problems than their non-neglected counterparts (Gaudin, 1993; Kendall-Tackett and Eckenrode, 1996).

Iwaniec (1983) describes how teachers reported that 17 out of 21 children who had experienced emotional neglect had poor educational attainment and experienced learning difficulties. Teachers said their social behaviour in the classroom was aimless, overactive and disruptive, and that the consequences of emotional neglect for children had been both attention-seeking and detached behaviour.

Kurtz et al. (1993) looked at the effects of child abuse and neglect on socio-emotional development. They controlled for socio-economic class and found that there were no significant differences between neglected children and those not neglected but that there were significant differences in academic performance.

Delinquency
Research findings suggest there are links between the presence of neglect and the development of antisocial behaviour. Situations where parents showed little active interest in their children were highly predictive of subsequent criminality in young people and they were also unlikely to develop effective social relationships (Cullingford and Morrison, 1997). Teenagers who have been neglected as children are also more prone to stealing, lying and behaviour that is destructive to themselves, others and property (Skuse, 1989, cited in Hobbs et al., 1993).

Such hypotheses are supported by studies in the USA. Jonson-Reid and Barth (2000) investigated whether children who received welfare services were more or less likely than those who did not to be imprisoned for youth crime. In a 10-county Californian study of 159,549 school-aged children who were reported for child abuse or neglect, they found that eight children per 1,000 were incarcerated. They went on to find that children reported for neglect were more likely to be imprisoned than those reported for physical or sexual abuse. Barnes and Farrell (1992) noted a link between parenting styles and delinquency. An absence of parental support and monitoring were important predictors of adolescent drug taking, deviance and school misconduct.

Effective interventions
Lally (1984) distinguishes three levels at which child neglect needs to be addressed. Firstly, the individual must initiate changes in behaviour to improve the caregiver’s ability to respond to the needs of the child. Secondly, intervention is needed at a societal level, which includes neighbourhood and community functioning. This will complement any intervention at an
individual level. Thirdly, fundamental beliefs and cultural agreements need to be restructured to change our perceptions of children and acceptance of poverty.

There is a lack of evaluative studies of social work interventions with neglectful families for a number of reasons:

• Neglect is often only one form of abuse that is present and therefore interventions are often not specifically for neglect but for other forms of maltreatment. This is highlighted by Stone (1998) and Stevenson (1998) who debate whether neglected children should be considered ‘children in need’ or as ‘child protection’ cases.

• Scholars who believe that poverty is the route to the existence of neglect advocate that social policies that relieve socially oppressive conditions are the only real interventions to bring about change (Nelson et al., 1993).

• Daniel and Baldwin (2001) establish that practitioners find it difficult to formulate effective responses to chronic neglect, especially at the assessment stage.

• Some scholars (Iwaniec, 1996) highlight the long-term effects of emotional neglect and question whether such damage can ever be repaired.

• As Thoburn et al. (2000) suggest, neglect, unlike other types of abuse, is often ‘filtered out’ of the child protection system.

• Other professionals in settings such as schools, pre-school services and in homes run by community professionals fail to address neglect.

Despite the wider structural issues that perpetuate neglect, there are some positive examples of effective interventions with families that are neglectful. These are discussed under the headings:

• Empowering parents.
• Expanding parental networks.
• Day care.
• Removal of children.

Empowering parents

Sullivan (2000) explains that practitioners who adopt an ‘empowerment-based’ approach to working with parents aim to develop partnerships and mutual respect as the basis for change. The underlining principles of this approach are that people are able and willing to change their behaviours and act competently. The aims of this empowerment work are to make cognitive changes with parents in order to improve their sense of self-efficacy and understand how they can change their actions.

Hobbs et al. (1993) also developed a programme to empower parents based on the following principles and aims:

• To reduce the level of family dysfunction and improve parenting skills.
• Foster skills of emotional development between adults and children.
• Focus on the family as a whole rather than just the child.

Iwaniec (1997) evaluates how parent-training classes can have a significant positive outcome for parents who are unable to provide for and protect their children. Providing cognitive and counselling work, as well as stress management and anger control techniques, can help to empower parents and teach new skills.

Expanding parental networks

It has been well documented above that social isolation and lack of both formal and informal networks is a significant feature of parents who are considered to be neglectful. Therefore, this characteristic has traditionally been the focus of intervention by social workers and other professionals who are aware of the types of community support available.

Various local and national support groups are available for families to access on a voluntary basis. Services such as pre-school facilities, adult education, welfare benefits, legal advice, parenting classes and community activities are promoted as ways to develop networks.
Lessons from the literature

In England, the SureStart early years programme for families with children under 4 years of age has been a significant resource targeted at areas of deprivation. More specific help is available through programmes such as Homestart which provides a trained volunteer to assist parents in their own homes. Stevenson (1998) notes that informal support for neglectful parents is often not readily available because other family members are caught up in their own multiple problems and deprivation. Therefore, limited interventions have been attempted through making links within families. However, specific therapeutic interventions such as family therapy can be effective in multi-type forms of abuse.

**Day care**

Much of the intervention for young children in neglectful families focuses on providing day care. Hobbs et al. (1993) insist that empowerment of adults and specific help for children can be the focus of intervention. Giving the child access to stimulating environments can go some way to repairing developmental delay, especially language and gross motor skills. However, attachment theorists like Crittenden (1993) warn that removing children into a protective daytime environment may exacerbate the danger of home environments. Iwaniec (1997) highlights that a combination of family work and day care support can be a solution for severely neglectful families and their children.

**Removal of children**

In some cases, removing children from the family home can result in improvements (Schor and Holmes, 1983). The chronic nature of neglect means that intervention can be offered after children have already suffered considerable physical, developmental and emotional damage.

In conclusion, Stevenson (1998) suggests the following approach to working with neglect:

- A holistic assessment of deficits in children’s upbringing.
- A realistic approach to working in partnership with parents.
- An acceptance of the need for long-term work.
- Flexible and intensive provision for children.
- Specialised work between social work professionals and schools.

**Collaborative practice in child neglect**

Inter-agency practice with specific reference to child neglect (or other forms of maltreatment) is significantly absent from the literature. The findings that are available have been summarised below.

**Different perceptions?**

Stone (1998) explored practitioners’ perceptions of neglect in a workshop of agency representatives from the Area Child Protection Committee for an urban area in England. Social workers, health visitors, teachers, police and probation officers were involved. The results illustrated a consensus on definitions of physical and emotional neglect that focused on the child’s needs and care. The main focus was primary needs, such as food, clothing, shelter and medical care. Surprisingly, supervision was not mentioned. Instead, the situations where children were left alone or unsupervised prompted a wide range of diverse opinions. There was also recognition of an inter-generational cycle of neglect.

When the findings from the multi-disciplinary workshop were compared to that of social workers who had recently registered families for neglect, there was a consensus on indicators of neglect. The results from Stone’s study show that there is not one overwhelming factor that professionals use to identify child neglect.
Collaborative practice in Ireland

In Ireland, Skehil et al. (1999) examined 400 referrals of child maltreatment and 100 case files of current interventions. In-depth interviews were conducted with social workers and other professionals involved in 18 ongoing child abuse cases. They found that discretion was used as to whether guidelines were implemented by practitioners. Only 60% of cases were notified to the Director of Child Care within 24 hours and only one third of cases were reported to the Garda Síochána.

Despite these inconsistencies in practice, Skehil et al. (1999) found that generic professionals, especially teachers, general practitioners and the Garda Síochána played a key role in kick-starting the child protection process. However, there were concerns about the lack of communication between professionals, especially those outside the Health Boards. The Garda Síochána were highlighted as a professional group that had difficulties networking and cooperating with other professionals. This was related to a different professional culture and training and the absence of an officer designated to child abuse issues. Ultimately, the researchers concluded that the inter-agency rhetoric was making little difference to the responsibilities and practices placed on social work professionals.

Public health nurses

The most relevant piece of research in relation to the NEHB study of child neglect was conducted by Butler (1996) with 12 public health nurses from three Health Boards in Ireland. Butler found that the views of the public health nurses on their involvement in child protection differed considerably despite officially stated commitments to interdisciplinary collaboration and coordination within Ireland’s regional Health Boards.

Butler (1996, p. 305) states: ‘Public health nurses may perceive new child care policy and practice, with its emphasis on surveillance of families, its explicit use of authority and its tendency towards adversarial relationships with clients, as being at variance with their traditional image of the nursing role.’ Butler found that public health nurses felt that the child protection role, in particular the element of social control and policing dangerous or deviant families, was at odds with their day-to-day activities and traditional role of social care. Ultimately, this meant that public health nurses ‘would not refer a family to the social worker, except in a crisis’. Public health nurses were critical of social workers for not keeping them informed and failing to respond to requests efficiently. However, Butler found that public health nurses had positive working relationships with general practitioners in childcare cases and that these could be used as models to build working partnerships with other professionals.

Lavan (1998) quotes Kelly, a public health nurse in Ireland, who explained that the effect of public health nurses’ involvement in child protection issues is a significant change from their traditional role and that many are uncomfortable with dealing with ‘at risk’ situations when individuals are so well known to them. This is a particular issue in Ireland where professionals often work and live in small tight-knit communities.

Christensen (1999) surveyed health visitors in Denmark. A questionnaire was sent to 1,242 health visitors and a response rate of 83% (1,031) was achieved. This covered 786,250 children between the ages of 1 and 4 years. She found that physical and emotional neglect were among the most prevalent types of maltreatment that health visitors observed. Of the children under 1 year, 10% received special care from the health visitors. Among these families, health visitors said that 80% of parents displayed psychosocial stressors such as alcohol abuse, relying on social welfare, physical violence towards mothers, mental illness or physical illness, and drug abuse.
Lagerberg (2001) studied how child health nurses identified child abuse or neglect and the determinants of reporting to the child protection services in Sweden. Of the 3,000 nurses in the sample, only 30% had made a referral to the child protection services. The reasons for not reporting were: a perceived lack of evidence, lack of skills, the fear of negative consequences (i.e. putting the child in a worse situation or a risk of the parent abstaining from the service), and also suspicion of the child protection services. Lagerberg (2001) concluded that personal interest was an important determinant in the identification and reporting of child abuse or neglect among child health nurses. The implications to practice were that more joint meetings and communication could be facilitated between child health nurses and other professionals.

By the very nature of their job, health visitors come into contact with a wider population of children and families than other specialist professionals. Taylor and Daniel (1999) found that health visitors often note failure to thrive, which can be associated with neglect, because they are in an ideal position to monitor relationships between the mother and child at an early stage of the child’s life.

Social workers, however, are not particularly close to families and do not have the medical expertise to diagnose such conditions. Therefore, health visitors and general practitioners should play a more active role in detection of failure to thrive cases. Anderson (1990) makes similar suggestions regarding the place of the community health nurses when intervening in the cycle of child maltreatment. Nurses who work with children and families are well placed to identify parenting problems and develop a therapeutic relationship with parents. Having established a relationship with parents, they can use such strategies as role modelling, problem solving and teaching parenting skills to promote better outcomes for children.

General practitioners and hospital doctors

Traditionally, there has been evidence to suggest that doctors, in particular general practitioners, are reluctant to report child abuse and get involved with child protection agencies (Polnay, 2000). In Britain, Polnay (2000) began with the hypothesis that the commonly cited reasons, such as inconvenient timing, fail to provide explanations for poor participation in child protection case conferences. Polnay conducted a pilot study involving telephone interviews with 12 general practitioners and then a further 94 questionnaires completed by general practitioners in Nottingham, UK. He found that attendance at case conferences is low because too many other tasks take priority. Contrary to expectation, issues of patient confidentiality and parental attendance did not affect decisions to attend conferences. Polnay suggests that recent vocational training in the UK for general practitioners had made a positive impact on attitudes regarding involvement in child protection processes.

Vulliamy and Sullivan (2000) surveyed 26 paediatricians regarding mandatory reporting of suspected cases of child abuse. They found that generally paediatricians were positive about filing a report but were critical about the lack of feedback from social workers, and they were undecided about whether their actions had any positive outcomes. They explored the reasons for failing to report cases and found that there was dissatisfaction with the child protection service and a concern about the loss of relationship with the child’s parent.

With specific relation to medical neglect, Johnson (1993) surveyed 52 staff in a paediatric hospital in the USA. He found that there was a mistrust of social service agencies that decreased the propensity to report. The failure to recognise and report medical neglect was related to the lack of professional training, personal experience of the system and a lack of financial compensation. In Australia, Van
Haeringen et al. (1998) assessed the responsiveness and attitudes of medical practitioners in reporting suspected cases of child neglect. Of 124 paediatric registrars and 100 general practitioners, 43% said they had considered a case of child abuse or neglect but had not reported the case despite mandatory reporting. The reasons for the low rate of referral were the perceived problems in the child protection services, the lack of intervention available for families, and a general lack of faith in the system.

**Education**

There is relatively little research regarding the role of education or teachers in child welfare, especially child neglect. Jones (1997) summarises some findings and concludes that children who have experienced multiple types of maltreatment have very specific problems within the education system and that girls rather than boys tend to have greater difficulties as time goes on. Gilligan (1998) explores how the school should be considered an ally for children and a guarantor of basic protection. Special support can be provided through schooling for children who have undergone adverse experiences.

**Social workers**

Minty and Pattison (1994, p. 734) describe how the recognition of neglect by social workers is likely to be influenced by two factors: firstly, by their own understanding of the nature of neglect and, secondly, by their expectation of achieving any change through intervention, either on a voluntary or statutory basis.

Tanner et al. (2000) found that social workers find neglect a particularly difficult area of practice because of the diverse operational definitions of neglect that often result in a lack of agreement about the basic standards of care. Given the difficulties in constructing a framework for understanding neglect and the quality of relationships in families, social workers found it difficult not to criticise mothers. They also highlight that the chronic and long-term nature of neglect means that any specific harm against a child is difficult to determine.

Empirical evaluations of the impact of social work intervention confirm why professionals’ perceptions regarding neglect are pessimistic. Daro and McCurdy (1993) found that intense social work activity achieved a long-term effect in only 40% of neglect cases, whereas in incidents of physical or sexual abuse, there is a higher likelihood of effective impact.

What further impedes social workers’ willingness to work with neglectful families are the legal criteria to establish significant harm. Social workers must collect evidence of neglect over time and therefore must try to work in partnership with non-compliant families for lengthy periods. In Ireland, Powell (1998, p. 320) summarises the influences of modernisation on social work policy and practice by stating: ‘The preoccupation with detection and risk assessment at the expense of welfare has inevitably resulted in failure.’ This not only applies to the changing role of social workers but other professionals, such as health visitors, who, through legislation, must take on social policing roles.

The findings from the Study 1, Child Neglect – *Is my view your view?* (Horwath and Bishop, 2001, p. 3), found that social workers lack a common understanding of the meaning of child neglect and that a range of perspectives influence the way that neglect is managed. However, the lack of clarity did not lie only with the social work practitioners, as managers of child protection services did not issue guidelines and there was a lack of standardisation of procedures. Nevertheless, despite these difficult working conditions, Horwath and Bishop (2001) found that social workers were highly skilled and committed to identifying and addressing issues of child neglect.
In Britain, relationships between social workers and health visitors have been perceived as having serious problems since the 1950s. Fox and Dingwall (1985, p. 467) looked at the quality and effectiveness of inter-agency collaboration between these two groups and found that: ‘problems of interagency liaison have consistently been attributed to deficiencies in the professional education of the staff involved resulting in variations in their perceptions of, and attitudes to child mistreatment’. Fox and Dingwall surveyed 20 health visitors and 20 social workers and found that there was agreement over the most serious incidents concerning maltreatment of a child. However, this often focused on the physical harm of children (i.e. burning with a cigarette), rather than neglect issues.

From the preliminary research of collaborative practice among professionals concerning child neglect, it can be concluded that there are continuing disagreements about the definition of neglect. Of more concern though is the shortfall in communication between different professionals and that the relationship between social workers and other professionals appears to be ineffective. Ultimately, these factors discourage other professionals from referring child protection cases, especially those of neglect.

**Multi-disciplinary training**

As a result of child death tragedies, those responsible for child protection have focused on multi-disciplinary training as a vehicle for highlighting the importance of neglect. A significant finding from the review of Paul’s case was that the professionals involved had not received up-to-date child protection training and had no specific knowledge of how to work with neglect (Bridge Child Care Consultancy, 1995, p. 183). As a result, the Area Child Protection Committee at Islington Borough Council proposed the following training for all professionals:

- Communicating with children.
- Working with families.
- Child protection investigations.
- Carrying out comprehensive assessments.
- Identifying neglect and abuse.
- Working together on an inter-agency basis.
CHAPTER THREE
RESEARCH DESIGN
AND METHODS
Research design and methods

Introduction

This research design and methods chapter describes how the research was planned, how a collaborative approach between the researchers and the NEHB was adopted and the type of methods that were used to collect data. It includes details on the following:

- Planning the research.
- Research methods.
- The questionnaire.
- Focus groups.

Planning the research

The methodological and theoretical principles that underpin this research sought to create a partnership between researchers, managers and professionals from a range of disciplines working in the NEHB region. The aim was to ensure their ownership and investment in the design, delivery, implementation process and outcome of the research. This approach has a number of benefits:

- It enables researchers who are not members of the organisation to learn from and build on the experience and knowledge of a wide range of professionals who work within the organisation.
- Professionals within the organisation are able to inform the design, delivery and analysis of the research, ensuring it addresses the needs of the organisation.
- Robson (1995) highlights that collaborative work reduces problems related to implementation.
The Steering Group

A multi-disciplinary Steering Group, comprised of members of the Child Care Advisory Committee and other relevant professionals, was established in order to achieve these benefits.

This Steering Group was made up of 20 senior managers and practitioners across the 15 different disciplines (e.g. health and social care, education and the Garda Síochána) that were to be included in the research (see Table 1 on p. 38). The Steering Group met on five occasions and advised the researchers on realistic objectives, sample groups and size, appropriate methodology and how Study 2 should be administered.

The research methods

The researchers together with the Steering Group agreed that an approach bringing together qualitative and quantitative methods of data collection and analysis would meet the aims and objectives of Study 2. The strengths of using both qualitative and quantitative research methods to research child neglect have already been established by Polnay (2000).

The following research methods were used:

- An anonymous postal questionnaire.
- Focus groups.

These methods were selected to provide data on the following areas:

- To identify professionals’ understanding of neglect as defined under Section 3.2 of Children First – National Guidelines for the Protection and Welfare of Children.
- To understand factors that inform professionals’ decisions to report potential cases of child neglect to the Community Care social work teams.
- To explore professionals’ understanding of their role in terms of identifying, referring, assessing and intervening in cases of child neglect.
- To explore professional and organisational needs in view of guidance regarding multi-disciplinary assessment and intervention.

Questionnaires, a successful tool for gathering information

Questionnaires have long been established in social science as the main quantitative technique for collecting information from a large number of people (Dillman et al., 1993). Questionnaires have also proved to be a successful tool when studying child neglect practice among paediatricians and general practitioners (Van Haeringer et al., 1998; Johnson, 1993; and Vulliamy and Sullivan, 2000). Given the time scale and aims of this project, and given that questionnaires are a proven method for providing reliable answers to social questions, this was the main method chosen for the research.

An anonymous questionnaire was used successfully in the NEHB’s Study 1 of social workers’ perceptions of child neglect. With this in mind, the Steering Group decided to pilot an adapted version of the questionnaire. The aim was to provide data that could be used to compare social workers’ responses regarding perceptions of child neglect and their roles and responsibilities with those of other professionals.

The pilot study

Six different professional groups (e.g. health, education and the Garda Síochána) were included in the pilot study. This selection reflected the target groups for the multi-disciplinary research project. Of the 25 professionals targeted, 15 responded giving a response rate of 60%. The analysis of the results and comments generated at this stage resulted in the questionnaire being adapted to meet the needs of multi-disciplinary respondents. The main changes to the original questionnaire used with social workers were:

- A reduction of the number of open-ended questions.
- Inclusion of more structured questions.
- A shortened version of the questionnaire for general practitioners.
- Adapting the scenarios to make them relevant to the different professional groups.
The questionnaire

The questionnaire used in the study included 60 questions (see Appendix 1). Some were open-ended questions, others multiple choice and a number used a Likert scale to grade responses from ‘strongly agree’ to ‘strongly disagree’. Two case scenarios were also used. The questions were designed to elicit information on the following topics:

- Socio-demographic factual details about the types of professionals responding, e.g. their age, gender, ethnicity, length of time in post and profession.
- The professionals’ role in identifying, referring and assessing neglect.
- Specific factors used by professionals to determine neglect.
- Understanding the concept ‘good enough parenting’.
- Attitudes relating to how decisions are made by professionals regarding the nature of neglect and referring cases.
- Factors that prevent professionals making referrals to Community Care social work teams.
- Decision-making in specific situations.
- Specific reasons that negatively affect the referring of child neglect, e.g. workload/time pressures/poor working relationships.
- Ways in which practice with neglected children can be improved.
- Changes that could help improve the identification of, and response to, neglect.

Scenarios have been successfully used in other studies to explore professionals’ perceptions of child neglect (see Giovanni and Becerra, 1979; Fox and Dingwall, 1985; Stone, 1998). Horwath and Bishop (2001) used case scenarios in the first phase of this research (Study 1) with managers and social workers from the NEHB region. Here, scenarios proved a successful method of extracting detailed information about professionals’ understanding of thresholds. Hence, they were included in this study to elicit respondents’ perceptions of neglect and their approach to identifying and intervening in these cases.

The two case scenario questions were omitted from the general practitioners questionnaire because members of the Steering Group considered that questions that required considerable reading and writing would result in a low response rate. These changes reflect other experiences of researching doctors by questionnaire (Minty and Pattison, 1994, p. 744). The general practitioners questionnaire did, however, include all the other questions that the rest of the sample were asked.

The sample

Table 1 (on p. 38) shows the range of professional groups that were included in the sample. The aims of the project determined that a purposive sample selection was necessary. This means that the Steering Group decided on specific groups of professionals for inclusion in the research due to their everyday contact with children and families, rather than a random selection of professionals.

The professional groups were selected in consultation with the Steering Group because they are considered to come into contact with children and families and have a responsibility to identify and refer cases. Of the following professionals groups, all those working in the NEHB region were included in the sample population:

- Public health nurses.
- Speech and language therapists.
- Clinical psychologists.
- Consultant paediatricians and paediatric nurses.
- Area medical officers.
- Drugs outreach workers.
- Child psychiatry.
- General practitioners.
In addition, a sample from the following groups was selected:

- Primary school workers.
- Pre-school workers.
- Post-primary school workers.
- Accident and emergency nurses.
- Mental health workers.
- Paediatric nurses and consultants.
- Disability service.
- The Garda Síochána.

Table 1
Breakdown of questionnaire sample by profession

<table>
<thead>
<tr>
<th>Profession</th>
<th>Sent questionnaires</th>
<th>Returned questionnaires</th>
<th>Response rate for occupation %</th>
<th>Total % of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>141</td>
<td>59</td>
<td>42</td>
<td>14.5</td>
</tr>
<tr>
<td>Public health nurse</td>
<td>119</td>
<td>56</td>
<td>47</td>
<td>13.8</td>
</tr>
<tr>
<td>Primary school workers</td>
<td>115</td>
<td>56</td>
<td>49</td>
<td>13.8</td>
</tr>
<tr>
<td>The Garda Síochána</td>
<td>80</td>
<td>50</td>
<td>63</td>
<td>12.3</td>
</tr>
<tr>
<td>Pre-school workers</td>
<td>80</td>
<td>42</td>
<td>53</td>
<td>10.4</td>
</tr>
<tr>
<td>Post-primary school workers</td>
<td>57</td>
<td>33</td>
<td>59</td>
<td>8.1</td>
</tr>
<tr>
<td>Speech and language therapists</td>
<td>34</td>
<td>24</td>
<td>71</td>
<td>5.9</td>
</tr>
<tr>
<td>Mental health workers</td>
<td>45</td>
<td>15</td>
<td>33</td>
<td>3.7</td>
</tr>
<tr>
<td>Clinical psychologists</td>
<td>29</td>
<td>11</td>
<td>38</td>
<td>2.7</td>
</tr>
<tr>
<td>Child psychiatry</td>
<td>22</td>
<td>11</td>
<td>50</td>
<td>2.7</td>
</tr>
<tr>
<td>Accident and emergency nurses</td>
<td>39</td>
<td>10</td>
<td>26</td>
<td>2.4</td>
</tr>
<tr>
<td>Paediatric nurses and consultants</td>
<td>13</td>
<td>8</td>
<td>62</td>
<td>1.9</td>
</tr>
<tr>
<td>Drugs outreach workers</td>
<td>6</td>
<td>6</td>
<td>100</td>
<td>1.4</td>
</tr>
<tr>
<td>Disability service</td>
<td>10</td>
<td>5</td>
<td>50</td>
<td>1.2</td>
</tr>
<tr>
<td>Area medical officers</td>
<td>10</td>
<td>4</td>
<td>40</td>
<td>0.9</td>
</tr>
<tr>
<td>Spoiled data</td>
<td>/</td>
<td>15</td>
<td>/</td>
<td>3.7</td>
</tr>
<tr>
<td>Total</td>
<td>800</td>
<td>405</td>
<td>/</td>
<td>100</td>
</tr>
</tbody>
</table>

Eight hundred questionnaires were distributed, 405 were returned and 390 were used in the data set. Fifteen returned questionnaires were classed as spoiled data because of either a lack of complete information or due to the fact they were returned after the cut-off date required for inclusion in the analysis.

There was an overall response rate of 49%. When considering the nature of the questionnaire and the short time frame of three weeks in which to return the questionnaire, the response rate is in line with expectations from postal questionnaires (Salant and Dillman, 1994).

---

6 Questionnaires from one family support worker, one accident and emergency nurse, one garda, two general practitioners, three mental health workers and seven public health nurses.
Two main factors appeared to have influenced the response rate: the time required to complete the questionnaire and the perception of some professionals that they were ‘over-researched’. In the context of modern day practices for health and social care practitioners, 40 minutes is a considerable amount of time. The reality is that time is money and research in this field competes with other demands on staff as is reflected in one response from a general practitioner on returning an uncompleted questionnaire: *Thank you for the questionnaire. 40 minutes of my professional time is currently valued at 96 euros. On receipt of this sum I will be more than happy to spend 40 minutes filling in your questionnaire.*

**Item completion**

The tables in the appendices reporting all professionals’ responses highlight the level of question completion. To summarise, for the majority of the questions there was no less than 4% of responses missing. There were some exceptions to this. The open-ended questions received the highest non-response rate and two final qualitative questions that required a written response regarding ideas for changing practice and effective ways of working also recorded relatively high non-response rates. 17% of responses to these two questions were missing.

**Data analysis**

Overall there were some 182 items, or parts of questions, on the main questionnaire to be analysed and a further 83 items to be analysed on the general practitioners’ questionnaire. The questionnaire responses were inputted into a Statistical Package for Social Sciences (SPSS) database and analysed for descriptive statistics and cross tabulations.

---

**Focus groups**

**The advantages of focus groups**

To explore the experiences of several people, to find out substantive meanings and to interpret quantitative findings, focus groups have been adapted from market research for research into social issues. The advantages of focus groups have been described by Kitzinger (1994), Morgan (1997) and Gibbs (1997) as:

- A research tool that obtains several perspectives on the same topic at one time.
- A way to gain insight into peoples shared understanding of a particular topic.
- A tool to explore respondents’ attitudes, feelings, beliefs, experiences and reactions in a way that is not possible with other methods.

Focus groups have also been used successfully in studies of professionals’ involvement in child maltreatment cases. For example, Bulter (1996) used focus groups with public health nurses to find out about their experiences of working with child protection issues and Horwath and Bishop (2001) used focus groups in Study 1.

Focus groups were used in this study, Study 2, to give professionals an opportunity to comment on and interpret some of the findings from the questionnaire. In addition, the groups provided opportunities for the researchers to test some of the hypotheses arising from preliminary analysis of the questionnaire data.
Focus group participants
Ten focus groups were held between 3 March and 13 March 2003 within the NEHB region. Members of the professional groups were selected for participation in focus groups, enabling them to comment on any profession-specific issues. As it was not viable to run focus groups for each profession, the various disciplines were divided by the Steering Group into the following groupings:

- Heads of departments (directors of public health nurses, principal psychologists, garda superintendents, etc.).
- Community Care (clinical psychologists, speech and language therapists, area medical officers, disability social workers).
- Public health nurses for Louth and Meath.
- Members of the Garda Síochána.
- Primary and post-primary school workers for Louth and Meath.
- General practitioners.
- Pre-school workers.
- Hospitals and Community Care (accident and emergency nurses, speech and language therapists, drugs outreach workers, paediatric nurses).
- Public health nurses for Cavan/Monaghan region.
- Primary and post-primary school workers for Cavan and Monaghan.

Focus group content
Six themes were explored in the focus groups:

- The role and responsibility of each professional in relation to identifying, referring and assessing child neglect.
- Thresholds and perceptions of what constituted neglect.
- The meaning of ‘gut feeling’, ‘anonymous referrals’, as well as the definition of neglect and experiences of referring to Community Care social work teams.
- The barriers to attending case conferences.
- Barriers impacting on the ability to refer cases of child neglect to Community Care social work teams.
- Changes that could be made within the social work department and within their own profession to improve practice.

A range of methods were used to elicit information:

- Individual exercises.
- Exercises in small groups or pairs.
- Specific questions/headings to which respondents were asked to respond.
- Tablecloth exercise where all respondents were invited to make written contributions.
- All exercises were followed by a general feedback discussion where notes and verbatim comments were collected.

The researchers were given a 30-minute slot at a training session for general practitioners. In the light of the time constraints, three questions were asked:

- What are the inhibitors to referring cases of child neglect to the Community Care social work team?
- What are the barriers to attending case conferences?
- What changes could be made to address these issues?
Focus group sample

Table two below provides a breakdown of the 85 professionals who took part in the focus groups.

Table 2:
Participants of focus groups by gender and professional group

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers from public health nursing, child psychiatry, clinical psychology, the Garda Síochána, and speech and language therapists</td>
<td>2</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Primary and post-primary school workers</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Community Care, including disability social workers and clinical psychologists</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Public health nurses</td>
<td>0</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Hospitals, including drugs outreach workers, speech and language therapists, accident and emergency nurses managers, and paediatric managers</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Pre-school workers, including playgroup providers, crèche managers, after-school supervisors, private nurseries, childcare coordinators, nursery directors, pre-school coordinators and nursery managers</td>
<td>0</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>The Garda Síochána</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>General practitioners</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13</td>
<td>72</td>
<td>85</td>
</tr>
</tbody>
</table>

Bearing in mind staff shortages and workload pressures in the public sector (Jones, 1992), attendance was high. Senior professionals in particular, however, noted the impact of work commitments on engaging in research. A number of apologies were received citing work commitment, not lack of interest, for failure to attend.

Data analysis

The results of the focus groups were transcribed into textual documents that were then analysed by a computer package (Atlas.ti) specifically designed to identify general overall themes and patterns. A process known as ‘open coding’ was used to find out the main issues reported by respondents.

Based on what is already known from the literature and the preliminary findings of the questionnaire, categories were selected (e.g. problems with communication) and then the transcripts were read to see if these categories were or were not present, or if there were new categories. Then, with the aid of the computer package, relationships were mapped between categories and professionals to establish whether there were common experiences or whether some experiences are specific to certain groups.
CHAPTER FOUR
QUESTIONNAIRE FINDINGS
Questionnaire findings

Introduction

This section reports on the findings obtained from the questionnaire that was distributed to professionals who work with children and families in the NEHB region. Eight hundred questionnaires were sent out and 405 were returned. Of these, 390 contained sufficient data for analysis. This included 59 responses from general practitioners who completed a shortened version of the questionnaire.

This section describes the overall findings for the whole sample7 under the following headings:

- Respondent profile.
- Working with child neglect and maltreatment.
- Role of the professional.
- ‘Good enough parenting’.
- Unacceptable home environment.
- Making decisions in cases of child neglect.
- Case studies.
- Decision-making and planning actions.
- Factors which influence decision-making.

Respondent profile

Of the 390 respondents, 98% identified themselves as white European and 61% were female. The majority of respondents were aged 30 years or over (89%), with the largest percentage of respondents aged between 40 and 49 years (36%). 77% of respondents had experience of caring for children in a professional or personal capacity.

---

7 A separate booklet of appendices is available which provides a detailed breakdown of the questionnaire findings for each professional group.
Questionnaire findings

Table 3:
Breakdown of respondents to questionnaire by profession

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioners</td>
<td>59</td>
</tr>
<tr>
<td>Public health nurses</td>
<td>56</td>
</tr>
<tr>
<td>Primary school workers</td>
<td>56</td>
</tr>
<tr>
<td>Pre-school workers</td>
<td>42</td>
</tr>
<tr>
<td>Post-primary school workers</td>
<td>33</td>
</tr>
<tr>
<td>Mental health workers</td>
<td>15</td>
</tr>
<tr>
<td>Clinical psychologists</td>
<td>11</td>
</tr>
<tr>
<td>Child psychiatry</td>
<td>11</td>
</tr>
<tr>
<td>The Garda Síochána</td>
<td>50</td>
</tr>
<tr>
<td>Speech and language therapists</td>
<td>24</td>
</tr>
<tr>
<td>Accident and emergency nurses</td>
<td>10</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>8</td>
</tr>
<tr>
<td>Drugs outreach workers</td>
<td>6</td>
</tr>
<tr>
<td>Disability workers</td>
<td>5</td>
</tr>
<tr>
<td>Area medical officers</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>390</td>
</tr>
</tbody>
</table>

The respondents were experienced professionals. Of the 390 respondents, 72% had been working in the same profession for over 10 years. Only 3% had embarked on their professional career within the last year. The remainder had been working for between one and 10 years in the same profession.

The majority of respondents had considerable experience in their current posts, with 150 (38%) having worked in their current post for over 10 years. A further 63 (16%) had been in their current post for between six and 10 years. 126 (32%) had been in their present post for between one and five years, with only 3% of respondents having been in their post for less than one year.

Over half of the sample, or 176 (53%), identified themselves as practitioners and 32% as managers. 12% identified themselves as occupying both practitioner and managerial roles.
Table 4:
Child neglect referrals made by respondents to Community Care social work teams

<table>
<thead>
<tr>
<th>Number of referrals made</th>
<th>Number</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>None within the last year</td>
<td>204</td>
<td>52</td>
</tr>
<tr>
<td>One case</td>
<td>70</td>
<td>18</td>
</tr>
<tr>
<td>Between two and four cases</td>
<td>89</td>
<td>23</td>
</tr>
<tr>
<td>Between five and seven cases</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Between eight and 10 cases</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Eleven + cases</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Missing responses</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>390</td>
<td>100</td>
</tr>
</tbody>
</table>

As Table 4 above shows, over half of the sample had not made a referral of child neglect within the last year to the Community Care social work teams. Only a minority of professionals were referring suspected cases of child neglect on a regular basis. Of this group, the average number of referrals made to social work teams was between two and four reports within the last year.
Role of the professional in relation to cases of neglect

The questionnaire included questions designed to identify the role the professional played in cases of child neglect. Questions were included that explored their role in relation to identifying, referring, and assessing child neglect. Respondents were also asked about their involvement in providing services to children who have been neglected, providing services to parents to improve parental skills, and working with parents in other ways. Involvement with other professionals on neglect cases and their role in writing reports on children who have been neglected was also explored.

Table 5:
Professionals who did not see identifying neglect as part of their role

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child psychiatry</td>
<td>6</td>
</tr>
<tr>
<td>Drugs outreach workers</td>
<td>3</td>
</tr>
<tr>
<td>Mental health workers</td>
<td>6</td>
</tr>
<tr>
<td>Primary school workers</td>
<td>15</td>
</tr>
<tr>
<td>Post-primary school workers</td>
<td>9</td>
</tr>
<tr>
<td>Clinical psychologists</td>
<td>3</td>
</tr>
<tr>
<td>Area medical officers</td>
<td>1</td>
</tr>
<tr>
<td>Pre-school workers</td>
<td>9</td>
</tr>
<tr>
<td>Disability workers</td>
<td>1</td>
</tr>
<tr>
<td>The Garda Síochána</td>
<td>6</td>
</tr>
<tr>
<td>Accident and emergency nurses</td>
<td>1</td>
</tr>
<tr>
<td>Speech and language therapists</td>
<td>2</td>
</tr>
<tr>
<td>Public health nurses</td>
<td>3</td>
</tr>
<tr>
<td>General practitioners</td>
<td>1</td>
</tr>
</tbody>
</table>

Of the 390 responses, 66 (17%) replied that it was not their role to identify neglect. As Table 5 above shows, over half of child psychiatry professionals and half of drugs outreach workers did not regard identifying neglect as part of their role. However, caution should be taken when interpreting these findings as the sample size was small. 40% of mental health workers did not see it as part of their role and more than a quarter of all school staff did not see identifying cases of neglect as part of their role. The remaining professionals displayed more varied views with between 5% and 20% stating that identifying neglect was not part of their remit. However, only one general practitioner said that identifying neglect was not part of a general practitioner’s role.
Questionnaire findings

As can be seen from Table 6 below, referring cases of neglect was a role confirmed by 90% of all professionals questioned. Identifying neglect was considered part of their role by 83% of respondents and working with other professions to identify neglect was a role recognised by 82% of respondents. Working with parents and writing reports about cases of neglect was confirmed as a role by 63% and 58% of professionals respectively. Assessing neglect, providing services for cases of neglect or helping with parenting skills were much less common roles played by professionals with just one third of professionals, identifying these as roles they fulfilled.

Table 6:
Professionals who confirmed their role in identifying neglect cases

<table>
<thead>
<tr>
<th>Responses</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer neglect</td>
<td>351</td>
</tr>
<tr>
<td>Identify neglect</td>
<td>323</td>
</tr>
<tr>
<td>Work with other professions</td>
<td>318</td>
</tr>
<tr>
<td>Work with parents</td>
<td>246</td>
</tr>
<tr>
<td>Write reports about</td>
<td>224</td>
</tr>
<tr>
<td>Assess neglect</td>
<td>128</td>
</tr>
<tr>
<td>Service for neglected</td>
<td>127</td>
</tr>
<tr>
<td>Help with parenting skills</td>
<td>121</td>
</tr>
</tbody>
</table>

Although a high percentage of professionals confirmed their role in neglect cases, only a relatively small proportion had attended case conferences. As Table 7 below illustrates, 39% (151) of the respondents had no experience of attending case conferences, while only 25% (100) had experience of regularly attending conferences (i.e. five or more cases per year). Nearly three quarters of the sample had either no experience or only minor experience of attending case conferences.

Table 7:
Number of professionals who had attended case conferences

<table>
<thead>
<tr>
<th>Responses</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended none</td>
<td>151</td>
</tr>
<tr>
<td>Attended one</td>
<td>48</td>
</tr>
<tr>
<td>Attended two to four</td>
<td>85</td>
</tr>
<tr>
<td>Attended five to seven</td>
<td>47</td>
</tr>
<tr>
<td>Attended eight to 10</td>
<td>19</td>
</tr>
<tr>
<td>Attended 11 +</td>
<td>34</td>
</tr>
<tr>
<td>Missing responses</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>390</td>
</tr>
</tbody>
</table>
‘Good enough parenting’

Respondents were asked to describe what they understood by the term ‘good enough parenting’. Key themes were identified and the responses were coded into themed interpretations of ‘good enough parenting’. As Table 8 shows, the largest proportion of professionals, (115, 29%) equated ‘good enough parenting’ with parenting that is just adequate. The parent meeting both the physical and emotional needs of the child was identified by 84 (22%); with a further 53 (14%) identifying the term as meaning the child’s physical needs are being met. 26 (7%) of the respondents identified ‘good enough parenting’ as meaning the parent was doing his/her best and 17 (4%) interpreted it as meaning the child was safe. For 37 (10%) of the respondents, the term was either unfamiliar to them or was seen to be vague or meaningless.

Table 8:
Professionals’ understanding of the term ‘good enough parenting’

<table>
<thead>
<tr>
<th>‘Good enough parenting’</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting is just adequate</td>
<td>115</td>
<td>29</td>
</tr>
<tr>
<td>The parent is meeting both the physical and emotional needs of the child</td>
<td>85</td>
<td>22</td>
</tr>
<tr>
<td>Meeting the child’s physical needs</td>
<td>53</td>
<td>14</td>
</tr>
<tr>
<td>The parent does his/her best</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>The concept is vague or meaningless</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>The parenting is not meeting the child’s needs</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>The child is safe</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Promoting the child’s development</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Unfamiliar with the term</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Parents providing emotional warmth</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Missing responses</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>390</td>
<td>100</td>
</tr>
</tbody>
</table>
Questionnaire findings

Unacceptable home environments

Study 1 highlighted that professionals referring and assessing child neglect used generalised terms to describe unacceptable home environments, such as ‘poor general décor’ and ‘soiled furnishings’. In order to establish whether professionals shared a common understanding of these terms, professionals were asked to elaborate on their understanding of these generalised terms. Respondents were given a list of indicators of child neglect and were asked to rate the factors causing most concern.

Table 9:
Factors causing most concern to professionals regarding décor

<table>
<thead>
<tr>
<th>Indicators of neglect: general décor</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and safety risks in the home</td>
<td>328</td>
<td>84</td>
</tr>
<tr>
<td>Loose electrical wires</td>
<td>293</td>
<td>75</td>
</tr>
<tr>
<td>Parents unmotivated to change the environment</td>
<td>128</td>
<td>33</td>
</tr>
<tr>
<td>Damp</td>
<td>110</td>
<td>28</td>
</tr>
<tr>
<td>Unclean home</td>
<td>87</td>
<td>22</td>
</tr>
<tr>
<td>Lack of furniture</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Torn wallpaper</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Missing carpets</td>
<td>1</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Table 10:
Factors causing most concern to professionals regarding soiled furnishings

<table>
<thead>
<tr>
<th>Indicators of neglect: soiled furnishings</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faeces or urine on furnishings</td>
<td>332</td>
<td>85</td>
</tr>
<tr>
<td>Infestation</td>
<td>321</td>
<td>82</td>
</tr>
<tr>
<td>Animal soiling in house</td>
<td>237</td>
<td>61</td>
</tr>
<tr>
<td>Stale food</td>
<td>136</td>
<td>35</td>
</tr>
<tr>
<td>Very dirty house</td>
<td>71</td>
<td>18</td>
</tr>
<tr>
<td>Broken furniture</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Bad smells</td>
<td>17</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 11:
Factors causing most concern to professionals regarding bathroom hygiene

<table>
<thead>
<tr>
<th>Indicators of neglect: bathroom hygiene</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathroom dirty with faeces</td>
<td>348</td>
<td>89</td>
</tr>
<tr>
<td>Health hazards in bathroom</td>
<td>315</td>
<td>81</td>
</tr>
<tr>
<td>No running water</td>
<td>313</td>
<td>80</td>
</tr>
<tr>
<td>Foul smells</td>
<td>68</td>
<td>17</td>
</tr>
<tr>
<td>No toilet paper</td>
<td>57</td>
<td>15</td>
</tr>
<tr>
<td>No toilet seat</td>
<td>20</td>
<td>5</td>
</tr>
</tbody>
</table>
There was significant consensus among professionals that exposing children to danger through health and safety issues as a result of poor hygiene and house maintenance is an indicator of child neglect. In terms of assessing the child, professionals varied more in their responses, although ‘clothing unsuitable for the weather’ and a child who smelt as a result of the ‘lack of parental care’ were considered indicators of neglect by the majority of respondents.

Table 12:
Professionals' understanding of the term ‘inadequately dressed child’

<table>
<thead>
<tr>
<th>Understanding of ‘inadequately dressed child’</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clothing unsuitable for the weather</td>
<td>257</td>
<td>66</td>
</tr>
<tr>
<td>Ill-fitting garments</td>
<td>107</td>
<td>27</td>
</tr>
<tr>
<td>Clothes likely to be unwashed</td>
<td>70</td>
<td>18</td>
</tr>
<tr>
<td>Clothing that was worn</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>Clothing that was soiled</td>
<td>55</td>
<td>14</td>
</tr>
<tr>
<td>Clothing likely to stigmatise or isolate the child</td>
<td>50</td>
<td>13</td>
</tr>
<tr>
<td>Wet clothing</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Smelly clothes</td>
<td>8</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 13:
Professionals' definitions of a ‘smelly child’

<table>
<thead>
<tr>
<th>Defining of a ‘smelly child’</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of parental care</td>
<td>281</td>
<td>72</td>
</tr>
<tr>
<td>Clothes would be dirty</td>
<td>116</td>
<td>30</td>
</tr>
<tr>
<td>Faeces and urine smells</td>
<td>100</td>
<td>26</td>
</tr>
<tr>
<td>Likely to have medical condition</td>
<td>96</td>
<td>25</td>
</tr>
<tr>
<td>Body odour</td>
<td>94</td>
<td>24</td>
</tr>
<tr>
<td>Clothes could be damp</td>
<td>29</td>
<td>7</td>
</tr>
<tr>
<td>Smell of alcohol on child</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Smell of cigarettes on child</td>
<td>2</td>
<td>0.5</td>
</tr>
</tbody>
</table>

There was significant consensus among professionals that exposing children to danger through health and safety issues as a result of poor hygiene and house maintenance is an indicator of child neglect. In terms of assessing the child, professionals varied more in their responses, although ‘clothing unsuitable for the weather’ and a child who smelt as a result of the ‘lack of parental care’ were considered indicators of neglect by the majority of respondents.
Questionnaire findings

Making decisions in cases of child neglect

Respondents were asked to consider the following statements and indicate to what extent they agree or disagree with them. The responses to the statements regarding perceptions of social workers indicate a lack of consensus among professionals about social workers’ approaches towards child neglect.

Figure 1:
Social workers accept lower standards of parenting than other professionals who are in contact with children and families

Although the largest proportion of respondents (32%) disagreed that social workers accept lower parenting standards compared with other professionals, there was considerable ambiguity and 28% were not sure.

Figure 2:
Social workers are more concerned with specific incidents of abuse than ongoing concerns regarding neglect

41% of respondents agreed with the statement that social workers provide parents with the support required to keep their children out of care. However, a further 27% said they were unsure about this statement.

Figure 4:
The criteria for accepting a referral by a Community Care social work team depend on which social worker takes that referral

Professionals again showed a range of opinions regarding how social workers understand and treat cases of child neglect. Virtually one third of the sample (30%) disagreed with the statement that social workers are more concerned with single incidents rather than ongoing concerns of neglect, whereas a similar proportion (27%) agreed with the statement.

Figure 3:
Social workers provide parents with the support required to keep their children out of the care system
Nearly one third (28%) of respondents disagreed with the statement that the acceptance of a referral regarding child neglect depends on the social worker that takes that referral. However, 34% of respondents were unsure about this statement.

**Figure 5:**
Whether we like it or not, if one of the carers is physically aggressive we may tolerate standards of care that we would not normally accept among less aggressive carers

28% disagreed and a further 22% strongly disagreed with the statement that professionals tolerate standards of care among physically aggressive carers that would not be accepted among less aggressive carers.

**Figure 6:**
The essential aspect of parenting is providing for a child's physical needs and safety: 34% disagreed while 26% agreed with the statement.

**Figure 7:**
Children witnessing violence can suffer as much as if they themselves were being hit

There was considerable contention regarding the statement that the essential aspects of parenting are to provide for a child's physical needs and safety: 34% disagreed while 26% agreed with the statement.

**Figure 8:**
The most damaging environment for a child is one of high criticism and low warmth

There appeared to be considerable consensus that an environment of high criticism and low warmth was most damaging for a child, with 34% of respondents strongly agreeing, and a further 41% agreeing with this statement.
Figure 9: A child who is physically neglected is likely to be experiencing emotional neglect as well.

Again, there appears to be some consensus among respondents regarding the links between emotional and physical neglect. 51% of respondents strongly agreed that there was a link, while a further 32% agreed that the presence of physical neglect was likely to mean a child was also experiencing emotional neglect.

Figure 10: A drinking problem always influences a parent’s ability to care for their child.

35% of respondents agreed while a further 41% strongly agreed that a parent abusing alcohol always influences their ability to care for a child.

In summary, the responses to questions relating to professionals’ own attitudes towards aspects of neglect varied. This was most notable when professionals were questioned on the essential aspects of parenting, with 45% agreeing that the focus should be on the child’s physical needs and safety, and 48% disagreeing. Results show that there is a division among the following professions – general practitioners, public health nurses, primary schools, paediatrics, the Garda Síochána, speech and language therapists – regarding the essential aspects of parenting. However, professionals tend to agree that witnessing violence, parents drinking excessively and living in a high-criticism, low-warmth family would impact on children. In addition, 83% believe physical neglect is associated with emotional neglect.
Case scenarios

Apart from the general practitioners, all other respondents were asked to consider the following two scenarios and answer the related questions.

Case 1: Liam takes a child into care

An anonymous telephone call is made to the Community Care social work team at 2.30pm on a winter afternoon. The caller says that he is aware of a case of child neglect. The caller gives the name of the family and address and states that an 8-year-old child is currently in the house on their own. The family is not known to the NEHB.

Liam, a social worker with many years’ experience, responds to the call at 5pm. The address that was given is a very run down isolated farm. The social worker knocks on the door, which is answered by an 8- to 9-year-old boy.

At first glance, Liam sees that the child is dirty. There are bruises on the child’s knees and there is a scrape on his right elbow. Liam notices that the house is messy. He ascertains that there is no heating and there is little food in the fridge or cupboards. Liam asks the child about his parents’ whereabouts. The child says he does not know where they are but they have been out all day. Liam waits an hour for the parents to return and when they do not appear, Liam decides to take the boy into care.

Do you agree with Liam’s decision?

Respondents’ responses to this situation varied with 56% either agreeing or strongly agreeing with the social worker’s decision to take the boy into care, while a further 21% disagreed with Liam’s decision. When the results are further analysed by professional group, it appears that within most professions there are varied ideas as to what course of action should be taken in this situation. Apart from the four area medical officers who all agreed with Liam’s decision, there were significant differences among individual professional groups. For example, in all of the other professional groups, there was a proportion of respondents who disagreed with the decision.

Table 14:
Do you agree with Liam’s decision?

<table>
<thead>
<tr>
<th>Agree/disagree with Liam</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>86</td>
</tr>
<tr>
<td>Agree</td>
<td>132</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>12</td>
</tr>
<tr>
<td>Disagree</td>
<td>68</td>
</tr>
<tr>
<td>Not sure</td>
<td>30</td>
</tr>
<tr>
<td>Missing responses</td>
<td>3</td>
</tr>
</tbody>
</table>

Those who agreed with Liam’s decision to remove the child from the situation (218) ranked the following 11 indicators of child neglect as causing the most concern, to causing the least concern.

Table 15:
Indicators of child neglect causing most concern, as identified by professionals

<table>
<thead>
<tr>
<th>Indicators of child neglect causing most concern</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child alone</td>
<td>124</td>
</tr>
<tr>
<td>Length of absence</td>
<td>24</td>
</tr>
<tr>
<td>Child injured</td>
<td>17</td>
</tr>
<tr>
<td>Age of child</td>
<td>17</td>
</tr>
<tr>
<td>No food</td>
<td>9</td>
</tr>
<tr>
<td>Missing responses</td>
<td>9</td>
</tr>
<tr>
<td>No other adults</td>
<td>4</td>
</tr>
<tr>
<td>No heat</td>
<td>4</td>
</tr>
<tr>
<td>Winter</td>
<td>4</td>
</tr>
<tr>
<td>Isolated area</td>
<td>3</td>
</tr>
<tr>
<td>House rundown</td>
<td>2</td>
</tr>
<tr>
<td>Child is dirty</td>
<td>1</td>
</tr>
</tbody>
</table>

As Table 15 above illustrates, 56% of those who agreed with Liam’s decision did so because they were concerned about the child being left alone.
Table 16: Reasons for disagreeing with Liam’s decision

<table>
<thead>
<tr>
<th>Reasons for disagreeing with Liam’s decision</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should have placed child with relatives or neighbours</td>
<td>24</td>
</tr>
<tr>
<td>Should have waited longer</td>
<td>16</td>
</tr>
<tr>
<td>Should have contacted police</td>
<td>15</td>
</tr>
<tr>
<td>Should have consulted with supervisors</td>
<td>11</td>
</tr>
<tr>
<td>Should have contacted other agencies</td>
<td>5</td>
</tr>
<tr>
<td>Probably a reasonable explanation</td>
<td>4</td>
</tr>
<tr>
<td>Should have intervened earlier</td>
<td>3</td>
</tr>
<tr>
<td>Should have consulted the child’s wishes</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 16 above outlines the reasons given by the 80 respondents who disagreed with Liam’s decision. Those who were not sure whether Liam’s decision was the right one (30) explained why. It was suggested by 29% that there may have been a plausible explanation for the parental absence (see Table 17).

Case 2: The O’Connor family

Family composition:
- May O’Connor (mother), 32 years old, unemployed.
- Tony O’Connor (father), 38 years old, unemployed.
- Declan, 8 years old.
- Claire, 5 years old.
- Deirdre, 3 years old.
- Imelda, 18 months old.

May is described by professionals who know her as ‘pleasant but ineffectual’. She spends most of the time watching TV and expects the older children to fend for themselves and care for the younger children. She is expecting her fifth child in four months’ time and has told the social worker that she does not know how she will manage with another child.

The father, Tony, has been unemployed for seven years. He drinks heavily and it is believed he is violent towards May. He takes no responsibility for childcare and refuses to have contact with staff from the NEHB.

The NEHB has had involvement with this family for the last seven years because of concerns of neglect. The older children have been in care on two occasions when May said she was unable to cope. The children last returned home eight months ago and a family support worker was allocated to the family. Support has been ongoing. However, there has been little change in terms of improved standards of care. The NEHB regularly receives referrals from neighbours, public health nurses and the school stating that the children are unsupervised, ‘running wild’ and are inadequately fed and clothed.

There are concerns about all the children, particularly Imelda. She was on the sixtieth centile at birth but is now on the fiftieth. She spends most of the day in a pushchair in front of the TV. Imelda is unable to walk but can push herself to the standing position and can crawl. She has about five words. She presents as a miserable child rarely smiling.

Table 17: Reasons given by professionals for answering ‘not sure’

<table>
<thead>
<tr>
<th>Reasons given by professionals for answering ‘not sure’</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probably an acceptable explanation</td>
<td>9</td>
</tr>
<tr>
<td>Removal too drastic</td>
<td>6</td>
</tr>
<tr>
<td>Limited facts</td>
<td>6</td>
</tr>
<tr>
<td>Legal issues</td>
<td>5</td>
</tr>
<tr>
<td>Neighbours or family may be nearby</td>
<td>2</td>
</tr>
<tr>
<td>Should have waited</td>
<td>2</td>
</tr>
</tbody>
</table>
From a list of evidence presented, respondents were asked to note the five factors causing most regarding Imelda’s situation.

**Table 18:**
Five factors causing most concern regarding Imelda’s welfare

<table>
<thead>
<tr>
<th>Factors</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in centile</td>
<td>85</td>
</tr>
<tr>
<td>No change despite intervention</td>
<td>71</td>
</tr>
<tr>
<td>Allegations of domestic violence</td>
<td>43</td>
</tr>
<tr>
<td>Lack of stimulation</td>
<td>28</td>
</tr>
<tr>
<td>In pushchair all day</td>
<td>28</td>
</tr>
<tr>
<td>Mother depressed</td>
<td>19</td>
</tr>
<tr>
<td>Rarely smiles</td>
<td>16</td>
</tr>
<tr>
<td>Mother’s passivity</td>
<td>14</td>
</tr>
<tr>
<td>Frequent referrals</td>
<td>12</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>7</td>
</tr>
<tr>
<td>Poverty</td>
<td>4</td>
</tr>
<tr>
<td>Father neglects role</td>
<td>4</td>
</tr>
<tr>
<td>Child not walking</td>
<td>4</td>
</tr>
<tr>
<td>Speaks few words</td>
<td>2</td>
</tr>
</tbody>
</table>

Respondents were most concerned about the change in Imelda’s centile reading and that there had been no change in the family’s situation despite interventions by professionals, as shown in Table 18 above.

From a prepared list, respondents were asked to indicate the five factors causing most concern regarding the other children in the O’Connor family. As Table 19 below highlights, witnessing violence was highlighted as the most significant concern, with 17% of respondents identifying this as the factor causing most concern. Lack of parental guidance caused most concern for 16% and 14% highlighted the risk of potential physical harm as causing most concern.

**Table 19:**
Five factors causing most concern regarding the other children in the O’Connor family

<table>
<thead>
<tr>
<th>Factors</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnessing violence</td>
<td>56</td>
</tr>
<tr>
<td>No parental guidance</td>
<td>52</td>
</tr>
<tr>
<td>Poor physical health</td>
<td>46</td>
</tr>
<tr>
<td>Potential physical harm</td>
<td>45</td>
</tr>
<tr>
<td>Lack of supervision</td>
<td>44</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>14</td>
</tr>
<tr>
<td>Caring for younger siblings</td>
<td>13</td>
</tr>
<tr>
<td>Alcohol abuse by father</td>
<td>11</td>
</tr>
<tr>
<td>Poor nurturing</td>
<td>9</td>
</tr>
<tr>
<td>Trauma of being in care</td>
<td>8</td>
</tr>
<tr>
<td>Lack of role models</td>
<td>7</td>
</tr>
<tr>
<td>Lack of stimulation</td>
<td>6</td>
</tr>
<tr>
<td>Lack of stability</td>
<td>6</td>
</tr>
<tr>
<td>No boundaries</td>
<td>4</td>
</tr>
</tbody>
</table>
Given that resources are limited and that needs often have to be prioritised, respondents were also asked which *single* issue would they prioritise in relation to this family? The results are outlined in Table 20.

**Table 20:**
Main priority area for services

<table>
<thead>
<tr>
<th>Main priority area for services</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s passivity</td>
<td>138</td>
</tr>
<tr>
<td>Imelda’s development</td>
<td>71</td>
</tr>
<tr>
<td>Father’s aggression</td>
<td>54</td>
</tr>
<tr>
<td>Father’s lack of responsibility</td>
<td>20</td>
</tr>
<tr>
<td>Unborn child</td>
<td>16</td>
</tr>
<tr>
<td>Children’s behaviour</td>
<td>16</td>
</tr>
<tr>
<td>Father’s passivity</td>
<td>8</td>
</tr>
<tr>
<td>Missing responses</td>
<td>8</td>
</tr>
</tbody>
</table>

Although in responses to a previous question only 14 respondents were concerned about the mother’s passivity in terms of Imelda’s welfare, 138 of 331 (42%) considered this to be the issue that should be prioritised for services.

Respondents were also asked to consider, in their opinion, what should be the three priorities for the NEHB concerning this family? Their responses are outlined in Table 21.

**Table 21:**
Three main priorities for the NEHB concerning this family

<table>
<thead>
<tr>
<th>Three main priorities for the NEHB identified by professionals</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family support package</td>
<td>134</td>
</tr>
<tr>
<td>Increase intensive support</td>
<td>125</td>
</tr>
<tr>
<td>Medical check for Imelda</td>
<td>102</td>
</tr>
<tr>
<td>Case conference</td>
<td>74</td>
</tr>
<tr>
<td>Remove children/care proceedings</td>
<td>72</td>
</tr>
<tr>
<td>Respite/fostering</td>
<td>57</td>
</tr>
<tr>
<td>Arrange day care</td>
<td>53</td>
</tr>
<tr>
<td>Counselling for mother</td>
<td>39</td>
</tr>
<tr>
<td>Domestic violence support</td>
<td>37</td>
</tr>
<tr>
<td>Counselling for father</td>
<td>37</td>
</tr>
<tr>
<td>Parenting course</td>
<td>36</td>
</tr>
<tr>
<td>Supervision order</td>
<td>33</td>
</tr>
<tr>
<td>Alcohol programme</td>
<td>32</td>
</tr>
<tr>
<td>Barring order on father</td>
<td>26</td>
</tr>
<tr>
<td>Educate mother on contraception</td>
<td>24</td>
</tr>
<tr>
<td>Consider fostering</td>
<td>23</td>
</tr>
<tr>
<td>Monitor situation</td>
<td>18</td>
</tr>
<tr>
<td>Encourage father to work</td>
<td>17</td>
</tr>
<tr>
<td>After-school club</td>
<td>10</td>
</tr>
<tr>
<td>More assessment</td>
<td>8</td>
</tr>
<tr>
<td>Missing responses</td>
<td>7</td>
</tr>
<tr>
<td>Wait until baby born</td>
<td>1</td>
</tr>
</tbody>
</table>

Respondents varied in their response to this question. Over one third prioritised family support packages (134, 41%) and increasing intensive support (125, 38%). Over 20% prioritised the removal of the children (72, 22%).
Table 22:
Other professionals who should be working with this family

<table>
<thead>
<tr>
<th>Other professionals who should work with this family</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health nurse</td>
<td>177</td>
</tr>
<tr>
<td>Mental health workers</td>
<td>161</td>
</tr>
<tr>
<td>General practitioners</td>
<td>152</td>
</tr>
<tr>
<td>Schools</td>
<td>125</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>117</td>
</tr>
<tr>
<td>Family support</td>
<td>111</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>72</td>
</tr>
<tr>
<td>Clergy</td>
<td>64</td>
</tr>
<tr>
<td>Women’s Aid</td>
<td>53</td>
</tr>
<tr>
<td>The Garda Síochána</td>
<td>46</td>
</tr>
<tr>
<td>Alcohol counsellor</td>
<td>19</td>
</tr>
<tr>
<td>Missing responses</td>
<td>12</td>
</tr>
</tbody>
</table>

As demonstrated in Table 22 above, over half of the respondents considered that public health nurses should be involved with this family and 48% cited the involvement of mental health services. General practitioners and paediatricians were the next most commonly cited professionals by respondents as needing to be involved with the family, at 46% and 35%, respectively.

Decision-making and planning actions

The following statements were included in the questionnaire. They are based on literature regarding decision-making in child protection. Respondents were asked to consider each statement and say whether they agreed or disagreed. Statements fell into two categories: those that gave rise to a varied response and those that gave rise to consensus.

The following statements engendered a variation of responses:

Figure 11:
Decisions to refer are made on the basis of previous responses from Community Care social work teams

Of all the professional groups, clinical psychologists were most likely to agree that decisions are made on the basis of previous responses from Community Care social teams. Over half of child psychiatry staff (6) and half of all accident and emergency nurses and paediatric staff (4) agreed with this statement. Between 40% and 55% of educational professionals also agreed with this statement.
Figure 12:
Decisions are made on the basis of what the young person wants, provided they have the ability to understand and make informed choices.

Professionals from public health nursing, primary schools, speech and language therapy, clinical psychology, child psychiatry, disability and general practice either disagreed with this statement or were unsure, as were area medical officers. Professionals from pre-schools, the Garda Síochána, post-primary schools, mental health workers, accident and emergency nurses, drugs outreach workers and paediatric workers were divided equally between agreeing, not agreeing or being unsure about the statement.

Figure 13:
Decisions are made based on what I consider to be in the best interest of the child, irrespective of the views of the child and family.

Paediatricians and accident and emergency nurses were most likely to agree with this statement. Among educational professionals, less than 50% agreed that the best interest of the child was paramount in decision-making. This generally reflects the trend for the other professional groups.

Figure 14:
Decisions are influenced by the perceived consequences of making a referral.

The majority of professionals were split between agreeing, disagreeing and answering not sure to this statement. Two professional groups proved exceptional to this trend. These were the speech and language therapists, with 18 (75%) agreeing and the general practitioners, with 34 (58%) agreeing with this statement.
Respondents indicated greater consensus in response to the following statements:

**Figure 15:**
Decisions are made based on the impact of neglect on the child

A majority of the sample agreed with this statement (333, 86%). Mental health workers and clinical psychologists were less likely to agree with this statement, with just over 60% of both these professional groups agreeing with this statement.

**Figure 16:**
Decisions are made taking into account the views of supervisors and managers

General practitioners and public health nurses were less likely to agree with this statement with 40% and 55% respectively disagreeing. For the remaining professional groups, between 60% and 100% agreed that they were influenced by their supervisor.

**Figure 17:**
Referrals are not made because professionals have personal knowledge or associations with children and their families in the community

Drugs outreach workers were the only professional group that overwhelmingly agreed with this statement, with five of the six workers agreeing. Professionals from general practices, disability services, mental health services, speech and language therapy, child psychiatry, primary schools, public health nursing and the Garda Síochána disagreed with this statement. Clinical psychologists, paediatricians, area medical officers, accident and emergency nurses, and professionals from both post-primary and pre-schools were split in their responses to this statement.
Questionnaire findings

Figure 18:
It is acceptable for professionals to make anonymous referrals

The majority of professionals disagreed that it was acceptable to make anonymous referrals. Only paediatrics workers and pre-school professionals were split in their responses to this question.

Figure 19:
National guidelines state that professionals should always tell parents when they are making a referral regarding their children, unless doing so would place the child in danger. This would influence the decision to refer

Over 70% of clinical psychologists, area medical officers and paediatricians strongly disagreed with this statement. Over half of primary school and pre-school professionals agreed with this statement, as did members of the Garda Síochána. The remaining professional groups were split in their answers.

Figure 20:
Decisions are made using ‘gut feeling’ or ‘intuition’

All 11 clinical psychologists agreed that intuition was important in decision-making. This can be sharply contrasted with the figures that indicate that only between 23% and 30% of educational professionals and 40% of public health nurses and disability workers agreed with this statement.

Figure 21:
Decisions are made based on professional practice experience

In contrast to the above question, professional practice experience was rated as important by between 70% and 100% of professionals with the exception of mental health workers (66%), general practitioners (59%) and post-primary school professionals (60%).
Factors which influence decision-making

Respondents were asked to consider a list of possible constraints to the referral process and indicate the extent to which each of the factors negatively influences their ability to work with the Community Care social work teams in cases of child neglect. The list was based on constraints identified in Study 1. Responses are outlined in Table 23 below.

Table 23:
Constraints that negatively influence professionals’ ability to work with Community Care social work teams in cases of child neglect

<table>
<thead>
<tr>
<th>Constraint</th>
<th>All of the time</th>
<th>Most the time</th>
<th>Sometimes</th>
<th>Occasionally</th>
<th>Never</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time constraints</td>
<td>39 10.83</td>
<td>83 21.1</td>
<td>118 30.1</td>
<td>52 13.3</td>
<td>73 18.7</td>
<td>27 6.9</td>
</tr>
<tr>
<td>Workload pressure</td>
<td>44 11.3</td>
<td>84 21.5</td>
<td>99 25.4</td>
<td>63 16.2</td>
<td>78 20.0</td>
<td>22 5.6</td>
</tr>
<tr>
<td>Limited resources</td>
<td>41 10.5</td>
<td>83 21.3</td>
<td>87 22.3</td>
<td>69 17.7</td>
<td>84 21.5</td>
<td>26 6.7</td>
</tr>
<tr>
<td>Legislation</td>
<td>25 6.4</td>
<td>57 14.6</td>
<td>101 25.9</td>
<td>72 18.4</td>
<td>105 27.</td>
<td>30 7.7</td>
</tr>
<tr>
<td>Making contact with Community Care social teams</td>
<td>23 5.9</td>
<td>53 13.6</td>
<td>88 22.6</td>
<td>71 18.2</td>
<td>115 29.4</td>
<td>40 10.2</td>
</tr>
<tr>
<td>Views of supervisor</td>
<td>16 4.1</td>
<td>22 5.6</td>
<td>61 15.6</td>
<td>65 16.6</td>
<td>193 49.5</td>
<td>33 8.5</td>
</tr>
<tr>
<td>Nature of the job</td>
<td>29 7.4</td>
<td>48 12.3</td>
<td>80 20.5</td>
<td>61 15.6</td>
<td>141 36.1</td>
<td>31 7.9</td>
</tr>
<tr>
<td>Issues of confidentiality</td>
<td>36 9.2</td>
<td>21 5.4</td>
<td>64 16.4</td>
<td>74 19.0</td>
<td>170 43.5</td>
<td>25 6.4</td>
</tr>
<tr>
<td>Working relationship</td>
<td>11 2.8</td>
<td>34 8.7</td>
<td>81 20.7</td>
<td>63 16.2</td>
<td>171 43.8</td>
<td>30 7.7</td>
</tr>
<tr>
<td>Lack of training</td>
<td>29 7.4</td>
<td>47 12.1</td>
<td>117 30.0</td>
<td>70 17.9</td>
<td>97 24.8</td>
<td>30 7.7</td>
</tr>
</tbody>
</table>

None of the factors listed in Table 23 above had a significant influence on constraining the referral of cases to the Community Care social work teams. However, professions were more divided in considering whether some factors had a greater influence than others. For example, 62% believed time constraints had a negative influence some of the time to all of the time. 58% considered that workload had a negative influence some of the time to all of the time, and limited resources were deemed a negative influence by 54% of respondents. 49% felt that the views of the supervisor did not have a negative influence and 62% of respondents considered that confidentiality only occasionally or never negatively influenced their ability to refer.
Respondents’ reactions are recorded in Table 24 to the following open-ended question: What factors do you consider negatively influence your ability to refer to Community Care social work teams in cases of child neglect?

Table 24:
Negative influences on professionals’ ability to refer cases of child neglect

<table>
<thead>
<tr>
<th>Negative influence</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing influences my ability to refer</td>
<td>79</td>
<td>20</td>
</tr>
<tr>
<td>Missing responses</td>
<td>66</td>
<td>17</td>
</tr>
<tr>
<td>Poor access to social workers</td>
<td>50</td>
<td>13</td>
</tr>
<tr>
<td>Lack of communication from Community Care social work teams</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Previous lack of response</td>
<td>31</td>
<td>8</td>
</tr>
<tr>
<td>Lack of training</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td>Lack of experience</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>Unclear thresholds</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Lack of knowledge</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Always respond to intuition</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Aggressive parental attitudes</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Relationships with colleague</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Lack of resources</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Supervisor/manager</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Heavy workload</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Need to deal with cases more urgently</td>
<td>1</td>
<td>0.25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>390</strong></td>
<td><strong>99.75</strong></td>
</tr>
</tbody>
</table>

As shown in Table 24 above, although 20% of respondents were clear that nothing influenced their ability to refer, poor access to social workers was cited by 13% of professionals and lack of communication from Community Care social work teams influenced 10% of respondents.
In response to an open-ended question asking respondents to comment on what would make them more effective in cases of child neglect, respondents believed better communication from Community Care social work teams would make them more effective. Training was identified by 17% of respondents as increasing effectiveness. (See Table 25 below.)

Table 25:
Factors identified by professionals as increasing effectiveness in cases of child neglect

<table>
<thead>
<tr>
<th>‘I feel I could be more effective in cases of child neglect if just...’</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better communication from Community Care social work teams</td>
<td>86</td>
<td>22.0</td>
</tr>
<tr>
<td>More training</td>
<td>64</td>
<td>16.4</td>
</tr>
<tr>
<td>Missing responses</td>
<td>52</td>
<td>13.3</td>
</tr>
<tr>
<td>Clearer thresholds</td>
<td>38</td>
<td>9.7</td>
</tr>
<tr>
<td>Prompt intervention from Community Care social work teams</td>
<td>22</td>
<td>5.6</td>
</tr>
<tr>
<td>Increased resources</td>
<td>15</td>
<td>3.8</td>
</tr>
<tr>
<td>If Community Care social work teams worked more flexible hours</td>
<td>15</td>
<td>3.8</td>
</tr>
<tr>
<td>Better access to social workers</td>
<td>15</td>
<td>3.8</td>
</tr>
<tr>
<td>More time</td>
<td>11</td>
<td>2.8</td>
</tr>
<tr>
<td>Positive view of referral process</td>
<td>10</td>
<td>2.5</td>
</tr>
<tr>
<td>More experience</td>
<td>9</td>
<td>2.3</td>
</tr>
<tr>
<td>Confidentiality kept by social workers</td>
<td>9</td>
<td>2.3</td>
</tr>
<tr>
<td>Better supervision</td>
<td>8</td>
<td>2.0</td>
</tr>
<tr>
<td>More staff</td>
<td>8</td>
<td>2.0</td>
</tr>
<tr>
<td>Preventative work with families</td>
<td>8</td>
<td>2.0</td>
</tr>
<tr>
<td>Reduced caseload</td>
<td>7</td>
<td>1.7</td>
</tr>
<tr>
<td>Continuity of social workers</td>
<td>7</td>
<td>1.7</td>
</tr>
<tr>
<td>More authority</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>If I had greater dedication</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Welfare support given to parents</td>
<td>1</td>
<td>0.25</td>
</tr>
<tr>
<td>Total</td>
<td>390</td>
<td>99.15</td>
</tr>
</tbody>
</table>

Better communication from Community Care social work teams was cited by 22% of professionals as most likely to increase professionals’ effectiveness in cases of child neglect. 16% of respondents believed more training would increase effectiveness.
CHAPTER FIVE
QUALITATIVE RESULTS
FROM THE FOCUS GROUPS
Qualitative results from the focus groups

Introduction

Focus groups were used in this study to give professionals an opportunity to comment on and interpret some of the findings from the questionnaire. In addition, the groups provided opportunities for the researchers to test some of the hypotheses arising from a preliminary analysis of the questionnaire data. Ten focus groups were held between 3 March and 13 March 2003 within the NEHB region. Six themes were explored in the focus groups:

- The role and responsibility of each professional in relation to identifying, referring and assessing child neglect.
- Thresholds and perceptions of what constituted neglect.
- The meanings of ‘gut feeling’ and ‘anonymous referrals’, the definition of neglect, and experiences of referring to social workers.
- Barriers impacting on the ability to refer cases of child neglect to social workers.
- The barriers to attending case conferences.
- Changes that could be made within the Community Care social teams and within their own profession to improve practice.

Due to time constraints, the focus group with general practitioners was limited to 30 minutes and focused on three issues:

- What are the inhibitors to referring cases of child neglect to the Community Care social work teams?
- What are the barriers to attending case conferences?
- Suggestions for change.

After the data collection period, both the written and recorded verbal responses were collated and the computer package Atlas.ti was used to analyse the data. Content analysis was applied to the data to establish common themes. As described in the section on methodology,
some professionals were grouped together in the focus groups and therefore findings will be reported in terms of focus group clusterings as listed below:

- Managers (directors of public health nurses, principal psychologists, superintendents, etc.).
- Community Care (clinical psychologists, speech and language therapists, disability service).
- Public health nurses (two groups).
- The Garda Síochána
- Primary and post-primary school workers (two groups).
- Pre-school workers.
- Hospital workers (accident and emergency nurses, speech and language therapists, drugs outreach workers, paediatric nurses).
- General practitioners.

A number of professional groups that were included in the questionnaire and also invited to the focus groups were unable to participate. These were the area medical officers, paediatricians and mental health workers. A total of 85 professionals took part in the focus groups.

The questions used in the focus groups and the themes identified from the content analysis carried out on the data are used to structure the findings presented in this section.

**Defining child neglect**

Professionals recognise the complexity of defining neglect and that it incorporates a wide spectrum of factors as demonstrated by the comments below:

- ‘Neglect is a very broad issue and there are no definite guidelines, so [it’s] down to personal opinion.’ (Garda)
- ‘Psychological and emotional neglect – difficult to define in a situation where the mother is an alcoholic.’ (Pre-school workers)
- ‘Ignoring advice on safety devices in the home, parents smoking in the presence of children, Internet access unsupervised, not knowing who the father of the children is, not attending antenatal care, concerns about housing and diet, poor stimulation – watching TV all day, mother going out at night and leaving children.’ (Public health nurse)

Professionals described how they found it difficult to define neglect among minority ethnic groups and that different cultural values and parenting styles further complicated identifying neglect:

- ‘Significant cultural issues when defining neglect – no guidance.’ (Public health nurse)
- ‘Cultural differences mean that what may appear as neglect isn’t.’ (Public health nurse)
- ‘Depends on family and culture. What may be acceptable for one isn’t for another.’ (Garda)

**Identifying neglect**

A number of themes were noted. These are considered in detail below:

At least 35 (41%) of respondents consistently referred to their ‘obligation’ to identify child neglect and refer any suspected cases to the NEHB. This obligation was linked to awareness of their role in terms of national guidelines:

- ‘National guidelines state that we have to identify and report neglect.’ (Public health nurse)
- ‘This is a major part of my role...I am obliged to take action if I have concerns.’ (Education worker)

The respondents were aware that their position in relation to children’s families enabled them to identify neglect. Professionals said that they were not only responsible for identifying neglect themselves, but also for passing on the concerns brought to them by neighbours and occasionally other professionals who wanted to remain anonymous.
In line with findings from the questionnaire, all professional groups gave a detailed and lengthy list of the types of factors they consider when identifying neglect. Overall, however, the respondents tended to focus on physical neglect and parenting issues:

- ‘Lack of nutrition, hygiene, odour, dishevelled appearance, if quiet in group discussion, or tearful, erratic behaviour or quietness.’ (Education worker)
- ‘Look at the physical condition of the child, their clothing, weight, skin, and their emotional state – bonding and attachment, self-esteem.’ (Public health nurse)
- ‘Physical neglect, poor attention from parents regarding the child’s needs, Traveller families particularly vulnerable, tendency to miss speech appointments, and lack of stimulation.’ (Speech and language therapist)

During the identifying stages, the majority of professionals are involved in information gathering processes about the child and family. A variety of methods were identified as information gathering tools:

- ‘I would look at the history of the family and see whether they are dysfunctional, with a history of alcohol or drug abuse, poor parenting skills, e.g. diet, interaction with child. I would look at the history of the other children and whether they had been in care or had any history of physical abuse.’ (Public health nurse)
- ‘We use staff observations and records when identifying.’ (Pre-school worker)
- ‘We would contact the liaison officer or the primary school principal where the child was at school before referring on to social worker which is the last resort.’ (Education worker)

Team discussions are an essential part of the process of identifying child neglect. Over 60 (71%) of the respondents highlighted the importance of discussion with colleagues when identifying neglect:

- ‘We try and create a culture of care within the school, so that we all can identify neglect and that collective wisdom will prevail.’ (Education worker)
- ‘As coordinator, the issue of neglect would come up at team meetings and a decision would have to be made as to how to proceed or not.’ (Disability social worker)
- ‘Discuss with team the possibility and look for information from schools or Community Care team.’ (Child psychiatrist)

The role of the manager, in terms of establishing thresholds for concern, was also highlighted. Respondents believe the supervisor or line manager is crucial in determining whether a situation is neglectful or not:

- ‘I work in the drug addictions field so I would always identify a problem in a family and pass on the concerns to my line manager.’ (Drugs outreach worker)
- ‘Teachers make known (to the principal) their concerns for a child and observe for a time, then they will discuss with other teachers.’ (Education worker)
- ‘Role of the public health nurse is to report to her line manager and then the social worker.’ (Director of public health nurses)

Even when neglect had been identified, it did not necessarily mean that a referral was made to social workers. Instead, other agencies were considered more appropriate, relevant and responsive:

- ‘Information comes from class and subject teachers or from my own observations. Because dealing with children aged 12+, I often interview children myself, and get in touch with parents. This is normally sufficient. Otherwise I will go to the garda liaison or the primary school principal where the child was at school before referring on to social worker which is the last resort.’ (Education worker)
- ‘We would identify neglect and discuss with the line manager and the general...
practitioner. The needs may only be for family support, home help, finance and housing.' (Director of public health nurses)

Public health nurses considered they had a significant role to play in identifying neglect. They generally agreed that neglect had to be established over a period of time. Therefore, when meeting a family for the first time, it was difficult to make an instant judgement. Furthermore, given the growing pressures of workloads, less time was spent visiting homes which made it hard for them to monitor the development of neglect.

### Referring neglect

Respondents are aware of their professional obligation under national guidelines to refer cases of neglect to the NEHB:

- ‘Referrals made out of obligation rather than the expectation that something will come of it because the staff are so busy.’ (Education worker)
- ‘Teachers are mainly involved in this stage – consider it an obligation but doubtful that it will have a very positive outcome from NEHB as they are too busy to effect any change.’ (Education worker)
- ‘Mandatory to refer to a social worker.’ (Garda)
- ‘Public health nurses have a statutory obligation to refer cases of child neglect – all public health nurses are aware of this. Clear lines of referral to duty social worker and their line manager.’ (Director of public health nurses)

Key NEHB personnel used a variety of routes to access social workers and make referrals. These took the form of telephone conversations, contacting particular individuals, preparing detailed reports for Community Care social work teams or contacting team leaders for advice on the suitability of referrals:

- ‘Refer cases of suspected neglect to Community Care social work department and find out if referral acted on – re-discuss if necessary.’ (Child psychiatrist)
- ‘Submit a detailed referral to social work noting causes for concern and submit any relevant psychological reports.’ (Psychologist)
- ‘I would refer direct – person to person.’ (Psychologist)
- ‘Telephone conversation with the duty social worker, after discussing with line manager and then a report is written to the social worker.’ (Public health nurse)

Compared to the other professional groups, education professionals tried to deal with the situation as much as possible themselves:

- ‘Only make referrals if there is a marked deterioration after the school has addressed the issues.’ (Education worker)
- ‘It would be our practice to try and sort out the issues informally by our own sensitive inquiries. We would cooperate with the social worker if and when they would contact us.’ (Education worker)

Making referrals to social workers was considered a ‘last resort’ and appeared to be linked to professionals’ concerns regarding the negative impact a referral to Community Care social work teams might have on a family or child:

- ‘We usually use the public health nurse and any referral made to the social worker was a last resort.’ (General practitioner)
- ‘Referrals are made to social workers as a last resort because often they do more damage.’ (Education worker)
- ‘There is a stigma attached to social workers and there is no follow through so we tend to use other professionals.’ (Public health nurse)
Referring as a ‘last resort’ also appeared to be linked to respondents’ concerns for their own personal welfare. At least 50 comments were made in the 10 focus groups about respondents, concerns for their own personal welfare once they refer a family to social workers, particularly among professionals from schools:

• ‘We also have to consider that our business could be affected and we could lose our livelihood if a referral is made and there are negative repercussions.’ (Pre-school worker)

Experiences of referring

Some professionals relayed positive experiences of referring cases of child neglect to the Community Care social work teams:

• ‘Mostly positive but variable, depending on area and social work resources.’ (Manager)
• ‘Can be a positive experience if you have a good relationship with a social worker.’ (Public health nurse)
• ‘Sometimes positive and some social workers are excellent.’ (Hospital worker)

Some professionals were unclear about the referral process and unsure about the thresholds that social workers would accept. However, a key finding was that professionals generally had negative experiences when contacting social workers and frequently used the following adjectives to describe their feelings: ‘frustration’, ‘anger’, ‘lack of support’, ‘anxiety’, ‘fear’, ‘caution’, ‘discomfort’ and ‘problematic’:

• ‘Slow to react – not listened to, nothing done about referral, not taken seriously, only interested in facts, poor communication/feedback.’ (Manager)
• ‘Fear, caution, job done; frustrating, difficult, barriers, anxious, superior attitude, anger because left with problem, relief, disappointment, time lapse, poor communication, no feedback, lack of cohesion in the system or continuity of workers, no informal discussion with social workers, no chance to develop relationships with colleagues.’ (Public health nurse)

Anonymous referrals

The majority of professionals said that it was never acceptable to make an anonymous referral because of the Children First guidelines:

• ‘Remaining anonymous would neither be helpful to the child, school or the social worker.’ (Pre-school worker)
• ‘As a health professional we cannot make anonymous referrals.’ (Public health nurse)
• ‘Never acceptable because it goes through the superintendent who knows who they are. From a legal point of view it may lead to a prosecution. Gardaí are always made accountable, it is our duty to give our name.’ (Garda)

However, there were certain situations where anonymity was considered acceptable (for example, where the child or the professional may be in danger if the referrer’s name is disclosed):

• ‘When it may sabotage the therapy relationship to do otherwise and direct questions to the family have not been satisfactorily answered.’ (Psychologist)
• ‘Ideally it is not acceptable, but then if it could affect the personal life then it may be.’ (Public health nurse)
• ‘For the protection of the child, it is better to make an anonymous referral than no referral at all.’ (Education worker)

Some respondents said that anonymity was acceptable if there was the possibility that a referral could spark aggressive reactions from parents:

• ‘If there is a direct threat to your own welfare or safety.’ (Public health nurse)
• ‘If the referral source would be at risk, then it is acceptable from a member of the public.'
Must consider health and safety issues for staff too.’ (Speech and language therapist)

Barriers to referring neglect
Professionals said they were not prevented from referring cases of child neglect to Community Care social work teams, but it was the lack of responsiveness from the social work department that prevented action:
• ‘Nothing stops me making a referral but there is a feeling that nothing will happen and won’t be followed up unless in a crisis case.’ (Disability social worker)
• ‘Never have a problem referring but the way which social workers deal with referrals when they receive them means that they do more harm than good.’ (Garda)
• ‘History of being ignored, dismissed concerns and views not taken seriously.’ (Manager)
• ‘9-5 working hours means no on-call service over the weekends when it is the busiest time.’ (Hospital worker)

The two main areas of concern were the lack of feedback from the Community Care social work teams and the lack of continuity of staff:
• ‘No personal response or feedback from social workers – no follow-up as to what has happened to a family. No named social worker to contact, need to put a face to a name and strike up better liaison so there was room for informal discussions and to instil more confidence.’ (General practitioners)
• ‘Difficulty contacting social workers, poor availability, left messages and not returned.’ (Education worker)
• ‘Continuity of staff is appalling – three social workers on one case over a year.’ (Education worker)
• ‘High turnover of staff is major problem in continuity of contact and communication – never know who to speak with.’ (Public health nurse)

Professionals also expressed concern regarding the threshold of neglect and the importance given to the issue of neglect:
• ‘Referrals of neglect given low priority, lack of clear criteria for referral.’ (Manager)
• ‘Not clear when they should refer a case as there was no obvious criteria.’ (General practitioner)
• ‘Unsure of criteria to refer a child as neglect has different standards.’ (Public health nurse)
• ‘Lack of understanding of cultural issues regarding asylum seekers, hard to work out how to react and what is acceptable.’ (Hospital worker)

Professionals felt there was a lack of standardised response once a referral had been made:
• ‘Lack of standardisation of assessment, impact, or follow-up by social workers.’ (Manager)
• ‘Sense that once a referral was made there was a loss of control – not sure what would happen once the social worker was informed. One doctor reported how she contacted social services with initial suspicions and the whole situation mushroomed out of control.’ (General practitioner)

However, professionals from pre-schools did note that there had been some recent changes that made referring more standardised:
• ‘There have been some changes – there is now a standard form available for referring cases – but it would be useful to have a tool for observations so there was a framework. Communication is much better now.’ (Pre-school worker)

Professionals expressed concern regarding the implications of a referral in relation to aggressive parents:
• ‘Aggressive parents going to workers’ house and threatening them, personal danger from parents was a major concern and preventor
of referring to social workers. The service can be based in the providers’ home and this has major implications for individuals and their families.’ (Pre-school worker)

- ‘In the community the public health nurse works daily so there is a fear of violence from family in the area.’ (Public health nurse)
- ‘Fears over safety, making future difficulties for interaction with family.’ (Manager)

Public health nurses described a particular set of practical barriers that prevented them referring cases of child neglect:
- ‘Lack of time for reflective practice.’
- ‘Filling in forms, assessments can take time which necessitates prioritising work – feeling of undue pressure, forwarding forms to line manager and then may have to amend referrals.’
- ‘Due to a lack of time, child neglect may not be identified in the first place and therefore not referred on.’
- ‘Ongoing cases still demand a written contribution rather that discussion.’

Assessing

There was a strong understanding of the importance of multi-agency assessment of the needs of children and families:
- ‘Joint assessment work is important between the childcare team and the disability team.’ (Disability social worker)
- ‘Liaise with the social worker, share awareness of support services, sharing of information and developing good goals for the family.’ (Public health nurse)
- ‘Attend case conference or contact social worker to get up-to-date information and monitor the situation.’ (Education worker)

The majority of professionals experienced communication difficulties when trying to work alongside the Community Care social work teams, particularly in terms of feedback on the outcome of the referral:
- ‘Relationship between the public health nurse and social worker is poor with extremely poor follow-up.’ (Public health nurse)
- ‘Difficult to be involved in the multi-disciplinary process as social workers do not return with an update or an assessment of the case. It is often that I hear from the family direct what is happening which is not always the full story.’ (Public health nurse)
- ‘Occasionally the social worker will suggest we do joint work but they don’t follow it through.’ (Public health nurse)

Professionals described how they make their own assessment of families’ and children’s needs and engage in a continual process of information gathering:
- ‘Assess for developmental delay, intellectual functioning, and family dynamics before a referral is made.’ (Child and adolescent psychologist)
- ‘Would have already used a lot of my experience to assess the situation and the causes there are before the actual referral.’ (Education worker)
- ‘Involved in our own assessment and for community-based support services for children and families.’ (Public health nurse)

Fourteen professionals (16%), across several disciplines, said it was not their role to be involved in the assessment of child neglect:
- ‘Not our role to assess but we can assist.’ (Education worker)
- ‘Leave the assessment to the social workers.’ (Pre-school worker)
- ‘I wouldn’t be in a position to assess neglect due to lack of basic training.’ (Garda)
- ‘Psychologists only have a role in pre-referral assessment and any post-referral additional observations. No role in the formal validation of neglect.’ (Psychologist)
Decision-making

Each focus group was given a set of five case scenarios describing different situations and degrees of child neglect. For each of the scenarios, professionals were asked to discuss and respond to the following questions:

Q1. What course of action would you take?
   • Not refer to Community Care social work teams.
   • Monitor.
   • Not sure.
   • Definitely refer to Community Care social work teams.
   • Refer elsewhere.

Q2. Given the above decision, who, if anyone, would you discuss this with?

Q3. What do you think would happen to the child?

Q4. Would you take the child’s opinion into account in your decision?

Q5. If you decide to refer, what are the implications for you?

Respondents completed the work on these scenarios in small groups of three to four, creating a total of 34 sub-groups. Where possible, professionals from the same discipline were grouped together.

Case scenario 1:
A neighbour reports that an 11-year-old child regularly cooks an evening meal for himself and his 3-year-old sister while their mother, a lone parent, is out at work.

With this scenario, the most common response was to refer the case to the Community Care social work team. Fourteen of the sub-groups chose this response. Six groups would refer the case to Community Care social work team and also monitor the case. Five groups would refer the case elsewhere and five would monitor the case. Three groups responded that they would refer the case elsewhere and also monitor it and one group would not refer to Community Care social work team. Professionals from education and pre-schools were the least likely to refer to Community Care social work team.

Case scenario 2:
A 7-year-old child always wears shabby clothing and is unwashed and smelly.

The most common response to this scenario was for the professionals to monitor the case themselves. Thirteen of the 34 sub-groups gave this response. The next most common response was to refer the case to the Community Care social work team, with 10 groups giving this response. Six groups would refer elsewhere and five would refer elsewhere and monitor. Members of the Garda Síochána and Community Care professionals were the most likely to refer to the Community Care social work team. Among other professionals, there was a consensus that this was probably below the thresholds of the Community Care social work teams and therefore they would monitor the family themselves and perhaps refer to outside agencies for support.

Case scenario 3:
A child is seen with an ear infection for three weeks. The parents don’t appear to be treating the illness and ignore your concerns.

The majority of sub-groups (20) would refer this case to the Community Care social work team. Another four groups would refer to the Community Care social work team and monitor the case themselves, while six groups would refer elsewhere. Three groups would just monitor the situation themselves and one group would refer to the Community Care social work team and elsewhere. Education and pre-school professionals were least likely to refer to the
Community Care social work team but they would refer the case elsewhere.

**Case scenario 4:**
A 6-year-old child frequently misses school. When he does attend he is often hungry, tired and withdrawn.

Referring the case to the Community Care social work teams was the most common response given by professionals, with 16 of the groups choosing this response. Another four groups would refer to the Community Care social work team and monitor the case. Five groups would choose to refer elsewhere and five groups would monitor the case themselves. Three would refer elsewhere and monitor, and one would refer to the Community Care social work team and elsewhere. Education and pre-school professionals were again the professionals least likely to refer to the Community Care social work team.

**Case scenario 5:**
A family, which is known to social workers and has a history of neglect and children in care, has a 3-month-old baby who is failing to thrive and there is no organic cause.

The majority of groups (20) would refer this case to the Community Care social work team; with a further nine groups choosing to refer the case elsewhere. This scenario, where there are probably child protection concerns, highlights the differences in understanding of thresholds. All hospital professionals would refer this case to the Community Care social work team, and most of the Garda Síochána and managers would also contact the NEHB. However, four of the five educational professional groups would refer the case elsewhere, normally to the public health nurse.

Overall, respondents were very decisive about their actions. Out of 34 sub-groups of respondents, only one pair was ‘not sure’ about a particular situation. Of all the professional groups, education and pre-school professions were the least likely to refer to Community Care social work teams. Even where cases are not referred to Community Care social work teams, all professionals are involved in information gathering and consulting other professionals in relation to cases. When decisions are made in relation to cases, they involve team discussions and consultation with line managers and other professionals. Monitoring the case themselves and referring to other agencies were common responses, with health professionals such as general practitioners and public health nurses being referred to rather than contacting Community Care social work teams. For the professionals in the focus groups, the main implication of making a referral to Community Care social work teams was the potential damage it may do to their relationship with the family and the possibility that the family would negatively target the referrer as a result.

**Referring cases of child neglect: professional perspectives**

The professionals who participated in the focus groups made a number of comments about the referral process; relationships with children, families, other professionals and Community Care social work teams; and the assessment process. These comments are grouped together by professional group:

**Managers**
- Managers decided on a combination of referring all scenarios to Community Care social work teams and/or to other professionals. These included: school liaison officer, general practitioner, family support worker, paediatrician, solicitor, hospital staff.
- Even if a referral was made to Community Care social work teams, other professionals would also be asked for their input.
- The parent and the child would normally be spoken with.
- Managers would rarely decide to monitor the situation.
• Case discussions within their own team and feedback from other professionals would impact on the action taken.
• There was concern regarding the impact referrals would have on the ‘therapeutic alliance’ with the family or child.
• Following referrals, managers felt they were responsible for making resources available, possibly providing ongoing support and attending child-protection conferences.

Community Care (clinical psychologists, speech and language therapists, disability social workers)
• All professionals in this group suggested referring each case to Community Care social work teams.
• Also information would be gathered from the public health nurse, childcare social worker, general practitioner, paediatrician and school.
• There was an expectation that a referral would mean working in conjunction with social workers, a support plan for the family, and an increase in information about the family that would help them effectively manage the case.
• Professionals in this group automatically assumed a monitoring role.

Public health nurses
• A pattern emerged whereby public health nurses monitored a situation. Then, if there was no improvement, a referral would be made to both Community Care social work teams and other professionals. However, public health nurses were keen to state that ‘What services you hope for the child/family are different to what they would receive.’
• At an early stage, the public health nurse is involved in an extensive information-gathering and fact-finding exercise.
• During the monitoring stage, the issue would be discussed with both the mother and the father.
• Parents would be referred to the following services as well as Community Care social work teams: parenting classes, community welfare officer, family social worker, local council, dietician, police, area medical officer and paediatrician.

Public health nurses described the following implications that would arise from their decisions:
• ‘You run the risk of losing the trust of the family.’ This not only applies to the relationship an individual professional has with a family but has implications regarding the trust the parent affords the whole profession.
• There was a fear that referring to other services would only disappoint families: ‘Don’t go criticising unless you have something to offer.’
• Relief that the issue had been shared with other professionals.
• Regular follow-up visits and ongoing intervention.
• Working in conjunction with social workers, child-protection conferences and report writing.

The Garda Síochána
• There was a consensus that a child who appeared shabby and unwashed should be referred to Community Care social work teams.
• Where there was a clear legal implication (e.g. a mother begging on the street), the case should be referred to Community Care social work teams.
• Some monitoring would take place on less serious concerns and these would result in referrals to other agencies and Community Care social work teams.

The implications of their actions were described as:
• Excess paperwork and possibly a court case.
• Frustration due to lack of social work action.
• Possible backlash from parents.
• Further visits and follow-up to family.
Primary and post-primary school workers

- There is a high degree of discussion/intervention with parents.
- Management and other teachers are always consulted before action is taken.
- Generally they would not refer cases to Community Care social work teams but instead would refer to other professionals (education welfare officer/public health nurses/garda liaison).
- Monitoring neglect is a frequent task for teachers.
- Concern about the backlash from parents and that they might cause them distress.

Pre-school workers

- In any situation, the issues would be discussed with the parent first.
- Generally refer and consult other professionals (public health nurse/general practitioner) rather than Community Care social work teams. Involving social workers was considered a last resort.
- Monitoring is a frequent role for the pre-school worker.
- Direct support/advice/help is often given to parents.

The possible implications were:

- The child would be removed from the family home.
- The child would be removed from the service by the parent.
- Criticisms and threats from the parent and other parents.
- Tarnished reputation as a childcare provider.
- Concerns for the safety of staff.

Hospital workers

- There was a consensus that Community Care social work teams should be informed of all suspected child neglect cases.
- The public health nurse would act as a source of information.
- Consultation would also be made with line managers, colleagues, consultant paediatricians, general practitioners, schools and childcare services.

Implications are that:

- ‘All referrals to social workers have implications for our relationship with parents.’

Gut feeling and intuition

Participants were asked to explain what ‘gut feeling’ and ‘intuition’ meant to them. Participants described ‘gut feeling’ and ‘intuition’ as part of the working toolkit with which they made decisions about child neglect. They provided an array of definitions as to what these terms meant, including: a sixth sense, a hunch, body language, alarm bells, a prompt to investigate further, professional experience and a strange feeling.

- ‘Experience gives us the beliefs in our intuition which is really based on subtle data and observations.’ (Psychologist)
- ‘Suspicion without hypothesis. A hunch, sixth sense, professional experience, but also needs evidence, facts.’ (Manager)
- ‘A sense that something is wrong without any concrete evidence to support this.’ (Education worker)
- ‘Tacit knowledge, underlying professional experience, personal knowledge and life experience.’ (Public health nurse)
- ‘Must always go with your instinct because if there isn’t something right then there is something wrong.’ (Garda)

All respondents accepted that referrals could not be made to Community Care social work teams regarding suspected child neglect based only on personal intuition. Professionals described the importance of concrete evidence when identifying and referring neglect:

- ‘Intuition is not sufficient. There is a need to clearly state opinions based on specific observable facts and third-party reports. Establish the facts first and then share concerns with other professionals. Monitor the situation closely and try to get factual evidence before making a referral.’ (Manager)
Child protection conferences

Positive reflections were made about the process of child protection conferences and they were generally considered a useful forum for multi-agency work:

- ‘Child protection conferences encourage a multi-disciplinary approach and nurture the team approach in a formalised way.’ (Community Care group)
- ‘Works well in the hospital setting and it is normally a great multi-disciplinary meeting. They are well chaired and the outcome is a clear action plan.’ (Hospitals)
- ‘Positive experience of a forum where professionals can work together. Nothing prevents me attending. They have improved greatly and they are much more structured.’ (Public health nurse)
- ‘Child protection conferences are useful as there are many professionals involved and resources available for the child – also shows that the child is considered important. They are extremely useful events and always very good for bringing professionals together. Should be more efforts to create teamwork like this.’ (Education worker)

The organisation of child protection conferences, however, created obstacles and prevented professionals attending, as highlighted by the following comments:

- ‘Often invited at too short notice or not at all – find out after the event.’ (Manager)
- ‘Time, location and duration of the conferences often means a two hour meeting plus travelling time which often means a whole day is out.’ (General practitioner)
- ‘Demands on the teacher’s time as there is no cover for the classroom – so often principal attends.’ (Public health nurse)
- ‘Insufficient notification.’ (Garda)

Professionals said that there was sometimes a lack of clarity regarding the purpose of the conference. Minutes and action plans were rarely forwarded and professionals were often left not knowing the outcome of cases:

- ‘Lack of clarity about why child protection conferences take place at all – what is the point of them and why a conference is called at one particular time, is there any objective to the conference?’ (Manager)
- ‘A conference may be held a year after the initial referral and no other contact has been made or information passed on about what has happened during this time.’ (General practitioner)
- ‘No feedback from child protection conferences or action plans.’ (General practitioner)

The group of practitioners who worked in hospitals had a more positive experience of child protection conferences:

- ‘The hospitals get very good feedback and follow-up so this may be due to regional differences or down to childcare managers.’ (Hospital worker)

Improving the social work system

A theme that emerged in all the focus groups was lack of clarity regarding the role of the social worker and professionals sought clarification:

- ‘Not sure about the role of the social worker – need clarification of their role.’ (Education worker)
- ‘Clarification of roles – similar to community welfare officer? Better understanding of each other’s role and job.’ (Public health nurse)
- ‘Social worker needs to clarify their role in comparison to other professionals such as community welfare officer/public health nurse.’ (Hospital worker)
Professionals highlighted the lack of continuity of social work staff as a key area that impeded effective working relationships:

- ‘Skilled, experienced staff leaving, so the toughest cases are given to the newest most inexperienced social workers.’ (Community Care worker)
- ‘Change of staff too often – would be helpful to be informed of staff changes - simple introductions.’ (Manager)
- ‘High turnover of staff and issues of trust between schools and social work department.’ (Education worker)

Respondents made a number of suggestions as to how the lack of contact and communication between professionals and social workers could be improved:

- ‘Meeting to discuss regularly – a specific time to talk, encourage sharing of information.’ (Manager)
- ‘There is a lack of personal contact with social workers – making face-to-face contact would be useful – introductions etc. rather than just telephone conversations.’ (General practitioner)
- ‘Good relationships can be built up over time and if we can put a face to a name.’ (Education worker)
- ‘Opportunities to develop good relationships to breakdown the ‘them and us’ feeling. Joint study days etc.’ (Public health nurse)
- ‘High turnover of staff and issues of trust between schools and social work department.’ (Education worker)

Some professionals felt that aspects of the negative working relationships with social workers influenced multi-disciplinary practice and hence needed to be addressed:

- ‘Show of solidarity with other professionals, a consensus on approach so everyone was working together in a cohesive framework.’ (Education worker)
- ‘More of a multi-disciplinary team approach to reduce isolation.’ (Community Care worker)
- ‘The general negative attitude towards social workers was seen as a threat and not a help to developing effective relationships.’ (General practitioner)
- ‘Joint working depends on mutual regard.’ (Public health nurse)

Education professionals, public health nurses, general practitioners and hospital staff all described how a named person in Community Care social work teams would significantly improve their relationships with social workers:

- ‘Would help if social workers introduced themselves to the school – and they had a key person they could contact/talk with. Named person for heads to contact.’ (Education worker)
- ‘Need to meet on a multi-disciplinary basis through training with social workers, this has happened successfully in the past where social workers agreed that they would be available for discussions on certain days/times. This worked well and aided discussions – now there is no liaison role and communication is very limited.’ (Public health nurse)
- ‘Hospital-based social worker needed – some hospitals have this, others don’t.’ (Hospital worker)

Developing practice

Joint training initiatives were considered an effective method to promote positive changes:

- ‘Multi-disciplinary training has started but needs to be continued and updated frequently.’ (Hospital worker)
- ‘Focused multi-disciplinary workshops to identify how we can work together.’ (Hospital worker)
- ‘Need training about specific issues for key teachers. Need more recognition of the child protection in schools but not get overwhelmed.’ (Education worker)
Specific suggestions were made by each professional group regarding how practice could change within their own occupation in order to facilitate more effective engagement with social workers.

**Community Care group**
- ‘Protocols are needed for working together developed by managers – joint thinking at service head level.’
- ‘Co-working – sharing plans and review sheets.’

**Hospital workers**
- ‘Hospital-based social worker.’
- ‘Clearer definition of social workers’ jobs and how they relate to other professions.’

**Managers**
- ‘Advice in report writing and what information social workers need.’
- ‘Greater supervision of staff so we know what is happening.’
- ‘If not getting feedback should be proactive in finding out, make contact ask for meetings and clearly state when feeling that the situation has not been left satisfactorily.’
- ‘Avoid isolation in own job – as manager should support staff – and should be available.’

**Education workers**
- ‘Would welcome the NEHB personnel to attend staff meetings and explain their role and what can be done.’
- ‘Informing parents was an anxious area for teachers – often dangerous – often don’t refer because of the reaction from parents. Need support and protection when doing this.’
- ‘Proper home liaison scheme which is centrally funded and not down to individual schools.’
- ‘Teachers need to recognise that they are not just teaching a subject but teaching young people.’

**Pre-school workers**
- ‘Framework for assessing neglect: Developing an observation sheet about neglect based on the framework.’
- ‘A tool for identifying neglect – especially important for private providers as there is little support before a referral is made.’

**Public health nurses**
- ‘Secretarial support is desperately needed – filing, typing, reception duties, etc.’
- ‘Possibility of specialising in either elderly or children rather than generic.’
- ‘Ease workload through supervision.’
- ‘Opportunities for reflective practice.’
- ‘Clinical supervision is desperately needed – meant to be coming on line shortly.’
- ‘Lack of understanding by management of the issues public health nurses deal with – needs to be a greater understanding about the reality of the work. The assistant directors are difficult to contact and do not make time to speak about cases.’

**The Garda Síochána**
- ‘Often one person (normally policewoman) designated to deal with these kind of cases’ – no extra time or support to do all of the administration.’
- ‘Return of work’ at the end of the year – social work issues do not appear on their return sheets so is considered hidden, extra work that has no bearing on their overall performance.’
- ‘Lack of understanding of the garda’s role – social workers will try and keep the family together at all costs and this may not be what the garda think is best.’
- ‘The referral form has only two lines on which to write something down, which is inadequate.’
- ‘Garda is ultimately the one who is responsible and the one who will have to deal with any repercussions if they are wrong. They can be sacked if something goes wrong.’
CHAPTER SIX
DISCUSSION OF FINDINGS
Discussion of findings

The findings from the current study will be considered under the following themes:

- Perceptions and understanding of child neglect.
- Professionals’ interpretation of role when referring, assessing and planning regarding cases of child neglect.
- The decision-making process.
- Thresholds.
- Relationships with Community Care social work services.
- Multi-disciplinary practice.
- Professional commitment.

Perceptions and understanding of child neglect

A number of questions in both the questionnaire and the focus groups were designed to elicit professionals’ views as to what constitutes child neglect. As described in the literature review chapter (Chapter 2), perceptions of child neglect range across a broad spectrum. At one end are those who believe that an act of omission on the part of a carer, such as leaving a young child unsupervised, is neglect per se. At the other end of the spectrum are those who believe that neglect centres on the impact of such an omission on the child (Dubowitz, 1999).

Professionals in the study appeared to consider child neglect from the latter perspective. For example, 75% of respondents agreed with the statement that decisions should be based on the impact of neglect on the child. In addition, when commenting on the case scenarios, the focus was on the impact of the neglectful acts of carers on their children. This would be commensurate with the focus in Children First.

However, it contrasts with the findings from Study 1 where social workers tended to take one of three approaches towards defining child
Discussion of findings

neglect: perceiving it as an erroneous act in its own right; considering the impact in terms of safety issues for the child; or recognising neglect both in terms of both safety issues and also in terms of the impact of neglect on the developmental needs of the child.

Although professionals tend to consider the impact of neglect on a child’s development, in practice the primary focus appeared to be the effect on the child’s physical needs and issues relating to health and safety. For example, when considering features of an unacceptable home environment the dominant concerns were the health and safety risks. Professionals also tended to focus on physical neglect when asked in the focus groups to list factors they consider when identifying neglect. Moreover, when respondents were asked to consider factors causing concern regarding the O’Connor children, the emphasis was on health and safety. This contrasted with the views of social workers who had been asked similar questions in Study 1. These differences can have serious implications in terms of assessing child neglect.

Interestingly, when respondents in both studies were asked to comment on statements regarding parenting and assessment of neglect, there was considerable disagreement among respondents as to whether the essential aspects of parenting are to provide merely for a child’s physical needs and safety. In Study 1, 43% of practitioners agreed with the statement while 33% disagreed. In this study (Study 2), 45% agreed while 43% disagreed.

The majority of respondents in both studies considered neglect more broadly, recognising the damage caused to a child living in a high-criticism low-warmth environment (Irish Department of Health and Children, 1995). They also noted that a physically neglected child is likely to be experiencing emotional neglect as well which is supported by research evidence (Iwaniec and McSherry, 2002).

These findings would seem to indicate that while professionals recognise the importance of parents meeting a range of children’s needs as described above, the assessment focus in cases of child neglect is on physical needs and safety. The reason for this could be that evidence of immediate health and safety issues is easier to collect than evidence of the impact of neglect on the long-term emotional and developmental well-being of the child. Professionals in the focus groups commented on the lack of time available to them to make comprehensive assessments over time. This is supported by Stone (1998) who found that neglect is multi-faceted and complex and cannot easily be defined in the short term and Minty and Pattinson (1994) who found that a range of evidence has to be gathered systematically over time.

Respondents in this study also commented on the complex nature of child neglect and the issues they encountered when attempting to draw together evidence of neglect. For example, Iwaniec and McSherry (2002) highlight the importance of practitioners having guidance to raise their awareness of the physical and behavioural indicators that can act as warning signs that neglect may be occurring. Such guidance was developed as an assessment framework in Study 1. This could be used by all professionals to define neglect and would ensure that all practitioners and their managers are ‘singing from the same song sheet’.

Recommendation: Professionals from all disciplines need a common assessment framework, guidance and training to enable them to make a holistic assessment of the impact of neglect on the child and his/her developmental needs. All professionals should use the Framework for Assessing Child Neglect developed as part of Study 1.

8 The implications and the differences in perceptions between social workers and other professionals are explored in detail in the section ‘Is my concern your concern?’ on page 98.
Discussion of findings

The professionals in both studies are well aware of the impact of parenting issues on parenting capacity. For example, the majority of respondents in both studies recognised that witnessing violence can impact on children. However, 76% of respondents to the questionnaire also believed that a drinking problem always influences a parent’s ability to care for their child. Cleaver et al. (1999) are not so dogmatic arguing that alcohol or drug misuse will not always influence a parent’s ability to care for their child if they provide other supports for the child.

Issues associated with defining neglect

Respondents in the focus groups recognised the complexities associated with identifying child neglect. Two particular issues emerged that challenge practitioners: Firstly, the impact of poverty on child neglect and, secondly, the challenge of identifying neglect among minority ethnic groups. These two issues also challenged social workers in Study 1.

Poverty

As described in the literature review, if neglect is defined in terms of poor material conditions, then it leaves the gate open for all children in households below the poverty line to be classified as neglected. Crittenden (1999) argues that all families living in poverty do not neglect their children and policies to reduce levels of poverty have not impacted on reported rates of child neglect. Hence, the task for the professional is to consider why some families manage in situations of poverty while others struggle. Both Stevenson (1998) and Crittenden (1999) believe the focus for assessments in these cases should be the parenting behaviour.

Minority groups

Professionals in the study described problems in identifying child neglect among ethnic minority groups. Stevenson (1998) suggests that professionals consider the following:

- Do they as practitioners have detailed knowledge about child-rearing practices among particular groups?
- Have they got an understanding of the difficulties or changes of behaviour that arise from living as a member of a minority group within a majority culture?
- How can the answers to the above be applied to assessing neglect?

It is interesting that respondents focused on asylum-seeking families and Travellers when discussing neglect among minority groups. Assessing neglect among disabled children was not a feature. Yet, disabled children form a group that is particularly vulnerable to child maltreatment (Middleton, 1999) and as noted by Garbarino and Barry (1997), a vulnerable group with special needs that can be neglected.

Recommendation: All professionals who come into contact with children and families require training regarding the identification and impact of neglect on vulnerable groups of children.

Professionals’ interpretation of role when referring, assessing and planning in cases of child neglect

A number of themes emerged in terms of the assessment and planning process:

- Use of language.
- The referral process and factors that influence the referral process.
- Multi-disciplinary assessment and planning.

Use of language

Calder and Horwath (1999), Hallett and Birchall (1992), and Murphy (1995) have described ways in which technical language and professional jargon can act as blocks to communication between practitioners. Professionals can use different terms and expressions believing that they share a common understanding of the term.
when this is not actually the case. The findings from the study highlighted two terms, ‘identify’ and ‘good enough parenting’, which appear to mean different things to different individuals.

‘Identify’
Respondents to the questionnaire were asked to indicate whether they believed they had a responsibility to identify neglect and refer possible cases to Community Care social work teams. The questions were asked based on the premise that professionals need to recognise and identify possible neglect in order to go on and refer potential cases.

The findings would seem to indicate that not all professionals interpreted the term ‘identify’ in this way. Sixty-six (17%) said they did not have a role in identifying neglect while 38 (10%) indicated it was not their role to refer cases of child neglect. This indicates that 7% of professionals appear to be referring cases without identifying neglect.

It could be that professionals understand identifying neglect to mean making a specific judgement that the child is a victim of neglect rather than expressing possible concerns about a child. Alternatively some managers could be referring on the concerns of their staff and may not directly identify neglect. Even so, they still need to make a decision that the information they have received indicates a child is potentially being neglected, i.e. identifying neglect.

‘Good enough parenting’
Findings from Study 1 indicated that references are made on case files to ‘good enough parenting’. For example ‘parenting is good enough case closed’. However what is apparent from the responses to the questionnaire used in Study 1 is that social workers use the term to describe different standards of parenting. Some social work practitioners use ‘good enough parenting’ to describe what Cooper (1983) refers to as ‘border-line’ and ‘bad-enough parenting’ while others use it as was originally intended by Winnicott (1964) to describe a facilitating parenting environment that enables the child’s needs to be met.

Case records used in the social work study also indicated that social workers ask other professionals the question ‘Is parenting good enough?’. With this in mind, professionals in this study were asked to define the term. The findings indicate that as with social workers there is little agreement about the meaning of the term with 115 (29%) of the respondents believing it refers to parenting that is just adequate and only 11 (3%) of the respondents thinking the term means that the parent is promoting the child’s developmental needs. Thirty-seven (10%) thought the expression was meaningless or were not familiar with the phrase. These findings highlight how professionals can be talking at cross-purposes when discussing cases of child neglect.

Recommendation: All child protection guidance should include a glossary of common terms used in the context of work with vulnerable children by practitioners in different disciplines.

The referral process and pre-referral assessment
Findings from the study indicate that professionals often complete detailed assessments of the child and family and their situation before making a decision as to whether to report the case to Community Care social work teams. The professionals use a variety of assessment tools as part of the assessment process, such as direct observation and taking a family history. In addition, professionals spend time gathering information about the child and family both intra- and inter-agency.

10 The term ‘referral’ and ‘report’ are used to mean bringing concerns of child neglect to the attention of Community Care social work teams.
Discussion of findings

As a result of this assessment, practitioners make a decision about ways to address their concerns regarding the child and the family. This includes monitoring the situation, referring the family to other services within the community or referring them to social work services. Reporting to Community Care social work teams was seen as a last-resort measure.

The responses to the case scenarios used in the focus groups indicated that pre-school and education professionals were the least likely to refer immediately to Community Care social work teams while Community Care professionals and the Garda Síochána were most likely to refer immediately to social workers. Public health nurses gave a measured response, monitoring a situation and then referring it on if they do not see an improvement in the situation.

These findings would seem to indicate that professionals are managing cases of child neglect outside the formal child protection system and could explain the low levels of referrals from professionals identified in Study 1.

Bearing in mind that official child protection services are perceived as stigmatising and do not necessarily meet the needs of children and families (Department of Health UK, 1995; Ward and Rose, 2002; Buckley et al., 1997), one could argue that it is positive that cases are being managed using universal and community services rather than targeted social work child protection services.

However, this raises a number of questions. Firstly, is the decision not to report cases to Community Care social work teams based on an objective assessment? Secondly, does it place children in a vulnerable situation? These questions will be considered by exploring the factors that influence professionals’ decisions to report child neglect.

Factors that influence professionals’ decisions to report child neglect

The findings from the study would indicate that there are a number of factors that influence professionals’ decisions to report cases of child neglect. These include:

- Perceptions of Community Care social work teams.
- Personal fears.
- Knowledge of the community.
- Time.

Perceptions of Community Care social work teams

Although some professionals, predominantly public health nurses, described positive experiences when reporting potential cases of child neglect to Community Care social work teams, the majority described negative experiences. This description from a hospital professional summarises the feelings: ‘Frustration, non-supportive, anger, lack of communication, not enough liaison, anxious, slow, poor follow-up.’

As described above, the focus group respondents indicated that their concerns about the lack of response from Community Care social work teams, in terms of taking their concerns seriously and meeting the needs of families, meant that some professionals were referring to Community Care social work teams as a ‘last resort’. As one public health nurse put it: ‘There is a stigma attached to social workers and there is no follow through so we tend to use other professionals.’

These responses would seem to indicate that the decision to refer is not made just on the merits of the case. Rather, the professional who is made aware of the situation and their perception of Community Care social work teams will influence the referral process.
**Personal fears**

In the case audit completed for Study 1, Horwath and Bishop (2001) found that in 10 of the 57 cases (18%) a lack of cooperation from the carer resulted in either the case being closed or minimum social work intervention. Aggression from parents towards Community Care social work teams led to cases ‘drifting’, with minimal contact or no assessment of the child’s needs. Also, the failure to keep appointments often resulted in insufficient or inconclusive evidence of neglect, which led to the closure of the case.

Professionals in Study 2 also highlighted the impact of aggression from parents on referring and intervening with neglectful families. Professionals in all the focus groups expressed anxiety about their own personal safety, which influenced their approach towards reporting concerns about child neglect.

These fears centred on verbal and physical aggression and threats to workers and their families. Indeed, several professionals in the focus groups gave anecdotes where they had been physically and verbally intimidated or even attacked by carers because they had made a referral to the Community Care social work team. This had had a significant impact on individuals' professional and personal life.

Fear of aggression was identified by 90 (23%) of the questionnaire respondents as influencing decisions to report neglect when they agreed with the statement that ‘a physically aggressive carer could lead to standards of care being tolerated that would not normally be accepted by less aggressive carers’. Although professionals were clear that reports made by professionals to Community Care social work teams should not be anonymous, a minority considered that in situations where a professional could be placed in danger if the referrer’s name were disclosed, anonymity is acceptable.

Stanley and Goddard (2002) note that both policy and practice developments minimise the impact of violence on the assessment process. They argue that workers who are fearful of actual or perceived threats may act as if they are helpless or may engage in defensive practice and reality distortion. They note that ‘these behaviours may shield the worker against high levels of stress, but the cost may be borne by the child, whose safety may not be accurately evaluated’ (op. cit., p. 127).

The findings from these studies would support this. Study 2 found that families which are aggressive or uncooperative with professionals are less likely to be referred, while Study 1 showed that if children with aggressive carers are referred, there is more chance that they will fall through the net or drift out of the social work system, leaving the children in a very vulnerable situation.

**Recommendation:** The agencies may wish to consider implementing some of the strategies adapted from initiatives taken by the New Zealand Government department responsible for child protection. These include:

- Establishing teams/ coordinators that can act as a resource for workers in terms of guidance and support. These people can also be used to debrief staff following an incident.
- Regular review of situations of violence and threat to workers.
- Training on personal safety strategies.

**Knowledge of the community**

Many professionals indicated that reporting cases of child neglect was an issue for them as they feared members of the community would not trust them if they knew that they reported concerns to Community Care social work teams. For some the concern was more pragmatic. For example, a pre-school representative commented: ‘We also have to consider that our business could be affected and we could lose our livelihood if a referral is made and there are negative repercussions.’
Discussion of findings

The respondents were also asked whether personal knowledge and associations with children and families in the community influenced their decision to refer. Almost 25% of respondents felt that it did, with five out of the six drugs outreach workers agreeing that it influenced their decision not to refer.

These responses raise questions about the dilemmas encountered by professionals who either work in small communities or are employed in community-based jobs. Other professionals considered the negative impact on families of living in the community once its members knew that the Community Care social work team was involved with the family. If professionals hold these views either about their own position in the community or that of the family, they are likely to delay or fail to report concerns about child neglect. Alternatively, they may use inappropriate methods for managing the situation.

The professionals in the focus groups did however recognise that they had a responsibility to pass on the concerns brought to them by neighbours and occasionally other professionals. This was evident in Study 1 with public health nurses and the Garda Síochána passing on family, community and anonymous concerns to Community Care social work teams.

Recommendation: Consideration needs to be given to ways of both developing the skills of practitioners and also providing them with the support that will enable staff to manage the tensions of reporting child abuse when working and living in a close-knit community.

Multi-disciplinary assessment and planning

Although members of all the focus groups were clear that multi-disciplinary assessment is important in cases of child neglect, respondents to the questionnaire were not as clear about their role in assessing child neglect. *Children First* (1999, p. 77), outlines the essential components of a full assessment as:

- Gathering information.
- Coordinating and analysing information on the child and family.
- Considering any contextual factors.
- Evaluating risk and potential positive interventions.
- Formulating a child protection plan.

Although it is clear in the *Children First* guidance that a holistic assessment should be completed and information should be gained ‘on the child and his or her key relationships, the child’s parents/carers, the child’s familial and social networks including school’ (op. cit., p. 77), it is not clear how professionals other than social workers should be routinely involved in the assessment process. This may explain why only 33% of respondents believe they have a role in assessing child neglect. However, the guidance does state that ‘involvement’ in the assessment by clinical psychologists, paediatricians, addiction services, psychiatric services and child sexual abuse services may be required. Interestingly, the majority of respondents in these professionals groups, other than paediatricians, did not believe they had a role in assessing child neglect. In addition, the guidance states although it is normally the role of the social worker to carry out enquiries following a report of maltreatment, in some circumstances, other professionals such as public health nurses and clinical psychologists, may be asked to carry out enquiries on child protection concerns. Yet in this study, 5 (45%) of the child psychologists and 16 (29%) of the public health nurses did not consider they had a role in terms of assessing child neglect.

Recommendation: Local guidance is required that clarifies the assessment roles and responsibilities of professionals involved in cases of child neglect.
Assessment issues
The responses to the questionnaire case scenarios highlighted factors that professionals consider when assessing cases of child neglect. These are considered below:

Assessment of mothers
Findings from Study 1 highlighted how the focus of social workers’ assessments and subsequent interventions in cases of child neglect becomes the mother. Similar findings emerged from Study 2. For example, when respondents considered the focus for intervention in the O’Connor family, respondents emphasised interventions with the mother rather than the father. For example, 138 (42%) of the respondents focused on the mother’s passivity while only 8 (2%) focused on the father’s passivity as a priority area for intervention.

Swift (1994, p. 72) notes that early definitions of neglect were personalised and ‘seen as failure of individual mothers to carry out their mothering responsibilities’. While modern legal definitions tend to be written in gender-neutral language, they are still very individualistic and female focused. Scourfield (2000, p. 365) has argued that in the recent ‘rediscovery of neglect’, the dominant construction of neglect among the social work practitioners in his study was ‘maternal failure to service children’s bodies’. The findings from this study would support both this and Turney’s (2000) view that neglect is usually constructed as an omission in care, and the gendered nature of care means that neglect is associated with deficiencies in mothering. If professionals take this view, the role and influence of fathers becomes marginalised. And, as in the case of the O’Connors, the mother becomes responsible for protecting the children from the father with no interventions to address the father’s behaviour.

Recommendation: Professionals should have opportunities through training and case management to explore issues associated with completing assessments of child neglect that emphasise the role and responsibilities of the mother as the primary caretaker and minimise the role of the father or male partner.

Engaging parents and children
Respondents in the study made reference to the very real barriers to engaging parents in the assessment process, particularly at the early stages in terms of discussing with the parents their concerns that the parents were maltreating their children. These barriers included fear of both verbal and physical abuse from the parents towards not only the practitioner themselves but also the practitioner’s family and concerns that discussing maltreatment with the parent would jeopardise the existing relationship the professional has with the parents. These anxieties may explain why 52% of practitioners agreed with the following statement and 14% were not sure: National guidelines state that professionals should always tell parents when they are making a referral regarding their children, unless doing so would place the child in danger. This would influence the decision to refer.

Interestingly, no reference is made to the promoters and inhibitors to engaging children in the assessment process. This raises the question as to whether professionals even consider discussing a child’s circumstances with the child themselves. Laming (2003), in his report on the death of Victoria Climbie, highlighted that despite the many professionals who had been involved with Victoria, no one had any idea what a day in her life was like. The evidence indicated that no professional had attempted to establish a meaningful relationship with Victoria enabling them to elicit this information.

Recommendation: Professionals need guidance and training regarding the diverse ways in which children and families can be engaged in the assessment process in order to ensure that the assessment is child focused and identifies parenting strengths and weaknesses. Particular attention should be paid to ways of working with families where aggressive and uncooperative behaviour on the part of a carer impacts on a professional’s ability to assess the needs of a vulnerable child.
Discussion of findings

**Recommendation:** Professionals should make a point of communicating with children in the family in a way that takes account of the age, ability and circumstances of the individual child. Professionals should seek to gain an understanding of the child’s wishes and feelings and an understanding of what a day in the life of the child is like.

**Child protection conferences**

*Children First* (1999, p. 79) describes the three tasks of the child protection conference as:

- Facilitating and sharing information.
- Preparing an outline of a child protection plan.
- Identifying tasks to be carried out by different professionals.

In the case review of 57 neglect cases in Study 1, Horwath and Bishop (2001) found it was difficult ascertaining the criteria social workers used to call a child protection conference. Among the cases studied, there were 15 references to different conferences but often there were no notes or records of the action resulting from the conference recorded on the file. This led to the conclusion that there was a general lack of standardisation in the systems used to hold child protection conferences. Nevertheless, 21 (70%) of the social work practitioners agreed while completing the questionnaire that, most of the time, information obtained from other professionals and the child protection conference influenced decision-making, while a further 7 (23%) said this influenced decision-making all of the time.

In Study 2, professionals indicated that case conferences were a useful and sometimes effective forum for making collaborative decisions about neglect. The analysis of the findings from the questionnaire would seem to indicate that a minority of professionals are very regular conference attendees with 25% having attended five or more conferences in the past year, while 39% of the sample had never attended a conference. A number of issues emerged in the focus groups, which mirrored the findings from Study 1:

- Lack of standardisation: The professionals commented on the lack of standardisation across the region regarding conference procedures. For example, the timing of conferences in relation to a report of child neglect, invitations to the conference and feedback about conference outcomes.
- Practical concerns: Respondents noted limited warning of the conference, inaccessible venues and conflicting workload pressures.
- Personal safety: Some respondents had experienced verbal and physical aggression from parents at conferences and others were concerned that parents would use verbal and physical aggression against them if they said negative things about the family at conferences.
- Sharing of information with parents: Sharing of information with parents present was cited as an issue predominantly by the Garda Síochána.

In 1992, Una Ryan, at that time a social worker in the NEHB, studied child protection conferences in the region (Buckley, 2002). She found that professionals felt conferences lacked clarity and purpose. They were critical of the structure of the conferences, the short notice given, the venues used and the absence of written reports. Over 10 years later, professionals are expressing similar concerns.

Ryan piloted a conference framework, which was positively evaluated by professionals. The framework included:

- A standard agenda for each meeting.
- A standard letter of invitation, the agenda, a brief summary of the purpose and content of the conference and a list of participants to be sent to invitees.
- A personalised letter to be sent to parents.
- A standard conference report sheet.
- Arrangements made for taking minutes.
- Agreement on review date.
- Summary letter to be sent to parents following the conference.
- Standard summary sheet to be sent to all
participants following the conference. (Op. cit., p. 147.)

She also recommended that conferences should be independently chaired. A small group of child protection chairs who work closely together could standardise practice across the NEHB.

**Recommendation:** The Child Protection Case Conference policy and protocols developed by the NEHB in 1999 should be used for all conferences.

**Monitoring and forms of intervention**

‘Monitoring’ as a form of intervention was used throughout the case files analysed in Study 1. Monitoring was often referred to in plans and would refer to social workers checking that the child was safe and/or their needs were being met. In some instances the monitoring was allocated to other workers. For example, nine of the 57 cases were closed because other professionals, normally public health nurses, would take over the role of monitor from social workers. In the focus groups conducted with 85 participants in Study 2, professionals described how monitoring is a common aspect of their work in the following ways:

- Monitoring is conducted as soon as a family is suspected of neglectful behaviour and this takes place over a period of time before a decision is made as to whether to make a referral or not.
- Professionals monitor a situation either in conjunction with referring the case to social workers or other agencies.
- Practitioners are involved in monitoring a case as part of a multi-disciplinary plan.

Public health nurses and education professionals are most likely to monitor a child as they are in a position to have regular contact with children and families, whereas hospital workers and the Garda Síochána, due to the nature of their job, were least likely to monitor children and families.

The impression given through examinations of the case scenarios in Study 1 and the comments from professionals during this research is that monitoring is a passive intervention designed to prevent the situation deteriorating rather than practitioners proactively working to improve life for the child. In addition, Calder and Horwath (1998) found that vague terms such as ‘monitoring’ mean that there is a lack of clarity among both professionals and the family as to what they are expected to do. This in turn leads to problems when assessing whether the situation has improved or deteriorated as there are no baselines for measuring change. Lack of engagement with intervention strategies by both family and professionals is also linked to lack of clarity about the purpose of the intervention (Hallett, 1995; Calder and Horwath, 1998).

**Recommendation:** All child protection and family support plans for children should use a standardised format such as that in the Children First guidelines. The plans should include aims and objectives designed to safeguard children and promote their welfare. If monitoring by professionals is considered appropriate, exactly what should be monitored, why, how and by whom should be clearly recorded.

**The decision-making process**

Working with the child and families to assess, plan and intervene in cases of child neglect involves practitioners and their managers making a number of decisions. In order to make a decision about the needs of the child and their family, the professional needs to gather information and make sense of that information to form a judgment about the child’s situation. As Milner and O’Bryne (1998, p. 165) note, ‘Keeping an open mind is particularly problematic because all people are liable to be biased in all their assessments of each other. Good will and well-meant activity are no guarantee of impartiality’.
In addition, Munro (1999) comments on the type of information that is remembered by professionals in child protection cases. She found that it is often the colourful details of a case that a worker remembers and describes, ignoring the more mundane factors that actually provide a balanced picture. Concrete information is remembered over abstract information and emotionally laden information and recent events are more readily recalled. In addition, first impressions of a family tend to dominate further assessments. Who the professional consults with as part of the assessment process, the information they share, and the knowledge and skills they use to reach their decision will influence the outcome for the child and family.

Findings from the study indicate that a number of variables operate:

- The manager and the team.
- The use of practice wisdom.
- Recognising the views of children and families.

The manager and the team

Respondents to the questionnaire were asked whether decisions regarding child neglect were made taking into account the views of supervisors and managers. General practitioners and public health nurses were the groups that disagreed with this statement while the other professional groups tended to agree with it. This is understandable from the general practitioners’ perspective, as they are not managed in the same way as other professionals. In the case of public health nurses, their managers may not have expertise in the area of child protection.

In response to the scenario about the child left alone, 11 (14%) of the respondents believed Liam the social worker should not have made a decision about the child without consulting with his supervisor. In practice, the supervisor appears to have two roles: firstly, assisting practitioners to identify neglect and, secondly, advising practitioners on actions.

Although supervision is crucial, it is important to recognise that the supervisor and supervisee have their own agendas. They can interact together in such a way that decisions can become biased and distorted as both parties work towards their own agenda. For example, a practitioner might reason: ‘I’ll just focus on the problems and concerns. She is busy and I want her to realise I’m worried.’

Managers ask questions and elicit information in response to the information provided by the practitioner. This requires the manager to think through what pieces of information are missing and act accordingly. The questions asked by the manager are also likely to be influenced by the time available, their confidence in the practitioner’s work and the other demands that are being made on the team. For example, a manager might react, ‘X is always overreacting and if I agree to her doing more work on this then I do not know who will cover for her. I won’t ask her what the public health nurse said because she is another fuss pot.’

In this way decision-making becomes distorted (Horwath, forthcoming). Morrison (2001) describes how stress and the emotional impact of child protection work can also affect professionals’ perceptions of a case and this in turn can distort decision-making during supervision.

It is not only the manager but also the team that influences decision-making. Over 60 respondents in the focus groups highlighted the influence of the team on decision-making. For example, one educational professional stated, ‘We try and create a culture of care within the school, so that we all can identify neglect and that collective wisdom will prevail.’

Brown (1996) analysed the social influences that operate within groups. He found individuals tend to conform to the attitudes and behaviours of the majority to the extent that individuals are willing to deny the evidence of
their own senses to conform to the group perspective.

This has a number of implications for teams identifying neglect. Firstly, practitioners may treat information discretely and adjust their own standards to conform to the group norm. Secondly, the history and culture of the team will influence the decision-making. For example, if the team is under considerable work pressure a culture may develop of minimising child neglect. Alternatively, if the team has experience of a child being badly harmed or dying as a result of neglect then they may be overly cautious and report any minor concerns to Community Care social work teams.

Therefore, standardisation regarding decision-making can be an issue for managers and practitioners in both supervision and team discussions. Service users need to have confidence that their needs will be recognised in a uniform manner by service providers, irrespective of where they live and the team they are referred to (Hogan and Murphy, 2002).

**Recommendation:** The NEHB should ensure that all professionals who come into contact with children and families use the Framework for Assessing Child Neglect included in Study 1.

### Intuition and practice wisdom

There are a number of approaches towards analysing the way professionals make decisions: Klein (2000), cited in Munro (2002), explores the way professionals make decisions under time pressure. He observed firefighters and concluded that they use intuition, practice wisdom, mental stimulation, metaphor and story telling.

Intuition enables a professional to evaluate a situation quickly. An experienced decision-maker will use practice wisdom to recognise patterns and see similarities between the current situation and past situations that have been resolved previously by certain actions. Mental stimulation enables the person to imagine the outcomes of different courses of action in this particular situation based on past experiences, while the power of metaphor enables the professional to draw on experience to compare and contrast current and past experience. Finally, the story telling helps a professional explore the projected outcomes around the current situation.

Respondents to the questionnaire were asked whether they agreed with the statement that ‘decisions are made using gut feeling or intuition.’ All 11 of the clinical psychologists agreed with this statement while only 23 (30%) of the educational professionals and 22 (40%) of the public health nurses and 2 (40%) of the disability workers agreed with it.

Respondents in the focus groups were subsequently asked to describe what ‘gut feeling’ means to them. A theme emerged of ‘gut feeling’ being a hunch and a sense that things are not quite right. This would fit with Klein’s interpretation of intuition.

The majority of questionnaire respondents (299, 76%) believed that decisions are made based on professional practice experience, which as Klein notes is important in terms of assessing the current situation. The issue here is that the experiences may be limited and dated. Firstly, for example, 204 (52%) of the questionnaire respondents had not reported a case of child neglect in the past year, and secondly, the quality of past experiences will influence current decision-making. As 40% of questionnaire respondents stated that previous responses from Community Care social work teams influenced decisions to refer again, this can lead to subjective decision-making.

Decision-making is likely to be more objective if an evidence-based approach is adopted (Macdonald, 2001). Respondents in the focus groups also highlighted the importance of evidence-based decision-making as demonstrated by this statement: ‘Intuition is not sufficient. There is a need to clearly state...’
Discussion of findings

opinions based on specific observable facts and third party reports.’ (Manager)

However, the emphasis among respondents was on facts and information about the particular child and family rather than research and practice developments that could inform understanding of the situation. Sackett et al. (1997) define evidence-based social care as ‘the conscious, explicit and judicious use of current best evidence in making decisions regarding the welfare of those in need’. Evidence-based practice requires professionals to consider not only the facts about the particular case but also to use their knowledge of theory, research and practice developments to make sense of the information they have about the child and the family.

Sackett et al. argue this should be done in a transparent manner so that both the service users and other professionals understand the basis for decision-making. Improved communication between professionals and a greater understanding of different perspectives could be achieved if professionals used an evidence-based approach for reporting and assessing cases of child neglect.

Recommendation: The national standard reporting form for referrals introduced by the NEHB in line with the Children First guidelines, should be used by all professionals.

Recommendation: An evidence-based approach towards practice should be an integral part of training and case management.

Recognising the views of the child and family

Jones (2003) argues that by communicating with children, one can establish whether their welfare is being compromised and professionals can decide whether the child requires services to promote their welfare. However, in response to the child left alone scenario in the questionnaire, only two respondents mentioned ascertaining the views of the child. Respondents were also ambivalent in their responses about basing decisions on what the young person wants, with only 28% of respondents believing this should be the case. Likewise, respondents were ambivalent about the statement that decisions should be based on what the worker considers to be in the best interest of the child irrespective of the views of the child and family, with 50% agreeing.

Trotter (1999), summarising the research on work with voluntary and involuntary clients, concludes that collaborative problem-solving approaches are effective. This involves ‘working with the client’s definition of the problem, developing modest achievable goals, which are the client’s rather than the workers (or at least collaboratively developed), and identifying strategies with the client to achieve the goals’ (op. cit. p. 21).

Macdonald (2001) notes that the participation of service users in decisions and plans is not only good practice but also influences outcomes. She cites a study completed by Stein and Gambrill (1974, 1976) of work with children in residential care and their families. Practitioners made detailed explorations with the families as to what they wanted to happen to the child and then did their best to realise these outcomes using a goal-orientated approach. They noted even when the family’s desired outcome was not achieved the families felt they had been given a fair chance.

Thoburn et al. (1995) conclude in their study that involving children and families in child protection decision-making recognises the unique knowledge the family has about itself, both in terms of strengths and weaknesses, and involvement is more likely to result in promoting and safeguarding of the child’s welfare.
Thresholds

One of the most striking findings from this study is the diverse range of thresholds used by the different professionals when working with cases of child neglect. These threshold variations were notable in terms of:

- A neglectful environment.
- ‘Monitoring’ and reporting of child neglect.
- Interventions.

A neglectful environment

Professionals are unable to agree on the factors that indicate a neglectful environment. For example, different professional groups regarded different factors as a cause for concern for the child left alone in Liam’s scenario. Most social work practitioners (21, 53%), stated that the lack of food was the main reason for removing the child, whereas this was a priority for only 9 (4%) of the respondents in the second study. In Study 2, the most influential factor for 124 (56%) of the respondents was that the child was left alone, whereas this was the second most popular concern for 14 (43%) of the social workers.

As a multi-professional group, respondents could not agree on the key issues for the O’Connor children. 25 (63%) of the social work respondents from Study 1 said that a decrease in centile was the factor causing most concern for Imelda. This can be compared with the answers from Study 2, where only 85 (26%) rated this as causing concern. Instead, in Study 2, 71 (22%) of the professionals stated that the lack of change despite intervention was the factor causing most concern regarding this family.

Another difference between the findings was that 25 (63%) of the respondents in Study 1 said that Imelda being in a pushchair all day was a major factor of neglect, whereas only 28 (9%) of the other professionals rated this as significant.

Taken together with the differences already reported, it can be suggested that often social workers and other professionals do not necessarily agree on what is considered a significantly neglectful environment. These differences in understanding of what constitutes neglect could create difficulties in terms of making referrals, setting thresholds, gathering evidence and involving other professionals in neglect cases.

To monitor or report?

Professionals in the focus groups held differing opinions as to when they should monitor a potential case of child neglect and when they should refer the case to Community Care social work teams. Three groups of professionals – the Garda Síochána, hospital staff and Community Care professionals – were far more ready than other professionals to refer directly to social workers. These were the groups of professionals that indicated in response to a question in the questionnaire that they did not have a role in terms of assessing child neglect.

The groups of professionals who have the most contact with children are the ones who are most likely to monitor the situation or refer to services other than Community Care social work teams. Pre-school and school professionals were most likely to monitor the situation or refer to services other than Community Care social work teams. Public health nurses provided a mixed response, some groups opting for referral and monitoring, others monitoring and others referring to other services.

What does this mean for children and families?

This can best be answered by using the framework ‘dimensions of children’s services’ adapted from Hardiker et al. (2002) in Table 26.
### Table 26:
A framework that locates children’s services

<table>
<thead>
<tr>
<th>Level of intervention</th>
<th>Perceptions of role of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last resort safety net – services offered at damaging levels</td>
<td>Addressing needs – family support services</td>
</tr>
<tr>
<td>Combating social disadvantage – problems located in systems rather than individual</td>
<td></td>
</tr>
<tr>
<td><strong>Base: universal services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>First: vulnerable groups diversion services</strong></td>
<td>Support services</td>
</tr>
<tr>
<td><strong>Second: interventions to address early stresses</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Third: interventions to address severe stresses</strong></td>
<td>Remedial Interventions including social work</td>
</tr>
<tr>
<td><strong>Fourth: social breakdown out of home placements</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 26 shows the different levels of intervention in terms of service provision. The different levels serve different purposes. For example, level three and four interventions, which would include the services provided by social workers, act as a safety net and should be used as a last resort. Level one and two services are to support vulnerable families and would include family centres, while services such as education and public health nurses are universal and are designed to promote the well-being of the child and address the first signs of vulnerability.

The higher up the levels one goes the more stigmatising and interventionist the services offered become. Choice can also be reduced and in some cases interventions are non-voluntary, e.g. childcare legal proceedings.
Theoretically, families should work their way up through the different levels only moving on to the next level of provision if the previous level has failed to meet their needs. As a pre-school professional in the study stated: ‘Referral to social workers is a last resort as we make contact with other professionals first. Often pass on to public health nurse or general practitioner first.’

And a teacher commented: ‘Only make referrals if there is a marked deterioration after the school has addressed the issues.’

Hence, those professionals who provide universal services such as education, are keeping children and families down the ‘tariff’ by monitoring the situation or referring to other services at a universal or first level of intervention. However, professionals who refer children and families directly to Community Care social work teams will potentially push families with similar problems to those being monitored by other professionals up the ‘tariff’.

There are some situations, however, when it is appropriate to refer directly to Community Care social work teams, irrespective of the services the family have or have not received in the past. These are situations where the child may be suffering significant harm. An example of this is the scenario presented to focus group respondents of a 3-month-old baby who is failing to thrive. There is no organic cause. The family is known to social workers for a history of neglect and already has children in care.

In response to this situation, a minority of professionals from all disciplines other than hospital personnel decided they would refer elsewhere or monitor the situation. In such situations, professionals are dealing with child protection concerns inappropriately and outside the system. This means that they can lose focus on the child and marginalise issues of potential or actual harm.

The responses to the scenarios also highlight that professionals from the same discipline cannot agree among themselves on a common response to a situation. For example, in response to the scenario where Liam the social worker made the decision to remove a child who was alone in a rural area, half of the respondents in both studies agreed with his actions. However, in Study 1, 17% (n=40) were not sure, 23% disagreed, and 3% strongly disagreed. In Study 2, a similar pattern was recorded with 24% (n=390) disagreeing and 9% being unsure. Apart from the four area medical officers who all agreed with Liam, there was variation among professionals from the same discipline as to the appropriate response. This indicates that across all professional groups including social work practitioners, professionals cannot agree on the right course of action in situations like the one Liam was faced with.

In conclusion, the findings from Study 2 would seem to indicate that thresholds vary, not only between the different disciplines but also among professionals within the same discipline. In addition, the variations do not show that some groups of professionals operate with high thresholds and others with low ones. Rather they show that the use of thresholds is inconsistent and varies between professionals in the same discipline.

**Recommendation:** Senior managers within the NEHB region need to audit the cases of child neglect that are monitored or worked on by professionals other than social workers. The purpose of the audit should be twofold. Firstly, it should identify whether professionals are managing appropriate cases bearing in mind their areas of professional expertise and secondly, it should establish whether the level of service provision is commensurate with the needs of the child.

---

11 The kind of services cited by members of the focus groups included speech therapy and psychology.
Interventions

Information regarding thresholds in relation to interventions was gained from the findings relating to the O’Connor scenario. Professionals were divided on the most appropriate course of action, yet the divisions were relatively inconsistent among social workers and showed that respondents were considering interventions at very different levels.

For example 11 (28%) of the social workers in Study 1 said that care proceedings (a level four intervention) should be initiated, while in Study 2, 71 (22%) voted for this course of action. The most popular option for 41% of respondents in Study 2 was a family support package (a level two/three intervention) and in Study 1, 9 (23%) suggested this. A level three intervention of an intensive support package, including increased social work visits, was favoured by 125 (38%) of the professionals in this study and 10 (25%) of the social work staff in Study 1.

These different intervention thresholds could have very serious consequences for children and their families. Their fate is in the hands of the professionals who happen to be working on their case. In some cases, the thresholds are high, in others low. The consequence is that the service children and families receive is a lottery.

Relationships with Community Care social work teams

In this section consideration will be given to:
- Perceptions of social workers and social work services.
- Understanding of the social work system.

Perceptions of social workers and social work services

Respondents to the questionnaire were asked a number of questions regarding social work practice. These questions had been asked of the social workers themselves in Study 1. Both groups were asked whether social workers accept lower standards of parenting than other professionals who come into contact with children and families. Professionals in Study 2 (n=390) had mixed views, with 25% agreeing, 45% disagreeing and 28% being unsure. Very similar findings were found among social work professionals, with 23% of social work staff in Study 1.

Both groups were asked a similar question about whether Community Care social work teams provided support to families to keep children out of the care system. 41% of respondents in Study 2 considered that social workers did provide such support, while 27% were unsure. The social workers themselves were more positive, with 50% of practitioners and 57% of managers believing they provide the support.

Professionals in Study 2 were asked whether the criteria for accepting a referral depended on which social worker takes the referral. Again there was a mixed response, with 42% of respondents disagreeing and 34% not sure.

The social workers had been asked a slightly different question regarding managers and whether the criteria for triggering child protection vary depending on the manager involved. Interestingly only 50% of practitioners agreed while 71% of managers agreed with this statement.

Study 1 provided evidence that social workers took different approaches towards assessing child neglect. Some workers focus on the incident, others on the safety issues, while a third group considered both safety and the promotion of the child’s well-being. Professionals were asked in Study 2 if social workers are more concerned with specific incidents of abuse rather than ongoing concerns. Once again the responses were mixed with 38% agreeing, 38% disagreeing and 22% not sure. These findings would seem to indicate that social workers themselves do not agree on their approach towards assessing and planning...
in cases of child neglect and these inconsistencies are reflected in the perceptions of social workers held by professionals who report cases of child neglect.

**Recommendation:** The NEHB needs to consider ways of standardising the approach taken by practitioners towards the assessment of child neglect.

Scott (1997), describing an Australian study of the management of child maltreatment reports, makes reference to ‘gatekeeping disputes’. She notes that an overloaded and understaffed child protection service resists accepting referrals, which results in frustration among those attempting to refer cases. Scott found that referrers find ways to manage the system, notably by ‘upping the ante’.

In Study 2, groups of professionals used a different technique to so manage the system. They managed concerns about child neglect by monitoring or referring to other professionals. In some situations as described previously, this could be potentially dangerous for children.

What is not clear from Study 2, however, is whether professionals’ perceptions of overloaded teams that cannot always meet the needs of neglected children is based on myth or reality. Only 48% of questionnaire respondents indicated that past experiences of referring influence their decision to refer, so what is influencing the other 52%? Is their impression of overstretched social work teams based on hearsay? Are practitioners drawing on the experiences of other members of their team and managers?

**Recommendation:** See recommendation on case audit on page 96.

**Is my concern your concern?**

As part of the case audit in Study 1, an analysis was made of the professionals who were contacted as a result of a referral of child neglect. In response to 18 out of 62 referrals, no professional had been contacted. When professionals were contacted, case records indicate that they were asked generalised questions such as whether they had ‘concerns’ about the child and family.

What is interesting when comparing the findings from the studies is that a social worker’s concern may be different to another professional’s. Respondents were asked the same set of questions relating to how they would define an unacceptable home environment. The most common concern for 15 (38%) of the social work practitioners was evidence of damp within the home, whereas in the Study 2, only 110 (28%) said that damp was a factor causing concern. In the second study, the factor causing most concern for 328 (84%) of the respondents was considered to be health and safety risks in the home. This can be compared with Study 1 where only 6 (15%) were concerned with environments which posed health and safety risks. Also, loose electrical wires were considered a significant hazard for 293 (75%) of the respondents in the Study 2, whereas only 4 (10%) of the social work professionals stated that loose electrical wires were a factor of neglect.

If professionals have differing opinions about what is the cause for most concern in cases of child neglect, it can have three consequences. Firstly, children are not properly assessed and acts of omission that can have a serious impact on the child are ignored. Secondly, professionals either do not consider that social workers are listening to them or believe that their concerns are not being taken seriously and in the future they may be reluctant to report potential neglect. Finally, social workers may tend to dismiss certain professionals’ reports believing that they are overreacting or inappropriately reacting to certain situations or concerns.
Discussion of findings

Referral as a last resort
As described in the sections on pre-referral assessment and decision-making, many professionals make their own assessment of child neglect and refer to other professionals for help for the family. Although 20% of respondents (n=390) in this study said that nothing prevented them referring suspected cases of child neglect to Community Care social work teams, 8% said they were negatively influenced by the lack of responsiveness from Community Care social work teams on previous occasions. The lack of feedback and communication resulted in some professionals having little faith that much would happen even if they made a referral to the Community Care social work teams. Therefore, the focus group discussions concluded that many professionals regarded making a referral to Community Care social work teams as a formality rather than having an expectation of action or positive outcomes for the child and family. The following quote illustrates this point: 'Nothing stops me making a referral but there is a feeling that nothing will happen and won't be followed up unless in a crisis case.' (Disability social worker)

This sentiment is further influenced by the frustration experienced by professionals who try to make referrals to Community Care social work teams and receive a slow or non-existent response, if they feel cases are trivialised and if they have few opportunities to discuss concerns. As highlighted in the section on pre-referral assessments on p. 84, this raises issues about the types of cases that are being referred and indeed the ones that are being managed outside the formal child protection system. It would appear that some professionals decisions are not based on the merits of the case alone but rather on the professional’s perception of the way that the particular family will fare if referred to Community Care social work teams.

Lack of communication and feedback
The case audit in Study 1 highlighted a lack of correspondence and recorded consultation between Community Care social work teams and other professionals. Respondents in Study 2 identified limited communication and feedback from Community Care social work teams to other professionals as an issue. These findings are commensurate with the research carried out by Ferguson and O'Reilly (2001), which studied the processing of child protection cases in the Mid Western Health Board area. The study found that lack of communication and feedback from social workers left professionals working in a vacuum.

Recommendation: Social work services should have a standardised feedback procedure ensuring professional referrers are informed in writing of the outcome of their referral.

From the outside looking in
The professionals in Study 2 were asked to identify factors that acted as barriers to referring child neglect to Community Care social work teams. In addition to the lack of confidence in the Community Care social work system and poor communication with Community Care social work teams described above, the professionals identified three other issues:

Lack of continuity of staff: Respondents in the focus groups described the importance of establishing relationships and how professionals would pick up the telephone to talk over concerns with a worker they knew or indeed pop into the office for a discussion. Staff turnover was seen as a real issue preventing this occurring. As one general practitioner put it, 'I need to put a face to a name and strike up better liaison so there is room for informal discussion and to instil more confidence.' And a garda said, 'Trust in the exchange of information is vital but takes time and continuity to build up.'

The importance of ongoing multi-disciplinary relationships in order to build up trust and an understanding of different roles and responsibilities is well documented in the literature (Bell, 2001; Calder and Horwath, 1999; Murphy, 1995). Not only were professionals concerned about the impact of a high turnover of staff on their working relationships, they felt rapid
turnover affected relationships with families and the outcomes for children. The devastating consequences of high staff turnover for children and families are well documented in reports into child deaths (Reder et al., 1993; Reder and Duncan, 1999; and Laming, 2003).

The professionals were also concerned that skilled, experienced staff are leaving and cases are subsequently allocated to inexperienced staff. This was noted in Study 1 and is a cause for concern as it means workers may be managing cases without the appropriate level of knowledge and skills. Lord Laming (2003) discovered, for example, that the social worker who worked with Victoria Climbie in the months leading up to her death was newly qualified and had no experience of child protection inquiries or working with a child in hospital.

Recommendation: Managers should ensure that professionals have a caseload commensurate with the experience, knowledge and skills of the worker.

Lack of clarity regarding social work processes: Most professionals were clear about the referral process to Community Care social work teams. However, professionals in the focus groups were confused as to their ability to have ‘informal discussions’ with social workers prior to making a formal inquiry. At least 16 professionals described how they had believed they were holding informal discussions with social workers which were responded to as referrals. This is an issue for professionals who may wish to seek advice and guidance from social workers regarding their concerns without making an actual referral. One way of obtaining advice would be for professionals to describe the situation but not give the actual name of the child until it is clear a referral is appropriate (UK Department of Health et al., 2003).

There was a sense among study respondents that once professionals have made a referral it goes into a ‘black hole’ and they were unclear as to what followed. Some professionals were not even sure who was taking their referral. Experience indicated that in some cases it was a receptionist, in others a trained duty worker. When they knew it was a social worker, they were still unsure about the level of qualification or experience of the worker. This can influence professionals’ willingness to refer cases. For example, Burton (1996) found general practitioners were reluctant to refer cases to Community Care social work teams if they did not have confidence in the expertise of the person receiving the referral.

A number of professionals did not fully understand the role of the social worker. If this is the case, then they will be unsure what is appropriate to refer to the Community Care social work teams. Others were not sure what social workers should do in response to a referral. This was not helped by a lack of standardisation among Community Care social work teams regarding the assessment and planning process.

Recommendation: Community Care social work teams should use protocols introduced in Children First clarifying both the assessment and planning process.

Lack of access to social workers: Only 115 (29%) of the respondents stated that they never have a problem contacting Community Care social work teams. Findings from Study 2 indicate that professionals who are in physical contact with Community Care social work teams because they work in the same building were more likely to make a referral or seek informal advice from social workers. However, some Community Care group members were cautious noting that informal discussion can mean information is not recorded and can consequently distort assessments.

Those who were not in physical proximity to social workers described the frustrations of ‘poor availability and left messages not returned’. Lack of access creates a number of problems. Firstly, the invisibility of social
Discussion of findings

workers reduces professionals’ ability to build effective working relationships with them. Secondly, informal discussion about cases between professionals can often clarify thinking about the needs of the child. If social workers are not accessible, these discussions will not take place leading to inappropriate referrals or referral as a last resort.

The Garda Síochána, general practitioners and hospital staff were frustrated by the lack of an out-of-hours service. Laming (2003) notes that children are placed in a vulnerable situation if qualified and experienced childcare professionals are not available to respond to child protection concerns 24 hours a day, seven days a week.

Recommendation: Consideration should be given at national level to developing an out-of-hours service run by experienced social work staff trained in managing crisis childcare situations.

Social workers in Study 1 identified ways in which multi-disciplinary links could be made more effectively. They made the following suggestions:

- Multi-disciplinary teams.
- More networking and joint work with other professionals.
- Better communication between workers and effective relationships with other NEHB staff to improve the common goal of protecting children.
- Working in close liaison with other professionals and agencies such as housing, schools and doctors.

Suggestions along the same themes arose from the focus groups in Study 2:

- Named contact or liaison person for each set of professionals.
- Forming more effective, interpersonal and informal relationships with social work staff through joint training initiatives and site visits.
- Developing professional networks or multi-disciplinary teams.

It appears that both social workers and other professionals would welcome more opportunities to establish formal and informal networks that could help them work effectively.

Multi-disciplinary practice in cases of child neglect

Professionals in the focus groups demonstrated a belief that multi-disciplinary practice is necessary to keep children safe. However, they identified a number of issues which acted as barriers to effective practice. These include:

- Lack of understanding of roles and responsibilities.
- Poor access to Community Care social work teams.
- Confusion regarding thresholds.
- Dearth of guidance regarding assessment and planning procedures.
- Time constraints and workload pressures.
- Limited resources.
- Lack of training.

These issues have been identified in a number of studies of multi-disciplinary practice (Hallett and Birchall, 1992; Calder and Horwath, 1999; and Buckley, 2003).
Limited research has been completed into the different types of multi-disciplinary teams found within child welfare. However, Horwath (unpublished) completed a literature review that gives some clear messages as to the effectiveness of multi-disciplinary teams.

Networks and teams are generally viewed positively by service users who appreciate having coordinated services and welcome a diverse range of professionals working together to meet their needs. Although studies into the effectiveness of multi-disciplinary teams in terms of outcomes are limited, research indicates that multi-disciplinary working provides a more efficient, streamlined service for users than services delivered by workers from separate agencies. This service allows for high-quality assessments and a sophisticated deployment of resources. From the perspective of team members, an effective team can increase collaborative practice, staff motivation and creativity.

Multi-disciplinary teamwork can be challenging. One of the biggest challenges involves managing the differences between professionals in terms of power, status, values, pay and work conditions. These differences can lead to struggles over professional territory, role confusion and tensions between managing the demands of the team, the agency and the profession.

Research would indicate that these problems can be overcome. This is likely to occur if sufficient attention is given by senior managers to corporate ownership, clarity regarding the vision, identifying specific aims and objectives for the team, devising an operational policy, and establishing a viable role for the team manager. Teams need time to develop, and team building, ongoing training and support systems are important. Researchers and evaluators stress the importance of process in bringing together and developing a multi-disciplinary team. Hence, a team benefits from a stable team membership.

Multi-disciplinary teams and networks would seem to have a part to play in terms of developing effective collaborative practice provided there is:

- Agreement among professionals, managers and service users that a multi-disciplinary response is the most effective way to meet the needs of the identified user group.
- An active commitment to make multi-disciplinary practice work from senior and middle managers in all relevant agencies.
- A model that facilitates the achievement of the goal.
- A service population that would benefit from and be able to access a multi-disciplinary team.
- Financial arrangements that promote the work of the team.
- Service providers who will work together.
- Clarity regarding roles and responsibilities, and authority to achieve the task.
- Recognition by members of the value of the contributions of all members in achieving the goal and a specific operational framework.
- Understanding by all involved that multi-disciplinary working needs time to develop and requires continual opportunities for reflection and development in order to operate effectively.
- A stable workforce which will be able to develop its skills by working together.

Recommendation: The senior managers in the NEHB and other agencies may wish to identify the structures and systems acknowledged within the literature, and also those operating within the region, that promote multi-disciplinary practice.

Building relationships: the role of multi-disciplinary training

Inter-agency training can play a significant role in protecting children and enhancing their well-being (Charles and Hendry, 2000). This was recognised by respondents to Study 2, with 19% of respondents (n=338) considering multi-disciplinary training as the most effective way of improving practice in cases of child neglect.

Multi-disciplinary training is most effective if those who work together train together. Glennie
and Norman (2000) note that a locality approach to training provides structured opportunities for practitioners to evaluate practice and to develop it collectively. The training is particularly beneficial if it is provided on an ongoing basis. Regular locality training would provide opportunities for professionals to network and should assist in breaking down the barriers between professionals. An evaluation of child protection training for general practitioners (Weir et al., 1997) also highlighted the advantages of locality training, particularly when case scenarios that focus on issues encountered by the local professionals are used.

**Recommendation:** Multi-disciplinary training is an effective method for developing multi-disciplinary practice and should be given priority by senior and middle managers and front-line staff. The training where possible, should be provided on a locality basis. This means that those who train together will go on to work together. The training should be informed by research, theory and practice developments on child neglect. The following topics for training have been identified through this study:

- Working with aggressive and uncooperative service users.
- Effective communication with children regarding the impact of child neglect on their lives.
- Identifying and assessing child neglect among members of vulnerable groups.
- Assessing parenting capacity of both parents rather than focusing on mothers.
- Issues regarding working with child maltreatment when working/living in small communities.

**Community Care professionals**

This group of professionals is more likely than other professionals working with children to refer cases of child neglect without considering alternative courses of action. This is understandable as these professionals have a remit to work with adults, hence their knowledge of children’s needs and the services available is inevitably going to be limited.

What is a cause for concern, however, is that many respondents within this group of professionals did not believe they had a role to play in terms of assessing child neglect. Cleaver et al. (1999) outline the crucial role that adult workers have in terms of contributing to an assessment of child maltreatment as they have knowledge regarding the way parenting issues such as mental health, learning disability and drug misuse may impact on parenting capacity.

As Cleaver et al. conclude, parenting issues ‘affect people in their parenting ability and impact on their children in variable ways. Therefore, skilled, comprehensive and holistic assessments, which place equal emphasis on the child, family and environment are essential’. (1999, p. 99).

**Education professionals including pre-school workers**

As Burrows, Horton and Cruise (2001) explain, teachers should be at the forefront of referring child maltreatment. However, as respondents in this study note, the concerns over the consequences of making a referral and a lack of information about the child protection process act as prohibitors to referral for education professionals. As an alternative to referring the child and family to Community Care social work teams, education professionals monitor neglected children or refer them to a range of other services. Based on the information gained from this study, it is difficult to establish whether the children who are being monitored or referred to services other than Community Care social work teams are having their needs met and being protected from harm.
Public health nurses
The study highlighted the significant involvement that public health nurses have with neglectful families, as one could have predicted based on the work of Butler (1996). Respondents in the focus groups highlighted the way in which they will ‘monitor’ or ‘keep an eye’ on these families, frequently referring to Community Care social work teams as a last resort. The respondents explained that they do this because they recognise the pressure on Community Care social work teams. Nevertheless, this raises questions about the thresholds used by the public health nurses, particularly in terms of managing serious child protection concerns that should be brought to the attention of social workers.

General practitioners
General practitioners were the largest professional group who responded to the questionnaire. Despite virtually all the general practitioners recognising their role in identifying and referring neglect, few general practitioners actually referred any cases to social work teams, with 37 (62%) making no referrals in the last year. Equally, only 19 (32%) said it was their role to assess neglect. Taken together with the concerns raised by general practitioners in the focus group regarding poor ongoing relationships with social workers and the fear of retaliation from parents, low numbers of referrals could suggest a reluctance to contact Community Care social work teams. Nevertheless, the majority of general practitioners had been involved in child protection conferences and this therefore illustrates a significant degree of involvement in the decision-making process. These findings suggest that, overall, general practitioners lack confidence in the referral and assessment procedure and may benefit from closer liaisons and collaborative working relationships with Community Care social work teams.

The Garda Síochána
From the 50 garda respondents to the questionnaire, it can be suggested that the Garda Síochána see themselves as those who identify and refer cases of child neglect to Community Care social work teams but do not become involved in the actual assessment process. However, 6 (12%) did not recognise their role in identifying neglect and only 2 (4%) said it was their role to assess neglect.

These are areas that could be specifically targeted through intra – and inter-agency training on the factors and signs of neglect and a child protection process. Indeed, 19 (18%) of the respondents in this group requested more training on child neglect. If joint training was delivered with social workers, then staff could address the unfamiliarity and lack of trust between the Garda Síochána and social work staff that was conveyed in the focus groups.

Speech and language therapists
Virtually all of the speech and language therapists who responded to the questionnaire said it was their role to identify and refer cases of child neglect, but again, only 7 (29%) understood their role as part of the assessment process. Despite this, 11 (48%) had attended a case conference within the last year and a minority (3) had attended 8 to 10 conferences. There was a high degree of consensus on the emotional, physical and safety aspects of neglect rather than the material environment. However, 25% of therapists were concerned about a lack of clarity regarding thresholds, while a further 25% said their ability to work with Community Care social work teams was affected by a lack of previous response from social workers. As this group of professionals may not necessarily come into contact with child protection services unless they initiate a referral, speech and language therapists could benefit from inter-agency liaison and training to keep them up-to-date with current issues and procedures.

Clinical psychologists
Although only 11 clinical psychologists responded to the questionnaire, there are some interesting messages for multi-agency collaborative child protection work. Just over
half of respondents (6) had made a referral within the last year but the majority (9) had been involved in a child protection conference and most respondents had attended a high number of conferences.

This suggests that clinical psychologists are involved in long-term child protection cases and play an active role in the assessment of a child’s development and behaviour. Indeed, clinical psychologists were the second most likely professional group to recognise their role in assessing cases of child neglect. However, even this group, which appears to have significant contact with Community Care social work teams, identified how communication from social workers could be improved by increasing informal contacts, inter-agency liaisons and training for example.

**Child psychiatry**

The findings from the limited sample of workers in child psychiatry show that less than half of the 11 that responded said it was their duty to identify cases of child neglect. However, contrary to this, 10 (90%) said it was their role to refer cases of neglect to Community Care social work teams. This discrepancy could indicate confusion over the term ‘identify’, as discussed previously, or it could suggest that child psychiatric workers need to be aware of the possibilities of neglect among their client group. Given that this group of professionals sees children and families frequently, they could benefit from specific and inter-agency training regarding their role in terms of models and typologies that are useful tools to identify different types of neglect.

**Accident and emergency nurses**

Among the 10 respondents, 60% had not made a referral in the past year and 70% had not attended a case conference. Despite this apparent lack of involvement with Community Care social work teams, nine said it was their role to identify and refer neglect and five said it was their role to assess neglect.

Aside from this recognition of the child protection investigation procedure and their own obligations, there were suggestions regarding how practice could be improved. Nurses described how a named liaison social worker would benefit practice and make their communication with Community Care social work teams more effective.

**Paediatricians**

All eight paediatric workers responded to the questionnaire and from their answers some interesting findings can be deduced. Paediatricians displayed a clear consensus over what constituted neglect and over half of the respondents recognised the damage that witnessing domestic violence could cause children. Of all the 15 professional groups included in this study, paediatricians were the only professional group to all agree that it was their role to both identify and refer child neglect. Furthermore, seven said it was their job to assess child neglect.

This near consensus on all three aspects of the role to identify, refer and assess neglect highlights a significant degree of understanding of, and involvement with, the child protection process. However, this proficiency could be threatened by a lack of feedback from Community Care social work teams and poor access to social workers. Out-of-hours social work services were flagged as an additional service that could help improve collaborative work between hospitals and Community Care social work teams.
CHAPTER SEVEN
CONCLUSION AND
RECOMMENDATIONS
Conclusion and recommendations

This study, Study 2, highlighted that there is a great deal of effective and innovative practice taking place in terms of protecting neglected children. In the main, professionals in both children’s and adult services share a common understanding of neglect. They recognise that it is more than focusing on the physical and safety needs of the child. The majority of professionals in the study are also aware of their responsibility to identify and report cases of child neglect to the Community Care social work teams.

There are however areas for development in terms of both policy and practice. These are considered below with suggested recommendations for improving practice in order to promote better outcomes for neglected children and their families.
Conclusion and recommendations

Thresholds

This study has highlighted that there is no common agreement among professional groups or indeed between professionals within the same group as to the types of neglect that should be referred to Community Care social work teams or managed by professionals working with children and families. Unless some agreement is reached regarding thresholds for referral, children and families are entering a lottery, with the same needs being addressed differently depending on the professional or group of professionals who come into contact with the child and family.

Practitioners from all professional groups, including social workers, are not using the same baseline or sharing a common language. For example, professionals could not agree on the key factors of a neglectful environment. That is, individuals placed a different emphasis on different factors. They also interpreted terms such as ‘good enough parenting’ in very different ways.

The study also highlighted that professionals focus on gathering information about the family rather than making sense of that information in light of theory, current research and practice developments. If professionals do not make explicit the reasons why they consider that certain factors are a cause for concern, when communicating with each other, they can be overlooked or ignored by other professionals. An evidence-based approach towards cases of child neglect could improve communication and understanding between professionals.

Recommendation: Professionals from all disciplines need a common assessment framework, guidance and training to enable them to make a holistic assessment of the impact of neglect on the child and his/her developmental needs. All professionals should use the Framework for Assessing Child Neglect developed as part of Study 1. A common assessment framework should begin to standardise the approach taken by practitioners towards the assessment of child neglect.

Recommendation: All professionals should use the national standard form for referrals introduced by the NEHB in line with Children First.

Recommendation: An evidence-based approach towards practice should be reflected in all referrals and assessments and should be an integral part of training and case management.

Recommendation: All child protection guidance should include a glossary of common terms used in the context of work with vulnerable children by practitioners in different disciplines.

The child protection process

Professionals who referred cases to Community Care social work teams had varying degrees of understanding about the way in which the child protection system operates in terms of assessing, planning and intervening in cases of child neglect. Lack of clarity was notable in regard to:

- The types of cases that should be reported to Community Care social work teams.
- Contributions to multi-disciplinary assessments following a report of child neglect.
- The purpose and functioning of case conferences.
- Appropriate interventions to meet the needs of children and families.
Conclusion and recommendations

Recommendation: Local guidance is required that clarifies the assessment roles and responsibilities of professionals involved in cases of child neglect.

Recommendation: Community Care social work teams should produce protocols introduced in Children First clarifying both the assessment and planning process.

Recommendation: The Child Protection Case Conference policy and protocols developed by the NEHB in 1999 should be used for all conferences.

Recommendation: All child protection and family support plans for children should use a standardised format such as the Children First guidelines. The plans should include aims and objectives designed to safeguard children and promote their welfare. If monitoring by professionals is considered appropriate, exactly what should be monitored, why, how and by whom should be clearly recorded.

Perceptions of Community Care social work teams

Professionals recognised the pressure placed on Community Care social work teams resulting from high staff turnover and heavy demand for services. Although respondents to the study were able to cite positive experiences of working with social workers, many focused on the negative experiences and the consequences of these experiences for children and families.

The consequence causing most concern was that professionals, particularly those in contact with children, were referring cases of child neglect to Community Care social work teams as a last resort. The professionals expressed concerns that referral did not necessarily lead to any action that would ensure the needs of the child were met. As a result of this, many professionals were trying to find ways of meeting the needs of the child by referring to other services or monitoring the situation themselves.

Referral to other services and monitoring may be an appropriate response in many cases. However, it may be placing children in vulnerable situations. Based on the information gained from Study 2, it is difficult to ascertain whether this is the case.

Recommendation: Senior managers within the NEHB region need to audit the cases of child neglect that are 'monitored' or worked on by professionals other than social workers. The purpose of the audit should be twofold. Firstly, it should identify whether professionals are managing appropriate cases, bearing in mind their areas of professional expertise, and, secondly, it should establish whether the level of service provision is commensurate with the needs of the child.

Professionals also highlighted the problem of accessing social workers, particularly out of hours. This lack of availability could lead to cases being managed inappropriately.

Recommendation: Consideration should be given at a national level to developing an out-of-hours service run by experienced social work staff trained in managing crisis childcare situations.

Working with children and families

One of the most striking findings from this study is the impact of verbally and physically aggressive parents or carers on workers’ practice in cases of child neglect. The respondents acknowledged that fear of aggression or intimidation by parents can influence thresholds of concern and act as a barrier to referral to Community Care social work teams.
In addition, the presence of aggressive or intimidating parents at case conferences can inhibit discussion. Many respondents cited incidents of actual aggression and intimidation by parents after concerns had been expressed about their parenting ability.

**Recommendation:** The agencies may wish to consider implementing some of the strategies adapted from initiatives taken by the New Zealand Government department responsible for child protection. These include:

- Establishing teams/coordinators that can act as a resource for workers in terms of guidance and support. These people can also be used to debrief staff following an incident.
- Regular review of situations of violence and threat to workers.
- Training on personal safety strategies.

Professionals also highlighted issues associated with living and working in the same community. These issues centred on obtaining a negative reputation for reporting families to Community Care social work teams and the consequences for their relationships with community members.

**Recommendation:** Consideration needs to be given to ways of both developing the skills of practitioners and also providing them with the support that will enable staff to manage the tensions of reporting child abuse when working and living in a close-knit community.

Only a small minority of professionals placed any emphasis on consulting with children to ascertain what life is like for the child and ascertaining their wishes and feelings about their situation.

**Recommendation:** Professionals should make a point of communicating with children in the family in a way that takes account of the age, ability and circumstances of the individual child. Professionals should seek to gain an understanding of the child’s wishes and feelings and an understanding of what a day in the life of the child is like.

Although professionals recognised the challenges of assessing children from minority groups, the focus was on ethnicity. No mention was made of disabled children and their specific needs.

**Recommendation:** All professionals who come into contact with children and families should receive training regarding the identification and impact of neglect on vulnerable groups of children.

The majority of professionals associated neglect with poor mothering. This marginalises the role and influence of the father and makes the mother responsible for protecting her children without any interventions that address the father’s behaviour.

**Recommendation:** Professionals should have opportunities through training and case management to explore issues associated with completing assessments of child neglect that emphasise the role and responsibilities of the mother as the primary caretaker and minimise the role of the father or male partner.

**Multi-disciplinary practice**

Lack of communication, particularly feedback from social workers to other professionals, was a theme of this study. The respondents highlighted the importance of establishing
effective, ongoing relationships with colleagues from different disciplines in order to discuss concerns about a child and family. They recognised that building these relationships was particularly difficult with social work colleagues as staff turnover was high and they believed that formal and informal systems should be developed to promote multi-disciplinary practice. All staff groups identified the pressures placed on them through high workloads as a result of understaffing and sickness. In some settings, staff were working with families where the individual worker did not feel they had the knowledge and skills to meet the needs of the family.

**Recommendation:** Social work services should have a standardised feedback procedure ensuring professional referrers are informed in writing of the outcome of their referral.

**Recommendation:** Managers should ensure that professionals have a caseload commensurate with the experience and skills of the worker.

**Recommendation:** The senior managers in the NEHB and other agencies may wish to identify the structures and systems acknowledged within the literature, and also those operating within the region, that promote multi-disciplinary practice.

### Training

Respondents identified a number of areas for knowledge and skill development, which are incorporated into the recommendations above. In addition, respondents emphasised the advantage of joint training initiatives. These can be particularly useful if delivered on a locality basis as they bring work colleagues together for training.

**Recommendation:** Multi-disciplinary training is an effective method for developing multi-disciplinary practice and should be given priority by senior and middle managers and front-line staff. The training where possible, should be provided on a locality basis. This means that those who train together will go on to work together. The training should be informed by research, theory and practice developments on child neglect. The following topics for training have been identified through this study:

- Working with aggressive and uncooperative service users.
- Effective communication with children regarding the impact of child neglect on their lives.
- Identifying and assessing child neglect among member of vulnerable groups.
- Assessing parenting capacity of both parents rather than focusing on mothers.
- Issues regarding working with child maltreatment when working/living in small communities.
BIBLIOGRAPHY
Bibliography


Bibliography


APPENDIX
THE POSTAL QUESTIONNAIRE
Child neglect: professionals perspectives
A study of the factors that influence referrals of suspected cases of child neglect to Community Care social work teams in the NEHB.

Please answer the questions below and return the questionnaire in the envelope provided. The questionnaire will take about 40 minutes to complete and is divided into sections covering the following areas:

- Personal details
- Occupation
- Parenting
- Your opinion
- Case scenario 1
- Case scenario 2
- Decision-making
- What influences your work
- Change

All replies will be treated in the strictest of confidence.

Personal details (please ✓ the appropriate box)
1a) Gender
   - Male
   - Female

1b) Age
   - Under 24
   - 25-29
   - 30-39
   - 40-49
   - 50 +

1c) Ethnicity
   - White European
   - African/Caribbean
   - Asian
   - Chinese
   - Other, please specify
1d) Do you have experience of child rearing as a parent or carer?

Yes  No

Occupation
The following questions are about your current job and work experience in relation to vulnerable children:

2a) What is your current job title?

________________________________________________________________________________

2b) How long have you held this position?

Under 1 year  1-5 years  6-10 years  Over 10 years

2c) How many years’ experience have you had in this profession?

Under 1 year  1-5 years  6-10 years  Over 10 years

2d) Would you define yourself as a manager or practitioner?

Manager  Practitioner

2e) During the last 12 months, how many times have you made a referral regarding child neglect to Community Care social work teams?

Never  1  2 to 4  5 to 7  8 to 10  11 or more
2f) During your time in your current post, how many case conferences have you attended?

- None
- 1
- 2 to 4
- 5 to 7
- 8 to 10
- 11 or more

2g) Professionals have different roles in terms of working with child neglect. Answer yes or no as to whether the following roles apply to you?

<table>
<thead>
<tr>
<th>Your role as professional</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying cases of neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referring cases of neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessing the needs of neglected children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing services for children who have been neglected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing services to parents to improve their parenting skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with other professionals on neglect cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Writing reports on children who have been neglected</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Parenting
The following questions are about working with cases of child neglect:

3a) The expression ‘good enough parenting’ is one that is often used by social workers when assessing child neglect. What does this expression mean to you?
3b) Below is a list of factors that can be considered when assessing the family’s home environment. Consider the needs of a 3-year-old toddler and for each box, tick the three factors which cause the most concern:

<table>
<thead>
<tr>
<th>General décor</th>
<th>Furnishings soiled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Damp</td>
<td>Faeces/urine</td>
</tr>
<tr>
<td>Wallpaper torn</td>
<td>Stale, decaying food</td>
</tr>
<tr>
<td>Health and safety risks</td>
<td>Bad smells</td>
</tr>
<tr>
<td>Unclean</td>
<td>Very dirty</td>
</tr>
<tr>
<td>Loose electric wires</td>
<td>Infestation</td>
</tr>
<tr>
<td>Holes in wall</td>
<td>Animal soiling</td>
</tr>
<tr>
<td>Carpets missing</td>
<td>Broken/lack of furniture</td>
</tr>
<tr>
<td>Lack of furniture</td>
<td>Other, please state</td>
</tr>
<tr>
<td>Parents unmotivated to make changes</td>
<td></td>
</tr>
<tr>
<td>Other, please state</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bathroom hygiene</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dirty with faeces</td>
<td></td>
</tr>
<tr>
<td>Foul smelling</td>
<td></td>
</tr>
<tr>
<td>Health hazard</td>
<td></td>
</tr>
<tr>
<td>No toilet paper</td>
<td></td>
</tr>
<tr>
<td>No running water</td>
<td></td>
</tr>
<tr>
<td>No toilet seat</td>
<td></td>
</tr>
<tr>
<td>Other, please state</td>
<td></td>
</tr>
</tbody>
</table>
3c) If you were concerned that a child was particularly ‘smelly’, what would this mean?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
3d) If you were concerned that a child was ‘inadequately dressed’, how would you describe them?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Your opinion
4a) Listed below are a number of statements regarding parenting, decision-making and damaging environments for children. Consider each statement in turn and indicate to what extent you agree or disagree:

1 = strongly agree  2 = agree  3 = not sure  4 = disagree  5 = strongly disagree

Social workers accept lower standards of parenting than other professionals who are in contact with children and families.

1  2  3  4  5

Social workers are more concerned with specific incidents of abuse than ongoing concerns of neglect.

1  2  3  4  5

Social workers provide parents with the support required to keep their children out of the care system.

1  2  3  4  5

The criteria for accepting a referral by a Community Care social work team depend on which social worker takes the referral.

1  2  3  4  5
Whether we like it or not, if one of the carers is physically aggressive we may tolerate standards of care that we would not accept among less aggressive carers.

1 2 3 4 5

The essential aspect of parenting is providing for a child’s physical needs and safety.

1 2 3 4 5

Children witnessing violence can suffer as much as if they themselves were being hit.

1 2 3 4 5

The most damaging environment for children is one of high criticism and low warmth.

1 2 3 4 5

A child who is physically neglected is likely to be experiencing emotional neglect as well.

1 2 3 4 5

A drinking problem always influences a parent’s ability to care for their child.

1 2 3 4 5
Case scenario 1: Liam takes a child into care

An anonymous telephone call is made to the Community Care social work team at 2.30pm on a winter afternoon. The caller says that he is aware of a case of child neglect. The caller gives the name of the family and address and states that an 8-year-old child is currently in the house on their own. The family is not known to the NEHB.

Liam, a social worker with many years’ experience, responds to the call at 5pm. The address that was given is a very run down isolated farm. The social worker knocks on the door, which is answered by an 8- to 9-year-old boy.

At first glance Liam sees that the child is dirty. There are bruises on the child’s knees and there is a scrape on his right elbow. Liam notices that the house is messy. He ascertains that there is no heating and there is little food in the fridge or cupboards. Liam asks the child about his parents’ whereabouts. The child says he does not know where they are but they have been out all day. Liam waits an hour for the parents to return and when they do not appear, Liam decides to take the boy into care.

5a) Do you agree with Liam’s decision?
   1 = strongly agree   2 = agree   3 = not sure   4 = disagree   5 = strongly disagree

5b) If you agreed, go to question 1; if you disagreed, go to question 2; and if you are not sure, go to question 3.

1. If you agreed with Liam’s decision, please choose five factors causing concern from the 11 listed below and rate them on a scale of 1 to 5, 1 being the factor causing most concern and 5 being the factor causing least concern.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rate 1-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child alone</td>
<td></td>
</tr>
<tr>
<td>2. Age of child</td>
<td></td>
</tr>
<tr>
<td>3. No food</td>
<td></td>
</tr>
<tr>
<td>4. No heat</td>
<td></td>
</tr>
<tr>
<td>5. Child injured</td>
<td></td>
</tr>
<tr>
<td>6. No other adults</td>
<td></td>
</tr>
<tr>
<td>7. House rundown</td>
<td></td>
</tr>
<tr>
<td>8. Winter</td>
<td></td>
</tr>
<tr>
<td>9. Isolated area</td>
<td></td>
</tr>
<tr>
<td>10. Child is dirty</td>
<td></td>
</tr>
<tr>
<td>11. Length of absence</td>
<td></td>
</tr>
<tr>
<td>12. Other, please state</td>
<td></td>
</tr>
</tbody>
</table>
2. If you disagree with Liam’s decision, tick one main reason why:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should have placed child with relatives or neighbours</td>
<td>Probably a one-off incident</td>
</tr>
<tr>
<td>Should have consulted the child’s wishes</td>
<td>Liam should have consulted supervisors</td>
</tr>
<tr>
<td>Probably a reasonable explanation</td>
<td>Family are not know so probably no cause for concern</td>
</tr>
<tr>
<td>Contact police</td>
<td>Liam should have intervened earlier</td>
</tr>
<tr>
<td>Contact other agencies</td>
<td>Bruises probably from playing</td>
</tr>
<tr>
<td>Liam should have waited longer</td>
<td>Other, please state</td>
</tr>
</tbody>
</table>

3. If you are ‘not sure’, then please explain why:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
Case scenario 2: The O’Connor family

Family composition:
- May O’Connor, mother, 32 years old, unemployed.
- Tony O’Connor, father, 38 years old, unemployed.
- Declan, 8 years old.
- Claire, 5 years old.
- Deirdre, 3 years old.
- Imelda, 18 months old.

May is described by professionals who know her as ‘pleasant but ineffectual’. She spends most of the time watching TV and expects the older children to fend for themselves and care for the younger children. She is expecting her fifth child in four months’ time and has told the social worker that she does not know how she will manage with another child.

The father, Tony, has been unemployed for seven years. He drinks heavily and it is believed he is violent towards May. He takes no responsibility for childcare and refuses to have contact with staff from the NEHB.

The NEHB has had involvement with this family for the last seven years because of concerns of neglect. The older children have been in care on two occasions when May said she was unable to cope. The children last returned home eight months ago and a family support worker was allocated to the family. Support has been ongoing. However, there has been little change in terms of improved standards of care. The NEHB regularly receives referrals from neighbours, public health nurses and the school stating that the children are unsupervised, ‘running wild’ and are inadequately fed and clothed.

There are concerns about all the children, particularly Imelda. She was on the sixtieth centile at birth but is now on the fiftieth. She spends most of the day in a pushchair in front of the TV. Imelda is unable to walk but can push herself to the standing position and can crawl. She has about five words. She presents as a miserable child rarely smiling.

6a) Consider the following 15 indicators of Imelda’s neglect and rate the five factors causing most concern, 1 being the cause for most concern and 5 being the cause for least concern:

<table>
<thead>
<tr>
<th>Indicators of neglect</th>
<th>Rate 1-5</th>
<th>Indicators of neglect</th>
<th>Rate 1-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decrease in centile</td>
<td></td>
<td>9. Father neglects role</td>
<td></td>
</tr>
<tr>
<td>2. In pushchair all day</td>
<td></td>
<td>10. Mother’s passivity</td>
<td></td>
</tr>
<tr>
<td>3. Lack of stimulation</td>
<td></td>
<td>11. Mother is depressed</td>
<td></td>
</tr>
<tr>
<td>4. Rarely smiles</td>
<td></td>
<td>12. Poverty</td>
<td></td>
</tr>
<tr>
<td>5. Few words</td>
<td></td>
<td>13. Frequent referrals</td>
<td></td>
</tr>
<tr>
<td>6. Allegations of domestic violence</td>
<td></td>
<td>14. No change despite intervention</td>
<td></td>
</tr>
<tr>
<td>7. Child not walking</td>
<td></td>
<td>15. Other, please state</td>
<td></td>
</tr>
<tr>
<td>8. Alcohol abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6b) Consider the following 15 indicators of neglect for the other children and rate the five factors causing most concern, 1 being the cause for most concern and 5 being the cause for least concern:

<table>
<thead>
<tr>
<th>Indicators of neglect</th>
<th>Rate 1-5</th>
<th>Indicators of neglect</th>
<th>Rate 1-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of supervision</td>
<td></td>
<td>9. Potential physical harm</td>
<td></td>
</tr>
<tr>
<td>2. No parental guidance</td>
<td></td>
<td>10. Lack of stability</td>
<td></td>
</tr>
<tr>
<td>3. Poor physical health</td>
<td></td>
<td>11. No boundaries</td>
<td></td>
</tr>
<tr>
<td>4. Lack of role models</td>
<td></td>
<td>12. Poor nurturing</td>
<td></td>
</tr>
<tr>
<td>5. Witnessing violence</td>
<td></td>
<td>13. Low self-esteem</td>
<td></td>
</tr>
<tr>
<td>6. Trauma of being in care</td>
<td></td>
<td>14. Inappropriate caring</td>
<td></td>
</tr>
<tr>
<td>7. Alcohol abuse by father</td>
<td></td>
<td>responsibilities of children</td>
<td></td>
</tr>
<tr>
<td>8. Lack of stimulation</td>
<td></td>
<td>younger</td>
<td></td>
</tr>
<tr>
<td>15. Other, please state</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6c) Given that resources are limited and that often needs have to be prioritised, in relation to this family, which one of the following issues would you prioritise?

<table>
<thead>
<tr>
<th>Resource priority</th>
<th>Tick one</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s parenting</td>
<td></td>
</tr>
<tr>
<td>Father’s parenting</td>
<td></td>
</tr>
<tr>
<td>Father’s lack of responsibility</td>
<td></td>
</tr>
<tr>
<td>Father’s aggression</td>
<td></td>
</tr>
<tr>
<td>Imelda’s development</td>
<td></td>
</tr>
<tr>
<td>The children’s behaviour</td>
<td></td>
</tr>
<tr>
<td>Unborn child</td>
<td></td>
</tr>
</tbody>
</table>
6d) What should be the *three* priorities for the NEHB concerning this family?

<table>
<thead>
<tr>
<th>Action by NEHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remove children and initiate care proceedings</td>
</tr>
<tr>
<td>Increase intensive social work support</td>
</tr>
<tr>
<td>Parenting course</td>
</tr>
<tr>
<td>Family support package</td>
</tr>
<tr>
<td>Respite care/fostering</td>
</tr>
<tr>
<td>Case conference</td>
</tr>
<tr>
<td>Educate mother about contraception</td>
</tr>
<tr>
<td>After-school/homework club</td>
</tr>
<tr>
<td>More assessment</td>
</tr>
<tr>
<td>Counselling for mother</td>
</tr>
<tr>
<td>Wait till new baby is born</td>
</tr>
<tr>
<td>Counselling for father</td>
</tr>
<tr>
<td>Arrange daycare/creche</td>
</tr>
<tr>
<td>Monitor the situation</td>
</tr>
<tr>
<td>Domestic violence support</td>
</tr>
<tr>
<td>Alcohol programme</td>
</tr>
<tr>
<td>Consider fostering</td>
</tr>
<tr>
<td>Medical check for Imelda</td>
</tr>
<tr>
<td>Encourage/assist father to find work</td>
</tr>
<tr>
<td>Supervision order</td>
</tr>
<tr>
<td>Barring order on father</td>
</tr>
<tr>
<td>Other, please state</td>
</tr>
</tbody>
</table>

6e) Which other professionals, besides social workers, do you think should be working with this family?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
**Decision-making**

7a) Research identifies an absence of consensus as to how professionals make decisions to refer a case of child neglect to Community Care social worker teams. The following are statements about how decisions are made. Consider each one and say whether you agree or disagree:

1 = strongly agree  2 = agree  3 = not sure  4 = disagree  5 = strongly disagree

<table>
<thead>
<tr>
<th>Statement</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decisions to refer are made on the basis of previous responses from Community Care social work teams.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Decisions are made on the basis of what the young person wants, provided they have the ability to understand and make informed choices.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Decisions are made based on the impact of neglect on the child.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Decisions are made taking into account the views of supervisors and managers.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Decisions are made based on what I consider to be in the best interest of the child, irrespective of the views of the child and family.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Decisions are influenced by the perceived consequences of making a referral.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Referrals are not made because professionals have personal knowledge or associations with children and their families in the community.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>It is acceptable for professionals to make anonymous referrals.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>National guidelines state that professionals should always tell parents when they are making a referral regarding their children, unless doing so would place the child in danger. This would influence the decision to refer.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Decisions are made using 'gut feeling' or 'intuition'.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Decisions are made based on professional practice experience.</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
What influences your work?

8a. Consider the list below and indicate, based on your experience, the extent to which each of the following factors negatively influence your ability to work with the Community Care social work teams in cases of child neglect:

1 = all of the time 2 = most of the time 3 = sometimes 4 = occasionally 5 = never

<table>
<thead>
<tr>
<th>Factor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time constraints</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nature of your job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workload pressures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issues of confidentiality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legislation/departmental procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making contact with social workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issues of confidentiality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The views of your supervisor/manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Change

9a) What factors do you consider influence your ability to refer to Community Care social work teams in cases of child neglect?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

9b) Please complete the following: ‘I feel I could be more effective in cases of child neglect if…’

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Thank you very much for completing this questionnaire.