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Demonstration Practice Project

Title

Public Health Nurses' experience of assessing the vulnerable child using the Child and Family Health Needs Assessment Framework

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Abstract

For the purpose of completing this demonstration practice project [DPP], I carried a small scale qualitative research study to explore the Public Health Nurses experience of assessment of vulnerable children and families. The Public Health Nurse has a valuable role in early identification and prevention of child abuse and neglect. In response to the Roscommon Child Care Case and Monageer inquiry recommendations, the Child and Family Health Needs Assessment [CFHNA] tool was implemented into practice to provide a framework for PHNs to use in assessment of vulnerable children and families. Although an in-depth appraisal of the CFHNA is beyond the scope of this DPP, feedback on the use of the tool was obtained and issues around working with vulnerability outlined.

In keeping with a qualitative methodology, semi structures interviews with eight PHNs working in Wicklow LHO were carried out to gain insight into the PHN experience of assessment vulnerable children and families. The findings suggest that the PHN has a valuable role in working with vulnerable or 'at risk 'children and families in terms of early identification are using the CFHNA. On balance, the feedback on the assessment tool was resoundingly positive as it allows a more comprehensive assessment. It could be argued that negative comments on the tool could largely be attributed to the backdrop in which PHNs carry out the child protection role as part of a generalist role. As the complexity of working with vulnerability was raised strongly by the PHNs interviewed, recommendations are focused on promoting supports for PHNs.

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Chapter one

1.1 Introduction

In Ireland, the Public Health Nurse (PHN) provides child health screening as part of the Universal Child Health Screening Programme and is in a key position to detect and prevent child abuse (Mulcahy and Mc Carthy, 2008). The universality of the service allows the PHN to have access to all children and families in the country either in the child's home or in a clinic setting (O' Dwyer, 2012).Gaining access to the child in the home is valuable as the PHN can assess the child in the context of their family and home environment and can raise concerns on numerous vulnerabilities facing children and families (Hanafin, 1998).This exploratory study, examines the experiences of PHNs working with vulnerable children and families and the key issues involved in both assessment and decision making to effectively safeguard children.

1.2 Defining vulnerability

According to Mulcahy (2004: 259) a vulnerable family could be defined as

'A family where there are problems giving cause for concern, but there is no evidence of actual or potential harm to the child for social services to become directly involved'.

Mulcahy (2004) found that PHN's determined a family's level of vulnerability based on the following categories; maternal factors, family factors, baby factors, environmental factors. If vulnerability became increased then the child could be deemed 'at risk' and a referral is made to social services. Mulcahy (2004) and Appleton (1996) describe the concept of vulnerability as a continuum that families may go in and out depending on the factors causing the issue of vulnerability. The most common factors causing vulnerability include poor parenting capacity, postnatal depression, mental illness and domestic violence (Scott, 2003). According to Scott (2003) professional input should focus on early intervention to protect against vulnerability.

1.3 Background for study

In order to address some of the inefficiencies in the Irish child protection system, outlined in several public inquiries, TUSLA the new Child and Family Agency (CFA) was established in January 2014.This reform is quite significant for Ireland as it will be first time there will be a separate agency with responsibility for child protection services. The agency will integrate a range of services with responsibility for child welfare and protection such as the Family Support Agency and Education Welfare Board. One of the criticisms regarding the CFA is that several services relevant to child welfare and protection are not included in the agency. These would include the PHN service and speech and language therapy, mental health service (including addiction) and disability services (Office of the Minister for Children and Youth Affairs, 2012).

Since 1993, there have been 29 child abuse inquiries in Ireland, each recommending improvements to child protection services (Buckley and O'Nolan, 2013). In relation to the practice of the PHN, the two inquiries identifying weaknesses in PHN practice were the Roscommon child care case (Health Service Executive, 2010, here after HSE) and Monageer report (Brosnan et al, 2009). Several shortcomings were highlighted in regard to identification of risk, record keeping and inter professional communication. In response to recommendations, a Child and Family Health Needs Assessment (CFHNA) tool was developed to assist the PHN in identifying children at risk and families that need support in addition to the core child health screening (O' Dwyer, 2012).

1.4 Rationale for study

Impact of rising Child protection and welfare notification rates

Child protection services are increasingly under pressure and this is evidenced by the low substantiation rates in Ireland, in 2010 only 5 % of total reports were substantiated (HSE, 2012). Child protection and welfare reports to HSE Children and Family have seen a steady rise; in 2011 there were 31,626 referrals, which was a 36 % rise from 2007. A combination of rising reports and low substantiation rates in Ireland suggest families are in need of support and early intervention to prevent concerns escalating (Buckley, 2012). In my experience working with vulnerable families, PHNs are managing child welfare cases that do not meet

the high threshold for social work intervention. This research study will serve to identify the challenges PHNs encounter in supporting vulnerable children and families, often in the absence of other community supports.

According to annual reports, half of the referrals were child protection and the other half were child welfare referrals (HSE, 2012).The rate of referrals for child welfare issues has increased which indicate that although these children are not considered to be at risk of ongoing harm or abuse they are still considered at risk and in need of social work intervention (Buckley, 2012).Although referrals for emotional, physical and sexual abuse are increasing, it has been noted that child neglect is the most common reason for referral (HSE, 2012). Child neglect is one issue that can be identified and addressed by the PHN (Kent et al, 2011).

Child and family health needs assessment tool

The CFHNA training was rolled out nationally. Following a two day training course for all PHNs in Wicklow Local Health Office, the CFHNA tool was implemented in May 2013. The introduction of the CFHNA tool will assist the PHN to assess risk and protective factors and will inform a more child centred assessment (O'Dwyer, 2012). This study will explore the experience of PHNs working with vulnerability and allow feedback on the use of the framework.

1.5 Objectives of the study

This research is an exploratory study of PHN experiences in working with vulnerable families. The key objectives of this study are:

- To explore the PHN experience of assessment and intervention with children and families deemed vulnerable or 'at risk' using the Child and Family Health Need Assessment framework. Although an in-depth evaluation of the CFHNA tool is beyond the scope of this DPP, one of the objectives of the study was to gain some feedback on the use of the tool.

- To give PHNs an opportunity to identify key issues that arises when caring for vulnerable families.

Study setting

The study will take place in Wicklow, Local health office in Dublin mid- Leinster.

The next chapter will identify where the literature to support this chosen study was sourced, the existing literature on the PHNs role in both the assessment and working with vulnerable children and families will be critically reviewed.

Chapter two Literature review

2.0 Literature search strategy

The contents of a number of databases were used to search for literature relevant to Public Health Nurses working with vulnerable families. As there is limited research in Ireland in regard to the child protection role of the PHN, the researcher included the search term 'health visitor' to draw on literature from the UK setting. The electronic databases used included CINAHL, Science direct, and Lenus directory. The researcher searched the literature to gain insight into what is previously known about the PHN/HV role in identifying vulnerability, the use of structured health needs assessment tools by for PHNs /HVs and the challenges faced in decision making by PHNs and HVs.

2.1 The role of the Public health nurse in child protection and welfare

As outlined by the Heath Act (1970), the PHN is responsible for the provision of children service up to age of 6 years of age, including pupils attending primary schools that are offered vision and hearing screening (Department of Health, 1970). Child health screening provided by the PHN is guided by best practice as outlined in Best Health for Children Revisited (HSE, 2005). The core developmental screening allows the PHN to have a minimum of five contacts with the child and family (Hanafin, 1998, Denyer et al, 2000).The home or clinic visits happen at prescribed times, the first visit following notification of birth from maternity hospital occurs at 48- 72 hours. Subsequent visits for developmental screening occur at 3 months, 7-9 months, 18 -24 months and 3.25 -3.5 years (Health Service Executive, 2005). The PHN is a specialist in child health and development and monitors the child's a physical, emotional and psychological development (Marcellus, 2005).

Hanafin (1998) critiqued the role of the PHN in relation to child protection outlining the primary, secondary and tertiary roles in child protection. Primary protection refers to the prevention of child neglect and abuse. The child health surveillance role and health promotion role of the PHN demonstrate primary protection of children. Macmillan et al (2005) outlines the important role of referring families to other social services for support. PHNs can refer to statutory and voluntary agencies if there are risks identified, thus it is in

her role as referral agent that she is effective in protecting children at a secondary level (Hanafin, 1998). Tertiary child protection refers to the ongoing management of vulnerable families where risks have been identified. The PHN has a valuable primary and secondary protective role in child protection. Hanafin (1998) believes the tertiary protective role of PHN working with children deemed 'at risk' by Social Workers, to be limited.

It is recognised in Public Health Nursing, that some families need support in addition to the core child health surveillance visits and PHNs tailor the number of visits to the individual needs of the family and level of support needed (O' Dwyer, 2012). Vulnerable or 'at risk' families often have higher support needs and a co-ordinated multidisciplinary team approach is needed to protect the children (O'Dwyer, 2012).Promoting positive parenting practices can reduce the risk of child neglect and there is evidence to show that the domiciliary visits are a valuable source of support vulnerable families with young children (Aston, 2008, Browne et al, 2010, Peckover, 2013).

Like the PHN, the Health Visitor (HV) in the UK works as part of the primary care team assessing the needs of the community providing a health promotion role with the overall aim to promote health and prevent illness. As part of the health promotion role of the HV would include working closely with deprived groups. However, the work of the HV is primarily concerned with working with children and families delivering the 'healthy child programme'. In contrast, the PHN provides a more generalist role in the community providing domiciliary service to all client groups, child health service, clinical nursing care, care of older persons, people with disability and chronic sick as outlined in circular 27/66 (Department of Health, 1966) and Circular 41/2000 (Department of Health and Children (DoHC), 2000).This in itself is a challenge for PHNs, who have a legislative responsibility to child protection as laid out by the Child Care Act (1991). The overarching policy guiding practitioners in child protection in Ireland is Children First (Department of Children and Youth Affairs hereafter DCYA, 2011).

2.2 PHNs perspectives on role in vulnerability

The role of identifying and detecting of abuse was viewed by some PHNs as being in conflict with the traditional nursing role of the PHN (Butler, 1996). PHNs seeks to develop good working relationship with families and this at the core of providing a child protection role. De Boer and Coady (2007) view a collaborative working relationship with parents and families as essential to engage families and promote participation in the child protection process. It has been outlined that both PHNs and HVs have difficulty in defining their role in terms of actively seeking to detect cases of child abuse (Crisp and Lister, 2004).Not all HVs or PHNs are comfortable with the 'dirty' investigatory work of identifying vulnerability viewing it to be a social work role (Butler, 1996, Mac Kenzie, 2008).

2.2.1 Monitoring levels of vulnerability

Health visitors reported to Crisp and Lister (2004) that a supervisory role was being placed on them by Social Workers in some cases and that if they did not take on this role there would be no one else as the Social Worker often did not have regular contact with the families. PHNs in a study carried out by Kent et al (2011) expressed unease with this 'monitoring' role and compared it to policing or 'checking up' on a family.

Although it is argued that surveillance is a safeguarding role in so far as continually assessing for existence of risk or protective factors (Buckley et al, 2006). PHNs reported to Kent et al (2011) that the process of surveillance had potential to damage relationship with families and that monitoring alone did not protect the children involved. In the Roscommon child care case, PHNs had regular contact 'monitoring' the family situation and in the absence of clear record keeping, it was not obvious why the PHN was visiting. Although the surveillance did result in referrals to Social Workers, the regular visits by the PHN did not add to the protection of the children.

2.3 Identifying vulnerability using the Child and family Health needs Assessment tool

PHNs are now set to follow the practice of HVs in the use of structured assessment tools with the implementation of the CFHNA tool. The CFHNA is a framework structured around three domains, child development, parenting capacity and environmental factors (Appendix A). the assessment tool was adapted from a UK ' *Framework for the Assessment of Children in Need and their Families'* (Department of Health,2000) and Scottish model *'Get it Right for Every Child*' (Scottish Government, 2008) as the three domains are common to both frameworks. An assessment based on these domains will provide a clear picture of the child's needs as it will include all the environmental factors affecting their development (O' Dwyer, 2012).

It is the first framework for PHNs to assess risk factors and also protective factors in relation to child welfare and protection, to be used in Ireland (O'Dwyer, 2012). The change of focus from assessment of risk to a strength building perspective will be a change for PHN practice. Central to providing quality child protection is the professional capacity to assess the risks and protective factors, make decisions and engage with families to motivate a change (Turnell et al, 2013). Ultimately, professional assessment of protective and risk factors will underpin decision making.

In keeping with the Agenda for Children's Services, the CFHNA allows the use of professional reflective practice (DCYA, 2007).The assessment is undertaken when the child and his/her family requires support services in addition to the core Universal Child Health Screening and Surveillance programme provided by the PHN service (O' Dwyer, 2012).During every core assessment visit the PHN asks four trigger questions (Appendix B) to prompt the need to complete a CFHNA on the family. The levels at which children and families need support in the CFHNA are adapted from Hardiker et al (1991) cited in Agenda for Children Services, (DCYA, 2007) ranging from universal service need in level 1 to a more complex need in level 4 (Appendix A).Early identification is key, to prevent children and families moving towards higher levels of need to allow prompt referrals to support services. The fact that children and families can move in and out of the continuum of vulnerability as described by Mulcahy (2004) is central to the CFHNA framework as it attempts to focus the PHN assessment on the Hardiker model of need (O'Dwyer, 2012).

When a CFHNA is completed, a nursing care plan is made to address the risks identified and reviewed after a set period of time. For example, a family with reduced parenting capacity may require additional education or health promotion in relation to parenting. If on review of the care plan and reassessment using CFHNA, the risks are still present and despite the additional support from the PHN service there is need for a more intensive family support, then a referral to social work would be considered. The CFHNA will provide clarity to the PHN role in relation to vulnerability as it will allow PHNs to clearly document the cause of vulnerability (O'Dwyer, 2012). The CFHNA should be attached to the standard referral form when PHNs are referring to Social Workers for child protection.

Ling and Luker (2000) found that intuition was an important factor to prompt nurses to look for evidence of abuse when suspicions had been aroused. An evidenced based assessment tool can allow practitioners to be aware of personal biases that may misguide judgements made in relation to a child and family situation (Buckley et al, 2006). Munro (2008) observed that practitioners were often reluctant to waiver from their initial assessment on a family despite new information.

2.4 Clinical supervision

Despite the complex nature of working with child protection, there is a lack of supervision for nurses in relation to child protection. Supervision is not established in practice as a result of which supervision may be regarded negatively by PHNs who may view supervision as a means of monitoring practice rather than a formal support measure (Lister and Crisp, 2004). Ruch (2007) draws attention to the surveillance model of supervision in current practice that focuses on monitoring performance and recommends the use of a reflective practice approach. The value of supervision for frontline staff working in child protection services is well documented as it provides a forum for staff to discuss the emotional impact of the work (Morrison, 1990, Gibbs, 2001, Rowse, 2009). In a study carried out by Gibb and Smart (2011), supervision for health visitors was useful in assisting decision making in complex cases and identifying risk, referrals and record keeping.

Chapter three Methodology

3.1 Introduction

This chapter describes the research methodology selected for the purpose of this study. Data collection methods are described and the process of data analysis is outlined.

3.2 Study design

In order to obtain a detailed account of the PHNs perception of identifying and working with vulnerable or at risk families, I employed a qualitative research design approach. A qualitative design can yield a good understanding of lived experiences through discussion and can yield rich quality data exploring how participants feel on an issue (Barbour, 2008). Qualitative researchers are interested in accessing experiences in their natural context and allows for a more in depth understanding (Barbour, 2007).

3.3 Inclusion and exclusion criteria

For this study, the inclusion criteria were PHNs who have a high level of child welfare and child protection cases on general caseloads in LHO Wicklow. Selection was dependant on the PHNs experience in using the Child and Family Health Needs Assessment tool, therefore the PHNs in the study had to have completed the tool in the previous six months since implementation to practice. Excluded from the study were PHNs who have not yet used the CHFNA framework as their caseloads have a low level of child protection and child welfare issues.

3.4 Sampling technique

I employed a purposeful sampling approach. Purposive sampling is a common sampling strategy used in qualitative research; generally participants are selected according to preselected criteria relevant to a particular research question (Burns and Grove, 2009). The sample size was eight PHNs and although the sample is small, I obtained good quality data in relation to the experience of the PHN working with vulnerable families.

3.5 Data collection

For the purpose of data collection, semi structured interviews were used with each participant. The interviews lasted 45- 60 minutes and I used open ended questions to explore the topic. The use of open ended questions and probing in qualitative research allows participants to respond and discuss the issue in their own words, as opposed to a quantitative approach that yield more fixed responses to questions (Mack et al 2005, Barbour, 2008). An advantage of open ended questions is that they evoke meaningful responses that maybe unanticipated by the researcher (Mack et al, 2005).

3.6 Data analysis

Interviews were recorded digitally and transcribed verbatim to facilitate data analysis. Themes that were common to several interviews were identified and findings were organised thematically. I believe that I obtained data saturation in this study despite the small sample as there was recurring themes identified. 'Data saturation' according to Burns and Grove (2009), is when the researcher has collected enough data to know that no new findings could be identified.

3.7 Limitations

One of the limitations of the study as outlined by Bell (2010) was the small sample size and as a result the findings may not be generalisable to other community care areas. The findings are specific to Wicklow LHO and responses in interviews may have been influenced by local organisational culture, inter agency relationships and available resources for vulnerable families.

The fact that I work as a PHN in LHO Wicklow may have been a limitation in terms of researcher bias to findings. Researcher bias is a threat to qualitative research validity as the researcher may impose personal views when analysing data (Burke Johnson, 1997).Throughout the data collection and analysis process, I endeavoured to research reflexively in terms identifying personal biases and predispositions.

3.8 Ethical considerations

Although academic ethical approval was not required to complete this research study, the ethical considerations are centred on informed consent from participants. Approval to complete this study was sought and granted by the Director of Public Health Nursing [Appendix D], an information sheet [Appendix C] was posted out to each PHN with a copy of semi structured questioned for interview [Appendix E]. On the day of the interviews, participants signed an informed consent prior to interview.

Chapter four Findings and discussion

In this chapter the most significant findings will be presented thematically. Through analysis of the data, the recurring themes identified were as follows; the benefit of using the CFHNA tool and challenges experienced by PHNs working with vulnerable families.

4.1 The benefit of the CFHNA in assessment of vulnerable families

All the PHNs interviewed had positive feedback on the use of the CHFNA tool in terms of providing a structure allowing for a more comprehensive assessment.

4.1.1 Better structure to assessment

The purpose of using the CFHNA is to gather information on the needs of vulnerable children and families using the domains of child developmental needs/ parenting capacity/family and environmental factors and risk and protective factors (O Dwyer, 2012). Each PHN commented on the benefit of using the domains as a focus to the assessment and four PHNs mentioned that all three domains are interlinked and equally important during assessment.

' The framework covers it all ...think the parenting capacity and environmental factors so important because looking at these alone you get a good idea what life is like for the child before you even do the developmental check'[PHN 8]

'Every time I am doing developmental checks I am always looking at how the parents are with the child…how they talk about the child… [PHN 4]

The first thing I look for is how the home is and if it's warm, doesn't have to be sparkling or anything. I think you get a lot of information on how the kids present to you' [PHN 3]

Two PHNs commented on including protective factors in the assessment.

' Before I always concentrated on the risks that I saw , I would have known the protective factors but probably have not written them down and made them clear, so it's a good way of breaking it down why a family is vulnerable' [PHN 2]

'Now I wonder why I never commented on protective factors before' [PHN 7]

Critics of the use of structured needs assessment tool suggest they are inappropriate for Health Visitors as they restrict the professional judgement with an over emphasis on risk factors for vulnerability (Cowley et al, 2004). The inclusion of protective factors in the CFHNA supports professional judgement and a strengthening family approach. A strengthening family approach is one where the practitioner recognises the protective factors and abilities within the family and works to build on them (Seden, 2002). This approach is more positive and can benefit engagement of the family.

One PHN highlighted the value of gaining access to the children in the home for a better assessment of needs.

During a home visit you get a very clear picture of the environment for the child and whether or not their needs will be met...you learn a lot on observing how the mum is with the child' [PHN 4]

'Harder in the clinic to get a full picture on a family, being in the home is so much rawer' [PHN 1]

'Developmental checks are better in the home but a lot of our visits are in the clinic so you are relying on how they present to you' [PHN 5]

Three of the PHNs mentioned using the CFHNA handbook as a guideline when completing the assessment and commented on the usefulness of documenting their observations.

'I found the manual a god send as I was having trouble putting words on how to describe what I saw as risks' [PHN 5]

'Once I had it all the concerns on paper ...I realised there was very little I could offer this family from a PHN perspective…I was sure then that I had done all I could' [PHN 6]

4.1.2 Role clarity in engaging family

Five of the PHNs talked about how using the CFHNA gave better role clarity in terms of managing vulnerability.

PHN [4] identified that the recent training on the CFHNA tool was extremely beneficial as she felt the PHN role was now clearer when working with vulnerable families.

' You feel like you were visiting just to keep an eye and now at least we have some guidance on where to go next with a family, you know referring to Social Workers'[PHN 6]

Throughout the interviews with each PHN, it was clear that the PHNs involved had a good working knowledge of Children First policy and were clear on their own legislative responsibilities in relation to child protection. This was in contrast to Butler's (1996) exploratory study which identified that PHNs had little knowledge of child care legislation and felt uncomfortable with their child protection role. It should be noted that the CFHNA training occurred in the last year and this may have added to the knowledge and confidence of the PHNs in discussing child protection issues.

All the PHNs made reference to the working relationship with families and how important it was to engage family in order to protect the children in the home. Four PHNs outlined the need to engage the family in order to have a good assessment. They highlighted that the practice of identifying the problem with the parent and care planning was essential.

'It's easier for us than Social Workers because parents don't have a guard up unless there is already social work involvement….the mothers see you as a friendly face and someone who wants to help them…if they know you, well you have some hope of getting them on board' [PHN 2]

'The CFHNA tool is great but a good assessment really depends on the PHNs ability to get the parents to realise the concerns and why a care plan is needed …if they don't think there is a problem….then they are not likely to engage and that's a problem' [PHN 8]

'You can fill all the forms you like but if they don't let you in the door ...It's a waste of time' [PHN 5]

Moules et al (2010) examined the working relationships PHNs have with high priority

vulnerable families in Canada and found the relationship to be complex and multifaceted. In their findings they describe how PHN negotiate a reciprocal relationship with parents, gaining trust and engaging families.

One PHN outlined;

'This tool can show if a family are doing their best … or it can help us show Social Workers that there is no change and family are not engaging at all' [PHN 3]

' I was doing a home visit one time and there were lot problems with parenting….home chaotic … and the tool really helped me keep the focus on the child ..I did' nt mind discussing the child protection concerns I had with the mother...that was the one difference for me… I felt justified in referring to Social Workers because she wasn't engaging' [PHN 5]

The process of engaging the family in an assessment of needs is essential and how practitioners engage the family will determine the quality of the assessment. Buckley et al (2006) suggest that practitioners should make attempts to engage the family at the initial assessment and continually throughout the whole process. The CFHNA is intended to be used in partnership with families to help families identify their own needs (O' Dwyer, 2012).Cowley and Houston (2003) believe that the use of structured tools in assessment focused the HVs to ask questions rather than listening to clients who as a result did not identify own needs or concerns.

4.2 Challenges experienced by PHNs working with vulnerable families

The challenges highlighted by the PHNs will be presented in recurring sub themes;

general workload of PHN, stress of working with vulnerable families, need for supervision and high threshold held by Social Workers.

4.2.1 General workload of PHN impacting on child protection role

A recurring theme expressed by five PHNs was the difficulty in managing a general caseload in addition to child protection role.

‘ I feel I am out there running around doing other things that are not near as important as visiting children and families that need support’[PHN 7]

‘I had a family who were so vulnerable and I was worried about them … just could not get out to see them ..It’s not right that the clinical calls take priority over children’ [PHN 2]

The issue of diverse role of the PHN was highlighted as a genuine concern by the PHNs who felt they were not able to concentrate on child protection. Begley et al (2004) highlighted that some PHNs had geographical areas of more than 2,500 people which is too large to identify families at risk. The need for more specialised role in PHN in relation to child protection was also recommended by Kent et al (2011) who highlighted that with increasing caseloads and aging populations it is increasingly difficult to carry out the child protective function.

4.2.2 Time consuming tool

When asked about the drawbacks to using the tool, five out of the eight PHNs reported that it was time consuming to complete.

‘The CFHNA tool is good but it takes a good while to fill out and like you need to get it right if the social work will be deciding on taking on the case’[PHN 8]

‘You really need to clear your morning when doing out a CFHNA as it needs your full attention, that’s really hard to do when you have so many clinical calls to do’ [PHN 4]

‘I found it long to fill out but was glad I had it as it really named my concerns’ [PHN 6]

It should be noted that the CFHNA was only introduced in May 2013 in Wicklow and this could be attributed to some of the stress when completing the tool.

4.2.3 Anxiety of holding vulnerable families

One finding which is consistent with previous research is the need for more support for PHNs as the complex nature of working with vulnerability was highlighted as a challenge. On analysis of the data the anxiety experienced by the PHNs was related to the level of vulnerability and the perceived high threshold held by Social Workers. Six out of the eight PHNs identified working with vulnerable children and families as stressful and difficult to experience.

'Sometimes it's like watching a pot boiling and you are just waiting for it to boil over' [PHN 1]

'I have laid wake at night worrying about some of the children...you know they are on the brink' [PHN 7]

Another PHN [6] expressed concern at being a key worker with vulnerable families with little available family support.

'Often there is no one else calling to the family, so you end up calling to' weigh' the baby just to get in the door'

One PHN [5] stated that completing the assessment to send in with referral to social work was stressful as the nature of the referral was complex.

'Was a bit stressed filling in the assessment tool as it was a definite referral to duty team Social Worker…I don't know why I was so stressed but I think I was just upset over the referral' [PHN 5]

4.2.3 Need for supervision

The issue of supervision as a source of support for the PHN was mentioned by just four out of the eight PHNs interviewed but only one PHN used the term 'supervision'.

'It would be good to have supervision with someone you could talk through high risk families'

I feel this is significant as it highlights that supervision as a source of support is not one that is established for PHNs. All of the PHNs interviewed discussed the need for support around the area of child protection .One PHN stated that she got support by talking out cases with other colleagues.

'I had a family that I used to worry over , I had done the referrals to Social Work and family support services and by just talking it through helped me realise that I was doing all I could'

Following the pilot of using the Child and Family Health Needs Assessment framework, O' Dwyer (2012) highlighted that PHNs had requested more support in child protection and identified the importance of supervision to support PHNs. The issue of individual practitioner

anxiety, and the notion that without supervision frontline staff can become desensitised to the highly emotive work in child protection was raised by Gibbs (2009). Gibbs (2009) makes the argument that supervision can allow practitioners to deal with emotional impact of working with abused children and families and empower them to make decisions and judgements not clouded by unchallenged emotions or personal biases.

4.2.4 High Thresholds held by Social Workers

In April 2014, TUSLA have published a threshold of need guide for practitioners which outlines the level of need accepted by social work services. Like the CFHNA ,the level of needs are based on the Hardiker model with the higher level 3 and 4 considered for social work allocation (TUSLA, 2014). The guide will promote clarity and consistency of responses to child protection and welfare referrals to TUSLA.

All eight of the PHNs voiced concern regarding the higher threshold held by Social Workers in relation to vulnerable families.

One PHN [2] expressed the view when discussing a child neglect case;

'You know when you refer that it won't take priority with Social Workers'

'It's very frustrating when you refer to Social Worker and they do not feel its reaches their level of child protection concern' [PHN 5]

'A family where there is neglect are smouldering away ...there may not be flames but they're still on fire' [PHN 8]

One PHN 3 stated

'I sent in a referral and it was child neglect case and in my eyes they were bad enough but it took about three weeks for Social Worker to call…I find that difficult'

During the interviews it was noted that the PHNs interviewed had little knowledge of the standard business processes used by Social Workers and that they were very frustrated in what they viewed as needless delays to respond to referrals. This is important as it shows the need for ongoing inter agency briefing sessions especially since social services have joined

TUSLA. Achieving effective intra agency communication and collaboration is difficult when there is fragmentation of services (Duggan and Corrigan, 2009).

One other PHN [1] reported that the social work department had not yet heard about the CFHNA.

'When a Social Worker phoned about one of my vulnerable families, I told her I would do out a CFHNA and she had not heard about it yet'

4.2.5 Lack of resources for vulnerable families

Following on from the high threshold theme, the PHNs were concerned about the families that didn't meet the criteria for social worker allocation. The issue of available family support services was raised by the PHNs with differing views of availability of services. The availability of family services was dependant on where you lived with rural areas having less than urban areas in Wicklow. One PHN [3] expressed the view;

'In terms of family support there isn't whole lot of services, I mean the family support worker only visits once a week ….need more intense family support'

This issue came up as a finding in O' Dwyer (2012) when reviewing the piloting of the CFHNA and a recommendation was made for PHNs to receive more intensive parenting programmes to assist PHNs support families in the absence of services. Buckley (2012) outlined the current child protection system to be under resourced and the families that do not meet the accepted threshold are relying on availability of local services which may or may not exist.

Chapter five

5.0 Conclusion

This small study highlights the vital role PHNs and HVs have in both identifying and supporting vulnerable families. One of the major findings of this study was the overall agreement by the PHN s that the CFHNA tool was a benefit as it provided structure to allow a comprehensive assessment of vulnerable children and families. The use of the CFHNA also allows for more clarity on the role of the PHN in ongoing managing of cases. It was interesting to note that the PHNs felt clearer about their own role in child protection and this should benefit other professionals also.

From a practical perspective the challenges faced by PHNs could not be attributed to the tool but rather the general caseload in which the PHN uses the tool. The consensus from the PHNs interviewed was that the large general caseloads impacted greatly on their ability to carry out the child protection role. In order to address this major issue, I would recommend a re-evaluation of the Public Health Nursing service in Ireland in order to address the needs of all client groups in the community. I would recommend segregating the child health screening of the PHN role from all other client groups in order to prioritise children and families. This change would equate to some PHNs having responsibility for older persons and other PHNs specialising only in child health. This recommendation could be the basis for inclusion of PHNs into TUSLA in the future.

Another issue outlined by the PHNs was the anxiety and stress of working with complex vulnerable families. There is a real need for formal support in the child protection for PHNs. would recommend clinical supervision for all PHNs to provide some support for PHNs .I am in agreement with O' Dwyer (2012) that clinical supervision should only be given by a specialist in child protection and therefore I would recommend that a specialist post be considered for a PHN on child protection.

Further research is needed to identify the types of vulnerable cases that PHNs are managing and whether early detection using the CFHNA supports families. With little research

available on the primary and secondary child protection role of the PHN in the Irish setting, it is hard to fully appreciate the pivotal role PHNs plays in protecting children from harm and neglect.

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Appendix A **Child and Family Health Needs Assessment Domains** **(O'Dwyer , 2012)**

Domain	Dimensions	Indicators
LEVEL ONE 1. Child Development Needs	Physical Health and Well being Emotional and Behavioural Development Education Family and Social Relationships Identity Social Presentation Self – Care Skills	Development checks up to date: Appropriate height and weight : Good nutrition: Immunisations up to date: Good vision and hearing: Fine motor skills Coos and smiles: Listens to voices: Responds to name: Imitates others: Explores with enthusiasm. Ability to communicate with others. Access to toys and books Stable and affectionate relationships with parents caregivers and siblings Growing sense of self as separate from others Early practical skills in feeding and dressing Appropriate dress hygiene cleanliness
2. Parenting Capacity	Basic care Ensuring safety Emotional warmth Stability Guidance and boundaries Stimulation	Provision of food warmth shelter and clothing Provision of a safe environment where parents and carers act to safeguard the health and welfare of the child Parents and carers feelings about the child are positive. Home environment is stable. Child is not exposed to violence alcohol or drug misuse. Modelling appropriate behaviour and control of emotions and interactions with others Appropriate stimulation of learning.
3. Family and Environmental Factors	Family history and functioning Housing Employment and Income Wider Family Family integration into the community Community services	Supportive family relationships. Good quality housing. Family able to provide for the child Support of wider family members Formal and informal support networks Access community resources and activities

Domain	Dimensions	Indicators
LEVELTWO 1. Child Development Needs	Physical and Health Well –Being Emotional and Behavioural Development Education Family and Social Relationships Identity Social Presentation Self-Care Skills	Slow in reaching developmental milestones: Weight not increasing as expected: Not attending scheduled appointments. Persistent minor injuries Passive withdrawn Uninterested Can be demanding Clinging Challenging behaviour at times Identified language and communication difficulties Reduced access to books, toys or educational materials Disharmony conflict within the family effecting child behaviour/ safety/ development. Poor self-esteem: withdrawn poor peer relationships poor eye contact Unkempt: inappropriate clothes social presentation and behaviour
2. Parenting Capacity	Basic Care Ensuring Safety Emotional Warmth Stability Guidance and Boundaries	Inconsistent care. Young inexperienced parent. Inappropriate child care arrangement .Exposure to harm substance misuses Poor bonding. Insecure attachment .Parent unavailable to comfort the infant / child is self-absorbed/ depressed. .Lack of consistency in routine Lack of response to concerns raised regarding the child. Discipline is a cause of concern
3. Family and Environmental Factors	Family History and Functioning Housing Employment and Income Wider Family Family integration into the community Community Services	Relationship problems within the family which impact on the family functioning as a unit. Poor quality housing , overcrowding, damp, chaotic Low income or unemployment causing stress anxiety impacting on the family's ability to provide reliable care. Family not connected to or supported by extended family. Family not assimilated into the local community

Domain	Dimensions	Indicators
LEVEL THREE 1. Child Development Needs	Physical Health and Well- Being	Physical development raising significant concerns. Disability requiring specialist support. Chronic recurring health problems and hospital, admissions. Misses appointment
	Emotional and Behavioural Development	Looking for attention and approval. Unwilling to share toys etc. Acting out .Challenging behaviour
	Education	No opportunities for play or interaction with other children. No access to books or toys Chaotic family lifestyle with significant impact on child health and development. Socially withdrawn. Isolated. Feel ashamed and guilty bullied victimised
	Family and social relations	
	Identity	
	Social presentation	
	Self-care skills	Poor personal hygiene, general appearance of being uncared for.
2. Parenting Capacity	Basic Care	Parent unable to manage day to day care of the child.
	Ensuring safety	High level of conflict in the home putting the child at risk
	Emotional Warmth	Parent emotionally unavailable to the child
	Stability	Multiple care givers
	Guidance and Boundaries	Difficulties in setting boundaries.
	Stimulation	Inadequate provided to the child ,Not receiving positive stimulation, with lack of new experiences or activities
3. Family and Environmental Factors	Family history and functioning	Acrimonious family relationships Suspicion of physical sexual emotional abuse or neglect
	Housing	Overcrowded or inadequate housing is likely to significantly impair health/development.
	Employment and Income	Poverty impacting on parent's ability to care for the child. Conflict as a result of financial debts
	Wider family	Family is isolated from immediate family and friends
	Family integration into the community	Parents socially excluded.
	Community services	Family under stress without extended network of support

Domain **LEVEL FOUR** 1. Child Development Needs	Dimensions Physical Health and Well- Being Emotional and Behavioural Development Education Family and social relations Identity Social presentation Self-care skills	Indicators Childs health requires specialist services. Physical disability. Complex emotional and behavioural problems that requires specialist intervention. Emotional; neglect. Significant language and communication difficulties. No education provision. Family relations have completely broken down. Self – harming and harming others. Dirty, unwashed, skin infestations.
2. Parenting Capacity	Basic Care Ensuring safety Emotional Warmth Stability Guidance and Boundaries Stimulation	Inability to recognise own health needs or those of the child to the extent that the child's health and development is seriously compromised. Continued exposure to dangerous situations. Mental or physical health needs or other health problems are significant and the child emotional needs are neglected. Frequency of house moves is significantly affecting the child's health and development. Erratic or inadequate guidance and boundaries No guidance and boundaries. Lack of response to concerns raised regarding the child's development and well –being.
3. Family and Environmental Factors	Family history and functioning Housing Employment and Income Wider family Family integration into the community Community services	Imminent family breakdown and risk of child becoming 'looked after'. Accommodation places child in danger. Child health and development seriously affected by low income and unemployment. Family lack a support network. Family subjected to racial harassment or abuse. Chronic social exclusion, no supportive network. Family significantly disadvantaged by lack of service provision to meet additional needs.

Appendix B

Feidhmeannas Seirbhíse Sláinte
Health Service Executive

Record for recording response to the Child and Family Health Needs Questions at core developmental screening checks

1. Has there been any change in the child and family circumstances from the previous contact? Yes/ No
   Comment _____
2. Parenting issues expressed or identified ?Yes / No
   Comment _____
3. Housing / Environment issues expressed or identified? Yes /No
   Comment _____
4. Access to family/community supports ? Yes /No
   Comment_____
5. Other parental concerns expressed or identified ?Yes/No
   Comment_____

Child and family health needs assessment required? Yes/No Care plan Commenced Yes/No

Feidhmeannas Seirbhíse Sláinte
Health Service Executive

TRINITY COLLEGE DUBLIN

Appendix C Information sheet

Dear Public Health Nurse,

As part fulfilment of post-graduate diploma in Child protection and Child Welfare, I am undertaking research on the Public Health Nurses (PHNs) experience on assessing the vulnerable child using the Child and Family Health Need Assessment framework.

In order to gain insight into the lived experience of PHNs, I plan to hold individual semi-structured interviews with eight PHNs over the coming weeks. Taking part in this research is completely voluntary and you may withdraw from the research at any time. The interview will last approximately one hour. Each interview will be recorded and transcribed with anonymity assured to each participant. All material will be destroyed on completion of the study. Once completed, the research will be held at Trinity College Dublin. I will be happy to forward you a copy of the project for informational purposes.

Consent

Title: Public Health Nurses experience on assessing the vulnerable child using the Child and Family Health Need Assessment framework

I agree to participate voluntarily in this research study by undertaking a semi-structured interview. The research purpose has been explained to me in writing. I understand that anonymity is assured and that I can withdraw from the study at any time.

Signed:

_____

Kathy Walsh

Appendix D

Feidhmeannas Seirbhíse Sláinte
Health Service Executive
Wicklow Local Health Office,
Glenside road

Ms. Michele Megan

Director of Public Health Nursing,

LHO Wicklow,

Glenside rd,

7/2/2014

Dear Michele,

As you are aware, I am currently undertaking a Postgraduate Diploma in Child Protection and Welfare at Trinity College Dublin. For partial fulfilment of this course, I am undertaking research on the

'Public Health Nurses experience on assessing the vulnerable child using the Child and Family Health Need Assessment framework'

I write to request your permission to undertake this study with eight public health nurses in LHO Wicklow. In consultation with my course tutor, it was decided to hold semi- structured interviews for the purpose of the study with eight Public Health Nurses. Pending your consent, I would like to commence the interviews in March. The research will be held by Trinity College Dublin. If you have any queries about the research, please do not hesitate to contact me. I would be grateful if you would look favourably upon my request.

Yours sincerely

Kathy Walsh

_____

Public Health Nurse

Appendix E Guide Questions for Semi-structured Interviews

1. How would you view the role of the PHN when working with vulnerable children and families?
2. In your experience how do you identify vulnerable children and families?
3. What is your experience of using the Child and family assessment tool?
4. Do you find it a benefit using the tool?

   Prompt How did using the tool help in identifying children?
5. When using the tool were there any limitations to the tool?

   Prompt Was there anything in the tool not included?
6. Can you describe the circumstances in which you completed a CFHNA?

   Prompt What was the reason you completed the assessment
7. What do you feel are the challenges for PHNs in identifying and working with vulnerable families?